



# Nursing Knowledge Development and Clinical Practice

**Sister Callista Roy and Dorothy A. Jones**  
Editors

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This book had its origins in the paradox of the rich growth in nursing knowledge at the beginning of the 21st century and, at the same time, unresolved concerns with health care delivery systems and with care. One vehicle for the growth of knowledge has been conferences that address nursing knowledge on multiple levels. A series of such conferences was conducted in the northeastern United States between 1984 and 2001. The cycle of conferences (see the Appendix, History of New England Knowledge Conferences) brought nursing scholars together with developing scholars to dialogue about the links of philosophy, theory, and research as the basis of outcomes for practice. As co-chairs of the last five conferences, the editors envisioned bringing the best of the deliberations about knowledge together in a volume that would address care delivery issues, identify major paradigmatic perspectives, and use those perspectives to create new approaches to practice. Some chapters originally were presented at the conferences; others were solicited to complete the total vision of providing exemplars that link paradigmatic perspectives to practice outcomes.

As the project developed and time passed, the goals and approaches seemed to gain more urgency. Nursing knowledge can have an impact on practice issues today. However, that knowledge needs to be focused and articulated in a way that meets the needs of practice. Examining the range of paradigmatic perspectives, we focused early in our thinking on the classical problem-solving and process-oriented approaches and added a third perspective aimed at a future vision of integrated knowledge based on the thinking of several scholars, including knowledge as universal cosmic imperative.

The scholars whose papers are included have provided thoughtful approaches to nursing knowledge that we believe will be helpful to the whole field of nursing. A wide audience of nurses today are accepting increasing accountability for quality of patient care and seeking articulation of the science of nursing. Masters and doctoral students and faculty are primary groups immersed in increasing levels of responsibility in advanced practice and clinical research. In addition, we hope to speak to nurses holding responsibility for patients from the level of vice-presidents for patient care services and chief nurses to those providing primary care across the health care spectrum in both in-patient and out-patient settings. We aim to stimulate a dialogue of how nursing knowledge is envisioned and how these perspectives can affect practice. Further, this dialogue will include involvement in health care policy as a way of handling the increasing complexity and inadequacy of the systems. The text provides both principles and exemplars for

improving practice based on nursing knowledge. The hope is that readers can draw on the depth and breadth of the presentations in this volume to help shape the future of nursing.

We organized the book into four parts, each with an introduction. In Part I we look at the state of the art of nursing knowledge and some of the issues and visions of the contemporary scene of knowledge and practice. It begins with a chapter laying out the many factors influencing knowledge development in nursing and documenting some of our achievements, along with the challenges for practice. This section closes with a chapter that presents a call to action. Part II examines the philosophical basis for knowledge and provides a synthesis of problem-solving and process perspectives and examines how a synthesis of these perspectives provides insight into nursing knowledge development, utilization, and evaluation in clinical and academic settings for the future. The chapters in Part III are focused on specific approaches to integrated knowledge and the effects these can have on practice on both the individual and systems level. Part IV provides six exemplars to provide future impact on health care systems and patient care.

The authors, and our editors, have been very patient while we shaped and re-shaped this text, updated material, and synchronized the various chapters into a whole. We admit that sometimes the work had to wait while ongoing commitments took priority. However, our urgency to bring these insights about nursing knowledge to the nursing readership did not waver and we are happy to have this opportunity to present them to you.

In a time of change within health care as well as nursing education, it is hoped that this text celebrates the nursing knowledge developments to date and those to come as well as their impacts on patient care and most importantly the unique focus nursing has on the human experience. It is in fact this knowledge that can demonstrate nursing's complementarity with other health care providers, be shared within interdisciplinary forums addressing health issues on a global level, infuse curriculum, and shape clinical investigations. Having found the Knowledge Conferences so effective a channel for our developing field, we end our remarks with both hopes and plans for the next sequence of conferences on nursing knowledge to be initiated in the near future.

Sister Callista Roy  
Dorothy A. Jones

# Part

**State of the Art of Nursing  
Knowledge: Visions and  
Issues**

## Introduction

The end of the 20th century saw unprecedented growth in nursing knowledge. An understanding of the nature and focus of nursing knowledge finally had been articulated. Programs of research were contributing to an accumulated knowledge base for practice. Yet this era also saw a time of great turmoil and seemingly ineffective efforts to improve the quality of health care. When market-driven principles ruled health care reform, nursing knowledge failed to provide transformed nursing care systems. This text explores this paradox and then provides a link to an alternative preferred future where nursing knowledge offers opportunities and new directions for clinical practice.

Nursing knowledge is positioning itself to provide visions that can create effective responses to the issues facing health care. The need for cost containment ushered in an era of health care reform during the 21st century. Serious cost containment strategies have been in effect since the mid-1990s; still, the United States far exceeds all other nations in per capita health care spending. Technological advances, including genomic science, have also created unique issues for health care providers. In general, ethical and public policy debates have not kept up with these advances.

Larger social trends raise equally complex issues for nursing knowledge to address. Information technology brings concerns for confidentiality, privacy, and security for an increasingly enlightened public. Changing demographics including an aging population, increasing ethnic diversity, poverty and other disparities are creating challenges to accessing care. Attendant issues involve ethical concerns about quality of life in both chronic and end-of-life care; culturally competent care and marginality; and the paradox of lack of health care insurance in a land of plenty. The vision that nursing knowledge brings to the challenging issues of nursing practice are based on principles and values for creating effective practice systems. Nursing is a human practice discipline that facilitates well-being of individuals, families, and communities using a scientific knowledge base within caring relationships. As a discipline with a social mandate, nurses are eager to take responsibility for social transformation. Possibly there is no time in history when this need was deeper and more far reaching. So, too, nursing has never been more ready to respond to the challenge. This text provides direction for relating nursing knowledge development to clinical practice.

Part I outlines the vision that nursing knowledge can bring to contemporary health care issues and how that vision can create a better reality for the future. In chapter 1 advances in nursing knowledge and the challenges in health care delivery are described together with a Consensus Statement that provides the basis for transforming practice. The author of chapter 2 focuses on the specific vision of careful nursing, a unique tradition that Irish nurses bring to contemporary issues. The crucial role of terminology in nursing as a practice discipline is addressed in chapter 3. Chapter 4 addresses the impact of mid-range theory on knowledge development and practice. Chapter 5 presents a call for more universal language from nurses in Brazil. Finally, in chapter 6, the author sounds a clear challenge to action and a movement toward unity around disciplinary purpose and articulation of goals true to an agreed upon mission.

# Advances in Nursing Knowledge and the Challenge for Transforming Practice



**T**he rich growth in nursing knowledge at the beginning of the 21st century was marked by increased understanding of conceptual nursing knowledge and how to create knowledge for practice. The depth and breadth of these developments is noted in the nursing literature, in the development of doctoral education in nursing, and in the content of nursing conferences. These advances in knowledge are explored in this chapter along with the recognition of unresolved concerns with health care systems and care delivery. From the juxtaposition of these developments and challenges, the assumptions that set the stage for change are derived. Finally, the basis for transformation of nursing care is provided in a Consensus Statement.

## Advances in Knowledge

In nursing literature, doctoral education, and professional conferences, we note the maturing of the discipline, particularly in conceptual focus, philosophical perspectives,

methodologic inquiry, and sociopolitical commitments. As with the development of any discipline, the manifestations of progress in different arenas are interactive and iterative. Advances in one area stimulate movement in another area, and each time the spiral evolves to higher levels. This interrelatedness is particularly so for nursing as a professional practice discipline. The profession utilizes specialized knowledge to contribute to the needs of society from nursing's specific perspective of promoting health and well-being. Practice, then, is the unifying factor for all of knowledge development. For example, nurses often enter doctoral education with burning issues from advanced practice. In these programs modes of thinking are exercised that produce new insights to pose challenging questions for research. The results of this thought and research are presented at conferences and in journal articles. Likewise, seminal articles in the literature both stem from and stimulate innovative thinking about practice. Scholars and developing scholars in practice and academic settings build on these insights to further knowledge for practice. Developments in each of these interrelated spheres depict the maturing focus of nursing knowledge, methods of inquiry, and potential for relating knowledge to practice.

### Conceptual Focus Reflected in Theoretical Literature

Nursing literature at the beginning of this century, whether textbooks or journals, basic or advanced, reflects a view of knowledge as holistic and rooted in a broad perspective of human persons and their environment as related to health. The movement toward focusing nursing knowledge development within an understanding of the nature of nursing practice was advocated in the literature of the last three decades of the 20th century. Johnson (1974) articulated this perspective in a seminal article in which she described alternative approaches for developing nursing as a primary health profession. The medical model and laissez-faire approaches to describing nursing knowledge were contrasted with the possibilities of nursing describing the nature of its practice as the basis for developing knowledge. In a related influential article of this period, Donaldson and Crowley (1978) identified the commonalities of nursing to include concern with principles and laws of life processes, patterns of human behavior in interaction with the environment, and positive changes in health status.

Concurrently the 1970s saw the publication of several major conceptual approaches to nursing that continue to influence the discipline and have provided theoretical bases for nursing knowledge development. Orem (1971) viewed the person as a *self care system* and nursing as fulfilling one of three roles relative to meeting self care needs, that is, wholly compensatory, partially compensatory, and supportive-educative. Roy (1970, 1976) conceptualized the person as an *adaptive system* and the goal of nursing practice as promoting adaptation. Rogers (1970) described the person as a *unitary energy field* identified by pattern and organization that is coextensive with the environment. She viewed nursing as strengthening the human-environment energy field.

These authors, and other nurse theorists, continued to write in the 1980s and 1990s. They and their colleagues contributed to the depth of the discipline's philosophical perspective, particularly in relation to an understanding of the human person. Orem (1997) explored the person as a free agent and the significance of human choice. Roy (1997) emphasized the common purposefulness of human existence in a universe that is creative. Newman (1994) expanded upon Roger's concept of unitary human-energy

fields and replaced the dichotomy between health and disease with a synthesis of health expressed as the pattern of the whole person–environment that encompasses disease and nondisease. Orem, Rogers, and Roy had the largest number of nursing publications based on their work from 1982 to 2000 as reported by one survey (Alligood, 2002, p. 645). Their conceptual work has continued to influence the profession through education and research, as well as through ongoing organizations and conferences devoted to knowledge development within each perspective.

Another major thrust of theoretical writing in nursing, beginning in the past century and continuing to influence nursing knowledge development, is the work on caring and cultural care. Leininger, a nurse anthropologist, developed the concept of *cultural care* over four decades from 1950 to 1990 and challenged nurses worldwide to reflect on care as the essence and central focus of nursing. Leininger (1991) noted that human care is a universal phenomenon because care acts and processes are necessary for human birth, development, growth, survival, and peaceful death. Cultural care, however, according to Leininger, involves both universality and diversity. Diversity is the variability and differences in meanings, patterns, values, lifeways, or symbols of care within and among social groups. Universality includes the common, similar, or dominant care patterns and symbols that are noted among many cultures.

Other nurse authors, notably Watson (1979, 1985) and Benner (Benner & Wrubel, 1989) also focused on care as the central concept of nursing. Watson regarded caring as the essence of nursing practice and as a moral ideal rather than a task-oriented behavior. She proposed that caring was intrinsically related to healing and focused on the authentic caring relationship between the nurse and the patient. Initially Benner's work examined the relationships among caring, stress, coping, and health. She noted that caring is primary as a basic way of being in the world. Further, what is stressful and what coping options are available are determined by caring. In later work with other colleagues, Benner has expanded upon the development of caring practices of the nurse, particularly in critical care (Benner, Tanner, & Chesla, 1996; Benner, Hooper-Kyriakidis, & Stannard, 1999).

Morse, Solberg, Neander, Bottorff, and Johnson (1990) published an analysis of 35 authors' works on the concept of caring. The purpose of the analysis was to identify various conceptualizations, evaluate their use and applicability to nursing practice, and identify trends and gaps in caring research. Five perspectives on caring—a human trait, affect, moral imperative, interpersonal interaction, and therapeutic intervention—were identified, as well as outcomes related to the patient's subjective experience and the patient's physiological response. The authors made two major recommendations for knowledge development: first, that further conceptual development and refinement of the concept is needed and second, that the focus of theory and research shift to incorporate a focus on the patient and the difference caring makes.

Other scholars have used research to derive theories related to caring. For example, McCance (2003) used a hermeneutic approach with narrative method to develop a conceptual framework based on caring in nursing practice. In this study, 24 patients were interviewed shortly after discharge from the hospital. Categories of the experience of caring were derived and placed into a framework using the three constructs. For *structure*, the author identified the nurses' attributes, such as professional competence and commitment, and organizational issues, for example, time and skill mix. *Process* included variables such as providing information and reassurance and showing concern. Feelings of well-being and patient satisfaction were among the *outcomes* identified.

## Metatheory and Philosophical Perspectives

The decades following the formal introduction of nursing theory into the literature saw increasing discussion at the metatheoretical level. Dialogue on epistemology raised issues about the nature of knowledge and how one knows in nursing. Ontological questions looked at the nature of person and the nature of nursing. A major setting for the discussion of these issues and the philosophical roots of nursing knowledge was journals specifically dedicated to the integration of theory, research, and practice. Development over time is noted by looking at the founding of some of these journals and their current mission.

*Image*, as the journal of the Sigma Theta Tau National Honor Society, was first published in 1967 in response to a need for communication between the organization's National Council and the local chapters and individuals. A major purpose was to publish selected articles to communicate ideas of interest to nursing and in particular to establish a column known as a Forum. The *Forum* was to be a medium for reaction to "issues that are of particular concern to nurses who have a collegiate education, who strive for high professional standards, who practice nursing in leadership roles, who are committed to the ideals and purposes of the profession and who engage in creative work" (Goodwin, 1967, p. 10). The journal's role as a vehicle for communication on building knowledge for practice grew in the nearly 40-year history of the journal, as did its international focus. The renaming of the publication as the *Journal of Nursing Scholarship* reflects this growth. Currently, major sections are dedicated to world health, genomics for health, clinical scholarship, profession and society, and health policy and systems. In one rating of characteristics and database coverage of journals, this publication scored 10 out of a possible 10 points (Allen, 2001). The content of the journal, reputation, and citations were considered in the ratings.

*Advances in Nursing Science (ANS)* was founded in 1978 by Chinn. In her first editorial, Chinn noted that the premise for initiating the journal was that "for far too long, the wealth and diversity of nursing literature have suffered a lack of timely and creative reporting of the efforts of nurses concerned with the development of nursing science" and therefore the new journal would "focus on articles that address the full range of activities involved in the development of science, including empirical research, theory construction, concept analysis, practical application of research and theory, and investigation of the values and ethics that influence the practice and research activities of nursing science" (Chinn, 1978, n.p.). Currently, the primary purposes of the journal are

to contribute to the development of nursing science and to promote the application of emerging theories and research findings to practice. Articles deal with any of the processes of science, including research, theory development, concept analysis, practical application of research and theory, and investigation of the values and ethics that influence the practice and research endeavors of nursing sciences. (<http://www.nursing.uconn.edu/~plchinn/ANSathgd.htm>)

In the nursing journal ratings noted earlier, ANS scored 8 out of 10 possible points, having lost points only on percent of research articles, but scoring high in reputation and citation, highlighting the wider contribution to scholarly dialogue.

In 1987, *Scholarly Inquiry for Nursing Practice* was designed by faculty at Adelphi University as a forum for dialogue on the development and testing of theory and research relevant to nursing practice. The editors used the additional strategy of having invited

response papers to articles. This journal was retitled *Research and Theory for Nursing Practice: An International Journal*. Ketefian (2002) noted that the evolutionary changes of the journal meant the embrace of articles that address knowledge development in its broadest sense and that reflect research using a variety of methodologic approaches and that combine several methods. In addition, a fully international journal was envisioned whereby nurses on all continents would find articles relevant to their practice and find a voice to address concerns not specific to the Western social environment and context.

Parse initiated *Nursing Science Quarterly* in 1988 with a focus on “the publication of original works related to theory development, research, and practice, which tie directly to the knowledge base as articulated in the extant nursing theories.” After 18 years, the journal continues to be devoted to the enhancement of nursing knowledge. The focus on existing nursing frameworks has been maintained. The last two journals discussed score 4 and 5, respectively, on the rating scale noted earlier.

Two important journals published abroad that make contributions to the metatheory and philosophical dialogue in nursing are the *Journal of Advanced Nursing* and *Australia Journal of Advanced Nursing*. The former was founded in the United Kingdom in 1976 “to become an international medium for the publication of scholarly papers and a means of documenting the ever growing body of nursing knowledge” (Smith, 1976, p. 1). The intent was that the journal become a means toward improving the effectiveness of practice, of enhancing standards of education and service management, and of fostering research-mindedness. The editor urged nurses to document and to share their scientific, theoretical, and philosophical information. Currently, under Alison Tierney as editor, the aim of the journal remains the same while the scope has expanded widely. Papers reflect the diversity, quality, and internationalism of nursing and particularly deal with areas such as: issues and innovations in nursing practice, education, and management; nursing theory and conceptual development and analysis; philosophical and ethical issues; integrative literature reviews; methodological issues in nursing research; health and nursing policy; and health management issues.

The Australian journal was founded in 1983 to extend the scope of writers in the nursing discipline beyond that provided in the all-purpose journal of the professional organization. Papers with a scholarly approach, that is, objective and analytical base, in every area of nursing were invited. In the 20th year of publication, the editor noted that the journal has served as a mechanism for disseminating ideas about nursing and evidence from scholarly activities in practice, education, and research. In particular, the editorial policy notes that the journal publishes scholarly papers that recognize the eclectic nature of global nursing, midwifery, and health care, and that contribute to their development and advancement. The editors urge that papers submitted have a sound scientific, theoretical, or philosophical base and reflect the diversity, quality, and internationalism of nursing. The British journal scores a strong 9 out of 10 in the review reported and the Australian journal scores 4 out of 10.

Among the many contributions of these journals and others like them, collectively the published papers reflect the rising the level of debate on the philosophical perspectives in nursing. The scope of perspectives has expanded to include papers on middle-range theory, nursing practice theory, and cultural theories in *Journal of Nursing Scholarship* (1998, 1999, 2005); studies of gaining meaning and environmental paradigms in *Advances in Nursing Science* (1996); spirituality and hermeneutic-phenomenology in *Journal of Advanced Nursing* (2000); and positivism and qualitative research in *Scholarly Inquiry for Nursing Practice* (2001). In one landmark paper in the inaugural issue of *ANS*, Carper

challenged the reluctance of nurses to extend the term *knowledge* beyond the “empirical, factual, objectively descriptive, and general” (Carper, 1978, p. 35). She described four ways of knowing: the empiric, personal, ethical, and aesthetic. This articulation of extended ways of knowing was influential in generating both philosophical and methodologic debate.

### Paradigmatic Positions

Nurse authors in the last two decades of the 20th century addressed a central issue about knowledge, that is, how do we know, which led us to consider our paradigmatic stance. Empirical science, from Aristotle’s detailed observations of the development of the chick embryo in ancient Greece to Bacon’s articulation of experimental design in medieval Europe to Crick’s discoveries related to DNA in 20th-century United States, assumes that knowledge is developed from observations of the external world. This approach is based on the belief of Greek philosophers, reemphasized by later thinkers, that knowledge is obtained through the senses. Hegel and other German philosophers of the later 19th century suggested that the only reality that exists is in the mind and therefore knowledge is obtained only through intuited meanings. These two views of reality provide the basis of two distinct paradigms for how knowledge is developed.

Hardy (1978) introduced the term *paradigm* to the nursing literature. Using Kuhn’s (1962) discussion of how science works and how it changes, Hardy questioned whether nursing was in a pre-paradigmatic stage. The rapid development of theoretical literature in the three decades that followed seemed to be a response of clarifying the general schools of thought in nursing, that is, to establish its paradigms. Thus the developing literature refuted the position of pre-paradigm status for nursing. However, what followed was also a vigorous dialogue of the deeper issues about the paradigms used for nursing knowledge development. Initially, the discussion centered on the demise of logical positivism and the rise of postmodernism (Stevenson & Woods, 1986; Suppe & Jacox, 1985).

Several strong voices in the literature argued against the dangers of overemphasizing one approach or the other, or making them mutually exclusive and incompatible (Gortner & Schultz, 1988; Norbeck, 1987). By the end of the 20th century, nurse authors identified several categorizations of paradigms from the nursing literature such as those by Parse (1987), Newman (1992), and Fawcett (1993). However, it seems reasonable to continue the discussion within the classic distinctions about knowledge as “discovered in the world,” that is, problem solving, empiric, or “created in the mind,” that is, process-oriented, interpretive.

The several schools of thought in nursing that emerged from these distinctions are articulated in the literature and summarized from both a knowledge perspective and philosophical basis, as well as related to research and practice in Table 1.1. The approach we take is that it is timely to summarize two paradigmatic positions on knowledge for practice as problem solving and process-oriented. A third perspective, the universal cosmic imperative, is introduced in chapter 11. It builds on Roy’s philosophical assumption of veritivity (Roy, 1988; Roy & Andrews, 1999) and assumes a purposeful universe implying a broad use of research traditions.

Other scholars continue to work toward creating a synthesis of the first two approaches that can be called integrative. The fragmentation resulting from dichotomizing approaches to nursing knowledge development was noted by Leddy (2000). She promoted

Table

1.1

## Paradigms: Linking Philosophy, Research, and Practice Theory

Knowledge Perspective	Philosophical Basis	Research Tradition	Practice Theory	Related Terms
Problem solving	Empiricism Rationalism Positivism Postpositivism Normal science Contemporary empiricism	Received view Observation Experimentation Confirmation or refutation Deductive theory Explanatory laws	Descriptive Predictive Prescriptive	Functionalism Instrumentalism Reductionism Causal teleology Particulate-deterministic
Process-oriented	Idealism Postmodernism Phenomenology Existentialism Humanism Hermeneutic Relativity Dialectic	Perceived view Interpretive science Inductive theory Grounded theory	Contextual Perception of meaning Discovering patterns Feminism Caring praxis Dialogue Choice and action Personal transformation	Constructivism Deconstructivism Social meaning Ethnography Historicism Interactive-integrative
Universal cosmic imperative	Veritivity Humanism Purposefulness Shared meaningful destiny Spirit & matter Cosmic view of creation Person-environment self-organization	Discover truth Discern meaning Metaphysical and ethical inquiry Evolutionary creativity Critical analysis	Reflection on truth Choosing good Primacy of common good rooted in value of person Unity, diversity, subjectivity Collaboration Social transformation	Consilience Moderate realism Unitary-transformative

the notion of the two worldviews as complementary in nature, rather than competitive. Further, Kikuchi (2003) proposed that conceptualizations of nursing and nursing inquiry be placed in the philosophical view of moderate realism that obviates the dichotomies of the two worldviews, empiricism and idealism (see Liu, chapter 13 of this text). Similarly, Roy's view of a universal cosmic imperative perspective on nursing knowledge is a way of bridging current debates and provides a basis for new insights and multiple approaches to developing knowledge for nursing practice.

### Use of Paradigms to Advance Knowledge

Advances in knowledge for practice have been made using the major paradigms. The stances taken by scholars at given academic and practice institutions reflect varying ways to expand upon the problem-solving, empiric approach, to expand upon the process-oriented, interpretive perspectives, or to provide for integration of the two. From the view of problem-solving empirics, two examples of developments include work on knowledge as symptom management and focus on a physiologic knowledge base for nursing practice. In symptom management studies, for example, Dodd and colleagues (1988) examined nursing interventions related to patient management of given symptoms, such as nausea, vomiting and retching, and mucositis resulting from the effects of chemotherapy and radiation. Similarly, a focus on the physiologic basis of nursing is a problem-based approach. Carrieri-Kohlman, Lindsey, and West (1993) developed a text on pathophysiological phenomena in nursing as human responses to illness. A number of programs of research also are problem solving for physiologic phenomena. Mitchell studied intracranial adaptive capacity and related nursing interventions (Mitchell 1999, 2001; Mitchell & Ackerman, 1992; Mitchell, Johnson, & Habermann-Little, 1986). Larson, Covey, and Corbridge (2002) focused their research on the effects of inspiratory muscle training and cycle ergometry training on strength and endurance of the respiratory muscles and pulmonary rehabilitation of people with chronic obstructive lung disease.

The nursing diagnosis movement begun in the United States in 1973 provides another example of knowledge development strategies based on the belief that knowledge exists in the external world to be discovered and in this case classified. Interestingly, some nurses developing ethical knowledge also use an approach based on Laudan's (1977, 1984) articulation of knowledge as problem solving (see, for example, Fry, 1994). The founding of the National Institute of Nursing Research, beginning with the National Center for Nursing Research in 1986, also was based on the premise of the need for a strong empiric base for nursing science.

Contributions from an interpretive perspective have grown significantly in recent years. The Holistic Nursing Society has published a journal for more than two decades. An important text by Blattner (1981) 25 years ago introduced holistic nursing concepts, including self-responsibility, caring, and life styling. The book was well-documented and cited many nurses making contributions to holistic understanding of people and their health. Nurses also made significant contributions to holistic knowledge from human experience by using or adapting qualitative methods. Perspectives used to develop such knowledge included grounded theory (Benoliel, 1996; Quint, 1967; Schreiber & Stern, 2001), ethnography (Maggs-Rapport, 2000; Sorrell & Redmond, 1995), phenomenology (Oiler, 1982; Omery, 1983; Lopez & Willis, 2004), and historical research (Donahue, 1996; Hughes, 1990; Sarnecky, 1990).

### Summary of Conceptual Focus and Paradigmatic Contributions

The expanding nursing literature reflected a focus on the substance of knowledge for practice as the philosophical and scientific principles concerning the processes and patterns of persons in interaction with the environment to promote health. The third paradigmatic distinction may well prove most fruitful as the basis for visions of the future for nursing knowledge. Although it was apparent in the nursing literature in the last two decades of

the 20th century, it is only now being identified and debated. Implied or explicated by some authors is the philosophical distinction between a relativistic universe and a purposeful and ordered universe as the basis for understanding person and environment. This distinction is explored further in this book.

## Methodologic Inquiry and Advancing Knowledge

In addition to clarifying the conceptual and philosophical basis of knowledge development, scholars in nursing were also making advances in the methods that nurses use to develop knowledge. Thus parallel to the maturing theoretical nursing literature, authors in nursing were demonstrating advances in methodologic inquiry. Research approaches to create and test theories for practice were increasing in breadth and depth from empiric, interpretive, and integrated perspectives.

Gortner (2000) described a shift in thinking in nursing knowledge development when nursing *research* became nursing *science*. Nurses recognized that what we thought was science was really research, the tool of science. By the closing decades of the last century and into the 21st, Gortner noted that “nursing science was depicted as a human science that had the additional requirements of intervention or clinical therapy” (p. 64). She described the progress that had been made in identifying and documenting the phenomena of interest and related propositions through research. Accordingly, this research was based on the knowledge domains and syntax identified by Donaldson and Crowley (1978) and further clarified by Meleis (1980). Gortner concluded that nursing science came of age with an explosion of fundamental and clinical science activities in nursing. Gortner’s analysis suggested factors that influenced this coming into maturity. These included a shift from discrete studies to aggregates of studies, nursing faculty with doctoral preparation that included excellent research preparation and interests that fit with concentrations of research at the schools, more collegiality among faculty, external competition for research support, the waning of arguments over appropriate methods, and the science enterprise being enhanced in many settings when a number of scientists became deans.

## Research Literature

Journals focusing on nursing research were significant in the development of nursing science. *Nursing Research* was launched in 1951 to serve two purposes, first to inform members of the nursing profession and allied professions of the results of scientific studies in nursing and second to stimulate research in nursing. More than 50 years later rankings by the Institute for Scientific Information (ISI) Journal Citation Report (Journal Citation Reports, 2004) ranked the journal number 2 of 32 ranked and noted that it also has the second highest impact factor. This factor is based on the average number of times the articles from the journal published in the past 2 years have been cited in the review year. In the rating system noted earlier, the journal scores 10 and includes points for being listed high in other ratings.

It was 25 years before nurses in the United States, specifically those in the Midwest, identified the need to establish another such journal, *Research in Nursing and Health*. Harriet Werley, the journal’s first editor, noted that the purpose, as for any scientific journal,

was to “communicate newly discovered knowledge that was verified and deemed significant” (Werley, 1978, p. 3). Besides original research, the journal invited manuscripts on health issues relevant to nursing and investigations of implementation of research findings in clinical settings, as well as theoretical and methodological papers and integrated and critical reviews. This journal scores 9 out of 10 in the Allen rating (2001).

Werley was responsible for another major contribution to the publication of nursing research and to review and critique of cumulative knowledge. Working consistently from the late 1960s, first informally, then through nursing organizations, Werley with coeditor Joyce Fitzpatrick launched the *Annual Review of Nursing Research* in 1983. The preface of the first volume noted that as most disciplines mature, they develop media to review critically the work that leads the discipline forward. This provides the opportunity on a regular basis to evaluate advances made, existing gaps, and areas for further work. Werley envisioned that the review would result in a systematic assessment of knowledge development and provide nursing with an appropriate data-based foundation. Initially the annual volume of the *Annual Review* contained four parts: research on nursing practice, on nursing care delivery, on nursing education, and on the profession of nursing. After two decades, Fitzpatrick, the editor, noted that the series “has reflected the development of nursing science from infancy to its present maturity” (Fitzpatrick, 2002, p. ix). The first 14 reviews included chapters in the four key areas. Later, several volumes included research review chapters in clinical nursing and nursing care delivery, emphasizing the focus on clinical nursing research. Recent volumes have been topically focused including chronic illness, women’s health, geriatric nursing care, the state of the science in nursing, health disparities among racial and ethnic minorities, and alcohol use and abuse.

### Publication of Qualitative and Quantitative Research

Nursing literature in the latter half of the 20th century reflected to a representative degree the quantitative versus qualitative debate in relation to strategies for nursing research. However, this dialogue did not seem to produce significant insights beyond those identified in the discussions of the paradigmatic schools of thought discussed in the philosophical literature. What is apparent is the preferences of editorial boards at given times for one approach over another. A review of articles from the first few decades of *Nursing Research* showed a preponderance of quantitative research. It may be true that most research of the era was quantitative in nature, but it seems that the publication of qualitative research lagged behind the development of the use of these methods.

Although qualitative research seemed at times to be unwelcome by the editors of research journals, some journals had a greater receptivity. For example, the *Western Journal of Nursing Research* was founded in 1978 by Pamela Brink, a nurse prepared in anthropology and known for promoting qualitative methods. The journal had a stated three-pronged editorial philosophy with the following functions: publish completed research papers; disseminate information about research conferences, research grants available, and developing research projects; and provide practical “how-to” columns on the research process and its functions. In 2002, Brink continued her open editorial policy and promoted discussion of issues in research methodology. The Allen rating of this journal is 8 out of 10.

Two other journals that have a history of publishing qualitative research are the *Journal of Advanced Nursing* in the UK and the *Australia Journal of Advanced Nursing*.

Their role in philosophical discussions from varying paradigmatic views has been noted. Likewise, the publication of research using multiple approaches has been significant. Just as an example, it was noted that a recent issue of *Journal of Advanced Nursing* included articles on ethical debate, an ethnographic study, patient narrative as method, an observational study using discourse analysis, and a mixed methods study.

It can be noted that qualitative research by nurses is also published in journals edited by one or more other disciplines. Further, the editor of the widely esteemed journal *Qualitative Health Research*, Janice Morse, holds the PhD degree in both nursing and anthropology. What seems clear is that nurse scholars, and nurse editors included, are recognizing multiple ways of developing knowledge for nursing and thus the research literature is enriched.

### Programs of Research

Other advances in research for practice, as noted by Gortner (2000), included focused programs of research. Investigators develop cumulative knowledge that includes integrated biobehavior foci and multiple methods. Johnson (1972) and colleagues conducted one of the early programs of research on sensory information, coping strategies, and recovery. These investigators used laboratory research and several clinical situations as well as descriptive, correlational, and intervention strategies.

Mishel's (1981 and 1997) program of research focuses on uncertainty in illness and interventions to prevent and manage chronic illness. Using multiple qualitative and quantitative research strategies, Mishel and her colleagues have theoretically and clinically derived and tested relationships among the antecedents of uncertainty, stimuli frame and structure providers, outcomes of uncertainty, and the mediating roles of appraisal and coping. Continually funded by the National Institutes of Health since 1984, Mishel has been cited as an exemplar of nursing intervention studies, for example, presenting her research for a Congressional Breakfast in 1999. Mishel has maintained a strong link of her theory and research to practice and her work has been foundational for research of other scholars (Stiegelis et al., 2004; Wineman, Schwetz, Zeller, & Cyphert, 2003).

Morse developed a program of research in the areas of comfort and comforting, enduring, and suffering from a qualitative perspective (University of Alberta Web site <http://www.u.ualberta.ca>, last accessed August 23, 2006). These studies also have included instrument development derived from qualitative strategies and tested empirically. This work has been funded by federal grants from both the United States and Canada. Morse has focused on the nurse-patient interaction and relationship, experience of illness and major trauma, the cross-cultural aspect of health care, patient falls and use of restraints, and women's health.

Given the theme of this text on nursing knowledge development and clinical practice, one final observation may be noted about methodologic inquiry reflected in the nursing literature. Highly rated specialty journals, based of the rating system noted earlier, increasingly publish nursing research. A total of nine clinical specialty journals were rated either 7, 8, or 9 out of 10 based on content, reputations, and citations, and the same journals had 37 to 84% of the content rated as research. For example, *Cancer Nursing* rated 9 out of 10 and had 84% of the content considered research articles in the period rated, and *Public Health Nursing* was rated 7 on the same scale with 78% of the content research articles.

## Sociopolitical Commitments Basic to Nursing Knowledge

As a profession, nursing has a social mandate to contribute to the good of society. Just as the focus and methods of nursing knowledge development have “come of age” so too we identify an increasingly mature development of sociopolitical knowledge and of social responsibility. White (1995) noted that Carper’s patterns of knowing in nursing were consistently cited in the literature for nearly 20 years. In her critique, the author makes a major modification by adding a fifth way of knowing, the sociopolitical, to better represent nursing knowledge in the last decade of the 20th century. White stated that Carper’s patterns addressed the “who,” the “how,” and the “what” of the practice of nursing. However, the “wherein” of nursing practice is addressed by sociopolitical knowing. Specifically, she stated that “it lifts the gaze of the nurse from the introspective nurse–patient relationship and situates it within the broader context in which nursing and health care take place. Understandings of both the sociopolitical context for the nurse and patient and of nursing as a practice profession are needed” (pp. 83). Particularly in the 21st century, nursing needs this understanding to have a voice in bringing about alternative conceptualizations of health and health care. This need is emphasized by the fact that health care has become driven primarily by economics. White draws upon a model developed by Jacobs–Kramer and Chinn (1987) to facilitate Carper’s patterns of knowing into clinical practice in nursing.

Later Chinn and Kramer (1999) further explicated the ways of knowing in the 5th edition of *Theory and Nursing: Integrated Knowledge Development*. The authors presented a model that provided an overview of the patterns, their interrelationship, and usefulness to conceptualize the broad scope of holistic practice. The model identified questions for knowledge development and processes related to knowing. *Empirics* related to the questions *What is this?* and *How does it work?* and used processes of replication and validation. *Personal* knowing asked, *Do I know what I do?* and *Do I do what I know?* and used response and reflection. *Aesthetics* focused on questions such as *What does it mean?* and *How is it significant?* used processes of envisioning and rehearsing. *Ethics* asks, *Is it right?* and *Is it responsible?* and relied upon valuing and clarifying. By the 6th edition in 2004, the authors renamed the text *Integrated Knowledge Development in Nursing*.

In addition, Chinn (1995) articulated an approach to nurses’ accountability for helping to deal with imbalances of power in society. She used the acronym PEACE as both an intent and process rooted in women’s ancient wisdom. PEACE was valued, and the skills, actions, and abilities that go with the value were articulated. Again, a series of questions, this time about the congruence of intent and actions, was used to identify how to work effectively with empowering all members of a group. *Praxis* asked, *Do I know what I do?* and *Do I do what I know?* Empowerment questioned: *Am I expressing my own will in the context of love and respect for others?* Awareness focused on *Am I fully aware of myself and others?* Consensus added the question *Do I face conflicts openly and integrate differences in forming solutions?* Finally, the skill and ability of Empowerment questioned: *Do I value growth and change for myself, others, and the group?*

Early nursing publications on the concept of oppression discussed the characteristics of oppressed groups and how oppression is maintained, often based on the work of Freire (1968). For example, Roberts (1983) developed such a description from literature on groups, including Latin Americans, American blacks, and Jews. Roberts noted Friere’s insight that the major characteristics of oppressed behavior stem from the ability of

dominant groups to identify their norms and values as the right ones in the society and from their power to enforce their norms and values. Roberts then analogously applied the model to nurses as an oppressed group.

A later paper by Kendall (1992) outlined a theory of emancipatory nursing actions derived from the work of Freire, as well as the critical theory of Habermas (1988) and R. Katz's (1984) description of synergistic community. The author noted that the proposed theory is a practice theory that advocates for oppressed groups. Further emancipatory nursing actions "are those that increase the potential for oppressed groups to take power from those who oppress them, whether that be fighting for a national health insurance policy, and increase in funding for the homeless, or a change in the political power base of an organization" (Kendall, 1992, p. 9). Because poverty, education, and social problems are linked to health concerns, Kendall, and many others, noted that they cannot be addressed in isolation. To respond to the challenge to care for clients who are socially, politically, and economically disadvantaged, nurses must develop knowledge that addresses health within the social context of their clients' lives.

The sociopolitical approach to knowledge has been given impetus by concerns related to health disparities. The Institute of Medicine (IOM, 2003) published a report showing clearly that members of racial and ethnic minorities receive lower quality of health care than whites even when income and health insurance are comparable. The range of health conditions for which care is substandard is broad, including cardiovascular disease, cancer, and diabetes. The causes are seen as multifaceted. The National Center on Minority Health and Health Disparities was established within NIH in 2000 and since that time all the Institutes, Centers, and Offices, including the National Institute for Nursing Research, have included reducing health disparities in their goals and funding priorities. Nurse scholars are making significant contributions to understanding health disparities and developing effective strategies toward the goal of eliminating them (Anderko, Bartz, & Lundeen, 2005; Giddings, 2005).

Meleis (1997; Meleis & Im, 1999) proposed that an important goal for nursing research is to develop knowledge about the nature and consequences of marginalization. The authors defined marginalization as the process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments. As noted in the IOM report, people are marginalized by the inequities that they experience in the societies where they are living and this process leads to depriving them of quality care. Meleis makes an appeal for researchers in nursing to passionately "bring public attention to the needs, the voices, the suffering, the dehumanization, and the strategies to provide quality care for the marginalized such as the poor, the homeless, the lesbians, the gays, the immigrants, the home workers, the domestic workers, the commercial sex workers, the confused elderly and the disabled" (Meleis & Im, 1999, p. 101).

## **Summary of Advances in Knowledge**

In summary, the developments of the latter part of the last century and at the beginning of the 21st century reflect nursing as a maturing practice discipline with a clear focus for knowledge, multiple philosophical perspectives, strong methodologic inquiry, and increasing sociopolitical commitments. These developments are also reflected in and received impetus from doctoral education and professional conferences.

## Doctoral Education and Professional Conferences

The maturing of nursing as an academic and practice discipline relates to doctoral education and professional conferences because both serve key roles in socialization, dialogue, debate, and emerging trends. Again, these influences are interactive with developments in the focus for knowledge, philosophical perspectives, research methods, and sociopolitical involvement.

### The Role of Doctoral Education

The focus of doctoral education in nursing currently is “to prepare students to pursue intellectual inquiry and conduct independent research for the purpose of extending knowledge” (American Association of Colleges of Nursing [AACN], 2001, p. 10). The first doctoral program for nurses was established at Teachers College, Columbia University, in 1933 and led to the EdD degree. New York University initiated a doctoral degree program in 1934. The PhD degree was first offered at the University of Pittsburgh in 1954. DNSc programs were initiated in 1964 at the University of California at San Francisco (UCSF) and in 1967 at the Catholic University of America. According to the AACN, since 1970 most new programs in nursing have offered the PhD degree and many DNS programs have been converted to PhD programs. Thirty new programs were added in the decade of the 1980s and 26 in the 1990s. The total institutions offering doctoral programs in nursing as of February 2006 was 101. Ten programs offered the Nursing Doctorate (ND), which prepares individuals for practice and is not a research-focused degree. Discussions continue on alternative forms of a practice doctorate.

Indicators of quality in research-focused doctoral programs in nursing (AACN, 2001) noted that the program of study is influenced by the faculty's areas of expertise and scholarship, the mission of the parent institution, and the discipline of nursing. The core and related course content is described as including historical and philosophical foundations to the development of nursing knowledge; existing and evolving substantive nursing knowledge; methods and processes of theory/knowledge development; research methods and scholarship appropriate to inquiry; and development related to roles in academic, research, practice, or policy environments.

Some doctoral programs in nursing take a given perspective on knowledge development and are known for related contributions. A few examples can be cited. The problem-solving approaches of Dodd (1988) and Carrieri-Kohlman and colleagues (1993) described earlier and originating with faculty at UCSF have resulted in large numbers of doctoral graduates prepared in physiologic and symptom-management research. At the same time, other doctoral and postdoctoral students studying at UCSF with Benner contributed to knowledge development from a process perspective, particularly hermeneutic-phenomenologic. Similarly, humanistic transpersonal caring, under the leadership of Watson, has provided a paradigm for knowledge development by students at the University of Colorado.

Practice level theory and empiric research is a main focus for doctoral and postdoctoral studies at the University of Michigan, particularly in health promotion and risk reduction. Faculty mentors involved in this work have included Nola Pender, studying

interventions to promote physical activity among youth; Carol Loveland-Cherry, who is looking at school and family interventions to decrease adolescent substance abuse; and Susan Boehm, whose work includes behavioral interventions as they relate to health promotion, illness prevention, and screening and detection. Boston College selected ethical reasoning as one foci for the PhD program started in 1988. In the first 15 years of the 120 graduates, many conducted research in this area and significant papers were published (Hanna, 2004, 2005; Olson, 1991).

Meleis and Im (1999) identified the effect of developments in doctoral education as part of the tremendous changes in nursing as a discipline. They noted that nursing has better graduate programs “designed to educate scholars and graduates who are well-prepared, well-mentored and well-supported individuals as agents for knowledge development” (p. 94). This trend of strong doctoral programs leading to varying paradigmatic perspectives that yield knowledge for practice can be expected to continue in the first decades of this century. One contribution to this effort is the rapid growth of doctoral programs globally. The International Network of Doctoral Education in Nursing (INDEN) listed 273 doctoral programs located in every region of the globe by 2003.

## Conferences

The historical role played by conferences in the theoretical development of nursing is often acknowledged (Alligood & Tomey, 2006; Moody, 1990; Walker & Avant, 2005). One important series of conferences were those held as part of the nurse–scientist program. The topic for an early conference held under the auspices of Frances Payne Bolton School of Nursing in 1966 was “Research—How Will Nursing Define It?” Papers by nurse investigators about research from varying approaches were used to discuss the kinds of questions that could be conceived to be nursing questions and how methods and designs could be constructed for systematic study. The following year the title was “Symposium on Theory Development in Nursing.” The role of theory related to research was addressed. Significant papers from the conference were published in *Nursing Research* in 1968 and included those by Dickoff and James, Johnson, and Ellis that contributed greatly to ongoing theoretical dialogue for many years following. The conference in 1968, under the auspices of the School of Nursing at the University of Colorado, was called “Conference on the Nature of Science and Nursing.” Focus of the panel discussion was on the position of the pure and applied scientist (Simon, 1968). Notably in 1969 the topic changed to “The Nature of Science in Nursing” and again University of Colorado was the sponsor. Leininger, the conference chair, noted that 70 participants from 21 universities attended. Important papers published included “The Nature of Nursing Science” (Abdellah, 1969) and “Theories, Models, and Systems for Nursing” (McKay, 1969).

The University of Kansas Medical Center, Department of Nursing Education, held three conferences funded by the Division of Nursing on nursing theory, two in 1969 and one 1970. Catherine Norris, chair of the conferences, noted in the introduction to the published proceedings, “Intelligent and effective clinical practice in nursing requires the rationale and guidelines provided by the scientific base. In a rapidly changing society which has a rapidly expanding technology, the nursing profession is ever more dependent on this scientific or theoretical framework if fragmentation of patient care and nursing services are to be avoided,” and she emphasized communities of scholars who created

“dialogues on critical nursing issues and which stimulate nursing research that has the potential for improving the quality of nursing care offered to patients” (Norris, 1969, n.p.). General systems theory and implications for nursing emerged as an important topic. Diers and Dye (1969) presented a paper on “Situation Producing Theory.” It is notable that at the 1970 conference, Loretta Zderad talked about empathy from a humanistic perspective.

Also as part of the nurse–scientist program, a symposium entitled “Approaches to the Study of Nursing Questions and the Development of Nursing Science” was held in 1972. Rozella Schlotfeldt chaired the symposium at Frances Payne Bolton School of Nursing and highlighted the issue that nursing is a practice discipline and may use knowledge contributed by basic science. She noted that, “A time arrives, however, when each profession spawns practitioner-inquirers who seek answers to important questions that no basic scientist has asked and those which none will ever ask” (Schlotfeldt, 1972, p. 484). Most nurses presenting papers had been prepared in other disciplines and all addressed approaches to the study of nursing questions.

Conferences to discuss and derive nursing diagnosis began in 1973 (Gebbie & Lavin, 1975). A nurse theorist group was convened by Sr. Callista Roy to contribute to the theoretical basis for the nursing diagnosis. The group met with the national conferences and as a working subgroup about twice a year from 1976 to 1980. The stated goals were to develop a theoretical framework for nursing diagnosis and to make recommendations regarding the levels of generality of the diagnostic categories. However, in retrospect speaking at the 25th anniversary of NANDA, Roy noted that a major contribution of the project was the face-to-face working of the theoretical thinkers of the time, including Margaret Hardy, Rosemarie Ellis, Joyce Fitzpatrick, Martha Rogers, Margaret Newman, Rosemary Parse, Marjorie Gordon, Imogene King, Dorothea Orem, and Callista Roy.

The professional nursing organizations also presented conferences that contributed to the development of nursing knowledge. For a number of years, the American Nurses Association (ANA) included the organizational unit of the Council of Nurse Researchers, which sponsored semiannual research conferences. Later, this work was continued by the Council for the Advancement of Nursing Science (CANS) whose mission is to better health through nursing science. In addition, the ANA convened groups of nurse scholars to develop and publish the first *Nursing’s Social Policy Statement* in 1980, which defined nursing as, “the diagnosis and treatment of human responses to actual or potential health problems” (ANA, 1980, p. 6). The revision published by ANA in 2003 emphasized essential features of professional nursing including: the provision of a caring relationship that facilitates health and healing, advancement of professional nursing knowledge through scholarly inquiry, and influence on social and public policy to promote social justice.

The National League for Nursing conducted a workshop on theory development in Kansas City in 1977 entitled “Theory Development: What, Why, and How?” The published papers presented different viewpoints on nursing theory development by nursing leaders most actively involved at the time, including Johnson, King, Fawcett, Zderad, Paterson, Rinehart, and Hardy. The content was significant, but reportedly the attendance was small. In contrast, conferences of the same era sponsored by a nursing journal attracted large numbers of participants and became very theory focused. Allgood (2002) noted that the Nurse Educator Conferences in Chicago (1977) and New York (1978) indicated a shift of emphasis from research to theory at the national level. The first conference did not have a theory theme, but 800 nurses attended the breakout session

in which Sister Callista Roy presented how to use the Roy Adaptation Model as a guide for nursing practice. Thus the second conference was planned around nursing theory and brought a large group of nurse theorists to the same stage to speak to an audience of 2,000 nurses. Allgood noted that this second conference underscored a growing awareness that the nature of knowledge needed for nursing practice was theoretical knowledge. The conference served as a vehicle for this awareness but not necessarily as a vehicle for the forward movement of knowledge development in nursing.

From that point forward, it seemed that the potential for conferences was not fully utilized in the struggle nurses face to bring knowledge to bear on the multiple problems of providing adequate health care. In the 1980s, one important contribution for growing perspectives on knowledge was the publication of *Setting the Agenda for the Year 2000: Knowledge Development in Nursing* (Sorensen, 1986), the results of the 1985 annual meeting of the American Academy of Nursing. The format of advisory group sessions, a scientific session, and forums was planned to enable fellows to exchange ideas to begin using the academy as a think tank. An important paper by Stevenson and Woods (1986) addressed “Nursing Science and Contemporary Science: Emerging Paradigms.” Stimulated by this analysis, the Academy Fellows brought their wealth of knowledge and experience to eight forum groups that addressed issues surrounding the content and process of nursing knowledge development. A synthesis of a common perspective was presented as “The Future of Nursing Science: Response of the Academy.”

Deliberations about the content of future nursing science described the phenomena of nursing as “human–environment interactions enhancing health” and further as

the organized diversity of theory, research, and practice is the basis for conceptualizing our phenomena. Explaining the philosophical foundation, practice heritage, and current social mandate of nursing enables us to decisively articulate our agenda. In the process the pragmatic concerns of language and political relevance will be balanced with the focused growth of our science. (Roy, 1986, p. 25)

Issues related to the process of knowledge development raised by the Academy forum groups included the plurality of methods to deal with holism, specialization and collaboration, and the need for longitudinal studies and replication.

### Nursing Knowledge Conferences

At the same time that the American Academy of Nursing was dealing with these issues, the basis for a resurgence of the potential of conferences was laid by a group of doctoral students with the assistance of Margaret Hardy who initiated a series called the “Annual Nursing Science Colloquia” at Boston University from 1984 to 1987 (see Appendix). Conferences focused on strategies for theory development and included presentations by nursing leaders such as Ada Sue Hinshaw, Glenys Hamilton, Shake Ketefian, Hesook Suzie Kim, Jean Johnson, Donna Swartz-Barcott, and Jeanne Quint Benoliel. Besides the forum to discuss the development of knowledge for nursing science, the colloquia were an important opportunity for doctoral students to be socialized into the discipline and associate with leaders in the field in a way reminiscent of the nurse–scientist conferences of the 1960s and early 1970s.

From 1990 to 1994, the University of Rhode Island (University of Rhode Island College of Nursing, 1993 & 1994) continued the impetus and ran a series of five symposia

devoted to knowledge development in nursing. The emphasis was on the interconnectedness among philosophy, theory, research, and practice and the influence on the development of nursing knowledge. Linkages among philosophy, theory, methods of inquiry, and practice were explored as were the philosophies of realism, relativism, interpretivism, humanism, and praxis. Nursing practice theories and pluralism in theories for practice were the focus of one symposium. Speakers throughout the series included Susan Gortner, Frederick Suppe, Margaret Newman, Marilyn Rawnsley, David Allen, Nancy Woods, Sr. Callista Roy, Hesook Suzie Kim, John Phillips, Lorraine Walker, Sue Donaldson, and Nancy Dluhy. Dialogue among all participants remained an important strategy for these conferences.

In the later 1990s, the Boston College School of Nursing (Boston College School of Nursing, 1996 & 1997), in conjunction with Eastern Nursing Research Society and Sigma Theta Tau, Alpha Chi Chapter, initiated a series of five conferences on nursing knowledge impact. Speakers included Beth Rogers, Margaret Newman, Sr. Callista Roy, Lorraine Walker, Hesook Suzie Kim, Janice Thompson, Peggy Chinn, Jean Watson, Dorothy Jones, Marjory Gordon, and Jacqueline Fawcett. A feature of the series was the Knowledge Consensus Conference in 1998 that used a participatory process to generate a value-based position paper linking nursing knowledge and practice outcomes signed by more than 90 participants. (The Consensus Statement appears at the end of this chapter.) Responses to the consensus paper were featured at the “Emerging Nursing Knowledge 2000” International Conference held in collaboration with the School of Nursing and Midwifery, University College Dublin, Ireland, and the Institute of Nursing Science at the University of Oslo, Norway. Eight invited international papers were presented as well as 26 concurrent sessions and posters by scholars from 6 countries and 12 states in the United States. Time was also planned for dialogue, refinement of the emerging consensus, and movement of the collective wisdom to an action plan for the impact of nursing knowledge on critical needs in practice. The Knowledge Conference in 2001 in Boston featured exemplars for knowledge-based changes in practice.

## Concerns With Health Care Systems and Delivery

The recent era of significant development in knowledge for nursing practice has coincided with a time of drastic challenges in the health care delivery system. The unparalleled growth of health care costs precipitated an era of health care reform. Serious cost containment strategies have been in effect in the United States since the mid-1990s and still the spending per capita in this country for health care far exceeds all other nations. Market-driven principles have ruled health care reform. Problems with health care systems and care delivery go beyond economic concerns. The juxtaposition of the developments in nursing knowledge for practice and turmoil in health care represent a great paradox for nursing; this time of growth is a time of great challenge.

### Health Care Challenges

Health care was dramatically impacted by major scientific and sociopolitical movements of the late 20th century. The wave-particle duality of quantum physics made it possible to

move from simple x-rays to magnetic resonance imaging and countless other diagnostic and treatment options. The human genome project was launched in 1990 with the goal of mapping the entire human genome sequence. With participation from numerous laboratories in more than a dozen countries, in February 2001 headlines proclaimed that the code of life had been mapped and findings published in the journals of *Science* and *Nature*. This and other potentially powerful information was accumulating more rapidly than it could be analyzed, understood, and thoroughly evaluated. It has been estimated that 20 million people were enrolled in health care research studies in the United States in 2001. Ethics and public policy have not necessarily kept pace with the advances in science and technology.

Information replaced energy as the most important resource. The information age brought with it issues related to confidentiality, privacy, and security. For example, as new regulations were put in place related to the patient's medical record, many questions remain of who can have access to what information and how it can be transmitted securely. With the almost infinity of data in cyberspace on the World Wide Web, any patient can have immediate access to an array of information on medical conditions and their treatments. Massive availability of health-related information that is not analyzed, understood, and evaluated raises similar difficulties as noted with rapidly advancing science. The result is a more informed, but not entirely knowledgeable nor an empowered, public.

### Sociopolitical Influences

Some sociopolitical developments greatly influencing health care include the increasing age of the population, income gaps, and diversity with attendant health disparities. In the 20th century, the number of Americans over 65 years grew from 3 million in 1900 to 36.3 million in 2004. The U.S. Census Bureau predicts that the number will increase to 86.7 million by 2050 (DeNavas-Walt, Proctor, & Lee, 2005). The significant effects on health care are highlighted in a comment from a report on aging that "the hospital is becoming the intensive care unit, the nursing home is becoming the hospital, and the home is becoming the nursing home" (Martin, 2001, p. 25).

The income gaps in the United States provide similar profound health care challenges. It is commonly reported that the wealthiest 20% of the population control as much wealth as the bottom 80%. In fact, between 2002 and 2003, the income of the lowest 20% of the population declined 1.9%, from \$18,326 to \$17,984, while the income of the top 80% increased 1.1%, from \$85,941 to \$86,867. The poverty rate and the number of poor rose in 2003 to 12.5% or 35.9 million. The depth of poverty within this group is striking: 40.8% (13.4 million) of the poor population are listed as severely poor; that is, their family incomes are below one-half the poverty threshold (U.S. Census Bureau report, 2004). One child in 6 is born poor and 1 in 3 will be poor at some point in his or her childhood. *Time* magazine (quoted by National Council of Churches USA on their Web site, <http://www.nccusa.org>, last accessed February 5, 2003) noted that the national assets in the United States have not been so unevenly distributed since just before the stock market crash in 1929.

Demographic changes have profound implications for health care. For example, the number of persons without health insurance is continually rising and in 2004 was at 45.8 million, 8 out of 10 of whom were in working families. One reporter (Lazarus, 2004) expanded on the problem, quoting public surveys showing that 5 million fewer jobs now

provide health insurance than just 3 years before, and for jobs that do provide coverage, insurance premiums climbed 11.2% in 1 year or four times faster than both inflation and average U.S. workers' wages. Most companies noted that in the near future it was very likely that they would raise employee contributions to health coverage.

Related figures showed that already 8.4 million children were without health insurance or 11.4% of all children under age 18 (DeNavas-Walt, Proctor, & Lee, 2005). A report on data assembled and analyzed by Physicians for a National Health Program was entitled "US Health Care Crisis Facts: Uninsured, Access, Quality, Cost, Superprofits, Market-Driven Chaos." The generalization is made that "Managed Care Companies are abandoning America's seniors and disabled (from Medicare Managed Care and Plus-Choice), contending costs and losses are forcing their hand. At the same time, their top executives take home millions." Some of the facts they provide are (a) The top executives in these companies received an average of \$2.4 million per year in compensation, exclusive of unexercised stock options in 1997. (b) Sixty-one of the 90 health maintenance organizations (HMOs) that are pulling out of the Medicare market are owned by 9 for-profit, publicly traded insurance companies. (c) The number of Americans without health insurance, nearly 1 in every 6 persons, constitutes a higher proportion than at any time since Medicare and Medicaid were passed in 1965. (d) Medicaid enrollment has fallen by 1.8 million, apparently as a result of welfare cutbacks. (e) Forty-three percent of the uninsured had a problem paying their medical bills last year and yet 16.5% of people with insurance also had problems paying medical bills, because they had only partial coverage.

Another challenge for health care delivery is the increasing diversity of the population of the United States, primarily reflected in the changing trends in international migration. Historically the foreign-born residents of this country increased each decade until 1930 and then declined until 1970 (Immigration and Naturalization Service Web site, <http://www.ins.usdoj.gov/graphics/index.htm>, February 15, 2006). From 1970 to 2005, there has been a rapid increase from 9.6 million to 35 million foreign-born residents. The increase of 7.5 million since 2000 makes this the highest 5-year period of immigration in American history. Further the percent of immigrants to the total population increased from 7.9% in 1990 to 12.4% in 2005 (Center for Immigration Studies Web site, [www.cis.org](http://www.cis.org), February 15, 2006). One in 20 persons in the United States is foreign born or has one or both parents who are foreign born. High concentrations of immigrants are found in major metropolitan areas such as New York and Los Angeles, with 4.7 million each. In other areas, the percentage foreign-born to native population is high; for example, Miami has 42.7% foreign born. Trends in countries of birth have also changed. Historically, European countries and Canada were leading countries of birth for the foreign-born population; however, in 1999–2000, the eight countries with the highest numbers were Mexico, China, Philippines, India, Cuba, Vietnam, El Salvador, and Korea.

An additional fact affecting health care is that in 2000 there were 72.1 million foreign-born children living in the United States. Births to foreign-born women in 1970 were 6% of the total but 20.2% in 1999. Poverty status for immigrants and their U.S.-born children is 18.4% compared with 11.7% for native born. As for education, one-fifth of the foreign born have less than a 5th-grade education as compared with 1 in 20 of the native born. Although the percent participating in the labor force for both groups is about the same, 44.5% of the foreign born in 1999 had employment-based health insurance compared with 54.6% of the native born. Among immigrants one-third lack

health insurance, which is two and a half times the rate for native born. The extensive diversity of languages, cultures, and resources presents challenges to health systems and individual nurses in practice.

## **Problems of Access and Quality**

Advances in science, medicine, and public health have not translated into better health care for all. Gulzar (1999) demonstrated that the gap between health care services available and the health care needs of people exist in the richest countries such as the United States and Canada and in the poorest such as Pakistan. The author defined access to health care conceptually as “the fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services” (p. 17). In Gulzar’s analysis, the operational definition of access to health care is related to its several dimensions. This means that “the ability of people to access health care is influenced by health care system and user-related aspatial characteristics including need for services, sociocultural, psychological, financial, and attitudinal variables and geographic or spatial characteristics such as distance, architectural, and transportation variables which may be barriers or facilitators” (p. 17).

The burgeoning literature on health care disparities was referred to earlier in the discussion of the contributions of nurses to social political knowledge. Problems of both access and quality are noted in this literature. In summarizing the issue of racial health care disparities, Katz (2001) noted key examples of specific treatments that Whites are more likely to receive than Blacks such as cardiovascularization even when judged necessary rather than discretionary cerebrovascular surgery, total hip and knee replacement, and renal transplantation. Hispanics were less likely to receive many interventions, including total hip replacement, cardiac procedures, and preventive measures. Recognizing the significant problem of racial health disparities, other scholars have argued for taking seriously the influence of geography in medical practice for both the statistical measurement of the incidence of disparities and for the design of reforms to reduce disparities (Chandra & Skinner, 2003).

Examples of problems of adequate access are found daily in nursing practice. Patients were sent home after same day surgery with instructions that may fall short in meeting their needs (Jones, Flanagan, & Coakley, 2000). An emergency department nurse may be dealing with the family of a child with a spinal cord injury and is acutely aware that there is no rehabilitation service in the state for children who have such injuries. Systemwide, one can easily infer the issues of access from the major demographic changes discussed. Increasing numbers of elderly living with multiple chronic illnesses raise questions of the physical capacity of the health system to deal with needs. At the same time, the elderly may have transportation and architectural barriers to what care is available. The continuity of care of the elderly is and will continue to be a major challenge. The significant income gaps noted and the rising numbers of persons without health insurance presents financial barriers to equal access. Financial and geographic barriers are intensified for the diverse populations who also have sociocultural barriers, such as differences in language and beliefs about health and health care.

The issue of quality of health care is tied to the issue of access. If access means timely, needed, necessary, continuous, and satisfactory health services, then quality health care means the level to which all persons receive care that meets these criteria. In particular, the beliefs about health care and its place in the economic system affect quality. Throughout the industrialized world all countries except the United States have some kind of national health system that considers health care a right and provides for basic level care to all citizens. Several attempts have failed to establish this right with an organized system to implement at least basic care for everyone in the United States. Federal legislation in 1965 established Medicare as a form of health insurance for persons over 65 and Medicaid administered by individual states as coverage for welfare recipients.

In the 1970s and 1980s, a number of factors, including advancing science and technology, caused health care costs in the United States to rise dramatically. At the same time, the public expected to benefit from such advances regardless of the cost (Schaag & Phipps, 1999). However, by 2004 the National Coalition on Health Care reported that premiums for employer-based health insurance rose by 11.2% and that this was the fourth consecutive year of double-digit increases. Further, this involved all types of health plans including HMOs, preferred provider organizations (PPOs), and point-of-service plans (POS). By early 2006, debates arose about shifting health care expenses and whether to mandate employer health benefits. When employers do not provide health care coverage, the individual states struggle to handle health care costs for citizens with the burden placed on the taxpayers. At the same time, businesses buckle under the rising cost of health insurance. Many labor contract disputes focus on health care coverage. In the climate of increasing costs, managed care, which had been evolving gradually, soon took over the health care system in what one author called “a de facto reform that was carried out by the private health insurance market” (Newbergh, 2002, p. 31).

### **Influence of Managed Care**

Managed care is a system of health insurance that offers health care coverage but limits the choice of providers and self-referrals. The two major types of managed care plans are HMOs and PPOs. The promise of this approach was cost containment strategies such as capitation, that is, a fixed sum of money for a patient’s overall care. This arrangement was meant to create an incentive to do only what was necessary for good care and not waste resources. Managed care was expected to reduce overuse of the system such as costly referrals to specialists and lengthy hospital stays. It was also expected to improve preventive care. Insurance companies and fee-for-service physicians have rapidly developed PPOs as an alternative to HMOs. Physicians and hospitals are now contracted to the insurance companies. Gage (1998) reported that in barely a decade managed care came to dominate health care insurance and delivery systems. In some cases, it is the only option offered by an employer. By 1995 nearly three-fourths of all employees with health insurance were enrolled in some form of managed care. In 1998, Gage reported that the expected cost containment had not been realized and that the research on quality of care is inconclusive.

In other words, the HMOs have not been the answer to access to affordable and high quality health care. One study (Nathanson, Ramirez-Garnica, & Wiltout, 2005) noted that children with cystic fibrosis (CF) using managed care attended CF centers significantly less frequently than those with nonmanaged care. The authors noted that

their findings suggest that under managed care children with CF may not have equal access to experts in CF. Another study (Simonet, 2005) reported that most surveys indicated that a lack of choice of a provider is a major source of discontent for patients under HMOs. In a broad study of psychiatric patients, authors concluded that managed care delayed rather than prevented return visits to the psychiatric emergency service and that increasing numbers of patients with mental illness in need of treatment were coming to the attention of law enforcement officials after managed care was implemented (Claassen, Michael-Kashner, Gilfillan, Larkin, & John-Rush, 2005).

Historically health care professions have been strategic in efforts to improve quality of health care. For example, in 1918 the American College of Surgeons aimed to improve medical care in hospitals by establishing a standardization program and the Joint Commission on Accreditation of Hospitals was formed in 1952, later becoming known as the Joint Commission on Accreditation of Health Care Organizations. With the federally funded programs in place and the insurance companies managed care, quality assurance activities proliferated. For example, the Health Care Finance Administration requires managed care plans contracted to Medicare to complete a quality report called *Health Plan Employer Data and Information Set*. The National Committee for Quality Assurance accredits HMOs. Most hospitals have utilization review programs and case management programs. Total quality management (QM) and continuous quality improvement (CQI) are widely marketed approaches that focus on patient outcomes and the systems that support attaining these outcomes.

Still the media report the numbers of patients who die each year in hospitals because of errors, large numbers of patients enter the system by using emergency departments, patients are befuddled by rejected claims for health care reimbursement, and debates are set off about the number of days of hospital care that should be paid for, for example, after giving birth. At the same time, the health care providers are overburdened with unreasonable amounts of paperwork to document eligibility and provide rationale why a patient needed more than the amount of care covered in the plan. Nurses in other countries can identify how concerns about access and quality have developed and are manifested in the health care systems of their own countries.

## Challenge for the Future

In the 21st century, the unresolved concerns with the health care system and care delivery present a challenge. Nurses are keenly aware of the changing demographics and issues of access and quality of health care. The late-20th-century developments of a clear focus of nursing knowledge and effective methods to develop knowledge are highly relevant to the current health care challenge. These advances in knowledge are the basis for dealing effectively with the challenge to transform the future of nursing practice. Four ways of thinking about the future have been outlined (Roy, 2000; Sullivan, 1999). *Possible futures* are unlikely and are referred to as wildcards because they have low probability, but high impact, such as the fall of the Berlin Wall. *Plausible futures* are based on trends and deal with what could happen based on a range of scenarios and one example could be increasing environmental consciousness. A *probable future* is one that will happen as an extension of the present, often in a direction one does not want such as spiraling health

care costs. The final type of future is a *preferred future*, that is, what one would want to happen, such as adequate health care for all.

One can use the vision of development in nursing knowledge to create a future for practice that does not exist yet and is not likely to unfold without changes in the present. Nurse scholars creating knowledge are called upon to provide visions for a possible future that is also preferred. The Nursing Knowledge Consensus Paper, featured in this chapter (see the following section), provides the assumptions and principles that are basic for transformation of practice. This book explores these possibilities.

Consensus Statement on  
Emerging Nursing Knowledge  
A Value-Based Position Paper Linking Nursing Knowledge and Practice Outcomes  
USA Nursing Knowledge Consensus Conference, 1998  
Boston, Massachusetts

INTRODUCTION: A Series of conferences was held in the Northeastern area of the USA during the 1980s and 1990s and were well attended by nurses from throughout the USA and representatives of other countries. This series was followed by the historic convening of Knowledge Consensus Conference 1998 in Boston, Massachusetts, from October 22–24, 1998. The focus of the conference was to build on previous presentations and perspectives on developments within nursing science using a participatory process. The goal for the 140 conference participants, consensus builders, and facilitators was to discuss and synthesize various perspectives on knowledge development related to (1) the nature of the human person, (2) the nature of nursing, (3) the role of nursing theory, and (4) the links of each of these understandings to nursing practice. This document summarized the key assumptions, scientific principles, and values for each issue that had the greatest amount of consensus.

I. ONTOLOGY OF THE PERSON

- A. Assumption: Understanding the human person, as individuals, families, communities, and groups, is the focal point of knowledge development and nursing.
- B. Scientific Principles and Values:
  1. The person is characterized by wholeness, complexity and consciousness. Personhood can be considered on individual, family and community levels. The person is sentient with multiple dimensions including individuality and embodiment. A human being is evolving, in process, fluid, and changing. Each person or social group has purpose, promise, and potential for continuing transformations. The social and cultural environment for the person, family, or community reflects multiple values and social-political perspectives. Nurses recognize both the commonalities and differences of people. Humankind is moving from an ethnocentric to global perspective.
  2. The person is capable of choice and has free will tempered by the context of one's past, present, and future. The individual is inherently good, has rights, and is self-directed. At the same time, each person recognizes the rights of others and works toward increasing freedom and emancipation for self and

other persons. Conflicting rights are to be resolved, resulting in balance and harmony. Such balance and harmony are sought at all levels for individuals and groups, from electrolytes to the cosmos.

3. The person is interdependent and lives in reciprocity, connection, affiliation and relationship. Through dialogue and exchange, together with self-reflection, the person makes meaning. Through such meaning, the person understands self, and other persons, particularly within family and community, as well as the larger world. Personal meanings and knowledge are shared through distributed cognition.
4. The person in both Eastern and Western traditions has a yearning beyond the human. This characteristic has been termed spirituality and involves seeking a common destiny. Spiritual beliefs may be spoken or unspoken and are particularly rooted in family and social traditions. For some, the soul of the person is viewed as the energy of the universe and an existential reality.

## II. ONTOLOGY OF NURSING

A. Assumption: Nursing is a human practice discipline that facilitates well-being using a scientific knowledge base and values in a caring relationship.

B. Scientific Principles and Values:

1. The essence of nursing lies in modes of being, including the nurse's true presence of his or the whole self. The nurse uses the mode of being with and being for, in the process of human to human engagement. Other terms used to describe this fundamental aspect of nursing include interaction, mutuality, and encounter. The engagement is mutual, an iterative process that includes giving and receiving and being humble. Nursing provides a presence with others derived from the soul or spirit of the nurse that interfaces with the soul and spirit of the other. This relationship includes respect and acceptance of where the person is and the nurse's openness to another person's reality. The nurse appreciates the patient and the space between the nurse and the patient. An empathetic presence requires reflection by the nurse and engaging persons in the process of their journey. It also includes intimacy, trust, and authenticity. Further, commitment, responsibility, and accountability are terms used to characterize the nature of nursing. Caring is described as including presence, feeling empathy, and nurturing that is oriented to promotion of health and well-being. Caring takes place within the context of a therapeutic relationship and is considered a moral imperative of nursing. Caring relationships occur with individuals, family, community, and societies as a whole.
2. Nursing by its nature brings intentionality to the therapeutic process. In addition to being for the other, the nurse acts for the other. Actions of the nurse focus on health. Health involves fulfilling human potential and enabling well being for individuals, families, communities, and groups. Some nurses refer to the goal of nursing action as movement on the health-illness continuum. For the nurse, the human encounter is purposeful and focuses on building and bridging human possibilities. The nurse uses both philosophic and scientific knowledge to empower others. Nursing knowledge is based on understandings and values related to the nature of persons. The science of nursing involves complex ways of knowing, including clinical wisdom. Nurses strive to be competent and recognize their limitations. Nurses' work is with

humans and includes the role of raising consciousness about the sacredness of human beings. Helping people to make healthy choices requires knowledge, integrity, and accountability. Nurses are responsible for their actions and put the patient, family, or community first. Ethical and moral principles are used in respecting the autonomy of persons.

3. Cultural competence is a core element of nursing. Caring by the nurse is transcultural. To be transcultural is more than a value; it is a demand for action. Cultural competence and scientific competence are not hierarchical but integrated in nursing action. Nurses have a special accountability to transcend ethnocentrism. A nurse cannot be effective if he or she is confined in the narrowness of one's own culture. The knowledge base of nursing is meaningful to the patient and the patient's needs and to the needs of the family and community. Such needs occur within a given social context. Nurses value cultural differences and strive to individualize knowledge for care. Nurses recognize the real and strive for the ideal. At the same time, nurses acknowledge the complexity in the world. They question how privilege may blind the nurse to the wisdom of ordinary people and thus how the needs of some people may not be recognized by nursing.
4. As a discipline with a social mandate, nurses take responsibility for social transformation. Political activism is one form of valuing and acting within the discipline. Nurses are altruistic and strive to do what is morally right in the service of human beings and society. Nurses are proactive in engaging health promotion and prevention of ill health. They advocate for others and work to provide access to health care for all. Nurses examine the constraints of modern organizations and work to create systemic change that is more responsive to the needs of the global population. Nurses strive to return the face of humanity to health care systems. Nurses are open to change, anticipate change, and respond to the challenge of change. Current challenges include changes in economic and technologic realities at national and international levels. A goal for nursing knowledge and action is to empower communities. Commitment to empowerment of others requires a fierce compassion from nurses.

### III. NURSING THEORY

- A. Assumption: Nursing theory expresses the values and beliefs of the discipline, helps to frame the human experience, and guides the caring process.
- B. Scientific Principles and Values:
  1. Nursing theory is the vehicle used to operationalize a disciplinary perspective. It embraces a wholistic view of what it means to be human and helps frame the nurse-patient experience. Theory is respectful of personal meaning, human diversity, the uniqueness of the individual, and spiritual expression. It provides the context from which nurses come to understand personal responses to a dynamic and changing health care environment.
  2. In nursing theory, the discipline articulates core beliefs and common assumptions. Guided by these universal philosophical links, multiple epistemological views emerge to help understand the complex, dynamic, interactive and transforming caring experience that occurs between the nurse and patient, family, community, or other social group. The result is knowledge (content and

language) that depicts how nurses think and what they think about. Nursing theory creates a way to link the disciplinary ontology with a unique perspective about the dynamic person/environment interaction. It is useful in providing an approach to guide nursing practice, education and research.

3. Theory creates a way to organize knowledge. It allows for the integration of knowledge from other disciplines that can inform and expand the sphere of understanding from a nursing perspective. Theory is not static. Rather, it is iterative, dynamic, and evolving. It must be continually updated and informed by practice and research. Theory helps to clarify existing knowledge and direct new discoveries. Through synthesis and reflection, nurses are able to develop the content of the discipline and create the bridge between theory and practice.
4. Theory helps to illuminate practice. It creates the disciplinary knowledge needed to guide clinical judgments, actions, and articulate clinical outcomes that acknowledge a disciplinary contribution to global health. Theory should reflect reality. It is only then that it is clinically useful. Theory directs the nurse to uncover new knowledge about the human experience in a unique way. The testing and refinement of theory helps to generate information that can be used to fill the existing knowledge gaps needed to describe and explain the human experience of individuals, families, communities, and groups.

#### IV. LINKING THE NATURE OF PERSON, THE NATURE OF NURSING, AND NURSING THEORY TO NURSING PRACTICE

A. Assumption: The essence of nursing practice is the nurse–patient relationship that embodies beliefs about the nature of person and the nature of nursing.

B. Scientific Principles and Values:

1. Nursing practice manifests a unique understanding of the person from a disciplinary perspective. The connection between the nurse and the patient fosters human health and supports self-discovery. The nurse uses problem solving and process skills, such as reflection, to come to know the person, family, community, or social group. This knowing results in actions that guide patients and groups in making choices and decisions that promote personal and group growth. Knowledge and creative artistry are used to tailor nursing care to an individual or group's unique responses and behaviors across the health care experience.
2. The nurse–patient relationship is a dynamic, evolving, and transforming partnership, grounded in trust and truth. It flourishes in an environment that is sensitive to the uniqueness of the person or group and includes attention to biophysical, cultural, and spiritual dimensions of both. The intentional presence of the nurse is essential for coming to know and understand what it means to be human and humans in relationships. This knowledge provides the basis for the mutual selection of interventions that can promote health and self-determination.
3. Nursing practice occurs within a sociopolitical environment. As a discipline, nursing continues to make visible the role it plays in problem solving and decision making. Nursing demonstrates the effectiveness for the health of

a society of a practice that achieves outcomes of personal growth for individuals and groups, promotion and evaluation of change, self-knowing, and personal and social transformation. It is essential that the contributions of nursing be described within the framework of quality and cost-effectiveness. Nurses use language that has collaborative acceptance in order to justify contributions to care that are recognized by sources of funding for health care. Nursing knowledge, both theory and research, are used to inform health care policy and provide the basis for nurses' voice for change and social reform.

4. Nursing practice uses knowledge, both theory and research based, to guide care and promote change. The patient, as individuals, families, communities, and groups, is the central focus of nursing care. Nursing education, practice, and research assist in optimizing the patient experience within a caring environment. Nursing education reflects the reality of practice while providing students with the knowledge needed to reform and direct health care across settings. Nurse mentors are essential to professional development and optimal patient care. Nursing theory provides a framework for understanding the nurse-patient interaction and helps direct patient care. The continued preparation of nurses who can define the discipline to the public and other health care providers is critical to the advancement of the discipline. Nursing practice creates environments that optimize and differentiate the unique contributions of nurses to patient care and the health of the society.

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