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Caring through Relation and Dialogue: A Nursing Perspective for Patient Education

Sanford, Rhea C. RN, MSN, CS

Author Information

Doctoral Candidate; School of Nursing; University of Connecticut; Storrs, Connecticut

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Abstract

Nursing's recognition of the importance of patient education is evident in nursing's history and in the work of early nurse theorists. However, to date, there has been no clear articulation of a nursing framework specific to this essential aspect of clinical care. A nursing perspective for patient education based on a conceptualization of caring is presented. This perspective includes explication of philosophic views for nursing and patient education. A middle-range theory for patient education is generated from this philosophic premise.

Nursing's professional role in patient education needs clarity and focus. From a historical perspective there is strong evidence that prominent nursing leaders viewed the education of patients and families as core to nursing care. Florence Nightingale defined nursing as the care that places "the patient in the best condition for nature to act upon him." 1(p133) Helping patients and families gain understanding in practices that supported those conditions was considered integral to the clinical practice of nursing. WIn fact, Nightingale viewed health teaching as within nursing's domain. 1

At the turn of the century, Lillian Wald and the public health nurses of the Henry Street Settlement in New York City worked with patients and families in their homes and neighborhoods to educate them about the spread of disease, how to improve sanitation, and how to treat symptoms of illness. 2 Their nurse colleagues in Canada and England performed similar work to achieve the same outcome-a more knowledgeable community. 2

Early nurse theorists acknowledged the role of the nurse as patient educator and the patient's need for knowledge about health and illness as central components in their theories. 3,4 In her theory of interpersonal relations in nursing, Hildegard Peplau identified a number of roles nurses assume with patients. Among them she described the role of resource person who provides health information and the teacher who facilitates instructional and experiential

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learning with patients. 5

Nursing guidelines for patient education extend beyond theoretical frameworks. Both the American Nurses Association (ANA) 6 and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) 7 define performance of patient education as an element of professional practice. Both organizations identify a number of standards of clinical practice intended to meet the needs of patients to gain knowledge and skills about disease, symptom detection and management, and behaviors that can improve general health. 6,7

Clearly patient education holds historical significance within the profession, is important to nurse theorists, and is incorporated into professional standards for practice. Such prominence within the profession suggests that nursing should be able to articulate philosophic and theoretical perspectives for this critical aspect of nursing care. Yet, no such articulation exists in the nursing literature. Instead, the literature cites the absence of formal education content specific to patient education in nursing preparation programs 8 and the presence of erroneous assumptions that become the basis for practice. 9

The purpose of this article is to present a nursing perspective for patient education based on a conceptualization of caring. This perspective includes a philosophy for patient education and a middle-range theory drawn from the proposed philosophic assumptions.

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PHILOSOPHIC PERSPECTIVES

Nursing's views and assumptions regarding patient education occur within the context of broader perspectives of nursing. Full attention to these broader perspectives is essential in the identification of the values that guide this area of practice, the phenomena of interest important to theory development and research, and the issues that prompt scholarly discussion and debate. 10 The work of theory development is better served if the philosophic tenets on which the theory is based are explicitly described.

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Philosophy of nursing

The philosophy of nursing proposed here is strongly grounded in Virginia Henderson's definition of nursing:

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would otherwise perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. 3(p21)

Henderson's definition defines and explains nursing's professional relationship with a person experiencing illness, recovering health, or relinquishing life. Her definition speaks to the importance of empowering the receiver of a nurse's care. Empowerment is achieved through mutual sharing of knowledge, strength, and personal and collective will. As a nurse, I do not "take care of" but am in a partnership to "care with." To be effective as a partner in care, I must have an understanding of my own space and time, as well as the time and space of my partner. This definition implicitly opens doorways to views of ontology and epistemology, views that espouse Watson's 11 description of nursing as a human science and Carper's 12 delineation of patterns of knowing in nursing.

Nursing as a human science embraces the view that all persons need to be viewed holistically. Holism welcomes the interconnectedness that we, as humans, have with our physical and social environment. 11 Personal, social, and cultural meanings are acknowledged and accepted as sources of insight for seeing each of us as unique, as well as recognizing the areas of common human ground. The meanings we construct from life experiences are as important as any physical evidence etched by those experiences. Constructed meanings manifest themselves in our subjective understanding and in actions that we take culminating from such understanding. 13

Personal action and issues of freedom of choice are bound by the environmental and social conditions of particular situations. Noddings' description of the individual as "a partially constituted subject-one who is shaped in large part by her situation in time and place but also in part by her own decisions and actions" 14(p163) provides a balanced resolution to the dichotomy of free will and determinism.

With this holistic perspective in mind, nurses and patients collaborate to discern what the issues of health and illness are, what meaning these issues have for both the nurse and the patient, and what decisions or actions are possible and preferred. As co-participants, nurses and patients engage in dialogue-a dialogue that evolves from mutual respect for the meaning each brings to the particular discussion at hand. Inherent beliefs and implicit assumptions are made known through a process that is reflective and dialectic.

Nursing as a human science fits well with the development of knowledge that is ethical, personal, aesthetic, and empirical. 12 As a human "science," the importance of empirical knowing in nursing is not inconsistent with an ontologic view of holism. Good, holistic nursing care is based on solid understanding of all the sciences that help define human existence. The explicit nature of empirical knowing allows for public exploration and verifiability. It is demonstrated in observable findings, and the ultimate goal is the development of theoretical formulations that describe and explain phenomena of importance to human existence. 12

The future of nursing epistemology lies in closer and more formal exploration of all patterns of knowing-knowing as it pertains to nursing and to the patients with whom we engage in care. Explorations of ethical, personal, and aesthetic knowing carry special considerations.

Ethical knowledge-and how that knowledge is learned and applied to nursing practice-presents unique concerns. Noddings 14 makes an important distinction about ethical knowledge and its relationship to caring, a concept used widely in nursing philosophy, theory, and research. She distinguishes between natural caring and ethical caring. *Natural caring* is "a spontaneous response … the motive to care arises on its own; it does not need to be summoned." 14(p187)

Ethical caring is caring that does need to be summoned in response to a conflict initiated by the thought of "I ought" versus "I want." Noddings recognizes the inner voices we may hear as we encounter situations where care is needed, but "our inner voice grumbles 'I ought, but I don't want to,' or … 'This guy deserves to suffer, so why should I help?'" 14(p187)

Nurses often are confronted by the dilemmas and consequent turmoil of ethical caring. Resolution of this turmoil is not achieved by relying on rules or principles. Resolution comes from "ethical discussions … made in caring interactions with those affected by the discussion." 14(p187) The nurse as carer and the patient as cared-for define the conflicts and the resolutions of ethical caring. Of critical importance is the need for mutual intimacy: "Carers must rub elbows

with the recipients of their care." 14(p187)

Personal knowing evolves from critical evaluation of the questions "Do I know what I do? Do I do what I know?" 15(p168) The practice of nursing is embedded in personal, often intimate, interaction. Awareness of how one presents oneself in that interaction, and how we avail ourselves to the experience of another, is the focus of personal knowing. This aspect of knowing links the knower to what is known or not known-a link that may be difficult for the knower to articulate.

Aesthetic knowing is expressed in practice as "transformative art-acts, in which the nurse moves experience from what is to a new realm that would not otherwise be possible." 15(p184) It is a person's lived experience of health and illness that is the focus of nursing's art-act; an experience shared by the nurse and understood in both its unique individuality and in its universal humanness. Exemplars of aesthetic knowing can be seen in the practice of the expert nurse, practice that is exquisitely depicted by Benner 16 and Benner and Wrubel. 17

This philosophy of nursing is formulated on the acceptance of multiple realities, patterns of knowing that are explicitly and implicitly developed and revealed, and human actions that are considered and executed within contexts that are both individually and collectively constructed. It is formulated on the essence of natural and ethical caring, 14 a formulation that accurately and honestly depicts the dilemmas of caring in nursing. It also is consistent with concepts valued by our discipline. Reed summarizes these as "self-reflection, personal autonomy, innate developmental potential, connections between truth and life, emancipatory practice and research, and chaos as opportunity." 18(p82) These values and inherent beliefs support the orientation presented by Reed as one that distinguishes nursing from other disciplines.

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Philosophy of patient education

Within the context of the philosophy of nursing described above, how do we as nurses engage with patients in the activities of teaching and learning? Elaboration is necessary-the roles of nurse as teacher and patient as student pose challenges to the depiction of nurse-patient relationships defined here as collaborative and bound by caring and mutual respect. By Henderson's definition, nurses need to share and impart knowledge to patients; knowledge is a factor that empowers all parties to engage as equals in discussions and decisions about health and health care choices. 3

How should we view the patient and ourselves in this important area of clinical care? The work of two philosophers of education is especially germane to this area of discussion: Nel Noddings' work describing the method or manner of education 14 and Paulo Freire's perspective on the matter and manner of education in the teacher-student relationship. 19

Noddings 14 recommends an approach to education that has the ethic of caring as its thematic center; caring is differentiated, as described above, as natural caring and ethical caring. Noddings' approach has relevance for the nurse-patient relationship as nurse-teacher and patient-student. Her approach has four components: modeling, dialogue, practice, and confirmation.

Modeling is the responsibility of the teacher. If we are "concerned with the growth of our students as carers and cared-fors, we have to show in our behavior what it means to care." 14(p190) Students are not given instruction to care, or assignments or tests on caring. Caring is demonstrated to them in their relations with their teachers.

Dialogue among teachers and students is critical to learning the roles of carer and cared-for. It fosters discussion about meanings of caring and encourages personal reflection about expressions of caring that might be confusing for learners as they enter into the roles of carer and cared-for. It requires receptivity-a willingness to "receive the other in an open and genuine way." 14(p191) Noddings further describes this openness as "engrossment … a nonselective form of attention that allows the other to establish a frame of reference and invites us to enter it. As dialogue unfolds, we participate in a mutual construction of the frame of reference [that] … involves total receptivity, reflection, invitation, assessment, revision, and further exploration." 14(p191)

Practice is required to learn the processes of receptivity and engrossment that are described by Noddings as critical aspects of effective dialogue. 14 Practice is accomplished through experiencing relationships as both carer and cared-for. Over time, the student has the opportunity to develop an appreciation for the presence and effects of caring. Both the teacher and the student view the world with a caring outlook.

Confirmation is the last component of Noddings' approach for moral education. Noddings credits the work of Martin Buber as the source for her definition and use of confirmation. 14 *Confirmation* is the "act of affirming and encouraging the best in others." 14(p192) Noddings contends that confirmation requires the presence of elements of truth, continuity, and trust in the relationship. These elements require time to develop, especially in relationships such as teacher-student, parent-child, physician- and/or nurse-patient, where there also is an element of unequal power. 20

Noddings' approach affords all students, including future nurses, the opportunity to learn roles of carer and cared-for within the context of real relationships with teachers and fellow students. The perspective gained by such an education would provide a referential background for nurses who struggle with the dilemmas of ethical caring described by Noddings 14-dilemmas that occur in the intimacy of the nurse-person, patient-person relationship. The ethic of care would then be extended to this important relationship of care.

In his *Pedagogy of the Oppressed*, Paulo Freire renders a careful analysis of the teacher-student relationship. 19 His analysis provides an exemplar of that relationship that is especially useful for nurses who play a role as nurse-teacher with patient-students.

The oppressed in Freire's text are the rural peasants and urban poor of Brazil. Their oppression is economic, social, and political. The pedagogy he describes is a pedagogy for liberation, not just liberation of the oppressed, but liberation of their oppressors. The focus here is on Freire's view of education and the use of education as a method of awakening social consciousness in the oppressed. Of particular significance are Freire's views of the dichotomy embedded in the teacher-student roles, the development of educational content, and the presentation of content in a setting designed for education that empowers and liberates.

In Freire's view, the traditional roles of teacher and student present a narrative duality. The relationship consists of a narrating teacher and a patient, receptive, listening object-the student. In this scenario, the learner is a passive receiver of facts and data, and education is reduced to "an act of depositing, in which the students are the depositories and the teacher is the depositor…. This is the 'banking' concept of education, in which the scope of action allowed to the students extends only as far as receiving, filing and storing deposits." 19(p53)

Freire decried the banking concept for education and advocated that a

solution be achieved wherein the relationship between teacher and student is no longer polar, but where "both are simultaneously teachers and students." 19(p53) A key ingredient to this change in relationship is dialogue.

"Through dialogue, the teacher-of-the-student and student-of-the-teacher cease to exist and a new term emerges-teacher-student with students-teachers. The teacher is no longer merely the one-who-teaches, but one who is taught in dialogue with the students, who in turn while being taught also teach. They become jointly responsible for a process in which all grow." 19(p61) Thus dialogue is a powerful tool in Freire's conceptualization of education, and it has important implications for how educational content is to be developed and delivered.

Development of educational content again focuses attention on teacher-student roles. Freire appropriately warns that educational plans are doomed to fail if the developers perceive their view as omniscient and ignore the views of the very people for whom the program is directed. Students-teachers need to be viewed as equal knowers in the experience of determining what is to be learned. "The program content of education is neither a gift nor an imposition-bits of information to be deposited in the students-but rather the organized, systemized, and developed 're-presentation' to individuals of the things about which they want to know more." 19(p74)

The delivery of educational material pays careful attention to the method of presentation. The choice of materials, and the response elicited by the materials, is of primary significance to the success of any educational program. Freire's recommended method is one of re-presentation of themes relevant to the life of the participant learner. Freire describes these re-presentations as codifications or images that depict conflicts or contradictions in the learners' lives. 19 The codification may be a reading or, for learners who are illiterate, a photograph or painting that represents conflict. This method of re-presentation facilitates the recognition of the contradictions and assists the learners' transition to posing problems and then dialoguing about suitable or desired solutions. "In problem-posing education, people develop their power to perceive critically *the way they exist* in the world *with which* and *in which* they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation." 19(p64)

Freire presents dialogue as more than an exchange of words. "If it is speaking their word that people, by naming the world, transform it, dialogue imposes itself as the way by which they achieve significance as human beings. Dialogue is thus an existential necessity." 19(p69) Teacher-students facilitate the dialogue of the students-teachers; they pose problems that help move the students-teachers to further dialogue. The outcome of this educational method and process is critical reflection on the part of all participants on the students-teachers' reality and identification of action(s) that the students-teachers are now empowered to name.

Like Noddings, 14 Freire 19 speaks of the need for trust in the relationship described as teacher-student and students-teachers. He also recognizes that trust is not a given in this relationship, but is nurtured through dialogue. What must be present a priori for dialogue to occur, is faith-faith that trust in the relationship is possible.

In summary, the process of patient education occurs within a holistic view of both nurse-student and patient-teacher. The interconnectedness of human lives is not just recognized, but nurtured through acts of personal engagement that embrace multiple perceptions of truth and reality. Dialogue is the method of choice to facilitate the construction of meaning and the identification of what is known and what needs to be discovered. The powerful link between knower and known is accepted as a fortuitous key to unlocking individual and shared understanding. This link establishes ties of epistemology to ontology.

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Philosophic assumptions

The following assumptions are derived from the philosophy of nursing and patient education delineated above. They serve as the premise for the middle-range theory presented here:

* Nursing epistemology is developed and explored through patterns of empirical, ethical, personal, and aesthetic knowing. 12 Knower and known are inseparable.

* Reality is individually and interpersonally constructed. Multiple perspectives and meanings for life experience, and for defining what matters, are produced.

* Natural and ethical caring define a unique context for interpersonal relationships in nursing. 14 Ethical caring is learned.

* The intimacy of the relationship between the nurse as (carer) and the patient as (cared-for) represents the uniqueness of caring in nursing. No other health provider as carer "rubs elbows with the recipients of their care" 14(p188) or, by definition, "gets inside [the person's] skin" 3(p34) the way nurses do.

* Dialogue between nurse-student and patient-teacher creates learning opportunities that foster decisions and actions that empower patients.

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GENERATION OF A MIDDLE-RANGE THEORY FOR PATIENT EDUCATION: CARING THROUGH RELATION AND DIALOGUE

Many of the nursing theories citing the significance of nurses as teachers (ie, theories by Henderson, Orem, and Peplau) are at the level of grand theories. 21 Grand theories broadly identify phenomena of concern to the discipline, but do not provide the practitioner with the focused scope of theories developed at the middle range. 22 Middle-range theories provide the link between the questions that emerge in everyday practice and "the all-inclusive systematic efforts to develop a unified theory" for a discipline. 23(p39)

A middle-range theory addressing the phenomenon of patient education through caring can add clarity and direction to this area of concern for nursing, and it can provide an opportunity to link theory, practice, and research. 24 To date, the concepts of caring and patient education have each, individually, guided practice decisions and research endeavors. The mutual benefit to nurses and patients of integrating these two concepts has not yet been explored.

After analysis of the current status of middle-range theory development in nursing, Liehr and Smith 25 presented five recommendations to creators of middle-range theory. Their recommendations support the generation of theory that will meet the needs of nursing in the new millennium. In the text that follows, the theory is presented within the context of these recommendations.

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Recommendation 1: Clearly articulate the approaches used to generate the theory and the theory name

Liehr and Smith 25 identify five approaches to theory generation best suited to the needs of nursing as we enter the 21st century. These approaches are: (1) induction through practice and research; (2) deduction from application of grand theories to practice and research; (3) joining of existing middle-range theories from nursing and other disciplines; (4) derivation from non-nursing theories that have relevance for nursing's disciplinary viewpoint; and (5) derivation from practice standards and guidelines that are rooted in research.

This theory is generated from the philosophical and theoretical perspectives of two disciplines: nursing and education. The philosophic perspective presented here represents views that are consistent with the current and evolving perspective of nursing. [18] The significance of professional practice guidelines [6] and regulatory standards [7] also contributes to theory development. These standards specify the importance of patient education to clinical practice, [6] and list specific outcomes to be achieved for patients through patient education activities. [7] However, these standards do not provide the practitioner with a description of the concepts important to engaging in patient education, or a framework in which to link practice and research.

The name chosen, Caring through Relation and Dialogue: A Middle-Range Theory for Patient Education, can be explored more fully through the exposition of its essential concepts.

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Caring

Two congruent definitions of caring provide the foundation for this theory. Benner and Wrubel [17] define caring as always occurring in context; a context of time, place, and situation in which caring determines what matters to people. Caring identifies the connections people perceive as important, and it defines the boundaries or possibilities of risk and vulnerability inherent in those connections. Noddings states that the "essential elements of caring are located in the relation between the one-caring [carer] and the cared-for." [26(p9)] In this definition as well, caring requires a specific context-a relationship defined by the one-caring and the cared-for, where constitutive engrossment and motivational displacement are essential elements.

Engrossment. The one-caring experiences a "feeling with" the cared-for. "Feeling with" is not an objective attempt of understanding what it is like to be in someone else's shoes by analyzing the situation as data. Rather, "feeling with" as engrossment is setting aside the temptation to objectify, analyze, and diagnose "a situation" involving another; engrossment requires a full receptivity to seeing what the other sees and feeling what the other feels. [26]

Motivational displacement. Engrossment is more than just an emotional connection; it necessitates a motivational shift. The energy of the one-caring is directed toward the cared-for. Motive energy of the one-caring is shared with the cared-for. In fact, it is "put at the service of the other." [26(p33)]

Natural and ethical caring. Natural caring is a spontaneous response, "the motive to care arises on its own; it does not have to be summoned." [14(p187)] In contrast, ethical caring does have to be summoned. The "I ought" arises but encounters conflict. "On these occasions we need not turn to a principle; more effectively, we turn to our memories of caring and being cared for and a picture or ideal of ourselves as carers." [14(p187)]

Caring relation. "Caring involves two parties: the one-caring [carer] and the cared-for. It is complete when it is fulfilled in both." [26(p68)] Critical to understanding this relation, is understanding that fulfillment may be experienced differently by the two parties. "Apprehending the other's reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one-caring." [26(p16)] The relational complement is that "caring is completed in all relationships through the apprehension of caring by the cared-for." [26(p65)] If the one-caring does not convey this apprehension to the cared-for, the one cared-for may feel like an object of care; just another part of the one-caring's workload.

In formal roles, like nursing, the professional expectation to provide care creates an unequal meeting of one-caring (nurse) and cared-for (patient). While recognition of caring by the cared-for (patient) is a necessary element of the caring relation, the cared-for need not equally reciprocate as carer in the relationship. 26 In a relation formed by nurse-patient such a requirement would place the burdens of care (worry and weight of obligatory care) on the cared-for at a time when he or she may be unable to relate as a carer.

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Dialogue

Dialogue is defined as a process of naming our world. It is a process that opens the possibility for participants to pose problems, to critically reflect, and to perceive solutions not previously realized. 19 This process occurs within a caring relation where the carer and the cared-for exhibit receptivity and engage in "reflection, invitation, assessment, revision, and further exploration." 14(p191)

To engage in dialogue as defined here, the nurse as carer must relate as nurse-student with the patient-teacher (cared-for). Retention of a traditional nurse-teacher approach precludes the kind of dialogue necessary for problem-posing discussions of reality and possibility, and the development of mutual trust necessary to effect such discussions. Traditional roles lend themselves to Freire's depiction of the banking concept of education where patients play a passive role of receiving information, without recognition of individual patient meanings for health, illness, or disease. 19

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Experience of patient education

The experience of patient education evolves as the integration of the key concepts defined above. It is a process that takes place through dialogue between a person-nurse-student and a person-patient-teacher within the context of a caring relation. The nurse-student as carer and the patient-teacher as cared-for enter the caring relation with receptivity to the apprehension of caring in each other and openness to engage in identifying the names and meanings for health, illness, and disease. Problems are posed as opportunities to evaluate current realities and contemplate future possibilities in an atmosphere of mutual trust.

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Recommendation 2: Clarify the conceptual linkages of the theory in a diagrammed model


Fig 1

Watson 11 visually portrays theoretical frameworks as being positioned along two continua: static-dynamic and concrete-abstract. The middle-range theory described here falls at the dynamic end of the static-dynamic continuum, close to the mid-point of the concrete-abstract continuum (Fig 1). Caring as a contextual phenomenon requires a concretization of the experience. Caring defines within a context of time, place, and situation what matters. 17 It occurs between people who exist in relation in roles that also are defined-carer and cared-for. 26 These experiential phenomena place the theory closer to the center of the concrete-abstract continuum. Evidence of the relation and the process of patient education are, however, interpreted uniquely by the individuals in the relation. The process and the caring relation are always evolving. This places the theory at the dynamic end of the static-dynamic continuum.

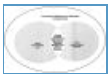
Fig 2

Concepts within a theory, by virtue of their interrelationships, exist in a certain form. Fig 2 depicts the proposed theory as it would exist if all elements of the theory were operationalized, as defined, in clinical practice. Critical elements of a caring context, the caring relation between the nurse-student and patient-teacher, and dialogue that involves receptivity, engrossment, and mutual trust are

present. As depicted here, discussion of aspects of health, illness, and disease can occur through this dialogue-a dialogue that leads to identification and recognition of meanings, posing of problems, and exploration of possibilities.


Fig 3

If this form is broken (ie, if the concepts are not operationalized as defined), the configuration may look more like the form in Fig 3. A caring relation does not evolve in this depiction. The nurse-teacher does not relate as carer to the patient-student as cared-for. This contrasting figure shows what can occur if patients are objectified and seen as "cases" in a nurse's workload, and if the process of education is carried out as "depositing" information into patients.

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Recommendation 3: Articulate the research-practice links of the theory

Most theoretical frameworks for research in patient education have been frameworks developed to assess the constructs of motivation and learning. 27 These constructs have their origin outside the domain of nursing and do not attend in full to the needs of persons who may be encountering experiences of illness, disease, and death. Linking patient education with a human science perspective of nursing, and within a conceptual environment of caring, connects practice to different questions of research than may be asked if motivation and learning are the driving constructs. Patient education as co-participation of nurse-student and patient-teacher connects best with research where person-patients are co-researchers. Ties to constructivism are evident.

Constructivist inquiry accesses knowledge through sustained interaction and purposeful interpretation between/among the researchers(s) and participant(s). 28 Research methods using dialogue, interview, narrative, participant observation, and case study provide data that add to pluralist and relativist views of reality and knowledge that reflect deeper meaning through in-depth, more sophisticated understandings of human experience. 29 Research questions and methods that are consistent with the constructivist paradigm blend well with the middle-range theory proposed here.

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Recommendation 4: Create an association between the proposed theory and a disciplinary perspective in nursing

This theory is explicitly drawn from philosophical perspectives and assumptions reflective of the evolving discipline of nursing. It is consistent with Reed's depiction of concepts that are not only valued by our profession, but also represent values and inherent beliefs that distinguish nursing from other disciplines. 18

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Recommendation 5: Place middle-range theory at the front lines of nursing practice and research

Situating middle-range theory at the forefront for practice and research is critical to epistemologic and ontologic growth in nursing. The theory proposed herein is strongly embedded in the practice relationship between nurse-student-carer and patient-teacher-cared-for. It fits well at the front lines of clinical practice. Further, focus on the experience of patient education provides guidance for an essential nursing activity that has historically and consistently been valued by our profession, but has not benefited from the enunciation of a theoretical framework for nursing. The theory described here provides the linkage needed among concepts inherent in and integral to effective patient education.

Patient education is an activity that crosses patient populations and permits use of the proposed theory in any clinical setting. Research opportunities abound. Philosophic ties with a constructivist paradigm open up multiple modes of inquiry

consistent with the nurse-researcher and patient-participant conducting research as co-investigators.

Application of this theory to practice poses challenges to how we educate nurses. Nurses practice patient education in a manner and from a perspective consistent with their own nursing education. 30 Patient education content needs to be more formally integrated into the curriculum of nursing preparation programs. Approaches to education described by Noddings 14,26 need to be considered as means to teach future nurses how to resolve the dilemmas of natural and ethical caring triggered by patient interactions in clinical practice and to assist them in learning the art of dialogue.

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CONCLUSION

Nursing's commitment to patient education is as old as its formal history. This commitment is woven into theoretical frameworks developed by early nurse theorists and into practice guidelines that define current standards of practice. The theory described here moves nursing's professional commitment to patient education from the realm of implicit expectations and assumptions to an explicitly described philosophic point of view that is grounded in the caring relation between a person-nurse-carer and a person-patient-cared-for. The intent of this theory is to place the practice of patient education in a position where meaningful links can be made between experiences of everyday practice and experiences of clinical research and scholarly inquiry. The relevance of this theory to a broad range of patient populations affords exciting opportunities for study of this critical aspect of nursing care.

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REFERENCES

1. Nightingale F. *Notes on Nursing: What It Is and What It Is Not*. New York: Dover Publications; 1969. [Context Link]

2. Dolan JA, Fitzpatrick MI, Herrmann EK. *Nursing in Society: A Historical Perspective*. 15th ed. Philadelphia: W.B. Saunders; 1983. [Context Link]

3. Henderson V. *The Nature of Nursing: A Definition and Its Implications for Practice, Research, and Education, Reflections after 25 Years*. New York: National League for Nursing; 1991. [Context Link]

4. Orem DE. *Nursing Concepts of Practice*. 5th ed. St. Louis: Mosby; 1995. [Context Link]

5. Brophy GH, Carey ET, Noll J, Rasmussen L, Seracy B, Stark NL. Hildegard E. Peplau: psychodynamic nursing. In: Mariner-Toomey A, ed. *Nursing Theorists and Their Work*. 3rd ed. St. Louis: Mosby; 1994. [Context Link]

6. American Nurses Association. *Nursing's Social Policy Statement*. Washington, DC: American Nurses Publishing; 1995. [Context Link]

7. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Oakbrook Terrace, IL: Joint Commission; 1996. [Context Link]

8. Redman BK. Patient education at 25 years: where we have been and where we are going. *J Adv Nurs*. 1993;18:725-730. **Full Text** | **Bibliographic Links** | [Context Link]

9. Redman BK. *Issues and Concepts in Patient Education*. New York: Appleton-Century-Crofts; 1981. [Context Link]

10. Salsberry PJ. A philosophy of nursing: what is it? What is it not? In: Kikucki JF, Simmons H, eds. *Developing a Philosophy of Nursing*. Thousand Oaks, CA: Sage Publications; 1994. [Context Link]

11. Watson J. *Nursing: Human Science and Human Care, A Theory of Nursing*. New York: National League for Nursing; 1988. [Context Link]

12. Carper BA. Fundamental patterns of knowing in nursing. *ANS*. 1978;1:13-23. **Ovid Full Text** | **Request Permissions** | **Bibliographic Links** | [Context Link]

13. Walsh G. Introduction to *Phenomenology of the Social World*. In: Schutz A, ed. *Phenomenology of the Social World*. Evanston, IL: Northwestern University Press; 1967. [Context Link]

14. Noddings N. *Philosophy of Education*. Boulder, CO: Westview Press, Inc; 1995. [Context Link]

15. Chinn P, Kramer MK. *Theory and Nursing: Integrated Knowledge Development*. 5th ed. St. Louis: Mosby; 1999. [Context Link]

16. Benner P. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, CA: Addison-Wesley Publishing Co; 1984. [Context Link]

17. Benner P, Wrubel J. *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park, CA: Addison-Wesley Publishing Co; 1989. [Context Link]

18. Reed PG. A treatise on nursing knowledge development for the 21st century: beyond postmodernism. *ANS*. 1995;17:70-84. **Ovid Full Text** | **Request Permissions** | **Bibliographic Links** | [Context Link]

19. Freire P. *Pedagogy of the Oppressed*. New York: Continuum; 1997. [Context Link]

20. Noddings N. The care professional. In: Gordon S, Benner P, Noddings N, eds. *Caregiving: Readings in Knowledge, Practice, Ethics and Politics*. Philadelphia: University of Pennsylvania Press; 1996. [Context Link]

21. Walker LO, Avant KC. *Strategies for Theory Construction in Nursing*. 3rd ed. Norwalk, CT: Appleton & Lange; 1995. [Context Link]

22. Jacox AK. Theory construction in nursing: an overview. *Nurs Res*. 1974;23:4-13. **Ovid Full Text** | **Request Permissions** | **Full Text** | **Bibliographic Links** | [Context Link]

23. Merton RK. On sociological theories of the middle range. In: Merton RK, ed.

Social Theory and Social Structure. New York: The Free Press; 1968. [Context Link]

24. Chinn PL, Kramer MK. *Theory and Nursing: A Systematic Approach*. 4th ed. St. Louis: Mosby; 1995. [Context Link]

25. Liehr P, Smith MJ. Middle range theory: spinning research and practice to create knowledge for the new millennium. *ANS*. 1999;21:81-91. **Ovid Full Text** | **Request Permissions** | **Full Text** | **Bibliographic Links** | [Context Link]

26. Noddings N. *Caring, A Feminine Approach to Ethics and Moral Education*. Berkeley, CA: University of California Press; 1984. [Context Link]

27. Redman BK. *The Practice of Patient Education*. 8th ed. St. Louis: Mosby; 1997. [Context Link]

28. Denzin NK, Lincoln YS. Entering the field of qualitative research. In: Denzin NK, Lincoln YS, eds. *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications; 1994. [Context Link]

29. Smith SE. Deepening participatory action-research. In: Smith SE, Willms DG, Johnson NA, eds. *Nurtured by Knowledge: Learning To Do Participatory Action-Research*. New York: The Apex Press; 1997. [Context Link]

30. Rankin SH, Stallings KD. Philosophical and power issues. In: Rankin SH, Stallings KD, eds. *Patient Education: Issues, Principles, Practices*. 2nd ed. Philadelphia: J.B. Lippincott Co; 1990. [Context Link]

Key words: caring; middle-range theory; patient education; philosophy; theory development

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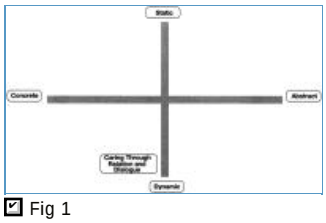

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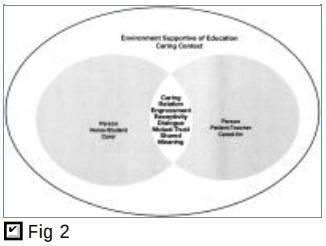

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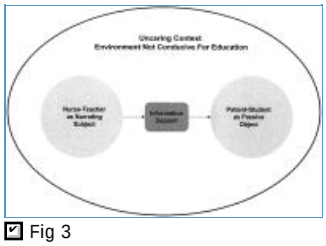

Fig 3

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