American Holistic Nurses Credentialing Corporation
American Holistic Nurses Association

AACN DRAFT Essentials Document 10.9.2020
Reflective Commentary

The *AACN DRAFT Essentials Document 10.9.2020* opens with an introductory discussion of nursing as a discipline in pages 1-7. Beginning with a key message "the Essentials serve to bridge the gap between education and practice" (p1), you cite in the work of noted nursing scholars who bring forth seminal points that illuminate a eudemonistic perspective of health (Smith,1981), consistent with holistic nursing paradigm. We recognize that pages 1-7 provide information regarding the *holistic paradigm* (add attachment, i.e. paradigm table), while the following pages shift and reflect the *wholistic paradigm*. While both are based in whole-person caring, the differences in practice implications are significant. These will be addressed in the following comments.

1. The second paragraph, page 1 states, *While the domains and broad competencies are identical for both entry and advance levels of education, the sub-competencies build from entry into professional nursing practice*. Assuming this sentence means ...*from entry into advanced professional nursing practice,* we pose the following;

a. The sub-competencies deal with core *and* specialty knowledge, yet the Essentials model shown on page 17 indicates that the specialty sub-competencies don't start until the second box, i.e. in advanced practice.
b. Core competencies and sub-competencies are derived by studying basic and behavioral sciences and liberal arts, and, as you say later, this explicit knowledge helps frame how students think about themselves in society and as professionals . This means that these competencies and sub-competencies affect the way students learn to think about their own beliefs and values. This tacit knowledge creates a philosophical base or a paradigm that provides a base for interpreting explicit information. Merged, it affects how students define whole-person, health, wellness, etc.; interpret information collected from patients/clients; apply it to the practice of professional caring-healing processes.

c. Interpretation of the model shown on page 17 is further complicated since it is not clear if *advanced nursing practice* starts at the baccalaureate level or the graduate level. While it might not be

intended, one can extrapolate from this model and assume that the current non-APRN master's level programs might be eliminated; nursing education would consist of two levels of Entry Level Professional Nursing: Basic and Advanced (i.e. with a specialty); and that the only recognized graduate programs would be either the four APRN-role programs and the doctoral level, with an emphasis on the DNP. If that is the intent, it should be spelled out, made clear to all.

d. If the intent is to reinforce the DNP as the primary track for doctoral education as stated in c above, that is somewhat short-sighted. We think that the DNP and the PhD programs both need to be clarified here with a discussion on how they differ, but need one another to advance the discipline of nursing. That is, the DNP is prepared to recognize problems in the practice arena and design practice models that will resolve them; the PhD nurse is prepared to design and carry out research programs that will provide the evidence needed for best practice.

2. On pages 1-2 it states that Core Competencies are formed by higher education, nursing education, the discipline, and a breadth of knowledge. They are equally informed by the lived experience of those deeply entrenched in various areas where nurses practice, *where the synthesis of knowledge and action intersect.* This is where one's paradigm lies…in the in-between, effecting the synthesis of ways of knowing. Yet, nothing is discussed in this work about that *knowing—i.e one's paradigm---* and how it affects relationships, interpretations of communication cues, etc. This issue is further alluded to on page 4 where you say, "…understanding of one's self and others…forms the basis for clinical reasoning and subsequent clinical judgements."

As an example, on page 3, the authors identify five concepts that Smith (2019) has found in the discipline of nursing: *human wholeness, health, healing, well-being, human-environment-health relationships, and caring,* each consistent with the holistic health and wellness paradigm. Yet, on page 13, common nursing actions are identified but the discussion doesn't tie these nursing actions back to the disciplinary concepts. Instead, the rest of the work builds on these actions, creating competencies and sub-competencies based in the biomedical model.

This confusion continues (p.2-3). The authors state, "Student must not only be introduced to the knowledge and values of the discipline, but they must be guided

to practice from a disciplinary perspective—by seeing patients through the "lens" of wholeness and interconnectedness with family and community…".

The key question here is what set of lens are they using? While wholeness is the concept, when we pick up a kaleidoscope, how we adjust the lens will determine the pattern we seem among the parts of the whole. Clarification of "which lens" is used is accomplished by articulating which paradigm and the effect it has on what is seen, how it is interpreted, etc. We believe that this confusion between the first few pages and the rest of the Essentials, understanding of prevention of disease means, etc., is because there was an unspoken switch in paradigm in pages 5-7.

3. Still on page 3, an interesting point related to theory states "While the work of early theorists was extensive, Green (2018) noted that none have been accepted as completely defining the nature of nursing as a discipline". An expanded discussion identifies this in the context of the complexities of the current healthcare environment. We posit that nursing theories guide practice, arise from nursing's metaparadigm – health, person, nurse, environment – and include the centrality of caring. Regardless of complexity of the situation, these concepts can and must be integrated into nursing care. Why is it necessary to have a singular theory? Certainly, other disciplines do not (e.g. psychology, education). Nurses well versed in nursing theory can build a practice, despite role, based in disciplinary knowledge framed by the requisite paradigm.

3. An extreme shift to a biomedical model begins on p. 6 where It states,

> "Nursing education for the 21st century must reflect a number of contemporary trends and values and address several issues to shape the future workforce, including workforce demographics and distributions; four spheres of care (including an enhanced focus on primary care); systems-based practice; informatics and technology; strong academic -practice partnerships, and career-long learning."

Given that a sphere is defined as, *an area of activity, interest, or expertise; a section of society or an aspect of life distinguished and unified by a particular characteristic*, it is clear that this work is not focused on the concept identified by Smith, 2019, but instead those who focus on a biomedical model. This position is further supported by the discussion on page 7 where the authors further define what they mean by four spheres of influence*…"it is becoming increasingly evident that the future of healthcare delivery will occur within four "spheres of care" 1) disease prevention/promotion of health and well-being, which includes the promotion of physical and mental health in all patients as well as management of minor acute*

and intermittent care needs of generally healthy patients; 2) chronic disease care, which includes management of chronic diseases and prevention of negative sequela; 3) regenerative or restorative care, which includes critical/trauma care, complex acute care, acute exacerbations of chronic conditions, and treatment of physiologically unstable patients that generally requires care in a mega-acute care institution; and, 4) hospice/palliative/supportive care which includes end-of-life care as well as palliative and supportive care for individuals in long term care or those with disabling conditions, complex chronic disease states, and those requiring rehabilitative care (AACN, 2019)".

> This reflects a focus on pathophysiological conditions, related problems, and potential complications disease – that term precedes health and seems to imply that nurses manage disease. While there is NO DOUBT that nurses are knowledgeable about disease processes, and skillful in implementing interventions as needed, the focus of nursing is on the health and wellbeing of the person. "*Health* is a eudemonistic perception of the individual's quality of life that includes an ability to find meaning in life and life-experiences (Smith, 1981), and a sense of well-becoming (Phillips, 2019). Individuals can be healthy even as they take their last breath (Erickson, 2020).
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> How, then, will these four spheres drive curricula? As written, it appears that it will manifest in a predominantly biomedical approach to care.

This position is further supported by the comment on page 9, …nurses seek to help individuals determine what information to use and how to use it. Given the discussion on the "spheres of care", we assume that the *information* offered to the patient would be related to disease-prevention, not promotion of eudemonistic health and well-being. As this section continues (p.9), it states, "…within that interaction the attitudes and behaviors of the nurse matter…nurses…create a culture that supports full engagement…". We agree, but the question is, engagement around what?? The *What* depends on the paradigm that the nurse uses to adjust her/his "lens" to understand the whole-person.

4. The Essentials, built within Domains, is based on Englander's 'interprofessional' work and adapted for nursing. In reviewing the interprofessional team, all authors are physician and other academicians associated with medical school. Furthermore, a review of the references consisted largely of medical professionals. The domains in the Essentials appear to be the same with the addition of Population Health. While "tailored to reflect the discipline of nursing" (p 12), the descriptors read very similarly

to Englander's work. Therefore, we suspect that the determinates of population health are there considered to be those identified in the literature that are based on a bio-medical model, rather than a holistic, health and wellness model that emphasizes the individuals perspectives of what they need, what will help them, and how nurses can help.

- The question, then is, Does biomedicine reflect nursing disciplinary knowledge? Or, to say it in another way, is nursing's discipline viewed through the lens of bio-medicine, or are there multiple ways to think about such concepts as whole-person, health, wellness, etc. (Smith, 1981)

- Domain 2: Because of what has been said above, we respectfully request that you replace the word "holistic" which refers to the specialty practice of Holistic Nursing and use whole-person or wholistic.

- Domains 9 and 10: There is no mention of the code of ethics, and reflective-practice should be added in Domain 10. There is a difference between reflective practice and self-reflection. The later refers to the nurse's reflection on self, explorations of our deeper-self, our life experiences that influences our values, beliefs, etc. This was discussed above in respect to Liberal Arts and life experiences as guides to know ourselves, beliefs and values. Reflective practice addresses relationships with others, how our interactions, values and beliefs affect others, how we want to continue, expand or exchange, etc.

5. Ethics is identified as a featured concept yet within the competencies it is not clear beyond general statements e.g. Demonstrate ethical decision-making" "Employ ethical decision making to assess, intervene, and evaluate nursing care" In the discussion of the concept, we find no discussion of ethical approaches nor reference to *The code of ethics for nurses with interpretive statements* (ANA, 2015). Perhaps this is the case because these pages are written based on a wholistic, bio-medical model of care while the code of ethics more fully reflects a holistic, eudemonistic health and wellness model of care.

6. Evidenced-based Practice (EBP) is identified as a featured concept yet there is no discussion of evidence-informed practice (EIP), leaving a huge void in the discussion. To be sure, evidence is essential in the provision of safe, quality care – it must, however, include patients values/desires and practitioner expertise. EBP has its roots in medicine and while some contemporary models do incorporate patient preference and practitioner knowledge, EIP offers the whole in more expansive approach. One

might even consider how Levels of Evidence (LOE) which posits the Meta-Analysis and RCT as strongest evidence. Presents a false reality when one is searching for evidence related to the human experience of suffering – which could perhaps be found in the qualitative literature.

The bottom-line to this issue is that the type of evidence and priority given to the three types of evidence is based on choice of paradigm. Holistic nurses focus on the *patient's perceptions* of needs as primary, the nurses understanding of how to merge those perceptions with the sciences, and of course, problems posed by other healthcare professionals , including medical. Nurses who practice from a biomedical position might approach practice based in evidence in the reverse order, often ignoring or shrugging off the significance of the patient's perceptions. Instead, they talk about the patient's preferences, which is translated to mean *preferences in how to treat the medical problem* or the signs and symptoms of the medical problem. Little consideration is given to the individual's perception of the root of the problem.

7. The Model of Nursing Education (page 16) is unsettling and appears to dismiss ~~certain~~ many graduate prepared nurses. Consider the Advanced Practice Nurse – NOT the APRN nurse of the consensus model, educated in a bio-medical paradigm, but the graduate prepared nurse who chooses to apply advanced nursing knowledge as an educator or in ambulatory settings, etc. What happens to them in a world of bio-medical APRNS? And what of the DNP? While this was discussed in #1 above, these issues are so important they deserve further discussion.

At the meeting on November 23rd, the question of h associations was posed and not clearly answered except to say that these "sub specialties" included people who were already nurses. Perhaps the most unsettling piece of this is the term subspecialty…what does that mean? If you are not one of the four roles in the Consensus Model you are less than? Or what? Or, if a specialty such as Holistic Nursing starts at the entry level and follows through to a DNP or PhD, what then?

It also appears that while much care is being provided in the community, the competencies lean toward more acute and episodic care. At the same time, nursing is transitioning into the community. As discussed during the meeting with the Specialty groups on November 23, many nurses use language such as, client, assets (rather than problems), needs, resources, and other words that reflect the holistic orientation to the individual, rather than words such as problem which comes from the bio-medical model. Because we think nursing is in transition, we believe that this document can be edited slightly, add a couple of paragraphs, and a word here or there

and it would be ok to move forward. With that in mind, we offer a table that identifies minimal changes for your consideration.

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