Jacqueline Fawcett

Contemporary Nursing Knowledge

Analysis and Evaluation of Nursing Models and Theories

Second Edition

CONTEMPORARY NURSING KNOWLEDGE

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Analysis and Evaluation of Nursing Models and Theories

SECOND EDITION

JACQUELINE FAWCETT, PhD, FAAN

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Preface

As we continue to be challenged by the organization and financing of the contemporary health care system, as well as a worldwide nursing shortage, the need to articulate what nursing is and can be has never been more critical. Conceptual models of nursing and nursing theories provide clear answers to questions about what nursing is, what nursing can be, and how what nursing is and can be influences what nurses do—or should do. Conceptual models of nursing and nursing theories also provide:

- Answers for nurse educators, who continue to seek better ways to prepare students for current and future trends in health services.
- Answers for nurse researchers, who continue to seek ways to identify the phenomena of central interest to nursing and to design studies that reflect nursing's distinctive perspective of people in matters of health.
- Answers for nurse administrators, who continue to seek ways to organize the delivery of nursing services in an efficient and effective manner and to document the quality of nursing practice.
- Answers for practicing nurses, who continue to seek ways to improve the quality of people's lives.

This edition of the book is the culmination of years of thinking, talking, and writing about the structure and nature of contemporary nursing knowledge. It was written for all nurses and nursing students who are interested in the development of nursing knowledge and the use of that knowledge to guide nursing research, education, administration, and practice. Although some reviewers have indicated that the book is most appropriate for graduate students, others, with whom I agree, insist that the book also is a valuable resource for undergraduates.

As with my previous books, this edition represents an ongoing attempt to clarify the confusion between conceptual models and theories that remains in the nursing literature. To that end, the book includes the abstract and general formulations of nursing knowledge that are called conceptual models of nursing, the somewhat less abstract and general formulations that are called grand nursing theories, and the relatively concrete and specific formulations that are called middle-range nursing theories. The book continues the tradition of my previous books by presenting the most up-to-date information available about the major conceptual models of nursing and nursing theories.

The book is divided into four parts. Part One introduces the reader to the world of contemporary nursing knowledge, as formalized in conceptual models of nursing and nursing theories. Chapter 1 acquaints the reader with what I regard as the components of contemporary nursing knowledge, including the metaparadigm, philosophies, conceptual models, theories, and empirical indicators. That chapter contains my latest thinking about the nature and structure of contemporary nursing knowledge, with attention to the current dialogue about nursing knowledge and others' critique of my work in this area. That chapter also contains discussion about my un-

derstanding of the relations among the metaparadigm of nursing, philosophies of nursing, conceptual models of nursing, nursing theories, and empirical indicators. Chapter 2 acquaints the reader with strategies used to implement conceptual models of nursing and nursing theories in the real world of nursing practice.

Part Two introduces the reader to conceptual models of nursing. Chapter 3 presents a distinctive framework for the analysis and evaluation of nursing models. Chapters 4, 5, 6, 7, 8, 9, and 10 illustrate the application of the analysis and evaluation framework, and acquaint the reader with the most widely recognized and most frequently cited nursing models. In these chapters, the reader enters the world of nursing as conceptualized by Dorothy Johnson in her Behavioral System Model, Imogene King in her Conceptual System, Myra Levine in her Conservation Model, Betty Neuman in her Systems Model, Dorothea Orem in her Self-Care Framework, Martha Rogers in her Science of Unitary Human Beings, and Sister Callista Roy in her Adaptation Model.

Part Three introduces the reader to nursing theories. Chapter 11 presents a distinctive framework for the analysis and evaluation of nursing theories. Chapters 12, 13, 14, 15, and, 16 illustrate the application of the analysis and evaluation framework. These chapters acquaint the reader with the most widely recognized and most frequently cited nursing theories. In Chapters 12 and 13, the reader learns about two grand theories—Margaret Newman's Theory of Health as Expanding Consciousness and Rosemarie Parse's Theory of Human Becoming. In Chapters 14, 15, and 16, the reader learns about three middle-range theories—Ida Jean Orlando's Theory of the Deliberative Nursing Process, Hildegard Peplau's Theory of Interpersonal Relations, and Jean Watson's Theory of Human Caring.

Part Four introduces the reader to the possibilities of nursing knowledge now and in the future. Chapter 17, the last chapter in this book, offers the reader an opportunity to consider a strategy to promote the integration of nursing knowledge with nursing research and nursing practice and to explore what the discipline of nursing could become.

The Appendix includes such resources as societies devoted to the advancement of particular conceptual models of nursing and nursing theories, internet home pages, audio and video productions, CD-ROMs, and strategies for computer-based literature searches.

Chapters 1 and 2 should be read before the remainder of the book. Those first two chapters provide the background that facilitates understanding of the place of conceptual models of nursing and nursing theories in the structural hierarchy of contemporary nursing knowledge and the use of nursing models and theories in nursing practice. Chapter 17 may be read at any time. That chapter should be of special interest to nurses who are committed to fostering the survival and advancement of the discipline of nursing. Chapter 3 should be read before the subsequent chapters dealing with various conceptual models of nursing. Similarly, Chapter 11 should be read before the chapters dealing with various nursing grand theories and middle-range theories.

I have continued to draw from my extensive personal conversations and correspondence with the authors of the conceptual models and theories, as well as from the vast literature about the conceptual models and theories, with emphasis on the latest primary source materials. The book includes comprehensive reviews of virtually all of the published literature dealing with the use of conceptual models of nursing and nursing theories as guides for nursing practice, nursing administration, nursing education, and nursing research. In an attempt to make the primary source material and other literature in each chapter more immediately accessible to readers, tables are used to present practice and research methodologies for each conceptual model and theory, as well as lists of uses of each conceptual model and theory as a guide for nursing research, nursing education, nursing administration, and nursing practice.
Special features of this edition include:

- An overview and list of key terms for each chapter
- A nursing process format, that is, a nursing practice methodology, for each conceptual model and theory
- Rules or guidelines for nursing research, education, administration, and practice for each conceptual model
- A research methodology for each nursing theory
- Strategies for the implementation of each conceptual model and theory in nursing practice
- A bibliography for each chapter on a searchable compact disk (CD)

Readers are encouraged to use this book in combination with the primary source materials that are cited in the chapter references and bibliographies. The references at the end of each chapter are supplemented by the CD, which comes with the book. The CD includes comprehensive bibliographies of all relevant literature that could be located through hand and computer-assisted searches of an extensive list of nursing books and journals. The bibliographies include citations to the full range of debate and dialogue about contemporary nursing knowledge and each conceptual model and theory. The bibliographies for each of the conceptual model and theory chapters are divided into several sections: Primary Sources; Commentary: General; Commentary: Research; Commentary: Education; Commentary: Administration; Commentary: Practice; Research; Doctoral Dissertations; Master's Theses; Research Instruments and Nursing Practice Tools; Education; Administration; and Practice. I continue to be grateful to the authors of the conceptual models and theories and to my students and colleagues for the many citations of relevant publications they have shared with me. I also continue to be grateful to the staff of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) for their technical support, which has greatly facilitated my searches of the literature over the years.

I believe that a hallmark of this book, as with my other books about nursing conceptual models and theories, is the care that I take to present an accurate account of each conceptual model and theory as it was developed by its author rather then to draw from secondary analyses and other interpretations of the author's work. Each of those chapters includes many direct quotes from the author's original works. The quotations reflect the author's writing style and the language customs at the time of publication of the particular book or journal article. Despite some criticism from colleagues, I have decided to continue to not alter pronouns to reflect current gender-neutral language. However, in this edition I have endeavored to replace the word "clinical" with "practice" or "nursing practice," in response to contemporary dialogue about "clinical" referring solely to bedside nursing. A chapter about Leininger's Theory of Culture Care Diversity and Universality has not been included in this edition of the book because I was unable to obtain permission for the quotations needed for the analysis of the theory. Readers interested in that grand theory are referred to the many books, book chapters, and journal articles by Madeleine Leininger and those who use her theory to guide their research and practice.

The success of the previous editions of my books, as well as the successive editions of other texts dealing with conceptual models of nursing and nursing theories, indicates continued interest of nurses in *nursing* knowledge, rather than in the knowledge of other disciplines. Nurses are especially fortunate to be able to select as a guide for their work any one of many conceptual models and theories that already have been used widely. Thus, novice users can draw from the experiences of those who forged the way. And, experienced users can expand their work by examining what other users have done.

The works included in the book continue, in my opinion, to be the major representatives of conceptual models and nursing theories in the contemporary nursing literature. Readers who are interested in understanding the content of other nursing conceptual models and theories are encouraged to use the frameworks for analysis and evaluation of conceptual models of nursing

and nursing theories that are given in Chapters 3 and 11. My sincere hope is that this book will stimulate readers to continue their study of conceptual models and nursing theories and to adopt explicit conceptual-theoretical-empirical structures for their nursing activities.

The writing of this edition of the book was, as always, a consuming, stimulating, and growth-enhancing experience. Thanks for its preparation is owed to many people. First, I continue to be indebted to Dorothy Johnson, Imogene King, Myra Levine, Betty Neuman, Dorothea Orem, Martha Rogers, Callista Roy, Margaret Newman, Ida Jean Orlando, Rosemarie Parse, Hildegard Peplau, and Jean Watson, whose efforts to continuously refine the knowledge base for the discipline of nursing made this book possible. My conversations and written communications with those nursing pioneers have greatly enhanced my understanding and appreciation of all the obstacles they have overcome to share their visions of nursing with us. I am greatly saddened by the deaths of Martha Rogers, Myra Levine, Hildegard Peplau, and Dorothy Johnson, but am heartened by the works of other nurses who have had the courage to advance Martha's, Myra's, Hildegard's, and Dorothy's ideas about nursing. I also am indebted to those courageous researchers, educators, administrators, and clinicians who stand for *nursing* by using explicit conceptual models of nursing and nursing theories to guide their work.

Moreover, I am indebted to my students and colleagues at the universities where I have been privileged to teach, serve as a visiting faculty member, or to present a paper, for their support, intellectual challenges, and constructive criticism. In addition, I am indebted to Joanne DaCunha of F.A. Davis Company for her encouragement and the time spent discussing the content and design of this edition of the book. Finally, I continue to be indebted to Robert G. Martone of F.A. Davis Company for his steadfast support of my work.

My gratitude to my husband, John S. Fawcett, for his unconditional love and support throughout our 40 years of marriage and his understanding of the demands of my nursing career, continues to extend to the infinite universe.

Jacqueline Fawcett
Waldoboro, Maine

Credits

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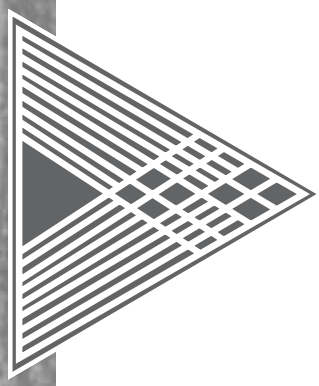

Part One

STRUCTURE AND USE OF NURSING KNOWLEDGE

Part One introduces the reader to the world of contemporary nursing knowledge, as formalized in conceptual models of nursing and nursing theories.

Chapter 1 introduces the reader to the components of contemporary nursing knowledge, including the metaparadigm, philosophies, conceptual models, theories, and empirical indicators.

Chapter 2 introduces the reader to the strategies used to implement conceptual models of nursing and nursing theories in the real world of nursing practice.

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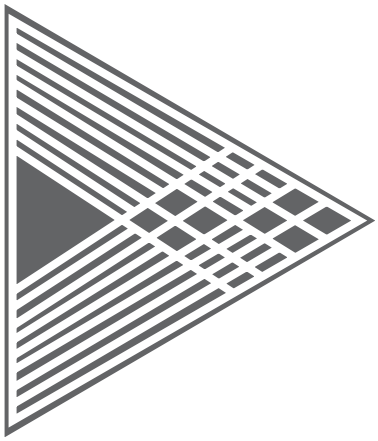

Chapter 1

The Structure of Contemporary Nursing Knowledge

This book celebrates nursing as a distinct discipline, and this chapter lays the groundwork for the remainder of the book. Here, a structural holarchy of contemporary nursing knowledge is identified and described. Each component of the structure—metaparadigm, philosophies, conceptual models, theories, and empirical indicators—is defined and its functions are delineated. Then the distinctions between the components are discussed, with special emphasis on the differences between conceptual models and theories and the need to view and use these two knowledge components in different ways.

Overview

The structural holarchy differentiates the various components of contemporary nursing knowledge according to their level of abstraction. Drawing from Wilber (1998), the term holarchy, rather than hierarchy, is used to denote components that are whole within themselves but also part of a larger whole. In this case, the larger whole is contemporary nursing knowledge. Thus, each component of contemporary nursing knowledge is a complete whole but also part of a larger whole. The components of the structural holarchy of contemporary nursing knowledge are listed here. Each component is defined and described in detail in this chapter.

Key Terms

STRUCTURAL HOLARCHY OF CONTEMPORARY NURSING KNOWLEDGE

CONCEPTS
PROPOSITIONS
- Nonrelational Proposition
- Relational Proposition

METAPARADIGM
- Requirements for a Metaparadigm
- Metaparadigm of Nursing

PHILOSOPHIES
- Philosophies of Nursing
- Reaction World View
- Reciprocal Interaction World View
- Simultaneous Action World View
- Categories of Nursing Knowledge

CONCEPTUAL MODELS
- *Conceptual Models of Nursing*

THEORIES
- Grand Theory
- Middle-Range Theory
- Nursing Theories

EMPIRICAL INDICATORS

STRUCTURAL HOLARCHY OF CONTEMPORARY NURSING KNOWLEDGE

An analysis of the terminology used to describe contemporary nursing knowledge led to the identification of five components: metaparadigm, philosophies, conceptual models, theories, and empirical indicators (Fawcett, 1993a; King & Fawcett, 1997a). These components comprise the unique disciplinary knowledge of nursing, the knowledge that separates nursing from other disciplines (Parse, 2001b).

The **STRUCTURAL HOLARCHY OF CONTEMPORARY NURSING KNOWLEDGE** is *a heuristic device that places the five components of contemporary nursing knowledge into a holarchy based on level of abstraction.* Similar structures have long been proposed by scholars in other disciplines, including Feigl (1970), Gibbs (1972), and Margenau (1972). The holarchy is depicted in Figure 1–1.

CONCEPTS AND PROPOSITIONS

With the exception of empirical indicators, the components of the structural holarchy are composed of concepts and propositions. Empirical indicators measure concepts. A **CONCEPT** is *a word or phrase that summarizes ideas, observations, and experiences.* Concepts are tools that provide mental images that can facilitate communication about and understanding of phenomena; they are not real entities (Babbie, 1998). A **PROPOSITION** is *a statement about a concept or a statement of the relation between two or more concepts.* A **nonrelational proposition** is a description or definition of a concept. A nonrelational proposition that states the meaning of a concept is called a constitutive definition. A nonrelational proposition that states how a concept is observed or measured is called an operational definition. A **relational proposition** asserts the relation, or linkage, between two or more concepts.

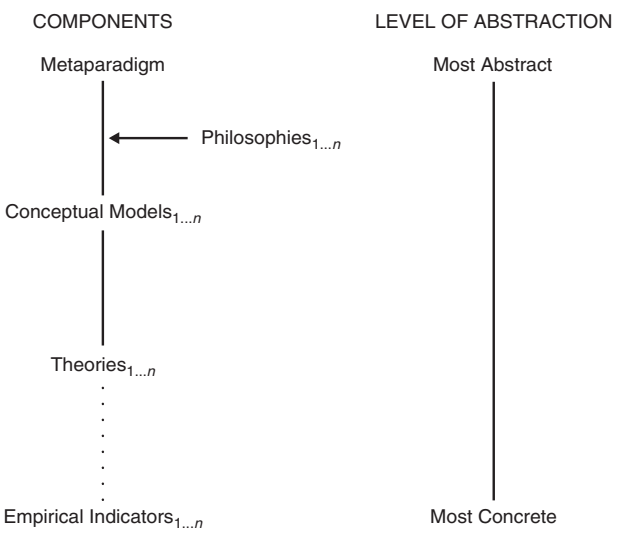

FIG. 1–1. The structural holarchy of contemporary nursing knowledge: components and levels of abstraction.

METAPARADIGM

The first component of the structural holarchy of contemporary nursing knowledge is the **METAPARADIGM** (see Fig. 1–1). A metaparadigm is defined as *the global concepts that identify the phenomena of central interest to a discipline, the global propositions that describe the concepts, and the global propositions that state the relations between or among the concepts.* That definition of a metaparadigm indicates that concepts alone are not sufficient to identify the subject matter of a discipline or to delineate the boundary for the subject matter of interest to a discipline (Kim, 2000b). Rather, both concepts and propositions about those concepts are required to specify the subject matter.

The metaparadigm is the most abstract component of the structural holarchy of contemporary nursing knowledge, and acts as "an encapsulating unit, or framework, within which the more restricted … structures develop" (Eckberg & Hill, 1979, p. 927). The concepts and propositions of a metaparadigm are admittedly extremely global and provide no definitive direction for activities such as research and practice. That is to be expected because the metaparadigm "is the broadest consensus within a discipline. It provides the general parameters of the field and gives scientists a broad orientation from which to work" (Hardy, 1978, p. 38). In other words, a metaparadigm "is concerned with general issues of the subject matter of a discipline … [that is,] what a discipline is concerned with" (Kim, 2000b, p. 28).

The idea for a component of knowledge called the metaparadigm arose in discussion of the multiple meanings Kuhn (1962) had given to the term, paradigm. Masterman (1970) pointed out that one meaning reflected a metaphysical rather than scientific notion or entity and labeled that meaning as the metaparadigm.

FUNCTIONS OF A METAPARADIGM

Articulation of the metaparadigm brings a certain unity to a discipline. In particular, specification of the concepts and propositions that represent the subject matter of a disci-

pline permits the members of that discipline to communicate to members of other disciplines and to the general public what is of special interest to that discipline. In other words, the members of the discipline can say, "This is who we are and what our work is all about." Similarly, specification of the metaparadigm concepts and propositions facilitates communication of what the discipline is *not* about. Thus, members of the discipline can also say, "This is what we are not about." In addition, the boundary imposed by the metaparadigm concepts and propositions helps the members of the discipline identify the focus of their knowledge development activities and to have confidence that what they are doing is, indeed, consistent with the subject matter of the discipline. Members of the discipline then can say, "This is *why* I am doing what I am doing."

The functions of a metaparadigm, then, are to summarize the intellectual and social missions of a discipline and place a boundary on the subject matter of that discipline (Kim, 1989, 2000b). Those functions are reflected in four **requirements for a metaparadigm** (Fawcett, 1992, 1996.). The four requirements, which pertain to the metaparadigm of any discipline, are:

1. The metaparadigm must *identify a domain that is distinctive from the domains of other disciplines*. That requirement is fulfilled only when the concepts and propositions represent a unique perspective for inquiry and practice.
2. The metaparadigm must *encompass all phenomena of interest to the discipline in a parsimonious manner*. That requirement is fulfilled only if the concepts and propositions are global and if there are no redundancies in concepts or propositions.
3. The metaparadigm must *be perspective neutral*. That requirement is fulfilled only if the concepts and propositions do *not* represent a specific perspective, that is, a specific paradigm or conceptual model, or a combination of perspectives.
4. The metaparadigm must *be international in scope and substance*. That requirement, which is a corollary of the third requirement, is fulfilled only if the concepts and propositions do not reflect particular national, cultural, or ethnic beliefs and values.

The requirements indicate that the metaparadigm of any discipline must be highly abstract and general; concise and free of redundant terms; not aligned with a particular disciplinary frame of reference; and free of particular national, cultural, or ethnic group orientations. Conflicting opinions have been voiced about the third requirement, which calls for perspective neutrality. That means that the metaparadigm should not embrace a particular philosophic stance or conceptual model within a discipline that encompasses diverse philosophies and conceptual models. Thorne and colleagues' (1998) comments reflect support for the third requirement. They stated, "We believe that our central concepts ought to be characterized by paradigmatic neutrality" (p. 1265). In contrast, Cody (1996) and Malinski (1996) maintained that the third requirement is not appropriate or even possible. Cody asserted that the requirement is "an impossibility recognized throughout post-positivist philosophy of science and the human science perspectives of hermeneutics and critical theory" (p. 98). Malinski (1996) pointed out that the metaparadigm of nursing, at least the proposal put forth by Fawcett (1996), "is reflective of the dominant view in nursing," which she labeled as the totality paradigm (p. 101). The differences of opinion about the requirement of perspective neutrality indicate that consensus about the appropriate requirements for the metaparadigm of any discipline does not yet exist within nursing.

METAPARADIGM OF NURSING

Origins of the Metaparadigm of Nursing

The notion of a metaparadigm was introduced in the nursing literature in the late 1970s, when nursing, as Rawnsley (1996) pointed out, "was struggling to defend its self-nominated status as a science" (p. 102). In 1978, Hardy defined a metaparadigm as "a gestalt … within a discipline" (p. 38). Hardy went on to explain that a metaparadigm "provides a map which guides the scientist thought the vast, generally incomprehensible world. It gives focus to scientific endeavor which would not be present if scientists were to explore randomly" (p. 38). Hardy likened the metaparadigm to the "prevailing paradigm in a discipline [that] presents a general orientation … that holds the commitment and consensus of the scientists in a particular discipline" (p. 39). In 1979, Smith used the term metaparadigm to refer to a way of organizing and structuring nursing phenomena. Later, Fawcett (1984b) defined the metaparadigm of any discipline as "a statement or group of statements identifying its relevant phenomena" (p. 84). She claimed that a review of the literature of the time revealed "evidence supporting the existence of a metaparadigm of nursing" (p. 84).

Proposals for the Nursing Metaparadigm

Fawcett (1978) initially identified what she called the central units of nursing as person, environment, health, and nursing. She then formalized those units as the concepts of the metaparadigm of nursing in her article, "The

Metaparadigm of Nursing: Present Status and Future Refinements" (Fawcett, 1984b). In her response to Fawcett's paper, Brodie (1984) pointed out, "Fawcett's metaparadigm can be viewed as an evolution of a nursing metaparadigm and an organization of the growth of nursing knowledge rather than as a completed and finalized product" (p. 87). Indeed, several proposals for different versions of the nursing metaparadigm have emerged since that time. Some of those proposals were in direct response to Fawcett's proposal, whereas others were offered without reference to Fawcett's work.

The Fawcett Proposal. The metaparadigm of nursing is made up of four concepts, four nonrelational propositions, and four relational propositions. The four concepts are:

- Human beings
- Environment
- Health
- Nursing

The nonrelational propositions of the metaparadigm of nursing, which are constitutive definitions of the metaparadigm concepts, are:

- The metaparadigm concept of human beings refers to the individuals, if individuals are recognized in a culture, as well as to the families, communities, and other groups or aggregates who are participants in nursing.
- The metaparadigm concept of environment refers to human beings' significant others and physical surroundings, as well as to the settings in which nursing occurs, which range from private homes to health-care facilities to society as a whole. The metaparadigm concept of environment also refers to all local, regional, national, and worldwide cultural, social, political, and economic conditions that are associated with human beings' health.
- The metaparadigm concept of health refers to human processes of living and dying.
- The metaparadigm concept of nursing refers to the definition of nursing, the actions taken by nurses on behalf of or in conjunction with human beings, and the goals or outcomes of nursing actions. Nursing actions are viewed as a mutual process between the participants in nursing and nurses. The process encompasses activities that are frequently referred to as assessment, labeling, planning, intervention, and evaluation.

The relational propositions of the metaparadigm of nursing, which were drawn from work by Donaldson and Crowley (1978) and Gortner (1980), assert the linkages between metaparadigm concepts. Relational proposition 1 links the concepts human beings and health. Relational proposition 2 links the concepts human beings and environment. Relational proposition 3 links the concepts health and nursing. Relational proposition 4 links the concepts human beings, environment, and health. The relational propositions are:

1. The discipline of nursing is concerned with the principles and laws that govern human processes of living and dying.
2. The discipline of nursing is concerned with the patterning of human health experiences within the context of the environment.
3. The discipline of nursing is concerned with the nursing actions or processes that are beneficial to human beings.
4. The discipline of nursing is concerned with the human processes of living and dying, recognizing that human beings are in a continuous relationship with their environments.

This version of Fawcett's proposal for the metaparadigm of nursing represents refinement of earlier versions (Fawcett, 1984b, 2000). One refinement is the modification in the labels for the four metaparadigm concepts. The frequently cited metaparadigm concepts of person, environment, health, and nursing were a modification of labels for four concepts induced from the conceptual frameworks of baccalaureate programs accredited by the National League for Nursing. The original concepts were labeled man, society, health, and nursing (Yura & Torres, 1975). "Man" was changed to "person" to avoid gender-specific language, and "society" was changed to "environment" to more fully encompass phenomena relevant to the person (Fawcett, 1978). In the current version of the metaparadigm, "person" has been changed to "human beings." That change was made in response to Leininger's (1991a) argument that the concept of person is not a globally understood term. She stated, "From an anthropological and nursing perspective, the use of the term person has serious problems when used transculturally, as many non-Western cultures do not focus on or believe in the concept person, and often there is no linguistic term for person in a culture, family and institutions being more prominent" (pp. 39–40). Furthermore, the change may address Jacobs' (2001) charge that "The concept of 'person' … is … insufficient to represent all of nursing's phenomena, thereby indicating a continued need for clarification and validation" (pp. 19–20).

Another refinement is the inclusion of a constitutive definition for each metaparadigm concept. Continued refinement of the constitutive definitions of the metaparadigm concepts has resulted in the current reference to the human being as a participant in nursing, rather than a recipient of nursing. In keeping with Thorne and colleagues' (1998) belief that the central concepts of nursing

should be characterized by "common currency" (p. 1265), that change was made to better reflect the contemporary emphasis on human beings as active participants in the process of nursing, rather than passive recipients of pronouncements by and ministrations from nurses. Continued refinement also has resulted in an expansion of the constitutive definition for the metaparadigm concept environment. That refinement was made to better reflect the multitude of environmental conditions that are relevant in nursing (Kleffel, 1991). In addition, refinement of the constitutive definitions has resulted in a change in the definition of health from states of wellness and illness to human processes of living and dying. That change was made in response to Cody's (1996) point that Fawcett's "view of health as a 'state' that can be characterized on a continuum from 'high-level wellness to terminal illness' … [implies that] everyone's health ultimately and unavoidably reaches abysmal levels in the natural dying process" (p. 98). Other refinements include the formalization of metaparadigm themes into relational propositions and the addition of the fourth relational proposition.

The current version of the metaparadigm meets the four requirements for a metaparadigm given earlier in this chapter. In particular, the four metaparadigm concepts—human beings, environment, health, nursing—generally are regarded as the central or domain concepts of nursing (Flaskerud & Halloran, 1980; Jennings, 1987; Thorne et al., 1998; Wagner, 1986). Additional support for the centrality of the four metaparadigm concepts comes from the successful use of those concepts as a schema for analysis of the content of conceptual models of nursing and nursing theories (Fitzpatrick & Whall, 1996; George, 2002; Marriner-Tomey & Alligood, 2002; Parker, 2001). The utility of the four metaparadigm concepts is underscored by their adoption, with appropriate modifications, as the concepts of the metaparadigm of dental hygiene. More specifically, Darby and Walsh (1994) identified the concepts of the dental hygiene metaparadigm as client, environment, health/oral health, and dental hygiene actions.

The relational propositions of the metaparadigm provide a unique perspective of the metaparadigm concepts that helps to distinguish nursing from other disciplines. Relational propositions 1, 2, and 3 represent recurrent themes identified in the writings of Florence Nightingale and many other nursing scholars and practitioners of the 19th and 20th centuries. Donaldson and Crowley (1978) commented, "These themes suggest boundaries of an area for systematic [i]nquiry and theory development with potential for making the nature of the discipline of nursing more explicit than it is at present" (p. 113). Relational proposition 4, according to Donaldson and Crowley (1978), "evolve[d] from the practical aim of optimizing of human environments for health" (p. 119).

Taken together, the four concepts, the four nonrelational propositions, and the four relational propositions identify the unique focus of the discipline of nursing and encompass all relevant phenomena in a parsimonious manner. The concepts and propositions are perspective-neutral because they do not reflect a specific philosophic perspective, a specific paradigm, or a specific conceptual model. Furthermore, the metaparadigm concepts and propositions do not reflect the beliefs and values of nurses from any one country or culture and, therefore, are international in scope and substance.

There is, however, some debate about whether the Fawcett proposal does, indeed, meet the four requirements for a metaparadigm. Cody (1996) explicitly rejected the claim that the Fawcett proposal meets the four requirements for a metaparadigm. He maintained that it is unreasonable to believe that "four common, global, disparate concepts, all studied by many disciplines, [could] reflect the unique focus of nursing at all, much less 'parsimoniously'" (p. 97). Continuing, Cody maintained that Fawcett's claim that the four metaparadigm concepts meet the requirement of encompassing all phenomena of interest to nursing is "manifestly unfounded in light of the many prevalent concepts in nursing that are excluded" (pp. 97–98). In addition, Cody maintained that it is impossible to present a perspective-neutral statement of disciplinary phenomena. Inasmuch as Cody most likely does not recognize a need for a disciplinary metaparadigm, it is not surprising that he did not offer an alternative to Fawcett's proposal.

Morse (1996) maintained that the four metaparadigm concepts in the Fawcett proposal "were—and remain—inappropriate and restrictive" (p. 78). She did not, however, explain in what way the concepts were inappropriate and restrictive, nor did she offer a different set of concepts.

Leininger (1991a) questioned the inclusion of environment as a metaparadigm concept. She commented, "While environment is very important to nursing, I would contend it is certainly not unique to nursing, and there are very few nurses who have advanced formal study and are prepared to study a large number of different types of environments or ecological niches worldwide" (p. 40). Cody (1996) also noted that environment is not unique to nursing, because it is studied by other disciplines. Leininger and Cody have failed to acknowledge that the point of the inclusion of the concept environment in Fawcett's proposal for the metaparadigm was to provide a context for human beings, to indicate that participants in nursing actions are surrounded by and interact or engage in mutual process with other people and the social structure.

Although Leininger (1991a) did not reject the inclusion of health as a metaparadigm concept, she did point out that the concept is not unique to nursing, because many

disciplines study health. Cody (1996) also pointed out that health is studied by many other disciplines. Several scholars have addressed the metaparadigm concept of nursing. Their comments indicate that the inclusion of this concept does not meet the requirement of a metaparadigm for parsimony. Conway (1985, 1989) responded directly to Fawcett's (1984) initial presentation of the metaparadigm of nursing. She claimed that the term "nursing" represents the discipline or the profession and is not an appropriate metaparadigm concept because it creates a tautology. Rawnsley (1996), who agreed with Conway's position, explained, "The rationale, or perhaps the rationalization, that [the] inclusion [of nursing] within the metaparadigm refers primarily to nursing actions and activities rather than to a holistic worldview is simply unacceptable. Such a myopic view of our discipline only reinforces reductionist themes that have too long stymied creative scientific breakthroughs" (p. 104).

Leininger (1988) also rejected the metaparadigm concept of nursing in Fawcett's proposal. She commented, "[I] reject the idea that nursing … explain[s] nursing, for one cannot explain nor predict the same phenomenon one is studying. Nursing is the phenomenon to be explained" (p. 154). Adding to her position in a later publication, Leininger (1991b) noted, "Nursing cannot be logically used to explain and predict nursing. The [concept] is a redundancy and a contradiction to explain the same phenomenon being studied by the same concept" (p. 152).

Cody (1996) and Meleis (1997) also regarded the inclusion of nursing in the metaparadigm of nursing as a tautology. Meleis commented, "It would be an instance of tautological conceptualizing to define nursing by all the concepts and then include nursing as one of the concepts" (p. 106). Cody (1996) asserted, "One could hardly ask for a better textbook example of a tautology" (p. 98).

Kolcaba and Kolcaba (1991) rejected the charge of a tautology. They noted that, inasmuch as the metaparadigm concept of nursing stands for nursing activities or actions, a tautology is not created. Furthermore, other scholars view nursing as a distinct phenomenon of interest to the discipline. Kim (1987) identified nursing as a component of two domains of nursing knowledge. She regarded nursing as the central feature of the practice domain and as an essential component of the client-nurse domain. In addition, Barnum (1998) identified nursing acts as a commonplace, that is, a topic addressed by most nursing theories; Newman (1983) included nursing as an action in her list of nursing metaparadigm concepts; and King (1984) found that nursing was a central concept in the philosophies of nursing education of several nursing education programs. That finding suggests that the concept nursing is an important concept that should be included in the metaparadigm. Furthermore, Thorne and her colleagues (1998) maintained that nursing should remain a part of the metaparadigm. They stated, "We contend that the term 'nursing' ought to remain prominent in our lexicon, whatever additional terms we use to qualify it, and that its essence retain the notion of an expert service that we can offer to individuals and society" (p. 1265).

The Newman Proposal. Newman (1983) proposed that the term "client" be one of four concepts that make up the domain of nursing, or what she called the nursing paradigm. Elaborating, she stated, "The phenomena of our concern—the major components of the nursing paradigm—are nursing (as an action), client (human being), environment (of the client and of the nurse-client), and health" (p. 388). Newman also offered what can be considered a relational proposition for her version of the nursing metaparadigm: "The nurse interacts with the client and the environment for the purpose of facilitating the health of the client" (p. 388). Despite its merits, Newman's proposal is not completely perspective-neutral, in that the concept of client reflects a particular view of human beings. Indeed, Levine (1996) maintained that "client" means "follower," which is not an appropriate perspective for participants in nursing processes.

The King Proposal. King's (1984) review of the philosophies of a representative sample of National League for Nursing accredited nursing education programs in the United States revealed nine concepts: man, health, environment, social systems, role, perceptions, interpersonal relations, nursing, and God. King found that not all nine concepts were evident in the philosophies of all schools included in the sample. She recommended that the most frequently cited concepts could represent the domain of nursing. Those concepts are man, health, role, and social systems.

King's proposal falls short of meeting all requirements for a metaparadigm. First, the inclusion of role and social systems reflects a sociologic orientation to nursing. Second, the elimination of environment and nursing results in a narrow view of the domain, and leaves a list of concepts more closely aligned with the discipline of social work (Ben-Sira, 1987) than with nursing.

The Kim Proposal. Kim (1987, 1997, 2000b) identified four domains of nursing knowledge. The client domain is concerned with the client's essential characteristics, pathologic or abnormal deviations from normal patterns of healthy living, and experiences in the health-care system. Kim (2000a) has proposed that the client domain be viewed as human living, which she conceptualized within three dimensions: living of oneself, living with others, and living in situations. She explained, "By orienting its

mission to clients' living rather than limiting its focus to clients' states, nursing can clarify its distinctive role within the community of healthcare providers, formulate client-centered outcomes that are uniquely related to its knowledge-based practice, and ensure public recognition of its distinctive professional contribution in healthcare" (Kim, 2000a, p. 38).

The client-nurse domain focuses on direct contacts, communication, and interactions between the client and the nurse. The practice domain emphasizes the cognitive, behavioral, social, and ethical aspects of professional nursing actions and activities performed in relation to patient care. The environment domain focuses on the physical, social, and symbolic boundaries of the client's environment.

Hinshaw (1987) pointed out that Kim's (1987) proposal work did not include the concept of health, and asked: "Is health a strand that permeates each of the … domains … rather than a major separate domain?" (p. 112). Kim (personal communication, October 31, 1986) indicated that the client domain could encompass health. In the most recent version of her proposal, Kim (2000b) has explicitly identified health within the client domain. She explained, "In a holistic posture, phenomena in the domain of client are conceptualized as systems of interlinked elements, either with respect to the nature of human beings or to that of health" (p. 61). Kim's proposal may be regarded as an informative explication of the discipline of nursing. However, her use of the term client for a domain of the discipline introduces a particular perspective, as noted earlier in the discussion of the Newman proposal. Her recent focus on human living may reflect her recognition of that problem and represent an attempt at perspective-neutrality. Rawnsley (2000), however, pointed out that Kim's descriptions of the processes within each of the dimensions of human living reflect a particular perspective.

The Newman, Sime, and Corcoran-Perry Proposal. Newman, Sime, and Corcoran-Perry (1991) claimed that the focus of the discipline of nursing is summarized in the following statement: "Nursing is the study of caring in the human health experience" (p. 3). In a later publication, they asserted, "The theme of caring is sufficiently dominant, when combined with the theme of the human health experience, to be considered as the focus of the discipline" (Newman, Sime, & Corcoran-Perry, 1992, p. vii).

Despite Newman and colleagues' (1992) claims to the contrary, their proposition represents just one frame of reference for nursing and for health. In fact, Newman and her colleagues (1991) ended their initial treatise by maintaining that caring in the human health experience can be most fully elaborated only through a unitary-transformative perspective. Moreover, although Newman et al. (1991) offered their proposition as a single statement that integrates "concepts commonly identified with nursing at the metaparadigm level" (p. 3), and they identified the metaparadigm concepts as person, environment, health, and nursing, their proposition does not include environment. In an attempt to clarify their position, Newman, Sime, and Corcoran-Perry (1992) later stated, "We view the concept of environment as inherent in and inseparable from the integrated focus of caring in the human health experience" (p. vii). Despite that clarification, their proposal is neither sufficiently comprehensive nor perspective-neutral.

The Malloch, Martinez, Nelson, Predeger, Speakman, Steinbinder, and Tracy Proposal. Malloch, Martinez, Nelson, Predeger, Speakman, Steinbinder, and Tracy (1992) suggested a revision of the Newman, Sime, and Corcoran-Perry (1991) statement. Their focus statement is: "Nursing is the study and practice of caring within contexts of the human health experience" (p. vi). Malloch and her colleagues (1992) maintained that their statement extends the focus of the discipline to nursing practice and incorporates the environment by the use of the term contexts. They noted that environment "includes, but is not limited to, culture, community, and ecology" (p. vi). Moreover, they claimed that the use of the term caring brings unity to the metaparadigm concepts of person, environment, health, and nursing. Apparently, they do not regard caring as a particular perspective of nursing. Thus, although the Malloch et al. proposal is sufficiently comprehensive, it is not perspective neutral.

The Leininger, Watson, and Lewis Proposals. Leininger (1995) asserted, "With transcultural nurse knowledge and consumer demands, many nurses are recognizing that human care, health, and environmental cultural context must become the central focus, essence, and dominant domains of nursing knowledge to replace the 'Eastern' four concept metaparadigm" (p. 97). In setting the stage for her proposal, Leininger charged that "a small group of 'Eastern' USA nurse researchers … declared in nursing publications that nursing's major foci or 'metaparadigm' for the discipline … would be health, nursing, person, and environment. It was quite clear to me that these nurses blatantly failed to recognize [that] human care, caring, and cultural factors were important phenomena of nursing. It appeared to me and other care scholars that this small elite group was lobbying against the rapidly growing interest in care and transcultural nursing" (p. 96). Leininger's charge regarding lobbying against her ideas by a small, elite group of "Eastern" nurses has no basis—none of the discussions of the metaparadigm concepts have included negative comments about caring or transcultural nursing.

In another publication, Leininger (1990) claimed that "human care/caring [is] the central phenomenon and essence of nursing" (p. 19) and Watson (1990) maintained that "human caring needs to be explicitly incorporated into nursing's metaparadigm" (p. 21). Even more to the point, Leininger (1991a) maintained: "Care is the essence of nursing and the central, dominant, and unifying focus of nursing" (p. 35). She also has claimed that "human care and caring [are] the central, distinct, and dominant foci to explain, interpret, and predict nursing as a discipline and profession" (Leininger, 2002, p. 47). Lewis (2003) asserted, "I believe that caring and healing are core processes of nursing" (p. 37). She went on to explain that she regards caring as "being with others" (p. 37).

Both Leininger and Watson failed to acknowledge that although the term caring is included in several conceptualizations of the discipline of nursing (Morse, Solberg, Neander, Bottorff, & Johnson, 1990), it is not a dominant theme in every conceptualization and, therefore, does not represent a discipline-wide viewpoint (Wilson, 1994). Indeed, caring reflects a particular view of nursing and a particular kind of nursing (Eriksson, 1989). Lewis (2003) acknowledged that point by explaining, "The frame of reference that guides my thinking is aligned with the unitary-transformative perspective (Newman, Sime, & Corcoran-Perry, 1991)" (p. 37). Furthermore, as Swanson (1991) pointed out, although there may be "characteristic behavior patterns that are universal expressions of nurse caring … caring is not uniquely a nursing phenomenon" (p. 165). Lewis (2003) has attempted to identify the unique features or characteristics of caring as being in nursing. She identified four pathways—honoring one another through artistic endeavors, moving beyond ourselves through caring relationships and spirituality, being grounded in our healing environment, and soulful caring consciousness—as the "ubiquitous or unique nature of caring as *being*" (p 38).

Caring behaviors, moreover, may not be generalizable across national and cultural boundaries (Mandelbaum, 1991). And, as Rogers (1992) asserted, "As such, caring does not identify nurses any more than it identifies workers from another field. Everyone needs to care" (p. 33). Rogers (1994b) went on to say, "I don't think nurses care any more than anybody else, or that it's a characteristic any more peculiar to nursing than to any other field. [But caring] does differ among different groups … It is the body of knowledge about the phenomenon of concern that determines the nature of the caring that one is going to demonstrate" (p. 34). Elaborating, Rogers (1994a) added, "Caring is doing, it is practice. Caring is a way of using knowledge" (p. 7). Viewed from a different vantage point, Roper (1994) commented, "I consider that 'care' is implicit in 'nursing' and therefore 'nursing care' is a tautology" (p. 460).

The Meleis Proposal. Meleis (1997) proposed that the central concepts of nursing are nursing client, transitions, interaction, nursing process, environment, nursing therapeutics, and health. She explained, "The nurse interacts (interaction) with a human being in a health/illness situation (nursing client) who is in an integral part of his sociocultural context (environment) and who is in some sort of transition or is anticipating a transition (transition); the nurse/patient interactions are organized around some purpose (nursing process, problem solving, holistic assessment, or caring actions) and the nurse uses some actions (nursing therapeutics) to enhance, bring about, or facilitate health (health)" (p. 106). Meleis and Trangenstein (1994) and Schumacher and Meleis (1994) highlighted the importance and centrality of the concept transitions. In particular, Meleis and Trangenstein (1994) maintained that "the transition experience of clients, families, communities, nurses, and organizations, with health and well-being as a goal and an outcome, meets … the criteria … of an organizing concept that allows for a variety of viewpoints and theories within the discipline of nursing, … [is] not culture bound, and … should help in identifying the focus of the discipline" (p. 255).

Although Meleis' proposal is meritorious, the inclusion of nursing process, nursing therapeutics, and interactions represents a redundancy that can be avoided by use of the single concept, nursing. The inclusion of transitions reflects a particular perspective of human life. Indeed, Meleis and Trangenstein (1994) referred to their discussion of transitions as a "conceptual framework" (p. 258).

The Parse Proposal. Parse (1997) asserted, "The core focus of nursing, the metaparadigm, is the human-universe-health process" (p. 74). She went on to explain that the "hyphens between the words create a … construct incarnating the notion that the study of nursing is the science of the human-universe-health process. Consequently, all nursing knowledge is in some way concerned with this phenomenon" (p. 74).

Parse's proposal has merit in that her use of the term universe extends the environment far beyond the immediate surroundings of human beings and the settings in which nursing occurs. However, her proposal does not explicitly name nursing as a concept of the metaparadigm. That omission is a problem in that many disciplines could be interested in humans, the universe, and health. Furthermore, the meaning Parse ascribed to the hyphens used reflects a particular perspective of the named phenomenon. That is, humans, the universe, and health must be viewed as unitary.

The Thorne, Canam, Dahinten, Hall, Henderson, and Kirkham Proposal. Thorne, Canam, Dahinten, Hall,