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AI and Human-Centered Care in Nursing: A Theoretical Perspective Informed by Parse's Theory of Human Becoming

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Abstract

This paper is a theoretical/conceptual analysis, not an empirical study: it uses hermeneutic reflection on the existing literature to examine what artificial intelligence (AI) means for the relational core of nursing practice. As AI integrates into clinical workflows, it delivers efficiency gains while also raising questions about the humanistic dimensions of nursing that current evidence suggests AI cannot replicate. This paper introduces Rosemarie Rizzo Parse's Theory of Human Becoming as a framework for examining these dimensions. It maps the theory's three core concepts—meaning, rhythmicity, and transcendence—onto specific AI-mediated clinical phenomena, illustrates each mapping with a brief clinical vignette, and considers the relational tensions this raises for nurses, patients, and health systems. Drawing on the theory's ontological and epistemological foundations, the paper argues that nurses must deliberately practice presence, listening, and co-participation alongside AI tools rather than in place of them. It concludes with implications for nursing practice, education, and leadership, and a discussion of the limits of this kind of conceptual analysis.

Keywords

Artificial Intelligence, Nursing Theory, Human Becoming, Nurse-Patient Relationship, Ethics, Human-Centered Care

1. Introduction

Healthcare systems are integrating artificial intelligence into an expanding range of clinical functions, from diagnostic imaging to predictive risk modeling and workflow automation [1] [2]. Topol's [3] influential account frames AI as a re-

sponse to three structural pressures on modern medicine: rising demand, workforce strain, and the cognitive burden of ever-larger volumes of clinical data. These pressures are real, and AI-enabled tools offer a plausible partial response.

At the same time, as AI expands the functional boundaries of nursing work, we should ask directly: when algorithmic systems take on tasks that once required a relational encounter between nurse and patient, what, if anything, is lost? This is not only an abstract philosophical question; recent systematic reviews of AI ethics in nursing identify the nurse-patient relationship as one of the domains most directly affected by AI adoption, alongside patient autonomy, privacy, and accountability [4].

This paper is a theoretical/conceptual analysis: it does not report new empirical data but instead applies an established nursing theory to a contemporary practice problem through structured conceptual reasoning and engagement with the existing literature. Section 2 describes the approach taken. This paper adopts Rosemarie Rizzo Parse's Theory of Human Becoming as its analytical lens. First proposed in 1981 [5] and elaborated by the author in 1992 [6], 1998 [7], and 2014 [8], the theory is rooted in existential phenomenology and holds that human unity is irreducible to biological or informational components—a claim that speaks directly to concerns about depersonalization as medical technology expands [5] [7].

The paper proceeds in four parts: it reviews the core principles of Parse's theory (Section 3); examines specific relational challenges that AI introduces into clinical nursing (Section 4); maps each of the theory's three core concepts onto a corresponding AI-mediated clinical phenomenon, with brief clinical illustrations (Section 5); and closes with implications for nursing practice, education, and leadership, followed by a discussion of limitations (Sections 6 - 7). This paper aims to offer nursing practice, education, and leadership a theoretically grounded framework, built on Parse's Theory of Human Becoming, for sustaining humanistic nurse-patient relationships as AI becomes a routine feature of clinical care.

2. Approach

This paper uses conceptual analysis informed by hermeneutic reflection: it reads an established nursing theory closely against a body of literature on AI in clinical practice and brings the two into structured dialogue to generate a practice-relevant framework. This approach is recognized in theoretical nursing scholarship, with the goal of conceptual clarification and application rather than hypothesis testing [7].

The literature informing this analysis was drawn from three overlapping bodies of work: primary and secondary sources on Parse's Theory of Human Becoming; recent (predominantly 2021-2024) empirical and review literature on AI adoption, ethics, and clinical decision support in nursing, identified through PubMed, CINAHL, and Google Scholar; and foundational texts on AI in medicine more broadly, including Topol [3] and Obermeyer and Emanuel [9]. Sources were selected for direct relevance to the nurse-patient relationship, AI ethics, or the phil-

osophical foundations of humanistic nursing theory, and were prioritized when published in nursing-specific journals or as systematic/scoping reviews. This is a narrative rather than systematic synthesis, and the selection is accordingly interpretive; the implications of that choice are discussed in the Limitations section.

3. Parse's Theory of Human Becoming: A Brief Overview

Parse proposed the Theory of Human Becoming in 1981 [5] and revised it in 1992 [6], 1998 [7], and 2014 [8]. The theory deliberately distinguishes itself from the biomedical, systems-oriented paradigms that dominated nursing science in the latter half of the twentieth century. Rather than treating patients as physiological systems to be stabilized or problems to be solved, it positions the person as an open participant, capable of free choice, who continuously co-creates health and quality of life through interaction with their environment.

The theory rests on three interlocking ontological principles. First, humans co-create reality through imaging, valuing, and languaging; health is understood as a subjective experience of life's meaning that emerges from a person's being-in-the-world. Second, rhythmicity describes a core structural feature of human existence, expressed through paired paradoxes—including the connecting-separating paradox, among others—that Parse argues require no resolution: they are inherent and worthy of respect rather than management. Third, transcendence refers to the human capacity to move beyond familiar boundaries toward new possibilities, even amid illness or decline.

Parse [6] argues that an authentic nurse-patient connection depends on the nurse's true presence, expressed through three intertwined capacities: interpreting meaning, synchronizing rhythms, and mobilizing transcendence. On this account, routine intervention or task completion alone cannot produce such a connection.

4. The Relational Challenge of Artificial Intelligence in Nursing

Parse's theory belongs to what is often called the simultaneity paradigm in nursing science, which holds that humans cannot be reduced to their biological or informational components. This creates productive tension with AI-integrated biomedical approaches, which, by design, operate on structured, quantifiable data. Several specific relational challenges have been identified in the literature on AI-integrated care.

4.1. Category Difference

Clinical AI systems, however capable, operate in a different ontological register from human relational presence. Obermeyer and Emanuel [9] note that predictive clinical AI tools are powerful within their design scope but are not built to register the kind of understanding, presence, or relationality that characterizes a human clinical encounter—a limitation these tools were never intended to overcome, ra-

ther than a design failure.

4.2. Attentional Displacement

A recurring concern in the literature is attentional displacement: electronic health records and similar systems can redirect nurses' attention from patients toward screens [10]. Several recent reviews suggest AI-generated alerts and dashboards may extend this pattern, though evidence is mixed—some studies report that AI-supported monitoring frees nurse time for direct patient contact by reducing documentation burden, while others report the opposite effect depending on implementation [1] [2]. Team-based, well-designed workflows appear to moderate this risk [11].

4.3. Algorithmic Reductionism

Another concern is that clinical AI draws its outputs only from data that can be quantified and coded, so it may not register a patient's experience of suffering, the personal meaning illness holds for them, or their individual rhythm of coping. Where AI-generated outputs are treated as a substitute for direct interaction, rather than an input into it, these subjective elements risk being overlooked. This concern is best read as a caution about implementation rather than an inherent, unavoidable property of all AI systems; recent scoping reviews of AI-based clinical decision support similarly call for the technology to augment, rather than substitute for, nurse judgment [12].

4.4. Surrogate Relationships and Moral Alienation

Conversational AI health assistants and AI-driven virtual care platforms raise a related question about surrogate, or agency, relationships: viewed through Parse's framework, an interaction between a patient and an AI assistant does not, on its own, constitute the mutual co-creation the theory describes. Nurses who adopt such tools without reflection on this distinction risk quietly narrowing their own relational role. Coeckelbergh [13] uses the term moral alienation to describe the diffusion of moral accountability that can occur in algorithm-influenced clinical decisions, and suggests that sustained, uncritical reliance on algorithmic recommendations may, over time, erode independent moral judgment—a hypothesis that, to date, rests more on conceptual argument than on longitudinal empirical evidence, and which future research should test directly.

5. Human Becoming in the Age of AI: Mapping the Three Themes

None of the challenges outlined above supports a categorical rejection of AI in nursing. What they support is a framework in which AI is treated as a practical tool that operates alongside, and never substitutes for, the nurse's in-person presence.

The subsections below apply a consistent structure to each of Parse's three con-

cepts: the concept itself, the specific AI-mediated phenomenon it engages, and the resulting implication for practice. Table 1 summarizes the mapping; two brief clinical vignettes then illustrate it in context.

Table 1. Mapping Parse's theory of human becoming to AI-mediated nursing phenomena.

Parse Concept	Corresponding AI Phenomenon	Relational Tension Introduced	Practice Implication
Meaning	Predictive analytics and documentation systems that reduce patient experience to codable data points	Clinical narrative risks being displaced by data entry; patients' own interpretation of illness goes unrecorded	Protect unstructured time for open-ended, patient-led conversation before or alongside data review
Rhythmicity	Continuous remote monitoring and algorithm-triggered alerts that set the pace of nurse attention	An exogenous, machine-driven rhythm can override the patient's own pace of disclosure and coping	Pair alert response with deliberate, unhurried bedside presence; treat silence and pacing as clinical information
Transcendence	Prognostic and discharge-planning algorithms that project a single most-likely trajectory	Patients whose goals or outcomes diverge from the algorithm's projection may feel unseen or foreclosed upon	Use AI output as one input among several; actively help patients articulate futures the model does not anticipate

5.1. Meaning: Presence over Data

Concept. Parse's meaning principle centers on the person's sustained, irreducible act of interpreting their own experience. In this view, health is not a measurable clinical parameter but an ongoing process through which individuals make sense of their lives. The nurse's role is to help patients explore and articulate that meaning and to witness the interpretations they assign to their circumstances.

AI application. Predictive analytics, structured documentation templates, and AI-generated summaries integrate large volumes of patient data efficiently, but by design they do not ask open-ended questions, tolerate narrative digression, or hold space for uncertainty. Current evidence does not indicate that conversational AI tools reliably replicate the sustained, curiosity-driven attentiveness meaning-making requires [4].

Implication for practice. To protect meaning-centered care in AI-integrated settings, nurses can resist workflows that prioritize data entry over patient engagement; care teams can protect bedside time that is not structured around algorithmic prompts; and institutions can formally recognize time spent listening to and interpreting a patient's account of their illness as legitimate clinical work, not as time outside of it.

Clinical vignette—AI-assisted triage. In an emergency department using an AI triage-support tool, an older patient presents with vague, intermittent chest discomfort. The algorithm flags the presentation as low-acuity based on vital signs

and structured intake data. A nurse applying meaning-centered attention asks the patient to describe, in their own words, what the discomfort feels like and what has changed for them recently; the patient discloses a recent bereavement and new difficulty sleeping, details the structured intake form did not capture, and that reframe the clinical picture. The algorithm's output remains a useful input—it does not disappear from the encounter—but it is one input among several, not the final word.

5.2. Rhythmicity: Being with, Not Just Doing for

Concept. Rhythmicity describes the paired paradoxes of human existence—among them, connecting and separating—which Parse holds require no resolution; they are dimensions of experience to be understood and respected rather than managed or corrected.

AI application. Continuous remote monitoring, fall-risk markers, and AI-generated care pathways structure clinical workflows around an exogenous, machine-driven rhythm: nurses respond to data-triggered alerts on a schedule set by the algorithm rather than by the patient. Withdrawn or slower-to-disclose patients, who need more time to express their needs, may be underserved by an attention system organized primarily around alert response [2].

Implication for practice. Rhythmic attunement asks nurses to align, as much as possible, with the pace at which a patient opens up and engages—an active, disciplined form of presence rather than a passive one. Recognizing meaningful silence, a shift in tone, or a private struggle a patient is not yet ready to name requires sustained interpersonal contact; current monitoring technologies aren't designed to detect them.

Clinical vignette—AI-based remote monitoring. A patient recovering from cardiac surgery is enrolled in a home-monitoring program that transmits vital signs and activity data to a nursing team, with automated alerts for values outside a defined range. Between alerts, the platform sends no signal, and the patient's video check-ins with the monitoring nurse focus on confirming numerical trends. On one call, the nurse—attentive to the patient's rhythm rather than only the dashboard—notices a longer pause than usual and a flatter tone when the patient is asked how they are managing, and follows up directly; the patient discloses new anxiety about returning to independent living that no monitored value would have surfaced. The monitoring system remains valuable for detecting physiological deterioration; it is not designed, and should not be relied upon, to detect this kind of relational or emotional shift.

5.3. Transcendence: Co-Envisioning the Possible

Concept. Transcendence refers to the human capacity to move beyond the boundaries of one's current experience toward new possibilities. Parse argues that nurses help even severely ill, functionally declining, or terminally ill patients envision futures that are meaningful on the patient's own terms.

AI application. Predictive and discharge-planning algorithms can identify patients at elevated risk of deterioration, flag treatment pathways associated with better outcomes on average, and project readmission risk with reasonable statistical accuracy. These tools are not built to support a patient's personal, reflective work of making sense of their future or the meaning of their illness.

Implication for practice. When care plans are tightly organized around an algorithm's projected trajectory, patients whose course diverges from that projection can end up feeling unseen or foreclosed. Nurses working from a Human Becoming framework can treat algorithmic projections as one useful input among several and actively help patients name possibilities the model was never designed to anticipate—holding both hope and grief where relevant, rather than resolving the two into a single prognosis.

6. Implications for Practice, Education, and Leadership

6.1. For Clinical Practice

As AI-generated care plans become more common, they risk narrowing patients' sense of what is possible, particularly for those whose disease trajectory departs from the plan's predicted path. Nurses are well positioned to translate algorithm-derived information into humanistic conversation, keeping the patient's own account of their future central to care planning rather than incidental to it. In practice, this means developing what might be called relational intentionality: a disciplined, sustained commitment to sincere, human-centered presence that persists even when technology competes for attention.

6.2. For Nursing Education

Where AI and digital workflows crowd out direct interaction, four concrete steps follow: reserving patient-led communication time that is not structured around algorithmic prompts; deliberately managing how much attention is allocated to screens during an encounter; treating AI-derived information as a starting point for discussion rather than a conclusion; and designing team workflows around relational, not only transactional, care. Nursing curricula should pair instruction in using clinical AI tools with explicit, structured practice in identifying those tools' limits—a combination Parse's framework is well suited to support, since it gives students an explicit vocabulary (meaning, rhythmicity, transcendence) for naming what a given tool does and does not do.

6.3. For Nursing Leadership

Two changes to training and evaluation follow from this analysis. First, simulation scenarios should include cases where an AI-generated recommendation conflicts with a patient's stated values, so students and staff practice navigating that conflict directly rather than encountering it for the first time in practice. Second, treat focused listening, open-ended questioning, and tolerance for uncertainty as core clinical competencies to assess, not soft skills incidental to "real" clinical work.

Nurse leaders and administrators also have a role in auditing AI-driven performance metrics—patient throughput, documentation completion rate, alarm response time—to ensure they do not inadvertently displace the time nurses need for interpersonal care.

7. Limitations

This paper is a theoretical/conceptual analysis and should be read as such: it does not report primary empirical data, and its claims about AI's relational effects are, at this stage, propositions for further study rather than established findings. Three limitations follow directly from this. First, because the analysis is conceptual rather than empirical, empirical research—qualitative, quantitative, and mixed-methods—must test claims about how AI actually changes nurse-patient relationships in practice rather than accepting them on the strength of theoretical argument alone. Second, the literature informing this analysis was selected narratively rather than through a systematic review protocol; while an effort was made to prioritize recent, high-quality, nursing-specific sources, the selection remains interpretive and may not represent the full range of available evidence or perspectives, including studies reporting more positive effects of AI on nurse workload and patient contact time. Third, the analysis is not tied to a specific clinical setting, national health system, or patient population, and the relational tensions it describes will not generalize uniformly: resource-constrained settings, different regulatory environments, and different patient populations may experience AI integration quite differently from the vignettes offered here. Readers should treat this paper's framework as a starting point for empirical, context-specific inquiry rather than a complete or final account.

8. Conclusions

Parse proposed the Theory of Human Becoming in 1981, motivated by concern that nursing as a discipline risked losing its own vision of the person. The theory asks nurses to accompany people through their own lived experience of health and illness, rather than positioning nurses primarily as agents who manage or control illness. That concern is, if anything, more pressing now than when the theory was first articulated.

This paper has argued against the assumption that technology is inherently opposed to humanistic care. Artificial intelligence is better understood as a test of the nursing profession's ongoing commitment to its relational core than as an enemy of that core. Where AI does erode relational nursing care, the mechanism is rarely malicious; it is more often a matter of unexamined workflow design, an unreflective drift toward prioritizing efficiency, or algorithmic convenience quietly displacing in-person presence—all of which are addressable through the kind of deliberate practice, education, and leadership choices outlined above.

Parse's theory reminds nursing practitioners that persons are irreducible, and that health, as an embodied and intersubjective phenomenon, is not something

any current form of machine intelligence is designed to fully capture, predict, or sustain. Nurses who consistently attend to meaning, rhythmicity, and transcendence are positioned to hold onto what makes nursing care distinctive, even as its tools change. That commitment is not incidental to nursing's ethical mission; it sits at its center—every person moving through a vulnerable period of their life is owed the responsive attention of another human being who is actually present.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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