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Holistic Nursing: Preface

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Preface

Noreen Frisch, PhD, RN, FAAN, APHN
Guest Editor

Evidence is all the rage in nursing these days, and the evidence-based practice (EBP) movement seems well-nigh unstoppable. Anyway, who would want to stop progress toward clinical care based on proven best practices? Many years ago, the nurse-scientist Dr. Norma Matheny reminded us how difficult it is to get any intervention/activity out of nursing practice once nurses are used to performing the activity. Nurses seem to be trapped in “we’ve always done it this way” kind of thinking, even when new knowledge shows a practice to be obsolete (or, worse, dangerous). Then, there is the equally daunting challenge of getting new ideas or procedures into clinical practice. This is often so slow that Rogers [1] wrote an entire book about how innovations “diffuse” into practice.

Even EBP itself diffuses slowly. Few practicing registered nurses (RNs) coming into my classes have a good understanding of evidence. That is unfortunate, because better understanding of the EBP movement would help us to use data wisely. I wonder, however, whether slow EBP diffusion is anywhere near as big a problem as is the troublingly limited understanding of some EBP “early adopters.” Last spring, when discussing Watson’s view of the essence of nursing as human caring, a student remarked that because she practiced on the basis of evidence only, she had no need to consider human connections—just the evidence and just the outcomes (measurable, of course), no more and no less. Well, she certainly had gotten some of the point of EBP, but had she missed the core of EBP, and of nursing itself?

So, I wondered: What have we done? As a holistic nurse, much of my reflection on practice has been guided by the philosophies and theories that

permit us to view each person wholly and individually. Use of evidence requires sophistication in our discipline that we may not be imparting to our students—sophistication that we also may not be demanding of each other in our roles as research producers and research translators. Proper use of evidence requires an understanding of research methods, research designs, probability and statistics, ways of knowing, and levels of error. It also requires a solid understanding of the practical limits of evidence as we currently gather and interpret it. Applying evidence in practice is not a trivial process and has no “cookbook” schematic. As holistic nurses, we serve as teachers, guides, advocates, and supports to people who are dealing with significant health challenges and life situations. So, how does this occur in an era of EBP? I attempt to answer this question in the paragraphs that follow.

First, we must be certain our practitioners understand that we face many more clinical problems than we ever have clinical trials. Inevitably, much of what we do is based on good judgment without evidentiary proof. Second, we must be certain that our practitioners who read published research recognize that there are many more individual cases with variations than can be accounted for in our clinical trials. As Stephen Jay Gould famously wrote, after personal diagnosis of a rare cancer:

Platonic heritage, with its emphasis in clear distinctions . . . leads us to view statistical measures of central tendency wrongly . . . as the hard “realities,” and the variation that permits their calculation as a set of transient and imperfect measurements If the median is the reality and variation around the median just a device for its calculation, the “I will probably be dead in eight months” may pass as a reasonable interpretation. But all evolutionary biologists know that variation itself is nature’s only irreducible essence. Variation is the hard reality Means and medians are the abstractions [2].

The randomized controlled clinical trial (RCT) is acknowledged as the “gold standard” of evidence. The controlled clinical trial provides the best data we have on how the average patient responds to the experimental interventions addressed in the study. As Gould reminds us, however, the average (mean or median) patient is an abstraction. Much of today’s evidence is based on meta-analytic combinations of relatively small trials, often with moderately heterogeneous effect measures. If that heterogeneity is not carefully assessed (sometimes leading to the decision not to perform a meta-analysis), we may create “evidence” just as liable to error as the conclusion that Gould would live only 8 months (he died 20 highly productive years later of a different malignancy).

The goal of most RCTs is to reduce bias rather than to produce evidence applicable to clinical practice. Bias is most often reduced by enforcing strict exclusion criteria for participation in the trial. Few trials these days are “pragmatic” all-comer trials that can tell us whether a treatment is “effective” in real life. “Explanatory” RCTs establish what we call “efficacy”—an idea that

Gould would call “platonic.” Participants are often selected only after a “run-in,” during which their adherence is assessed, and they are often followed up more carefully than is possible in real life. Virtually all EBP is derived from studies of efficacy. What should matter to us is effectiveness: how well a treatment translates into practical real-life experience.

Real life also enters our thinking about trials in other ways. Our growing understanding of genetic polymorphisms reinforces the common sense idea (at the root of holistic nursing) that we are all different from one another. Single-subject studies offer effective ways to address these differences. The powerful N-of-1 trial technique is a quantitative variant of single-subject trials (as is the “within-person case crossover design,” in which each individual acts as his or her own control). Neither study design is feasible in all circumstances, but both are useful in generating data that avoid abstraction.

Many people think that clinical trials determine “truth” independent of our prior knowledge or experience. To others, this concept is nonsensical. If evidence is not abstract truth, we need an entirely separate type of statistics, known as Bayesian reasoning, which has been developed to link statistical inference to individual likelihood. Used widely in genetics (Gould’s field of endeavor), Bayesian statistics allow us to apply evidence to specific individual circumstances, something that is not possible with more traditional statistical results. Bayesian methods are not yet used in nursing studies, let alone in holistic nursing studies, although they should be adopted by both. These methods have begun to find their way into studies involving complementary and alternative therapies and also have articulate supporters in the internal medicine literature [3]. No one (especially Rogers) ever said that change comes quickly, but it seems that our need for evidence to use in practice should force us to take a serious look at why Bayesian methods based on individual inferences might serve our needs better than the more familiar frequentist model based on *P* values and null hypotheses.

Recently, Holmes and colleagues [4] presented a well-considered critique of what they called the “evidence-based dogma.” These authors correctly point out that the EBP movement has served to reinforce a hierarchy of research designs that has prioritized frequentist quantitative methods over qualitative ones (and, I would add, over Bayesian or single-subject alternatives). Nursing, with its broad world view, seeks to understand the complexities of the lived experiences of those served, and it accepts ways of knowing that include esthetic, personal, and ethical knowledge as well as empiric knowledge. EBP in nursing requires consideration of evidence derived from a variety of points of view. Holistic nurses must ensure that evidence from a wide range of qualitative (and pragmatic or Bayesian) investigations inform practice decisions. We must not simply accept the hierarchy dictated by the current uncritical use of EBP. Just as Gould rescued himself by rejecting the tyranny of the median, so holistic nurses must rescue themselves and their clients from research methods enslaved to the mean and its distributions.

As we present the 11 articles that follow on philosophy/theory, scope of practice, modalities, education, care modalities, and research, we must do so in the context of EBP—the practical and pragmatic assumptions we bring to our care based on our experiences with real human beings, the data we obtain from research using a variety of investigative methods, and the practice decisions we make to assist our clients in their journey toward health.

It has been my privilege to compile and edit this issue. The work contained in it is a tribute to holistic care and a call for continuation of our need to build our body of knowledge in holism.

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