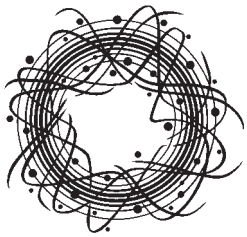

NURSING SCIENCE QUARTERLY

THEORY, RESEARCH, AND PRACTICE

About the Cover: Cover design by Alj Mary, The Iron Rose Complex, Finleyville, PA. The *Nursing Science Quarterly* logo is a symbolic representation of the process of expanding nursing knowledge. The circular configurations represent the known theoretical frameworks in their various processes of development. The dots and swirling lines depict early conceptualizations of ideas and perspectives. Green represents hope, a persistent moving on with anticipation of what will be as the discipline changes.

For Sage Publications: Kim Koren, Rebecca Lucca, Corina Villeda, and Kathryn Journey

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With Special Thanks

With this issue, April L. Hackathorn is retiring from her position as Associate Editor of *Nursing Science Quarterly.* She has skillfully, patiently, and lovingly managed the details of the journal for 10 years. Her dedication to quality through her precise concern for language and format, her artistic sense, and her personal presence have been invaluable to the success of the journal. She has earned the respect of all those involved with the publication of *Nursing Science Quarterly.* Our deep appreciation and warm wishes go with April as she moves to a new chapter in her life.

NURSING
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QUARTERLY

THEORY, RESEARCH, AND PRACTICE

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Editorial

Language and the Sow-Reap Rhythm

Every subject has its language, and one cannot know the subject unless one knows the language (Hirsch, 1987). The language seeds of a subject are sown when first coming to know it. The reaping arises as the knowledge is harvested in understanding the uniqueness of the subject. Every discipline has its own language elaborating the meaning of its phenomenon of concern, and the scholars of that discipline must know its unique language. Nursing is no exception. What is the unique language of nursing? It is not the language of medicine but, rather, is the conceptualizations articulated in the frameworks and theories elaborating the meanings of the human-universe-health process from the different paradigmatic perspectives. It is this language that undergirds the uniqueness of the discipline of nursing. Then should it not be this language that students of the discipline learn in their educational programs? How can nurses be expected to know the uniqueness of their discipline if they are taught and evaluated with the language of other disciplines?

Educators reap what they sow through teaching the language of a discipline, and a sow-reap rhythm is alive today cocreating the changing story of nursing. Nurse educators plant and sow the seeds for practice and research with the knowledge structured in the language of curricula of bachelor's, master's, and doctoral programs. If the curriculum in any of these programs contains courses developed from the medical model, as has been the tradition in nursing, then students will continue into the 21st century learning the language of medicine, deprived of a clear sense of identity as nurse professionals contributing in a unique way to the health and quality of life of humankind.

Now there is much concern over recruitment of nurses for myriad reasons, truncated by the working conditions that have surfaced under the managed care programs. It seems that the ground is fertile for initiating and sowing a major evolutionary change in the language and substance of nursing curricula, regulatory requirements, and practice. Even if the change is planted today, it will take years to reap the harvest. The shift should occur in all educational programs, even at the entry level, where students are learning the language and nature of the discipline. The first course should focus on an introduction to disciplinary knowledge by including content on the nursing paradigms, schools of thought, frameworks, and theories. Students should be taught the research and practice methodologies in the language of various nursing theoretical perspectives. For example, from the totality paradigm, Roy's model could generate research studies on phenomena related to adaptation and practice scenarios including assessing, planning, diagnosing, implementing, and evaluating according to the physiological, self-concept, role function, and interdependence modes with the regulator and cognator subsystems. With Rogers' science from the simultaneity paradigm, research would focus on studying pattern manifestations, and practice would focus on pattern appraisal and deliberative mutual patterning. These are different perspectives, articulated in different language, and like students in psychology and other disciplines, nurses should learn the language and substance of the schools of thought within their discipline in order to fulfill their mandate to humankind.

Nurses, in sowing seeds of change in healthcare agencies including community health centers, hospitals, hospices, and others, could set forth language in the standards of care, based on nursing frameworks and theories, to demonstrate the unique contributions of the discipline to health and quality of life. Regulatory agencies such as state boards of nursing, the National League for Nursing Accrediting Commission, and the Commission on Collegiate Nursing Education could develop language in the criteria for accreditation that reflects nursing-theory–guided practice as foundational to excellence in the discipline. These changes are beginning seeds, sown for a harvest that would fortify the uniqueness of nursing by having nurses use the language and substance of the discipline in their research and practice.

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Editor

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Interdisciplinarity and Nursing: "Everything Is Everything," or Is It?

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The phrase "everything is everything" is an African American saying meaning "all things pass; everything is all right," or "everything's going to be all right." It is an affirmation of well-being in the face of adversity and a reassurance of a tolerable outcome despite bad odds. Its meaning, however, is not readily apparent. Before learning the meaning of "everything is everything," I found that very phrase echoing in my thoughts over the years while listening to colleagues insist on the value of interdisciplinary learning and a view of knowledge as mostly interdisciplinary, or transdisciplinary, or, even best, left unconnected with disciplines. I have heard repeatedly that educating nurses in a variety of subjects pertinent to healthcare in interaction with other healthcare professionals would benefit the profession far more than any comparable single-discipline educational endeavor. In these conversations, however, I have noted that the purposes of nursing were often equated with the most common traditional activities of nurses in direct patient care. Fellow nurses have told me with great assurance that this interdisciplinary educational arrangement should and will constitute a major directional change for the future of nursing education, and all healthcare. Few advocates of increased interdisciplinary activities, however, have voiced concern at the same time for the future of nursing's own distinct body of knowledge.

There is a certain attractiveness to the iconoclastic and boundary-breaching implications of such a stance. Myriad problems are easily observed in the tradition-bound, hierarchical, formal and informal structures of disciplines, and these problematic structures do impede good science and good care. For example, leaders in the discipline of medicine struggle with the trend toward no longer considering medicine synonymous with healthcare and are reluctant to affirm the parity of other health-related disciplines. Psychologists educated in neuroscience argue, reasonably, that they should be granted the privilege to prescribe medications to treat mental illness, but they meet great resistance from physicians (and some nurses). Nurses struggle to raise the intellectual level of the discipline, to specify its domain of knowledge, and to refine their distinct approach to practice, while also grappling with workforce-related pressure from governments and other powerful interests that insist on the rapid production of nurses with the minimum qualifications. At the same time, as knowledge proliferates and becomes ever more vast and diversified, the question of whether disciplines are the best structures in which to "house" or "grow" knowledge presents itself. And ultimately, in this environment of rapid change and infinite complexity, even more profound questions of ontology and epistemology arise. The overall shift from modern to postmodern culture and philosophy has been concerned with changes in the production, use, and control of knowledge and the seemingly inevitable dissolution of hierarchical structures to contain it. One is obliged to consider whether the absence of disciplines, or the diminution of disciplinary powers in generating, using, and disposing of knowledge, might somewhat resolve, or at least ameliorate, those problems. It is abundantly evident in the literature that many people believe that this is the case (Koppel, Barr, Reeves, Freeth, & Hammick, 2001).

In 1997 in this space, Mitchell posed the question, "Have disciplines fallen?" She questioned whether disciplines could be identified anymore by a unique phenomenon of central concern, as was once axiomatic in theoretical nursing. Mitchell wrote,

> It may be that healthcare systems have evolved to a place that no longer supports the notion that disciplines can be identified according to a unique phenomenon of concern, such as health, illness, human caring, or mind/behavior modification—or according to their scope of responsibility in practice settings. Similar phenomena of concern and responsibilities are now being shared among different disciplinary groups in many healthcare settings. (p. 110).

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Keywords: disciplines, interdisciplinarity, interprofessionalism

The purpose of this column is to explore the implications of the interdisciplinarity movement for nursing knowledge development, theory, education, practice, and research. As the major foci in the movement have been collaborative practice and interprofessional education, these will be the major areas explored in the discussion.

A Note on Terminology

It is necessary to address terminology here, as there are several terms in usage that have different but overlapping meanings. Many terms are used to refer to aspects of knowledge production in research and scholarship, knowledge application in practice, and/or knowledge conveyance in education that involve multiple disciplines working together in a model that is more collaborative than that which generally obtains today. Among the adjectives used are *interdisciplinary*, *multidisciplinary*, *transdisciplinary*, *interprofessional*, and *transprofessional*. An increasingly popular noun is *interdisciplinarity*, which refers to situations and conditions in which interdisciplinary collaboration is accepted and practiced. It is beyond my ken to sort out all these terms thoroughly. I take *interdisciplinary* and *interprofessional* to refer to knowledge, collaboration, and education that involve multiple disciplines or professions, respectively, working with mutually understood and accepted concepts and principles toward shared goals. The prefix *multi-* more commonly refers to arrangements across disciplines that group professionals or students together for convenience, as in multidisciplinary courses that exist mainly to reduce costs and workload by combining cohorts. The term *interprofessional* has been used increasingly over the past decade and seems to be a bit less weighed down by esoteric fine points having to do with exactly what is meant by discipline-related terms. Hammick (2000) reported on a review of literature on interprofessional education (specifically that topic alone) that initially identified in excess of 3,000 papers. Reports of projects that are "interdisciplinary" or "interprofessional" run the gamut from trivial to grandiose, from 1-day experiences to national plans, and there are virtually no overarching authoritative definitions or standards strongly evident in the literature. Obviously, then, it is beyond the scope of this column to sort out differences in terminology on this scale. There are commonalities among most proponents, regardless of which of the terms meaning multiple disciplines/professions they may use. Chief among these is the belief that research, practice, and education that involve multiple healthcare disciplines working together will improve healthcare, enhance the knowledge base, and strengthen healthcare education. Because the semantic issues here are not central to the discussion, I have chosen not to belabor the fine points of the various definitions, which would resolve nothing in this context. Here, I use *interdisciplinary* as the generic term, distinct from multidisciplinary in the way that has become customary, and *interprofessional* to refer to deliberate, meaningful interaction (either during studies in a formal preprofessional program or after graduation in continuing education) between professions that usually work together in the healthcare system.

A Long History of Advocacy for Interdisciplinarity

The call for interdisciplinary education, research, and practice is not new. World Health Organization (WHO) documents from as early as 1978 explicitly endorse interdisciplinary education and practice (WHO, 1978). Healthcare in contemporary society inherently involves multiple disciplines that must communicate effectively with one another to provide care of a reasonably high quality to people. This is one of the principal justifications given by proponents of interdisciplinary education, research, and practice—that it is necessary in contemporary healthcare to have skills that enable one to collaborate across disciplines effectively. Rarely does the literature advocating interdisciplinarity acknowledge the extent to which interdisciplinary (or at least multidisciplinary) collaboration of one kind or another already must take place for healthcare to be provided. Rather, the bulk of the literature on interdisciplinarity continues as it has for years to bring up issues that can be characterized as exploring "how to do it" as though interdisciplinarity were a perpetually new idea.

Similarly, virtually all baccalaureate education includes content that spans several disciplines, albeit much of it material presented at an introductory level. Most postbaccalaureate programs of study also require coursework in multiple disciplines and some coursework that is, broadly speaking, interdisciplinary. Still, there is a burgeoning of increasingly urgent demands for far greater interdisciplinary education, research, and practice (Brashers et al., 2001; Laskin et al., 2001; Simpson et al., 2001). Such a thorough-going overhaul of the principal structures and processes that generate, disseminate, use, and critique advanced knowledge on a global scale would seem to demand extensive explication, justification, and persuasion, but the movement for interdisciplinarity is peculiarly short on these activities and long on proclamations and resolve. As Yanoshak and DelPlato (1993) stated, writing from the vantage of feminist humanities, "The value of interdisciplinary study seems self-evident in pedagogical circles today, and its purpose goes largely unquestioned" (p. 283). Because many of the outspoken advocates for greater interdisciplinary work frequently refer to traditions and paradigms within single disciplines as doctrine or dogma or quasi-religious belief systems, it is ironic that the interdisciplinarity movement appears to this author to have generated quite a lot of dogma and a strong quasi-religious belief system of its own.

Interdisciplinary Proponents' Claims

The movement toward interdisciplinarity in healthcare began more than 20 years ago and has slowly but steadily gained in strength up to the present (Larson, 1995; WHO, 1978). Pro-

ponents assert that collaborative interdisciplinary practice is the key to high quality healthcare and that interdisciplinary education is the key to establishing such practice as the norm. This entails adopting the belief, first of all, that knowledge that is useful across several disciplines or professions is readily identified and that collaborative university courses in preprofessional and graduate programs related to healthcare can be designed to impart this knowledge to students in several disciplines simultaneously and interactively. At my institution one frequently hears the casual but confident assertion that "*x* is *x*" (e.g., nutrition is nutrition; pathophysiology is pathophysiology; research methods are research methods) in discussions about this trend and the rationale behind it, in venues ranging from formal committees and task forces to lunch tables and back halls. Thence came the echoes of "everything is everything" ringing in my ears. From the perspective of the interdisciplinary proponents, courses such as these are merely multidisciplinary and do not reflect the full benefits of the movement. Proponents of what is sometimes called an interdisciplinary core hold that it only makes sense to save money and time and to promote interprofessional communication by educating students in the healthcare professions together. Furthermore, they maintain that interdisciplinary education, construed as learning together to promote collaboration (as distinct from multidisciplinary education, learning together for the sake of convenience or utility), is not only effective but necessary for optimizing collaborative practice among healthcare disciplines (Brashers et al., 2001; Hammick, 2000).

The view that a great deal of knowledge for healthcare is or would be best learned within an interdisciplinary context has been linked with the following desired outcomes.

- Professionals will be more familiar with one another's activities and roles, thereby improving interprofessional communication.
- Professionals will be better able to work collaboratively, thereby improving care.
- Professionals will have broader repertoires of knowledge and skills, thereby in effect increasing access to care for the people.
- Professionals will have more career mobility as healthcare systems change.
- With larger, more diverse research teams, research productivity on issues of importance in healthcare will increase.
- Cross-disciplinary peer review and critique of practice and research will be more available and more intellectually sound.
- Cross-fertilization with creative ideas from many sectors will enhance and accelerate innovations in healthcare (Finch, 2000; Gueldner & Stroud, 1996; Hammick, 2000).

Evidence in the Movement Toward Interdisciplinarity

Numerous authors in the relevant literature proclaim what they clearly believe to be the near-certainty of the predictions about interdisciplinarity summarized above. What is, unfortunately, routinely ignored in the interdisciplinarity literature is that, despite the production of a voluminous literature on interdisciplinary, transdisciplinary, and interprofessional knowledge development, education, and practice, there is minimal substantive evidence today for the effectiveness or ineffectiveness of interdisciplinary knowledge work in improving collaboration and/or practice (Hammick, 2000). Serious concerns that have been voiced by scholars about reducing discipline-specific knowledge work to accommodate interdisciplinary work (see, for example, Finch, 2000; Garber, 2001; Yanoshak & DelPlato, 1993) have been dismissed by the proponents of interdisciplinary knowledge work as "barriers" or "obstacles" (for examples, see Bauer, 1990; Bradford, 1989; Larson, 1995; Taylor-Seehafer, 1998), as though the desirability of hugely increasing interdisciplinary education and collaboration were uncontestable.

Although it may be reasonable to expect that greater interdisciplinarity will improve healthcare over the long run, documentation of actual substantive improvements is profoundly lacking, despite thousands of published articles. From my perspective, following a review of the literature, it appears that a blithe disregard for real issues and problems that confront even the most enthusiastic engagement in interdisciplinary education, research, or practice has paradoxically made it vastly more difficult than necessary to move forward with it.

Expanding on the positive turn of events signified by observations that members of different disciplines today talk together more and work more collaboratively today than in years past, proponents present several claims: that power differentials have been lessened, that respect of the more powerful for the less powerful has increased, and that understanding of the lesser known by the better known has been enhanced (Banks & Janke, 1998; Brandon & Knapp, 1999; Larson, 1995; Nissani, 1997; Taylor-Seehafer, 1998). There is very little evidence, however, that interdisciplinarity has anything to do with any progress made in these areas. Proponents of intensified discipline-specific knowledge work have made similar claims, so that any notable progressive change in power differentials, interdisciplinary respect, and understanding might just as well have come about through efforts to advance discipline-specific knowledge.

The quest for evidence of the effectiveness of interdisciplinary education and practice is an interesting one. Zwarenstein and colleagues (2001) reported on an attempted review of 1,042 articles that represented the total yield of a comprehensive literature search designed to identify substantive evidence of the effectiveness of interprofessional education

(IPE). The investigators had predetermined a reasonably rigorous set of inclusion criterion related to substance and method, and as it turned out none of the articles met the inclusion criteria. The authors concluded, "Despite finding a large body of literature on the evaluation of IPE, these studies lacked the methodological rigour needed to begin to convincingly understand the impact of IPE on professional practice and/or health care outcomes" (Zwarenstein et al., 2001). A more inclusive review found that there is mild evidence that interprofessional education for working professionals tends to result in changes in practice but that prelicensure education in colleges and universities has as yet yielded no methodologically rigorous evaluation findings (Hammick, 2000). Koppel and colleagues (2001) also suggested, based on a rigorous review of 99 articles (a small portion of a much larger initial search yield that was mostly unusable), that interprofessional education showed more effectiveness when offered in the context of continuing education for professionals already in their service careers. This only makes sense, but, logically, it also provides support for discipline-specific education that fosters professional preparation to a high level of expertise, whereupon the professional is better able to collaborate with professionals in other disciplines.

Upon close examination, it can be seen that many if not most of the interdisciplinary and interprofessional learning experiences that have been studied or adduced by proponents as exemplars are very time limited (one college course or less), and many have been elective or volunteer. Furthermore, outcome data other than general impressions and anecdotes are minimal to lacking. The response of the proponents has not been to attenuate their calls for greater interdisciplinarity but to focus the calls now on the need for evaluation research showing results (for example, see Hammick, 2000), while continuing to issue urgent calls and push for interdisciplinary initiatives as national priorities—not wishing to be confused by the facts, one would have to conclude. Hopefully, the increased attention to substantive evidence will help to shed light on the issues at play in the interdisciplinarity movement. Otherwise, observers will be wont to point out, like the boy who cried, "The emperor has no clothes," that there is little or no movement in this movement.

The Fate of Nascent Disciplines in an Aggressively "Interdisciplinary" Environment

As a scholar who works to specify and clarify the distinctive purposes, philosophies, theories, and methods in the discipline of nursing, I have found the demands for greater interdisciplinarity highly intriguing. Taking the long view, several important extant disciplines, including nursing (and, for example, social work), have only relatively recently emerged as specific fields of study wherein distinct domains of knowledge are generated, expanded, tested, and stewarded. This means that the promise of these disciplines as realms of specialized knowledge has been recognized, but their full potential to contribute to humankind has not yet been fully explicated. So, what about these fields of burgeoning-but-little-known knowledge as they struggle to thrive as distinct disciplines in the face of an interdisciplinary movement that is gaining momentum? The innovative emergence of modern nursing and of modern social work has already greatly benefited humankind, but the fullness of these disciplines' contributions has yet to be realized. Nursing science texts in their totality compose a tiny fraction of the volume of texts occupied by medicine or psychology; research dollars are similarly distributed. Is it realistic to expect that support for discipline-specific progress will continue at a level similar to the present or increase, when greater emphasis is to be placed on interdisciplinary research, education, and practice? The risk of nursing being swallowed up and its unique nascent knowledge disappearing is very real.

Are Some More Equal Than Others?

The countless profound historical, cultural, socioeconomic, and philosophical differences among the disciplines, although little discussed in the literature advocating interdisciplinary knowledge work, taken together, make extensive, productive, and substantive interdisciplinary collaboration in the context of a scholarly community of equals extremely challenging. For example, nursing's history includes a subjugation to medicine that has been blatant, at times near-complete, widely if not universally sanctioned, and brutal at times, which has persisted with only tentative stepwise progression toward intellectual autonomy from the dawn of modern nursing until the present. Not surprisingly, a nurse, Bradford, wrote in 1989,

> It is vital that the nurse be an expert in the [medical] care of her patient. Unfortunately, if the nurse is not working on a specialty unit, it becomes difficult for her to have the knowledge necessary to compete [*sic*] with the specialist physician. This lack of expertise places the nurse at a disadvantage and reinforces the dependent role. (p. 72L)

This passage betrays the true level of "collaboration" that obtains in much of what is touted as "interdisciplinary" work. The knowledge perceived as important is biomedical knowledge, and the physician is the acknowledged master. For members of other disciplines to learn more biomedical knowledge so as to be closer to the physician's level of discourse is not, in truth, interdisciplinary. Rather, this somewhat dated passage serves to remind us of the political realities of serving on the healthcare "team," which are still strongly in evidence in 2001 when interprofessional relations are examined with a critical eye. Another example of such relational challenges from outside nursing can be seen in the sciences traditionally viewed as "basic" (such as physics and chemistry), wherein medicine and even biology are seen as inexact sciences, even *soft,* a pejorative term that also happens to evince the thinly veiled traditional sexism embedded in

various human communities of scholars. Even more common than this snobbery today is the "wannabe" syndrome found among clinical scientists who wish their science to be considered "basic" (for example, see Redelmeier, Ferris, Tu, Hux, & Schull, 2001).

Many widely different projects, courses, collaborative practices, and other endeavors great and small qualify as "interdisciplinary" or "interprofessional" according to various sources. The literature reflects a diversity among ideas and practices in interdisciplinary knowledge work that makes it difficult to characterize the movement as a whole. Communication and practicality demand, however, that the disciplines involved share vocabulary and concepts and general goals of practice. I would venture to suggest that basic beliefs about the ontology, epistemology, and ethics of healthcare would need to be at least loosely compatible among disciplines and professionals committed to interdisciplinary collaboration for the optimal collaboration to take place. This logically demands some stability of ideas in relation to the status quo in knowledge work. The status quo being socioeconomically and politically imbalanced in many ways, stability of ideas in relation to the status quo is not likely to be a good thing. As Yanoshak and DelPlato (1993) wrote, "The call for interdisciplinary studies also function[s] as a guise for the continuation of conventional categories of knowledge-formation. Rather than assuming that 'interdisciplinary' is inherently progressive, teachers need to ask more penetrating questions about its politics" (p. 283). Furthermore, they continue, "Our principal objection to conventional interdisciplinary studies is that they claim to be politically disinterested when in fact they mask power relations. They reify the categories of the disciplines as they have existed and replicate their old hierarchical value systems" (p. 287).

It is interesting to note that nursing organizations' futurist documents broadly reflect a burgeoning value and enthusiasm for interdisciplinary education, research, and practice. Although WHO and similar organizations may share this enthusiasm, planning documents of medical organizations typically do not but, rather, assert the traditional primacy of the physician in healthcare. As but one example, the American Academy of Pediatrics (2000) stated,

> The pediatrician is the best and most extensively trained professional to provide quality health care services to infants, children, adolescents and young adults within the context of their families, communities, and environments. All children should receive primary care services through a consistent "medical home" . . . with availability 24 hours a day, 7 days a week, from a pediatrician or a physician whom families trust. (p. 164)

As Yanoshak and DelPlato (1993) reminded us,

> An interdisciplinary study which considers itself apolitical is premised on the flexibility and reformability of the academy, concepts which are suspect in their promotion of the status quo. While it appears to be a self-criticism about narrowness, it in fact is inherently limited in its stockpiling of new pools of old information. . . . On the contrary, the telos which we call for [as feminists] is academic work as an arena for effecting social change. We argue for the continuity of the political and the academic, not their separation. To that end, a consciously politicized interdisciplinary study holds the potential for disrupting the presumptions of the conventional mode of interdisciplinarity. (p. 288)

Unfortunately, such interdisciplinary endeavors are very much the exception rather than the norm. Gueldner and Stroud (1996) reported on "interdisciplinary" research undertaken with a physician in which the following is the description of their respective activities:

> The physician was an expert in identifying pertinent research questions and in interpreting the clinical significance of research findings within the medical perspective. The nurse team members participated in refinement of the research questions and design, were responsible for obtaining institutional review board approval for all studies, monitored the data collection process, and oversaw budgetary matters. The nurse members of the team also provided a "lens" through which to examine the findings for their relevance to nursing practice. (p. 59)

With all due respect to Drs. Gueldner and Stroud, they seem almost to have written this paragraph to illustrate Yanoshak and DelPlato's criticism of the tendency to support the status quo in interdisciplinary research. This is an ironic and unfortunate reality of the interdisciplinarity movement that has been little explored by the proponents. In a movement that is intended to foster greater equality among traditionally stratified professional groups and innovation in approaches to research, practice, and education, the gravitational pull of the status quo in power relations, the assumptions of the beliefs and values of the dominant paradigm, and the same old stereotypes of professional roles is great. Perhaps the movement is not radical enough. Perhaps the transformative dynamic will emerge when and if the interdisciplinary movement turns its gaze to the cutting edge of disciplinary movements rather than the mainstream.

Lindeke and Block (1998) wrote eloquently about the challenge of maintaining professional integrity in the midst of interdisciplinary collaboration: "Making nursing's contributions secondary to the group effort is particularly troublesome because of the nature of nursing's history, its legacy of delegated authority, and the lack of direct reimbursement for nursing care" (p. 216). They recommended that nurses assume leadership positions in interdisciplinary collaboration and that they role model nursing's core values and principles.

> Some of these values are self-determination and choice in health care decision making; respect for human beings; the imperative of caring; advocacy, especially for the disenfranchised and at-risk populations; and obligation toward person, family, and community. Nurses need to revere and embrace these values, as well as communicate them to colleagues in other disciplines. (p. 216)

This seems to be somewhat of a mixed message for nurse collaborators. First, most of the values listed are shared, or should be shared, by all healthcare disciplines, which leads one to wonder why nursing must take on the role of interpreting these for the interdisciplinary team. Second, this description sounds a great deal as though the nurse is assuming a disproportionate burden on the interdisciplinary team in serving as a kind of watchdog to ensure ethical comportment and caring. Does this mean that others may be less concerned with ethics and caring? Interdisciplinary work of this kind would seem to me to mean, for nurses, not working more efficiently but simply working more.

Doing more work that is collaborative and interdisciplinary within the belief systems of the dominant paradigms (the most likely belief systems to be shared across disciplines) will never address all needs or solve all problems because not all contingencies of living (or of existence) are encompassed by the dominant paradigms. Rather, the continuously evolving nature and increasing complexity of life as it is humanly lived produce new situations, new meanings, and new problems. There is no reason to believe that groups of workers laboring in the common ground of accepted norms and paradigmatic beliefs, merely because they are laboring together, are more likely to find new interpretations, new responses, and new solutions than those who labor in a single, focused discipline on the cutting edge of progressive work in a defined area.

Conclusions

This exploration of the movement for greater interdisciplinarity in healthcare leads to several logical conclusions. (a) Proponents of interdisciplinary approaches should be held to standards of evidence and scholarship equivalent to those of other professionals and academicians. This means they should be expected to produce substantive evidence to support their claims, particularly if they are calling for something of the magnitude of overhauling the entire global healthcare enterprise, or revolutionizing healthcare education, and so forth. This is no more than would be expected of anyone else, and it is remarkable that more demands of this kind have not been made on the movement to date.

(b) The healthcare disciplines and the infrastructures that support them should work to ensure support for the innovative and the unusual, the risky and the esoteric, as the movement toward greater interdisciplinarity progresses. That is where the best new ideas are most likely to come from, as these knowledge workers are not burdened with the yoke of accepted mainstream beliefs. Continued discipline-specific support will be critical for the nurturing of many if not most of these ideas.

(c) Interdisciplinary endeavors should be led by mature professionals in a context of unprecedented openness to the questioning of assumptions and the breaking down of stereotypes. There should be an explicit recognition that power resides in the clients and that professional dominance of one group over another serves no purpose in client-centered care. This is doubtlessly one of the aims of the interdisciplinary movement, but one that has made little headway to date (comparing political power, funding, salaries, prestige, the magnitude of institutes, and other measures). Still, the broad recognition that the power to make healthcare decisions properly resides in individual clients and the public as a whole would serve to equalize the disciplines in their service to humankind and would help to establish a much more fertile ground for progressive work, both interdisciplinary and discipline-specific.

Toward these ends, a number of specific recommendations are offered here in the spirit of affirming reasonable and fair interdisciplinary collaboration while also advocating continued support of discipline-specific development in theory, practice, education, and research. The recommendations are structured to be parallel between those that are interdisciplinary and those that are specific to nursing, and to be harmonious with each other. Readers may note that the final recommendation is the same in either context. Although the literal meaning of "everything is everything" that echoed in my thoughts so long when pondering these issues cannot be construed as an aphorism to live by, the figurative meaning may be reassuring as we, as nurse scholars, look to the future. Everything is everything. Keep working for the betterment of humankind.

Recommendations to Enhance Interdisciplinary Involvement of Nurses

- Focus efforts to enhance interdisciplinarity in the postlicensure practice arena through support of interprofessional continuing education, joint research, and collaborative practice.
- Create client-centered models of collaborative practice to be translated into educational endeavors rather than expecting educational change alone to be sufficient to change extant healthcare systems. All such models should be built on mutual respect and a presumption of equality among professionals and clients.
- Build into interdisciplinary endeavors ongoing opportunities to question assumptions and stereotypes and to engage with members of other disciplines in relation to individuals' personal and professional perspectives.
- Resist the tendency to allow collaborative efforts to gravitate automatically to "lowest common denominators" (i.e., "the bottom line" and the norms and methods of dominant disciplinary, or transdisciplinary, paradigms). Support innovation and risk undertaken in the interest of clients.
- Demand that nurses be able to articulate a scholarly perspective of nursing as a distinct discipline—its focal services, its philosophies, its purposes and goals, its theories and its methods—as appropriate to their level of

education, thereby bringing a unique, coherent perspective to the interdisciplinary collaboration.

Recommendations to Enhance Discipline-Specific Development in Nursing

- Focus efforts to prepare professional nurses in the practice arena through support of strengthening nursing knowledge in preprofessional nursing education, involving students in discipline-specific nursing research and role-modeling collaborative practice from a nursing perspective.
- Create client-centered models of collaborative practice in which nurses have fully autonomous roles in creating and managing healthcare endeavors and in bringing about significant changes in practice.
- Build into nursing curricula ongoing opportunities to question assumptions and stereotypes and to engage with members of other disciplines in relation to individuals' personal and professional perspectives.
- Resist the tendency to allow the focus of practice to gravitate automatically to "lowest common denominators" (i.e., "the bottom line" and the norms and methods of the dominant nursing paradigm). Support innovation and risk undertaken in the interest of clients.
- Demand that nurses be able to articulate a scholarly perspective of nursing as a distinct discipline—its focal services, its philosophies, its purposes and goals, its theories and its methods—as appropriate to their level of education, thereby bringing a unique, coherent perspective to the interdisciplinary collaboration.

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The Correct Sequence of Epithets — According to Bartholomew (1948, p. 80) the following order should be used in placing epithets after one's name. Abbreviations for licensure in an area are the first to follow immediately after the name. A semicolon follows to separate these abbreviations from those of the educational degrees. Educational degrees appear in order of their issue. Abbreviations for professional societies are always the last of the epithets and are separated from the educational degrees with a semicolon. Example: Helen Doe, RN; BSN, MSN, PhD; FAAN.

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Researching the Economics of Caring

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In this column Turkel and Ray present a synthesis of their qualitative and quantitative studies on both the nurse-patient relationship as an economic resource and the impact of managed care on nursing practice. This column is a follow-up to one that appeared in the Practice Applications Column of this journal in October 2000, where the authors suggested that the first step in facilitating economic healthcare choice is understanding the economic value of interpersonal resources such as the nurse-patient relationship.

This work presents a perspective that is usually absent in discussions of nursing practice based in the simultaneity paradigm, one that explores caring as a relational process in the context of quality, cost, and economic reform. Turkel and Ray use Parse's theory of human becoming in a novel way, linking it with economic, chaos, and complexity theories. If nurses want to be the ones defining nursing, according to the authors, then we must redefine nursing in a way that takes into account economics as well as advocacy, caring, and quality of care. Conversely, any efforts to reshape healthcare must take into account the value of the nurse-patient relationship. Their work offers nurses one way to participate actively in this process.

Relational Complexity: From Grounded Theory to Instrument Development and Theoretical Testing

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In the wake of the controversial healthcare reform process currently being debated in the United States, a central thesis in today's economic healthcare milieu is managed care. Managed care programs, which consist of factors relating to cost containment, cost efficiency, and management accountability outside or within health maintenance organizations, have evolved in all sectors of the healthcare system. Healthcare organizations are dealing with issues related to the reduction of payments to hospitals and physicians, the quest for efficiency, and reduction in Medicare and Medicaid payments. They are challenged to meet financial operational goals in a climate of concern about access to healthcare for all and the provision of quality care. Economic pressures, market forces, and the perceived need for cost-efficient management have dramatically changed the practice of professional nursing. Thus, nursing is in a process of dealing with gripping paradoxes as a result of these changing value priorities in economics and corpo-

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ratization. The perplexing system of an economically driven global culture and the corporatization of American healthcare are forcing a coming to terms with the nature and meaning of nursing practice.

What, then, are the critical issues facing professional nursing in the current healthcare economic reform environment, and how will the future of professional nursing be transformed by these economic changes? In an attempt to answer these questions within the context of changing value priorities in healthcare, the authors conducted a series of research studies to examine the relationship among caring, economics, cost, quality, and the nurse-patient relationship. This column is a synthesis of the research findings from a 5-year program of qualitative and quantitative studies of the nurse-patient relationship as an economic resource and the impact of a managed care environment on nursing practice in diverse for-profit and not-for-profit organizations.

Nursing as a Unitary Mutual Process

Nursing is a unitary-transformative science. A unitary worldview affirms mutuality with the environment and illuminates the process of increasing complexity, expanding consciousness, and transformation (Newman, 1992; Parse, 1998; Rogers, 1970). In the human becoming theory, Parse's (1996, 1998) fundamental assumptions about human becoming relate to freely choosing personal meaning in situations in the intersubjective process of relating value priorities, cocreating rhythmical patterns of relating in mutual process with the universe, and contranscending multidimensionally with the emerging possibles. Moreover, in her theory Parse (1996) identifies the relevance of paradox. Paradoxical processes are inherent in the universe and exist within a unitary design. They are not considered problems to be solved or eliminated but, rather, natural rhythms of life arising with changing patterns, and they are lived multidimensionally all at once. Changing value priorities invite nurses to reflect on and question how they can recognize and choose new patterns of relating while cocreating new possibilities in an increasingly complex corporate environment.

Changing Value Priorities in Nursing Practice: Paradox and Synthesis

The nurse-patient relationship invariably has been affected by complex organizational structures. However, it is only recently that nursing practice has been so directly influenced by contradictions associated with changing economic values, managed care, and reimbursement patterns in American healthcare (Ray, 1989; Turkel & Ray, 2000). Parse (1996) views nursing as unsettled, and she challenges educators, researchers, and managers to preserve nursing's identity by carving out our unique contributions to the healthcare delivery system. Nurses in practice can no longer hold to univocal or unidisciplinary positions but must emerge as leaders in integrating the many voices, especially the voice of economics that affects nurse-caring in today's corporate healthcare environment. As nurses give new meaning to mutuality within complex organizational situations, their choices will shape the discipline and profession of nursing for the future.

Scholars of nursing, such as Fawcett (1999), refer to the nursing situation as increasingly troubling because of the absence of attention to the metaparadigm of nursing, which encompasses traditional theories, conceptual frameworks, and methodologies of nursing. But, as Parse's theory and the theories and research of other scholars (Davidson & Ray, 1991; Moccia, 1988; Ray, 1989, 2001; Silva, 1999) attest, the challenge is to cocreate possibilities by reconciling paradox as diverse disciplines interact. What emerges as the possible (nursing's unique contribution) is understanding how opposites attract by advancing practice theories through research that captures the new reality.

Facing this reality as a mutual, relational caring process within an economic context calls for discerning the reconciliation of paradoxes (Foa, 1971; Moccia, 1988; Ray, 1989; Silva, 1999) by researching the unfolding mystery where the rhythms of nursing life and changing patterns are lived multidimensionally all at once (Parse, 1996). A paradox as a mystery is where a phenomenon is partially hidden and partially revealed. For example economics, although considered alien to nursing and therefore partially hidden by its focus on material goods, money, and services, also is partially revealed because of its core concept, exchange, which is similar to a mutual process or an interpersonal resource (Foa, 1971). The philosophers Hegel and Marx facilitate understanding of how a paradox as mystery is brought more into light by their presentation of the dialectic of opposites (Ray, 1989). Reconciling paradoxes calls forth dialectical tenets that are based on knowledge that phenomena reach their own completeness by the process of their own becoming. The characteristics that illuminate this notion are the connecting of polar opposites into a codetermining relationship (interidentification), the transformation of quantity into quality (qualitative difference), the negation of the negation (thesis, antithesis, and synthesis), and the spiral form of development (transformation and change). As such, human becoming (Parse, 1996), in relation to the natural rhythms of contemporary nursing life, reaches completeness through the integration of caring and economic processes in practice.

The use of qualitative and quantitative research methods from distinctive paradigms contributes to greater discernment of possibilities in nursing practice (Davidson & Ray, 1991; Silva, 1999). In this study, employing the grounded theory approach and instrument development techniques using both qualitative and quantitative methods, respectively, enabled testing, clarification, understanding, and explanation of the phenomenon of nursing as an economic resource. The non-linear theory of "Relational Complexity: A Theory of the Nurse-Patient Relationship Within an Economic Con-

text" emerged and was interpreted as both process and outcome. The theory was described using the tenets of complexity science and captured the contradiction (chaos or disorder and order) engendered by economics and cost containment and, simultaneously, unity (synthesis or relational self-organization) engendered by the human caring relationship as potentiating self-organization in the economically charged environment.

Nurse-Patient Relationship Patterns: An Economic Resource

The initial investigation of 60 nurses, patients, and administrators from three diverse sites (for profit, not-for-profit, and a military installation) was a grounded theory study generating both substantive and formal theories. The purpose of this study was to examine the nurse-patient relationship as an economic, interpersonal resource. This qualitative grounded theory study was guided by the following general research question: What are the patterns involved in the development of interpersonal relationships as an economic resource as experienced by nurses, patients, and administrators when linking quality and cost in the wake of healthcare reform?

Grounded Theory Method

The researchers approached the research situation with an openness to seeing the situation and its associated data in new ways. The researchers wrote memos to bracket out their own ideas prior to the study and during the interview process. During the interview process, the researchers maintained eye contact with the participants and used key phrases to enhance clarification. Examples of these phrases included "tell me more about that" and "can you give me an example of what you mean?" Prior to the start of each interview, the researchers spent a few minutes in social conversation with each participant to increase his or her level of comfort with the researcher.

Interviewing participants was the primary source of data collection. Participants' descriptions of their experiences provided the researchers with rich data for simultaneous data analysis. One interview, 30 to 60 minutes in length, was conducted with each participant. The interviews were semistructured with the researcher allowing each participant to speak openly. The initial interviews began with a general open-ended question. Nurses, for example, were asked, "Tell me about a typical day on your unit. Start with 'I come to work. . . . ' " Patients were asked, "Tell me about a day in the hospital." Administrators were asked, "How would you describe a typical day for a nurse from your understanding of the experience?"

As the interview process proceeded, more specific questions were asked, including describing specific nurse-patient interactions and the costs and benefits associated with these interactions. Use of the word *costs* was consistent with the challenge to nurse researchers by Buerhaus (1986) and Ray (1987) to conduct research that provides economic or dollar value data. In relation to constant comparative analytic techniques, each interview involved exploration of topics arising from the preceding interviews.

After each interview in this study was completed, the tapes were transcribed verbatim. The researchers first read these transcripts and generated questions for the subsequent interviews. On the second reading of the texts, the researchers highlighted meaningful segments of the text and wrote code words along the margins of the transcribed texts.

In the grounded theory method, data collection and analysis occur simultaneously. Through constant comparative analysis, data from each interview were used to enhance selection of questions in the next interview, leading toward identification of the social process and substantive theory (Glaser, 1978). Data were analyzed using the constant comparative method where each line, phrase, sentence, and paragraph from the transcribed interviews were reviewed. Formal theory advanced from substantive data, literature review, reflection, and intuitive insight.

Results of the Grounded Theory Study

Three central categories of relationship, caring, and costs emerged from the data. Refer to Table 1 for the categories and subcategories that are reflective of the findings from this study.

Data were put together in new ways (axial coding) after the open coding by making connections between categories (theoretical coding). This process led to the generation of a substantive theory. The substantive theory encompassed the patterns of relational behavior gleaned from the administrators, nurses, and patients who were involved with the changing resource-driven healthcare system. The substantive theory was named "Struggling With and Balancing Change With Limited Resources in Human and Organizational Relationships." This substantive theory revealed that there is a struggle to balance changes and sustain caring values with limited financial resources.

The formal theory of the study of the nurse-patient relationship as an economic resource emerged as "Relational Complexity: A Theory of the Nurse-Patient Relationship Within an Economic Context," which included economic and caring variables (Turkel & Ray, 2000). This formal theory illuminated that the caring relationship is complex and dynamical, is both process and outcome, and is a function of both economic and caring variables that, as mutual process, is lived all at once as relational and system self-organization.

The formal theory consists of two parts: (a) relationship as a function of interactions or the intentionality and actions of nurses, patients, and administrators and (b) the value of the interactions within an economic framework of the organization. The cost category with its properties, however, did not reveal an actual economic or dollar value associated with the relationship.

Table 1
Categories From the Grounded Theory Study

Category	Subcategory
Relationships	Valuing the nurse-patient relationship
	Recognizing the nurse-patient relationship
	Establishing trust
	Creating and maintaining the nurse-patient relationship
Caring	Being there
	Being, knowing, doing all at once
	Teaching
	Feeling rewarded
	Making a difference
Costs	Valuing the intangible
	Contending with limited resources
	Doing more with less
	Struggling with the meaning of change
	Maintaining a balance

Traditional economic theory is explained by a linear statement wherein satisfaction as the outcome variable is a function of strictly economic variables. This theory reveals that the nurse-patient relationship as an economic resource is a complex, non-linear, and dynamic process that is more like a feedback loop where relationship is both process and outcome and where economic and relational caring sets of variables are integrated.

Discussion of the
Grounded Theory Study

One central tenet of the relational complexity theory is relational interconnectedness. The interactors (the nurse and the patient) are interconnected by means of the relationship and the relational process. Administrators are interconnected by means of the organizational system, which manages the economics. The outcome thus extends beyond the actual caring occasion or transaction through communication and choice making. As such, "Relational Complexity: A Theory of the Nurse-Patient Relationship Within an Economic Context" is non-linear and falls within the realm of complexity science or complexity nursing. What can be expected in a non-linear theory? Determinism and non-determinism, predictability and nonpredictability, increasing complexity and unity, and relational disorder and order are some of the paradoxes of non-linear theory, as well as the focus on cocreativity or creative emergence (Goodwin, 1994). What the theory demonstrates is the strength of how the interactions of the nurse and patient and the economic and organizational caring and non-caring parameters shape the process and how the outcome, the relationship itself, is shaped by that process. The relationship is the "attractor" that facilitates choices and what is valued and how something is shaped. The relationship as both process and outcome is a resource, a value that drives the economics including the technical and organizational systems of healthcare. It serves the crucial function of helping patients fit their personal and environmental situations in terms of cocreating and responding to their changing health conditions. Certain cause-effect features do exist in the theory, such as the reality that patients and the organization are dependent on the caring relationship for assistance or survival in spite of how the economics of services are managed.

Henderson (1990), a social ethicist, calls for a new view of the world's monetarized economy. She argues that values are resources that propel all economic and technical systems. Nursing and economic scientists can begin to appreciate the value of the nurse-patient relationship as the way to link and understand cost and quality. Integrating relational caring interactions in conjunction with economic and technical variables will help to portray and manage the reality that exists in today's healthcare system. Furthermore, relational complexity can prompt new methods for research or analysis to measure or incorporate those values that potentiate care but may not have a specific dollar value attached to them.

Professional nursing is concerned about how it will exist in a cost-efficient, managed care environment controlled by others. Nursing, therefore, must redefine itself in terms of economics in relation to its traditional values of caring, quality, and patient advocacy. If not, managed care executives and corporate administrators who have a stake in the questions of who will pay and how much will be paid will certainly do so. Nursing must be in control of its own discipline and practice environment. Identification of interpersonal resources, the core of nursing within the context of the nurse-patient relationship as an economic resource, was the goal of this study. Testing "Relational Complexity: A Theory of the Nurse-Patient Relationship Within an Economic Context" by means of the Nurse-Patient Relationship Resource Analysis (NPRRA) instruments (the questionnaires) facilitated understanding of the worth and value of nursing in the healthcare system.

Instrument Development and Psychometric Testing

This second study shifted the focus of research from a qualitative approach to a quantitative design. Data from the grounded theory study were used to construct the NPRRA, a 66-item, Likert-type scale questionnaire. Data from the theoretical categories of relationships, caring, and costs, and the related subcategories and properties, served as the basis for the items of the questionnaire. The researchers were challenged to translate the richness of the qualitative data into quantitative form in order to measure the nurse-patient relationship as an economic resource.

Prior to distribution to participants, content validity was established by administering the questionnaire to a five-member panel of experts. Using the Index of Content Validity, all items were rated as *quite relevant* to *very relevant* by the panel of experts. The questionnaire was then administered to a sample of 90 civilian and military nurses, patients, and administrators.

Table 2
Items From Questionnaires

Question	Answer
Professional questionnaire	
The RN being there with the patient is an essential part of caring. What is your opinion?	*Strongly agree* to *strongly disagree*
How often do you see this in the hospital?	*Always* to *never*
How important is the RN being with the patient to caring?	*Extremely important* to *not at all important*
Patient questionnaire	
Nurses being there with me is a very important part of showing caring. What do you think?	*Strongly disagree* to *strongly agree*
How important is the nurse being with the patient to showing caring?	*Not at all important* to *extremely important*

Reliability analysis of the three subscales yielded the following standardized alpha coefficients: relationship subscale, .71; caring subscale, .83; and costs subscale, .66. Of these, only the coefficient associated with the caring subscale met the standard of approximately .80 for a newly developed research measure (Nunnally & Bernstein, 1994). Although cluster analysis had been described in the proposal as the means to explore item interrelationships, interitem correlations were used instead. The average interitem correlation for the items associated with each of the properties/themes within the subscales was compared with the average interitem correlation between those same items and either the remaining items from that subscale or the items from the other subscales. Using this method showed that three of the properties associated with the relationship subscale and four of the properties associated with the caring subscale were more closely related to themselves than to any of the other combinations of items. This provided further substantiation for the relationship and caring subscales and evidence that the costs subscale needed revision.

As a result of this study, refinements were made to the questionnaire. Of the original 66 items, 60 were retained across all theoretical subscales. Because some of the language was difficult for patients, two parallel measures were developed, one for professionals and one for patients. Finally, in order to facilitate item discrimination, two visual analog scales (frequency and importance) were substituted for the rating scale on the patient measure, and three visual analog scales (frequency, importance, and agreement) were substituted for the rating scale on the professional measure.

Psychometric Testing

This component of the research study was devoted entirely to psychometric evaluation of the two forms of the questionnaire: one for patients and one for professionals (nurses and administrators). Refer to Table 2 for an example of items from the questionnaires. Data were collected from more than 200 civilian and military nurses, patients, and administrators.

For assessing convergent validity, patient and nurse participants were administered the appropriate form of the Valentine questionnaire, a measure of caring without any economic emphasis. For assessing test-retest reliability, nurse and patient participants were given the economic measure a second time the day after the first testing. Because measurement of the response via the visual analog scale took an inordinate amount of time, responses for all scales were converted to a 5-point rating scale. Refer to Table 3 for results of reliability and validity testing. Factor analysis was performed on the data, and the number of items was reduced from 60 to 45.

Discussion of Initial Psychometric Testing

The reliability and validity results suggested that all the items were functioning acceptably. However, it was noted during data collection and data analysis that the visual analog scale was too complicated for patients to complete and too time-consuming to score. With that in mind, the researchers decided to revise the questionnaires to a 5-point Likert-type scale format. Refer to Table 4 for an example of the revised questionnaire.

Additional Psychometric Analysis and Theoretical Testing

The aims of this study were to refine psychometric evaluation of the questionnaire and begin testing of the relational complexity theory. Data were collected from examples of 500 civilian and military participants. Overall reliabilities for the two 45-item questionnaires were professionals = .86 and patients = .90. These Cronbach's alphas represent more than adequate internal consistency and support the idea that the items are measuring the same underlying constructs. Construct validity was verified using factor analysis.

Theory testing was done using multiple regression analysis. Within this analysis, the intent was to see whether the caring and costs subscale scores could predict the relationship

Table 3
Results of Reliability and Validity Testing

	Professional	Patient
Reliability (Cronbach's alpha)	.90	.94
Reliability (test-retest)	.95	.93
Convergent validity (Valentine's instrument)	.284	.320

Table 4
Revised Questionnaire

Professional questionnaire
The RN being there with the patient is an essential part of demonstrating caring.
Patient questionnaire
Nurses being there with me is an essential part of showing caring.

NOTE: 1 = *strongly agree*; 2 = *disagree*; 3 = *neither agree or disagree*; 4 = *agree*; 5 = *strongly agree*.

subscale score in patients and professionals. In both samples, the prediction of the relationship subscale score was due primarily to the caring subscale; the costs subscale was not a factor in the analysis.

This finding validates what the participants revealed in the grounded theory study. The intentionality of the caring interaction between the nurse and the patient is what makes a difference. From this quantitative study, it is clear that the notion of cost is diverse and has different meanings to different people.

In the qualitative grounded theory study, human caring, not cost, was the predictor of the value of the nurse-patient relationship in both civilian and military organizations. The patient and professional questionnaires developed thus far require further refinement through additional research. However, the research has shown that humanistic caring in a new economically driven healthcare system is valued and that the nurse-patient relationship can be studied as an economic resource.

Research in Progress

Currently, the researchers are in the process of linking the non-economic resources of caring, professional status, and patient education to the traditional economic resources of money, goods, and services. Although exchange theorist Foa (1971) calls for correlation among love, status, and information with traditional economic resources of money, goods, and services, this type of research has not been fully accomplished in the discipline of nursing. The results of the previous studies clearly demonstrated that the operational restructuring of healthcare that proposes to link cost and quality must include the nurse-patient relationship as a value-added component. Nurse caring can no longer be viewed solely as a cost center within the economics of healthcare.

The investigators are conducting further research through a series of three studies over a 3-year period using grounded theory, psychometric evaluation of the revised instrument, and outcomes evaluation to study cost issues and organizational caring in military and civilian managed care environments. Qualitative data have been collected. The data will be used to enhance the theory, reconstruct the costs subscale, and construct an additional organizational caring subscale of the NPRRA questionnaires for military and civilian healthcare settings. Additional psychometric testing and evaluation of the reconstructed patient and professional questionnaires will be initiated in the 2nd year of the research.

Upon completion of the research in Year 2, it is anticipated the NPRRA questionnaires will be a reliable and valid measure of relational caring within an organization. In Year 3, economic and patient care outcomes in the changing military and civilian healthcare settings will be studied. The primary question this research will attempt to answer is the relationship among relational organizational caring, patient outcomes, and economic outcomes.

Conclusion

From the results of this study emerged the practice theory "Relational Complexity: A Theory of the Nurse-Patient Relationship Within an Economic Context," which was generated and tested through rigorous qualitative and quantitative research methods. Overall, the theory and results related generally to Parse's fundamental assumption of relating cocreated value priorities (nurse-caring) with emerging possibles (the economic context). Moreover, the theory illuminated the view that human becoming reaches its commitment to choosing meaning or interpreting the nurse-patient relationship (mutual process) while relating new value priorities (the impact of economics on nursing and healthcare). The changing patterns revealed that relationship is both process and outcome. Nurses, patients, and administrators reached self-organization by the quality of relationships, and the relationships reflect quality within the organization. Relational complexity, including the integration of economic parameters for nursing in the organization, is the natural rhythm of nursing life that is lived multidimensionally all at once in the healthcare environment. By dealing with the paradoxes, insight was achieved to understand the paradox of nurse-caring and economics. Through reflection on and integration of the dialectical laws of interidentification, a synthesis was achieved by means of underscoring the importance of the trilogy of the thesis (human caring), antithesis (economics), and synthesis (relational complexity in an economic context). Furthermore, the theory grasped unity in light of the science of complexity and non-linear philosophy. The non-linear theory of relational complexity as relational self-organization is both outcome and process. It is a dynamical study of mutuality of the

person-environment relationship (nurses, patients, and administrators) in an economic context. The dialectic between the economic system and the human caring relationship (paradoxically both disorder and order) revealed life at the edge of chaos (Ray, 1998), an arena of turbulence in the organizational culture where nursing is practiced. The edge of chaos is where the search for order or reconciliation takes place. It is a communication point (phase space or choice point) where the hidden unity, relational complexity, is revealed. The questionnaire data and theory-testing showed that relational caring as a process was the strongest predictor in terms of the outcome—relational self-organization, which is aimed at well-being. Although nursing is practiced within an economic context, economics or cost, as a property, was only weakly predictive in terms of the outcome of relational self-organization. Relational complexity theory thus is the synthesis of emergent properties, the order or unity that is cocreated. Knowledge of this theory presents future opportunities for mapping caring patterns as economic or value-added resources that eventually will lead to a higher level integration and transformation (quality of care) in the healthcare system.

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Ethics and Bearing Witness

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Bearing witness–not bearing witness has been posited by Cody as a fundamental rhythm of human coexistence. In this column, Cody explores the ethical implications of bearing witness to the realities of persons' lives in the context of healthcare. The topic is explored in relation to ethical principles of nonmaleficence, respect for human dignity, veracity, and fidelity. It is proposed that bearing witness is vital to caring for others and a choice, with the potential to be quite life-changing, that each nurse has the opportunity to make in every instance of caregiving.

The Ethics of Bearing Witness in Healthcare: A Beginning Exploration

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> "Every man must fear the witness in himself who whispers to close the window."
>
> —A. M. Rosenthal

In recent years, scholars in several fields have given increased attention to the phenomenon of bearing witness (Cody, 2001a, 2001b; Cody, Bunkers, & Mitchell, 2000; Garfield, 1995; Glassman, 1994; Kayal, 1993; Parse, 1998, 1999; Price, 1989; Schindler, Spiegel, & Malachi, 1992; Wiesel, 1970). Many of these works have generated new insights into the nature of bearing witness. Most have called for greater awareness of the fundamental need to bear witness in a wide variety of human contexts, particularly in regard to human suffering, justice, and healthcare. There is a certain urgency to these calls to bear witness in that the need for bearing witness and the absence thereof are frequently identified in relation to such phenomena as family violence and other hidden traumas; the meaning of the Holocaust to victims, survivors, and descendants; and the experiences of persons living with HIV/AIDS.

One is reminded of the original impetus behind Husserl's (1931) invention of phenomenology, prompted by his sense that the essences of things as experienced by human beings were being lost in a plethora of scientific theorizing. Now, as in Husserl's time, the essences of human experiences are too often hidden, though not necessarily removed from plain sight—hidden behind, or perhaps rather within, the postmodern plethora of information, images, and noise delivered in an endless multimedia montage, and hidden behind the knowledge emanating from objectivist empirical science. The information overload is continually (re)produced by socioeconomic systems that involve millions of persons intimately yet remain more opaque than not to those persons. The objectivist empirical science has come to substitute for truth, and truth has come to be located in science (and perhaps in faith) but not in life experience. The contemporary call to bear witness is not a call like Husserl's to contemplate "things" more purely in order to apprehend their essences, but rather, it is a call to listen to people, to be open to the reality of their lives, and to speak of their lives with a devoted fidelity to their experiences as described and expressed by the people themselves. The call itself bears witness to the pervasive neglect of

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bearing witness to one another's joys and sorrows in contemporary life.

The Fundamental Meaning of Bearing Witness

Bearing witness by definition is attesting to the veracity or authenticity of something through one's personal presence. It is connected with the terms *to witness* and *witnessing*, which have traditionally been taken to refer to direct personal experience/observation. In its most humanistic sense, *witnessing* is attending closely and openly to another and to her or his expressions of the life she or he is living. In English we use these two closely related terms—*witnessing*, which is the direct, personal apprehending of something in the moment, and *bearing witness*, which is the telling, the attesting through one's personal presence to the veracity or authenticity of what was witnessed. In other languages these are often two different (non-cognate) terms (Derrida, 2000). Bearing witness, however, includes implicitly the idea of a prior or concurrent witnessing, in that it is not possible to attest decisively (by telling, speaking out, or writing) to the veracity or authenticity of something if one has not *witnessed it attentively* in the first place. For this reason, I use the term *bearing witness* to signify both meanings. This usage reflects a unitary multidimensional ontology in which all human life evinces limitless layers of meaning, an ontology that finds expression in Parse's (1981, 1998) human becoming school of thought, the perspective from which I approach this topic. One cannot be faithful to the imaging and languaging of the lived experience of the other when describing it to a third party if one has not attended faithfully to the person's telling (or other form of expression) in the first place.

In human affairs, witnessing and bearing witness are vital. I have written elsewhere of the rhythm of *bearing witness–not bearing witness* as one of the fundamental rhythms of life as it is humanly lived.

> Bearing witness happens face-to-face in moment-to-moment living, but it also takes multidimensional forms, such as rituals, testimonies, documentation, literature and art. . . . Choosing with whom to bear witness, how, when, and for what reason is at the very crux of human coexistence. To bear witness to one phenomenon is simultaneously not bearing witness to that phenomenon in other ways or to other phenomena. *Not bearing witness* is freely choosing not to be present with, acknowledge, respect, or offer testimony about *something* or *someone*, yet the very who one is bears witness to one's truths and one's values. Bearing witness–not bearing witness is a rhythmic, paradoxical unity. Whenever bearing witness is in the foreground of one's experience, not bearing witness is there, too, as a constituent element of the situation and an ever-present possibility for one's choosing. (Cody, 2001a, p. 97)

Over the years, scholars have explicated numerous ways in which presence—specified as authentic or inauthentic, respectful or disrespectful, attentive or inattentive—shapes realities and possibilities in human relations (Boykin & Schoenhofer, 1993; Buber, 1923/1958; Goffman, 1959; Parse, 1981, 1998; Paterson & Zderad, 1976/1988; Rogers, 1980; Sartre, 1943/1966; Watson, 1985). There is consensus among scholars in the humanistic tradition that authentic, respectful, attentive presence is the sine qua non of any human-to-human relating entered into with genuinely beneficent intent. This idea is not new. What is perhaps new, in positing the centrality of *bearing witness–not bearing witness*, is the explication of how bearing witness coconstitutes reality (Cody, 2001a) and the attendant notion that ethical behavior in human affairs turns largely on bearing witness. It is the purpose of this column to make more explicit the implications of bearing witness with regard to ethics in healthcare.

Bearing Witness–Not Bearing Witness in Contemporary Healthcare

It would be unwise to assume that nurses in practice today often truly bear witness to the lived realities of the persons they serve. It is quite possible to be near another person, to be aware of her or his situation, to have a verbal exchange, and to feel affection for the person while not bearing witness to the lived reality of the person; indeed it is common. Assessment, diagnosis, treatment, and "care" occur pervasively in healthcare institutions that hardly recognize the phenomenon of bearing witness, much less encourage it, and often do not tolerate it. Nurses in contemporary North American acute care environments commonly describe harried working conditions that, from their perspectives, do not permit them to listen to persons for any length of time, to try to understand in depth the experiences and values of the persons they serve, or to use valuable time (that "must" be devoted to biomedically dictated tasks) to perform small kindnesses or to provide elementary comfort measures.

Most often, the knowledge these nurses highly prize includes knowledge of pathophysiology, treatment algorithms, pharmacology, electrocardiograms, and laboratory tests far more often than knowledge of human-to-human relationships, authentic presence, and listening. (I have come to know this through the descriptions of hundreds of graduate nursing students over the past decade.) The former kind of knowledge (from objectivistic science) is commonly assumed to be important, complex, esoteric, and difficult to learn, whereas the latter kind (from humanistic relating) is assumed to be simple, easy to learn, not really necessary in professional relationships, even already widely practiced, and merely a matter of being "nice." These conditions and attitudes do not tend to foster opportunities or intentions to genuinely bear witness to the lives of the persons served. The devalued status of bearing witness (and much of genuine human-to-human relating) in healthcare must change if the quality of care is to improve significantly.

If there is one preeminent lesson that has surfaced in contemporary bioethics, it is that one cannot, on the basis of pro-

fessional qualifications, social status, or past performance, assume that persons will conduct themselves in ways that are ethically sound or make decisions that are ethically defensible. Even taken together, the fact that healthcare providers are exposed to a modicum of education on ethics, the fact that institutional policies and procedures are designed to meet minimum standards of healthcare ethics, and the probability that most healthcare providers have beneficent intentions ultimately cannot ensure ethical comportment on the part of practitioners. Rather, the dedicated pursuit of a strong common ethos in healthcare calls for public and scholarly discourse among all stakeholders, focusing on the needs and desires of the individual in the context of a shared desire for the common good. Can ethical comportment in any case happen automatically? The notion of a guiding ethos for healthcare praxis suggests that decisions about how to be with and care for human beings be considered contemplatively and deliberated from multiple perspectives. Upon reflection on the *bearing witness–not bearing witness* phenomenon as it unfolds in healthcare, several ethical implications emerge that warrant closer examination.

Selected Ethical Principles Relevant to *Bearing Witness–Not Bearing Witness*

Bearing witness relates to a wide range of ethical concepts and principles, so that undertaking a comprehensive analysis is well beyond the scope of this column. What is offered here is an examination of the phenomenon of *bearing witness–not bearing witness* in relation to selected ethical principles that are particularly salient in healthcare. Choosing to bear witness in a certain way to one phenomenon is simultaneously choosing not to bear witness in a different way or to different phenomena. In healthcare practice today, the pressures for the attention of a care provider are many. Further discussion of how to make choices about what to attend to in the context of caregiving is certainly needed, and this column is offered as a contribution to that discussion.

Nonmaleficence

The time-honored ethical principle of nonmaleficence means *do no harm*. This is often considered to be the highest duty of a professional care provider. Whether or not a way of acting or being with a situation is viewed as desirable for meeting one end or another, a basic consideration in all caregiving and in virtually all professional services is *first, do no harm*. One relevant question immediately arises: How can one keep from doing harm if one acts without knowing what the reality of the lived experience is for the person? The choosings that constitute the rhythmical interchange of *bearing witness–not bearing witness* are ways of coparticipating in the unfolding lives of the persons we, as nurses, serve. To refuse to bear witness to the experiences of persons who are living through times of profound pain, vulnerability, and angst is to choose a way of *being with–not being with* that will likely be experienced by those persons as injury and insult.

Respect for Human Dignity

The first statement in the American Nurses Association's (ANA) (1997) *Code for Nurses* sets forth a strong affirmation of the profession's respect for human dignity and forbids any restriction on caregiving related to characteristics of the client, the health problem, or the client's socioeconomic environment, thus mandating that this respect carry through the nurse's interface with all of nursing's "metaparadigm" concepts. It states, "The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (p. 1). Surely this broad injunction, the very first statement of ethics in the ANA's *Code for Nurses*, is not one that can be lived out casually, easily, thoughtlessly, or only sometimes, because such an approach could not logically stay true to either the letter or the spirit of the guideline. How can one live out a profound respect for human dignity, a respect that is foundational to professional nursing, if one does not *bear witness* to the very nature of life as lived and experienced by the person?

Veracity

The principle of veracity, or truthfulness, is widely viewed as foundational to ethics—although it has been somewhat late in being adopted as a strong value in healthcare (Yeo, 1991). Its present-day importance is made plain by enjoinders to be "honest" in the American Medical Association's *Principles of Medical Ethics* and the *Code of Ethics* of the American College of Healthcare Executives (Yeo, 1991). Interestingly, only a slight reference to truth or honesty is made explicit in the ANA's *Code for Nurses*. Discourse on truthfulness in healthcare is, however, predominantly focused on the truthfulness of what is told to the client by the provider. A contrast is often made between the principle of veracity, which holds that one should tell the truth unless doing so will clearly bring harm to the client, and paternalism, which holds that one should decide what is best for the client and whether truthfulness will serve that end. There is a pervasive assumption that the healthcare provider knows what the truth is and really no mention in mainstream healthcare ethics texts of the importance of truthfulness in apprehending, contemplating, and communicating the person's expressions of her or his lived experiences. Perhaps there is an implicit assumption that the nurse, being in a sense closer to science, is somehow closer to truth than the person receiving care. Once one becomes aware of it, the absence, in healthcare, of an ethos of truly attending to the person's lived reality becomes glaring. But if such a concerted attempt at apprehending the truth of the person's life as lived is not forthcoming, then let there be no pretense that such healthcare can be person-centered. Healthcare without a concerted attempt to understand the truth of a person's life as experienced by that person is indeed paternalistic—or

else merely mechanistic and routinized in enforcing whatever norms are selected by the healthcare provider to support. *Bearing witness–not bearing witness* emerges with the rhythmic cadence of attending to–not attending to and extends multidimensionally to the telling–not telling of the person's story. The care that lacks one lacks both and is thus lacking in truthfulness.

Fidelity

On a related note, the kind of truthfulness under discussion here has often been associated with fidelity. Fidelity, or faithfulness, requires a persistence that complements the focused attention of a first encounter and expands one's beneficent intentions beyond the moment. The concept of fidelity in turn has been used to examine how faithful the healthcare provider is to her or his own word or commitment to care, not necessarily to the human dignity of the person, the truth of that person's life, or the expressions of the desires, hopes, and dreams of that person. But faithfulness to the desires, hopes, and dreams of a person from her or his own perspective and honoring the human dignity of that person must surely be central to healthcare if we are to maintain the integrity of professional philosophy, actions, and outcomes around a client-centered focus. Bearing witness is the living-out of the commitment of professional fidelity to the person in the ever-changing nurse-person-family-community process. Lacking a fuller understanding of what it means to bear witness, the meaning of fidelity in the context of professional healthcare can ring hollow. It is necessary to more fully explicate the meaning of bearing witness to come to know what forces impel the rhythms of *bearing witness–not bearing witness* and what phenomena or surrounding circumstances distract the nurse from bearing witness or come to have a greater priority, thus undermining fidelity.

Bearing Witness–Not Bearing Witness and Nonmaleficence

Although it is not possible for any person to know fully and completely the lived reality of another, it is the nature of human understanding to draw on common experiences, common language, and common images in order to form relationships. The persons served by nurses often are living with pain, vulnerability, and angst that cannot be understood through the all-too-common means of interviews and checklists. A deeper understanding than that which commonly prevails is certainly within the reach of most practitioners, but the dominant contemporary paradigms in nursing and healthcare to some extent prohibit bearing witness. Behavioristically influenced traditions warn that accepting the subjective world of the patient as a reality can be dangerous; that the nurse may find herself or himself manipulated; and that she or he, by not challenging patients' expressions that diverge from objective observations or therapeutic norms, may feed into denial or delusion, thus actually violating the principle of nonmaleficence.

The assumptions and values of the dominant paradigm guide nurses to see their work as disease management and symptom control, problem solving, limit setting, and making certain determinations as to what the patient "should" do (see, for example, American Association of Colleges of Nursing, 1998; Stuart & Laraia, 1998). The implication, which gets communicated to nurses as they develop their professional expertise, is that the failure to carry out these duties properly would harm the patient. In its more humanistic manifestations, the dominant paradigm encourages the nurse to listen attentively to the patient and asserts that to engage in a "therapeutic relationship" the nurse must develop empathic understanding. The notion that failure to master these skills may result in harm to the patient, however, is not nearly so emphasized but clearly has the potential to result in significant injury and insult.

The nurse in the dominant paradigm is called on to bear witness to the perspectives and pronouncements of objectivistic science and to serve the person as a kind of messenger of the dominant paradigm. The person's expressions of personal experience are viewed as valid and "true," so long as the expressions are within parameters of normality, but are suspect once they venture outside the accepted parameters of normality or challenge the beliefs and values represented in the pronouncements of objectivistic science. The nurse practicing within a paradigm such as Parse's (1998) human becoming school of thought that values bearing witness to the person's expressions of her or his lived reality does not strive to connect humanly lived experience with judgmental diagnostic labels, predications about persons based on generalized statistics, or paternalistic/behaviorist interventions.

Hatley (2000), in his book *Suffering Witness: The Quandary of Responsibility After the Irreparable*, addressing collective responsibility in relation to the Holocaust, writes about witnessing as an "ethical involvement."

> Burdened by the other's suffering, we are called upon not only to understand . . . but also and in the first instance to witness it. By witness is meant a mode of responding to the other's plight that exceeds an epistemological determination and becomes an ethical involvement. One must not only utter a truth *about* the victim, but also remain true *to* her or him. In this latter mode of response, one is summoned to attentiveness, which is to say, to a heartfelt concern for and acknowledgment of the gravity of violence directed toward particular others. In this attentiveness, the wounding of the other is registered in the first place not as an objective fact but as a subjective blow, a persecution, a trauma. The witness refuses to forget the weight of this blow, or the depth of the wound it inflicts. (Hatley, 2000, p. 3)

Bearing witness to the reality of persons' lives is qualitatively, esthetically, and ethically worlds apart from the banalities of conducting everyday objectivistic scientific practice. It is sev-

eral magnitudes more complex, and incomparably more profound, when the nurse (or simply another human being) finds the strength and moral courage to truly bear witness. It requires an *imagining* that frequently expands the parameters of what one ever pictured as possible.

In writing about a poem by Primo Levi on bearing witness to the *Shoah* (the Holocaust), Hatley (2000) describes the compelling urgency with which Levi strives poetically to engender a profound attentiveness to the person who suffered and was harmed (here called the *Häftling* [prisoner]) and to the incomprehensible suffering that was endured.

> This attentiveness listens for a suffering, an undergoing of compulsion, that is utterly inexplicable in one's own terms. One does not suffer *as* the *Häftling* suffers. One does not even think as the *Häftling* thinks. Levi emphasizes this fact by incessantly pointing out the disjunction between the reader who is nested safely in his home and the *Häftling* who is utterly exposed to a cruelty that puts her or him beyond the bounds of categorization. (Hatley, 2000, p. 40)

To avoid harm to the persons we serve, then, is it not clear that we, too, must not only attend closely, no matter how painful, but also *refuse to forget?*

Bearing Witness–Not Bearing Witness and Respect for Human Dignity

As stated previously, the ANA *Code for Nurses* (1997) mandates that services be provided without regard to social or economic status, personal attributes, or the nature of health problems. What is not given in the guidelines, however, is a substantive description of exactly what composes "services," which is largely dependent on one's paradigmatic perspective. Some services in a mechanistic model can be provided without a trace of negative discrimination based on socioeconomic status, personal attributes, sexuality, race, or ethnicity, and these services can be delivered within recognized standards of practice, while a profound, abiding, and true respect for human dignity remains lacking. A profound, abiding, and true respect for human dignity requires bearing witness to the reality of the person's life as lived, to the extent that the person wishes to disclose it.

Johnson (1998), a therapist, described his work with incarcerated men who had been deemed especially dangerous and imprisoned for life. Most of the men had never had a respectful interrelationship with another human being, and Johnson found that gaining their *consent* even to approximate a relationship was a complex process that required many months. For Johnson, relating with another rests on a genuine consent that can only be reached through working hard at sustaining a sense of truthfulness and trust.

> Peace of mind is utterly dependent on this trio [truth, trust, and consent], as is peace within a family or across a globe. Here are values that every human can subscribe to. . . . Truth . . . means deploying deceit as little as possible, and working hard to convey what you understand to be going on, rather than deceiving first yourself and then your neighbour. . . . We none of us can define what we say with 100 per cent accuracy, so we must build up a reputation for keeping our accuracy and our truth as close as we can make it to this unattainable ideal. . . . Trust follows when you begin to believe the truth of what you are being told. . . . The notion of trust is commonplace. We all of us trust the floorboards we walk on not to collapse and drop us on to the floor below. When that trust is shown to be misplaced, then we scour the ground for rotten boards before putting another foot forward—and exactly the same happens in our human relations. The reason so many prisoners were where they were was because they had never had any experience of trustworthy human relations. . . . Once truth and trust are in place, then, and only then, have you a stable platform from which to begin to exercise your new facility for consent. In order to give meaningful consent, you first have to have control of your own mind, faith in your own value and self-image, and confidence that those relating to you will respect your consent, will seek it as an asset and deliver upon it with care and fruitfulness. (Johnson, 1998, pp. 151-152)

This passage calls into question whether healthcare consumers/clients commonly do *fully consent* to those actions visited on them by professionals, in the absence of a conviction on their part that the professionals are truthful and trustworthy. Does not respect for human dignity demand that the full engagement and confirmation of this "trio"—truth, trust, and consent—precede any "interventions" by healthcare professionals? And is this achievement possible any other way than through bearing witness?

Numerous works of literature and art document the potentiality for human dignity to shine through and to be honored, despite every kind of degradation imaginable, be it endemic poverty and filth in Calcutta (Lapierre, 1985) or the devastating disfigurations of something like severe neurofibromatosis (Pomerance, 1979). But what does it mean to suggest that the nurse live out a commitment to honoring human dignity throughout all dimensions of her or his practice? Contemporary practice would almost seem to suggest that *not bearing witness* to such wretchedness honors human dignity more than *bearing witness*, but it has been my experience that people who are suffering want the truth of their lives to be known, acknowledged, and addressed as such. To truly sustain respect for human dignity one must do so unconditionally while also witnessing with eyes and ears wide open to the truth of the person's life.

Bearing Witness–Not Bearing Witness and Veracity

Objectivistic science dominates healthcare in Western society and around the world. Often it is taken as the arbiter and closest approximation of truth among practitioners and stakeholders in the activities and processes of healthcare. The focal point of most discourse on veracity in the healthcare ethics lit-

erature is the question of whether or not to "tell the truth" to persons with disturbing, usually fatal, medical diagnoses. These actualities reflect a limited perspective on truth, a view that is not very useful in real human affairs and, indeed, from my perspective, a cheapening of the very concept of truth.

Paul Feyerbend (1975) offers the following assessment of society's relation to science.

> Scientific "facts" are taught at a very early age and in the very same manner in which religious "facts" were taught only a century ago. There is no attempt to waken the critical abilities of the pupil so that he may be able to see things in perspective. At the universities the situation is even worse, for indoctrination is here carried out in a much more systematic manner. Criticism is not entirely absent. Society, for example, and its institutions, are criticised most severely and often most unfairly and this already at the elementary school level. But science is excepted from the criticism. In society at large the judgement of the scientist is received with the same reverence as the judgement of bishops and cardinals was accepted not too long ago. (p. 4)

In this regard, perhaps public response today to the demands for protection of human subjects and patients' rights, the not-infrequent news stories of long-established theories being overturned, and the disproportionate expenditures on science as opposed to purely humanitarian causes mitigate at least slightly against the kind of scientific hegemony that Feyerabend describes. Scientific knowledge, however, remains the most privileged form of knowledge, and, similarly, objectivistic scientists remain the most privileged arbiters of truth in many quarters.

Gilligan (1982) brought a new perspective into the realm of theories of moral development when she broke with her mentor Kohlberg (1981), whose work was predominantly along the lines of a rule-oriented and individualistic ethics. In contrast, Gilligan posited, based on her research, that women and girls engaged in a kind of moral reasoning that was not rule-bound but rather threaded with ambiguity and weighted with infinite subtleties of relational context, an ethic of *care*. Prior to Gilligan's work, "experts" in the field of moral development *could not* bear witness to the reality of moral reasoning among girls and women because they had very little notion of what it really *was*. The ethic of care as elucidated by Gilligan involves bearing witness to the reality of persons' lives in ways that Kohlberg's deontological ethic does not. Ordinary caring women (and presumably some caring men) could appreciate this form of moral reasoning, all along, of course, and have now received "scientific" support for their perspectives. This development reflects an ongoing shift in the basic beliefs and approaches of the human sciences toward greater acknowledgment and appreciation of relational and aesthetic dimensions of human affairs.

This appreciation is generally consistent with the human becoming school of thought (Parse, 1998), which suggests that the primordial basis of truthfulness (over and above objectivistic science) in the caring professions should be an eyes-and-ears-wide-open intent to apprehend the truth of the person's life. Bearing witness in this manner requires an appreciation of aesthetic truths and a language in which to express them. Jacques Derrida (2000) posed the question of "whether the concept of bearing witness is compatible with a value of certainty, of assurance, and even of knowing as such" (p. 182). He also hypothesized that "all responsible witnessing involves a poetic experience of language" (p. 181). Parse (1998) suggests that the nurse bears witness to the mystery of being human, to the known and the unknown that coconstitute the reality that each human lives. Gadamer (1960/1989), Langer (1967), and others have insisted that the fullness of human understanding demands recognition and appreciation of esthetic truths, represented in aesthetic discourse. Bearing witness can occur only in the context of a real appreciation of such truths, which are verifiable only in the arena of humanly lived experience. These are not objectively verifiable (material, observable, measurable) truths but are felt, even *lived*, with one's whole being—with the prime example being the close relationship, the enduring presence, that is cocreated between two persons committed to one another. As Marcel (1961) says:

> Each of us . . . [can] recognize that there were presences and loyalties in his life which differ radically from worldly or professional relations and the obligations which issue from the latter. Let us note that we have here a kind of evidence which differs as much as anything could from Cartesian evidence; that is to say, from the evidence associated with clear and distinct ideas. Must we go so far as to say that it is a purely private and incommunicable evidence which exists for me alone? I do not think so. I rather think that in this case, as in many others, perhaps chiefly in the domain of art, we have to interpose . . . an intermediary kind of given, between that which is accessible to just anybody, on the one hand, and that which I alone am able to appropriate, on the other. This intermediary given is for a concrete Us. It is an open communion of selves, the kind which is formed around a world which is intimately loved, but which we know will remain a closed book for an infinity of creatures. These reflections permit us to see rather distinctly I believe why it is so difficult to speak of presence. It is because through this speech we inevitably transform and degrade presence.

Truthfulness vis-à-vis lived experience calls for a willingness to stand humbly before the mystery of life and accept the meanings that others have given to their experiences regardless of how these cohere or do not cohere with the meanings one has given one's own experiences. Wiesel has said that "a witness is a link," by which he means that a witness links an event or occurrence of some significance (one to be noted as having been witnessed) with other persons in other times who otherwise could have no knowledge of it (cited in Berger, 1993, p. 119). The responsibility of the witness in relation to veracity can be interpreted in a number of different ways, but only one way can be said to reflect a truthfulness dedicated

wholly to the welfare of the persons living the event: to be true not to an objective observation or to an abstract principle but to be true to *the persons themselves*.

Bearing Witness–Not Bearing Witness and Fidelity

In the early morning hours of March 14, 1964, on a heavily populated urban street in Kew Gardens, Queens, in New York City, a young woman named Catherine Genovese was stabbed to death over a period of more than 30 minutes, in a bizarre sequence of three attacks that began under a streetlight in front of several residential buildings and ended in the foyer of an apartment building within a few feet of her neighbors' homes. There were 38 admitted witnesses to this crime, yet no one did anything to help (with the exception of a lone man who yelled once from a high window, "Let that girl alone!"). No one called the police until the attacker departed on his own accord and Catherine was left dead. During the attack, several witnesses in the apartments above pulled up chairs or moved from window to window for a better view (Kroopnick, Schreiberg, & Crompton, 1999). Sociological analysis of this event contributed to a discussion of the notion of "diffusion of responsibility" (Latané & Barley, 1970), which is basically the idea that each person in a crowd or group feels less responsible to take action for a cause when he or she sees that others are not taking action for that cause. Rosenthal (1964), a journalist who wrote about the case, posed the question, however, What responsibility do we have for pain and suffering we know to be taking place, not just meters away, or within earshot, but across town, in the next region or state, or in the next country? We all know that war, famine, crushing poverty, and nightmarish diseases are being experienced by millions of people around the globe at any given time. What responsibility do we have toward those people? And if it is less than toward our near neighbors, how much less, and why?

For reasons that are compelling but unclear to me, I am reminded here quite imagistically of a woman I saw briefly in an intensive care unit (ICU) some 15 years ago. The woman had been treated (for what I do not recall) in the hospital in which I worked, and something had gone wrong. She was placed in the ICU and given vasopressors through a central venous line to keep her alive. The peripheral constriction that occurred was so extreme that it halted circulation to her extremities, and all four limbs became necrotic to the trunk of her body and were amputated. When I saw her, she was lying unconscious, intubated, on ventilator support, eyes swollen shut, with sutures winding around large portions of what remained of her body, with early signs of wound dehiscence and suppuration. There was no room on what was left of her body for any covering that would not interfere with the technical tasks of caring for her, so she lay there naked, exposed, and perfectly still except for the movement of her mechanically induced ventilations. Members of the hospital's supervisory team, of which I was a part, were invited by my boss to come by to view her, as an "educational" experience.

What does it mean to be faithful to those to whose life experiences we bear witness? Although I cannot say definitively, in light of the intrinsic ambiguity of situations involving ethical dilemmas such as these, I believe it is safe to say that a true committed faithfulness to the recipients of our care is sadly lacking in contemporary healthcare. As nurses, though, we are called to bear witness, not so much in the objective sense but really always in the context of an intersubjective relating. And isn't this an interrelationship in which our willingness to creatively imagine what life is like for the other, our seeking of understanding, and our upholding of human dignity unconditionally contribute greatly to the definition of who we are as nurses?

Marcel (1961) speaks of "*Being* as the place of fidelity." He explains that "to live in the light of fidelity is to move in the direction of Being itself" and "to live more faithfully is to Be more fully." To be faithful, then, is an active and creative involvement. Marcel continues,

> Fidelity is actually the exact opposite of an inert conformism. It is the active recognition of something abiding, not formally in the manner of a law, but ontologically. In this sense fidelity is always bound up . . . with something that can and should be upheld in us and before us as a presence, but which *ipso facto* can be just as well ignored, forgotten, obliterated—even utterly so—and this may remind us of that shadow of betrayal, which, to my mind, threatens to envelop our entire human world. Thus, the connection between fidelity and presence is affirmed with the greatest possible parity.

Thus, fidelity involves the *choice* to affirm a mutual presence with the other as important and meaningful and to act upon that meaningfulness accordingly, *or not* to so affirm and *not* to act. Only when the choice is present and the choice to be faithful is made does *fidelity* obtain. Marcel describes how a promise carries over from the time when we made it and we really meant it but arises again at times when we no longer feel the urgency. However, when we are again confronted with the evocative power of the instance that inspired the promise, we may recover the feeling that originally moved us. Fulfilling the promise *cannot* depend on reattaining the original conditions in which it was made. Perhaps a critical approach would indicate that a promise should only be made for a limited duration, so that one could carry it out within a context of personal honesty, still fully committed to it and before it fades. But Marcel insists, "It seems to me that something in us protests in a more or less inarticulate fashion against this radical elimination of unconditional commitment." He continues,

> Love, in the fullest and most concrete sense of the word, namely the love of one being for another, seems to rest on the unconditional. I shall continue to love you no matter what happens. This is at the very opposite pole from the conditional commitment that seems to presuppose a *de facto* if not a *de jure* stability for the time being in the conditions under which

> it is made. We should say also that love, far from merely requiring the acceptance of risk, demands it, in a certain manner. Love seems to be calling for a challenge to be tested, because it is sure to emerge the conqueror.

Bloom and Reichart (1998) in their book on violence and collective responsibility provide copious documentation of appalling facts about violence in American life. For example, 61% of rape cases occur before the victims reach age 18; 29% before the age of 11. Among adolescents ages 12 to 17, about 8% have been victims of serious sexual assault, 17% have been victims of physical assault, and 40% have been eyewitnesses to serious intentional violence. Between one third and one half of all women at some time experience violence at the hands of an intimate partner; 15% to 25% of pregnant women are battered during pregnancy. One in every eight American women will be raped in her lifetime, about one third of these at the hands of an intimate partner or family member. There are more than 100,000 children in American correctional institutions and more than 160,000 additional children whose mothers are imprisoned. Bloom and Reichert question whether perhaps the entire American culture has not become "trauma-organized" and inundated with powerful "traumatogenic" forces (pp. 14-15). They propose a large number of practical solutions—hundreds, in fact—but at the close of their book, they write,

> We have titled this book *Bearing Witness* because we wanted to convey the vital importance of the need for all those who are presently silent to speak up and bear witness to what they have seen. This is a particularly urgent call to health care workers and other service providers who spend a lifetime in the "trenches," attempting to fix what is already broken, while trying to prevent more damage from occurring. (p. 278)

Healthcare experiences in and of themselves can be devastatingly "traumatogenic" (Sawdon, Woods, & Proctor, 1995). The horrors that attend high-technology care are just as real and profound as those that attend low-technology care; they are merely less recognized by care providers. To be in need of the best products of the health sciences and best talents of healthcare providers, yet to be betrayed by those who offer help and claim to have the "expertise" to provide help, is an experience that carries with it the power to destroy one's faith in humankind. Something is called for in the way of bearing witness that transcends the technological cacophony and postmodern vagaries that are the context of contemporary healthcare where such tragedies occur. Perhaps in light of all that has been adduced for discussion here, it is not too radical to suggest to the caring professions that bearing witness to the realities of persons' lives as they are lived is fundamental to healthcare ethics. The question that arises for this author is whether anything less than faithfully offering unconditional love to the recipients of our care, and acting accordingly, does not in fact constitute a kind of betrayal.

Conclusions

Through this exploration, bearing witness has been revealed as vital to caring for others and perhaps more vital than anything else one can do. Much depends on one's paradigmatic perspective on the realities, goals, methods, and ethics of healthcare. Nurses, as members of a profession that has abided extremely closely with human experience for hundreds of years, have innumerable unique opportunities to actualize a choice with regard to bearing witness, each opportunity with the potential to be quite life-changing. The choice is, as Marcel (1961) says, between "the active recognition of something abiding . . . that can and should be upheld in us and before us as a presence, but which *ipso facto* can be just as well ignored, forgotten, obliterated." The concept of *bearing witness–not bearing witness* represents many different ways of practicing nonmaleficence, respecting human dignity, honoring the truth of persons' lives, and being faithful to the persons for whom we care. These are ever-present ethical choices that are incumbent on each of us in every instance of caregiving.

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On Global Health and Justice: A Nursing Theory–Guided Perspective

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> For justice to honor us and our relations with one another, We have to be there, all there, not just in body and possessions but in soul and meaning. We have to first honor ourselves by finding out who we really are and what's ours to do. What calls us to life?
>
> —Breton, Largent, & Lehman, 2000, p. 38

What calls nursing to life in this 21st century? What are we to become? What do nurse educators, nurse administrators, and nurses in leadership in a variety of settings hope to focus on in this century to continue to develop nursing as a discipline and as a practicing art-science? Florence Nightingale (1859/1992) wrote concerning this question the following:

> Just so if we were to take, as a principle—all the climates of the earth are meant to be made habitable for [humankind], by the efforts of [humankind]—the objection would be immediately raised, —Will the top of Mont Blanc ever be made habitable? Our answer would be, it will be many thousands of years before we have reached the bottom of Mont Blanc in making the earth healthy. Wait till we have reached the bottom before we discuss the top. (p. 5)

Nightingale's response, which is a response to the global health situation, is being echoed today by such nurse theorists as Rosemarie Rizzo Parse (1998) who posits that nurses must continue to develop unique nursing knowledge that is dedicated to "the betterment of humankind" (p. xi). The betterment of humankind is intrinsically linked with the health of persons, environment, nations, the universe, and the galaxy.

One of the prevailing issues haunting global health in the 21st century is the issue of justice for each person, family, and country. Breton et al. (2000) suggest justice is about how we live our lives. "Justice shapes how we think and feel about ourselves in the world because it touches everything we do—every expectation we have . . . it forms our sense of meaning and self-worth" (p. 33). So, what is necessary in the nursing academy for us to teach about health and justice and "making the world habitable for humankind"?

The idea of making the world habitable for humankind regarding health and justice suggests a radical look at the way we teach fundamentals of nursing as well as how we teach the nurse-person-community health process. We in education and service must consider the nurse-person-community health process not only as involving those in our local or even national community but also as involving those in our international communities; we must teach and practice from a global perspective.

Health and justice from a global perspective are important factors in considering quality of life issues. Serious quality of life issues arising from situations of health and justice include living in poverty, living as victims of war and genocide, living with environmental disasters, living with issues of racism and sexism, and living in situations where there is a lack of humanitarian effort (responses to the struggles of humanity). These identified issues of quality of life do not cover the entire span of human situations concerned with health and justice; however, they give an example of what nursing needs to attend to regarding global health conditions. Breton et al. (2000) suggest, "Ideally, we ask justice to harmonize and protect all relationships—with loved ones, communities, businesses, animals, nature, and the Earth—so that justice serves as the backbone of personal, social and planetary well-being" (p. 33). What kind of teaching-learning processes need to be in place to encourage and support planetary well-being?

In the following column, Dr. Cheryl J. Leuning, professor of nursing at Augustana College in Sioux Falls, South Dakota, suggests eight principles of teaching-learning that will facilitate understanding of global health and justice. She suggests that understanding global health issues from several nursing theory perspectives, as well as from perspectives from other disciplines, can enhance quality of life for humankind. Perhaps her insights will help inform us on what "is ours to do."

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Advancing a Global Perspective: The World as Classroom

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> S/he who travels far will often see things
> Far removed from what s/he believed was Truth.
> When s/he talks about it in the fields at home,
> S/he is often accused of lying,
> For the obdurate people will not believe
> What they do not see and distinctly feel.
> —Hesse, 1956, pp. 7-8

The year 2000 was heralded as the beginning of an international century. This new century is ushering in a period of changing relational patterns throughout the world that are often referred to as globalization. In its broadest sense, globalization is the flow of economic capital, technology, culture, information, people, and goods and services across and within national borders so that the world appears to be one global village with a population expanding beyond 6 billion (Friedman, 1999). The notions of "world as village" and "world as community" have become common metaphors that aid us in describing the complexity and interdependent nature of life today.

Although worldwide interdependence has many positive effects, it has just as many oppressive and limiting effects on health and human betterment. With more movement of people around the world, disease is spreading, and disparities in the burden of disease and access to health resources are widening. For a large proportion of the world's population health status and general well-being are static, if not deteriorating. The AIDS crisis in Africa and high infant and childhood mortality rates in developing countries continue to generate shocking statistics. Violence, poverty, and limited opportunities for education are linked directly to impaired health and early death throughout the world (Anderson & McFarlane, 2000).

Principles of Teaching and Learning Toward a Global Perspective

As the largest group of healthcare providers, nurses are critical to health and human betterment in the global community. For nurses to participate fully in healthcare arenas today they must develop proficiency and comfort with the changing dynamics within the world. The challenge for nursing education is to create teaching-learning environments that nurture development of a global perspective and an awareness of oneself in relationship with the world and with others. This knowledge leads us, as Parker Palmer (2000) states, toward our own authentic selfhood, where "we will not only find the joy that every human being seeks, we will also find our path of authentic service in the world" (p. 16). In this column are presented eight teaching-learning principles (see Table 1) that have aided me in understanding human experience in a global community and, in turn, in passing on that understanding to my students. Nursing knowledge, including transcultural nursing; public/community health nursing; and the nursing theories of Madeleine Leininger (1998a), Rosemarie Rizzo Parse (1998), Jean Watson (1999), and Margaret Newman (1994), and an ethic of justice have informed my conceptualization of the teaching-learning principles described.

The Principle of Health

Though defined differently in different times and by different philosophies, defining health broadly as a principle expands opportunities and avenues of response to health concerns. As a principle, health is viewed as a standard, a basic and essential part of human experience that encompasses human dignity, human rights, and the structures in society that uphold those rights, as well as an individual's personal beliefs and values related to health. In the past 25 years several global conferences have focused on health as a human right and on society's responsibility to its citizens (Anderson & McFarlane, 2000). The most far-reaching and memorable of the conferences was held in Alma Ata, Kazakhstan, in 1978. At this conference, representatives of 143 countries drafted the Alma Ata Declaration and set forth the major tenets of Primary Health Care (PHC). Recognizing that the health of the world's people is related to economic, political, industrial, and technological development, and to the degree to which human rights are honored, the Alma Ata Declaration reaffirmed the World Health Organization's (WHO's) (1978) definition of health as "complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." In addition, the declaration went on to note that health

> is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal, whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO, 1978, p. 3)

These definitions diverge radically from biomedical notions of health as the absence of disease or pathology. Rather, deter-

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Table 1
Eight Teaching-Learning Principles to Advance a Global Perspective

The principle of health
The principle of global-local connections
The principle of intentional caring
The principle of justice
The principle of challenging indifference
The principle of wholeness
The principle of transcultural and transnational relationships
The principle of peacemaking

minants of health from a global perspective are interconnected with sociopolitical processes, economic security, and access to appropriate education and healthcare. These broad, yet explicit, definitions of health direct our responses toward political advocacy, access issues, and education. From this frame of reference, safeguarding and assuring health allow for an imaginative and creative range of actions that target structures in societies that are limiting human rights and human potential (Mann, Gruskin, Groden, & Annas, 1999).

The catchphrase that emerged from Alma Ata was "health for all by the year 2000," and PHC was the model for achieving this far-reaching goal. PHC is essential healthcare that "evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities" (WHO, 1978, p. 5). It is difficult to discern how close the world would have come to "health for all" if an AIDS epidemic was not destroying entire generations and all nations were economically strong, stable, and at peace. The idea that health is determined by political and economic choices made by those who govern is addressed throughout the Alma Ata Declaration. Articles IV and V state (WHO, 1978),

> People have the right and duty to participate individually and collectively in the planning and implementation of their health care. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. (p. 4)

When governments select to limit spending on health, when destabilized economies and wars divert resources away from health and education, and when corrupt leaders siphon the resources away from the people, a community suffers and health within that community is compromised. Teaching and learning toward a global perspective calls us to view health broadly through multiple lenses. Health as a principle draws us toward seeing health in terms of human rights, the preservation of human dignity, and a community's political will to assure that these standards are upheld.

The Principle of Global-Local Connections

In an ecological model everything is connected to everything else, everything has to go someplace, and everything is constantly changing (Anderson & McFarlane, 2000). Advancing a global perspective calls for teaching-learning content and experiences that recognize the multidimensional forces that have an impact on health and human betterment globally while being felt locally. In their haunting book, *War and Public Health*, Barry Levy and Vic Sidel (1997), both former presidents of the American Public Health Association and both active leaders in Physicians for Social Responsibility, have compiled a chilling epidemiological account of the toll violence takes on the health of the world's people. They point out that war, homicide, and suicide compose the second leading cause of death and lost life years in the world, lagging just behind respiratory infections.

It should be no surprise that war and violence uproot millions of people annually, creating overwhelming numbers of refugees. At the start of the new millennium the number of refugees reached 22.3 million, or 1 out of every 269 persons. In addition, there were 20 to 25 million internally displaced persons in the world, one third to one half of whom were children (Grant, 1997; United Nations High Commissioner for Refugees, 2001). These numbers do not take into account the millions of Americans who are homeless for myriad reasons. Reading *War and Public Health* while meeting and working with refugees locally who have escaped killing fields in their homelands is a powerful teaching and learning experience for faculty and students alike. Equally as powerful are experiences with persons who live with severely limited choices due to poverty, mental illness, and responsibilities for the care of others. Global and local connections deepen as people describe their struggles to survive with so much uncertainty.

The Principle of Intentional Caring

Intentional caring maintains an awareness of life as a citizen of the world and nurtures an outlook of attentiveness. Teaching and learning to advance a global perspective embraces caring as a vital and guiding principle. Madeleine Leininger (1998a) speaks of care as the essence of nursing and a distinct, dominant, central, and unifying focus of the discipline. Not only does Leininger proclaim care to be the essence of nursing, she states that care "is essential for well being, health, growth, survival, and to face handicaps or death" (p. 39). Through ethnonursing research, several dimensions of care have been identified as care constructs—commonalities (or universals) among various cultures. They describe "what care looks like," what it "feels like," and what one might see people doing when they are engaged in caring. Some of these care constructs are respect for, concern for, attention to, active listening, giving presence, being connected, protecting, and providing comfort (Leininger, 1998b). Watson (1999) also cites caring as central to the art and science of nursing. She identifies transpersonal caring as

> an intersubjective, human-to-human relationship, which encompasses two individuals in a given moment, but simultaneously transcends the two, connecting to other dimensions of being and a deeper-higher consciousness that accesses the universal field and planes of inner wisdom: The human spirit realm. (p. 115)

Both Leininger and Watson emphasize person-to-person relationships as central to caring. From a global perspective, personal relationships with 6 billion people individually, or even in smaller enclaves within this population group, are not possible. Can theories of caring guide us toward a global perspective that recognizes community when individual relationships are emphasized? Watson's (1999) science of human caring, along with feminine ethics, gives us direction in answering this question.

Implicit in caring theories is the notion of intention. Watson (1999) calls this aim "intentionality," which means "the projection of awareness, with purpose and efficacy, toward some object or outcome" (p. 119). One of the ways that caring theories in nursing can lead us toward a global perspective is our intention to care about an issue, a group of people who are suffering, or a political action. Feminist ethics of care give further direction in developing global- or community-level understandings. Rita Manning (1992) states that caring involves acting in appropriate ways to respond to the needs of others, communities, values, or objects. She notes that to care requires a disposition to care, which means "a willingness to receive others, a willingness to give the lucid attention required to appropriately fill the needs of others" (p. 61). Manning suggests that when suffering takes place in distant places, we do not become as moved to respond as when a suffering person or loved one is in our presence. In these situations, Manning states that we must

> remind ourselves that although we do not know the sufferer, we can assume that the sufferer shares essential characteristics with someone who is close to us. . . . Here what we see is sentiment, colored by reflection and we respond by imagining ourselves in contact with the sufferer or suffering group. (p. 68)

We then try to become as aware as possible of the situation. Organizing a political response to homelessness, Manning suggests, is caring about a concern and a group of people. In an interdependent world, more and more of our caring encounters will be indirect. Teaching-learning experiences that assist us in recognizing how we can develop skills to care for groups and communities in responsible ways further a global perspective.

The Principle of Justice

In a global community, justice is concerned with sharing resources and the way resources are shared or not shared. Questions of justice arise when more than one group is competing for the same resources. Justice is also about all people being able to enjoy and exercise all of their human rights. Teaching and learning toward a global perspective considers questions of justice in relationship with health and human rights. The question of "Who suffers and why?" should always be in the foreground in our scholarly discussions and in our practice. Critical questions related to disease, knowledge, poverty, violence, the distribution of resources, or any claims that people and groups might have on a human condition must also be part of our teaching-learning dialogues.

The fact that injustice is widespread throughout the world is not difficult to determine. The newspapers are filled with incidents of injustice and blatant abuses of human rights. In 1993 a group called Parliament of the World's Religions gathered in Chicago to address these growing concerns. The result was a two-page document that begins as follows:

> The world is in agony. The agony is so pervasive and urgent that we are compelled to name its manifestations so that the depth of this pain may be made clear. Peace eludes us . . . the planet is being destroyed . . . neighbors live in fear . . . women and men are estranged from each other . . . children die! This is abhorrent . . . but this agony need not be. (Kung, 1996, p. 9)

Addressing justice requires that one adopt a critical attitude. That is, we should adopt a pattern of thought and action that challenges institutionalized power relations or relations of domination. Teaching-learning processes of praxis (critical reflection and action) and consciousness-raising (unveiling the world of oppression) lead to a more integrated understanding of life in the global community (Mann et al., 1999). This is not easy when the very institutions and values are so deeply embedded in our collective sociocultural psyche. For instance, we have heard all of our lives that "diamonds are a girl's best friend," that "diamonds are forever," and that "diamonds say I love you!" What are the critical questions we should be asking about diamonds? Where do they come from? Who sells them to whom? Why are they so expensive? In reality, diamonds, the emblems of human love, are being used to fund brutal rebel armies in the Congo and in Angola. Even when buying and selling diamonds are legal, oppressive tactics are in place to assure that profits are funneled from the developing or "third" world into the highly developed societies of the "first" world (Mann et al., 1999). Teaching and learning toward a global perspective begs us to hear the voices of others whose experiences can help us to identify and ask the critical questions of justice.

The Principle of Challenging Indifference

Although all the principles of teaching and learning presented in this column challenge our indifference, it is still easy to become oblivious to massive accounts of pain, death, and destruction of the earth. Annie Dillard (1999) writes about indifference in the following way:

> "One death is a tragedy; a million deaths are a statistic." Joseph Stalin, that gourmandizer, gave words to this disquieting and possibly universal sentiment. . . . One small town's soup kitchen serves about 115 men a night. Why feed 115 individuals? Surely so few people elude most demographics and achieve statistical insignificance. After all, there are 270 million Americans, 19 million people who live in Mexico City, 16 million in greater New York, 26 million in greater Tokyo . . . and so forth. We who breathe air now will join the al-

> ready dead layers of us who breathed air once. We arise from dirt and dwindle to dirt, and the might of the universe is arrayed against us. (p. 75)

Challenging and dissipating the numbing sense of being insignificant are critical to a global perspective. Teaching and learning toward a global perspective acknowledges our discouragement with the state of the world, while not giving in to despair and immobility. Listening to the experiences of those who have endured the pain and confusion of oppression is a powerful message of hope, as well as a call to action. In his inaugural address, Nelson Mandela (1994) proclaimed the following:

> Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us. . . . It is not just in some of us, it's in everyone! And as we let our own light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others. (p. 1)

Rosa Parks lived this proclamation when she refused a back seat on an Alabama bus. Her story is now part of American history—her arrest, her trial, the Montgomery Bus Boycott, and, finally, the Supreme Court's ruling in 1956 that segregation on public transportation was unconstitutional. Teaching and learning toward a global perspective requires opportunities to voice our fears while staying focused on our potential to make a difference.

The Principle of Wholeness

Nursing science is characterized by multiple paradigms or worldviews that reflect the values and beliefs embraced by various segments of the discipline. In recent years, paradigms that honor meaning and qualitative methods of understanding and research are valued for advancing insights and knowledge embedded in human experience. In addition, the complexity of the global community is leading us toward philosophies that can embrace the wholeness in the world. Some equate this complexity as a shift out of the Industrial Age, which was driven by linear, reductionistic, analysis-based processes and highly functional orientations, into a Quantum Age, where synthesis and integration require that we look at whole systems. Margaret Newman (1999) sees this as a positive shift from looking at parts to recognizing the whole. However, she states, this is not always easy:

> The problem in not recognizing wholeness is that our thinking has become fragmented by our language, by the Cartesian view of science, and by a medical model of health. We think it is only natural to separate things into parts. These separations are useful and are so ingrained in our thinking that we think they are real, when what is really real is the unity of our world. (p. 228)

Nurturing a global perspective requires that we focus on patterns of the whole (Newman, 1999). Staying focused on the unitary nature of the world is foremost in the simultaneity paradigm (Parse, 1998). Within the simultaneity paradigm, persons are viewed as unitary, indivisible, and in mutual ongoing change with the past, present, future, and universe all at once. Community, from Parse's (1999) human becoming perspective, is a "oneness of human connectedness" (p. 119) that is the individual, a city, a group, and the galaxy. Community is seen as "coconstituted with all the personal histories of the individuals who are present" (p. 119). Bunkers (1999) describes community as "a process of multidimensional interconnectedness" (p. 119). Teaching and learning toward a unitary global community perspective calls us to be open to all philosophies that connect us profoundly to the world and anchor us in a relationship to other people as well as all sentient life.

The Principle of Transcultural and Transnational Relationships

Relationships nurture understanding and foster our sense of connectedness in the world. Margaret Newman (1994) believes that today we are moving into a new paradigm of health in which a unitary pattern of changing relationships is the norm. She states that our "task is not to try to change another person's pattern but to recognize it as information that depicts the whole and relate to it as it unfolds" (p. 13). As globalization draws us faster and faster into a multicultural society, we are presented with many challenges regarding our traditional ways of relating to others, to ideas, to cultural values and beliefs, and to the world as a whole.

By emphasizing the universal and diverse nature of culture and human experience, culture care theory (Leininger, 1998a) guides us in coming to others on the common ground of our shared experiences of being human. The major premise of culture care theory is that care is essential for human survival. Care is also viewed as a universal human experience with diverse meanings and uniquely patterned expressions in different human communities. Culture, the gestalt of human experience and knowledge, including values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally, influences care meanings and expressions. Differences (diversities) and similarities (universals) in care knowledge and practices among persons, families, groups, and communities are predicted by the theory to be shaped by, and therefore embedded in, worldview, environmental context, language, and cultural and social dimensions of kinship, religion, values, lifeways, technology, politics, economics, and education. Health, from a transcultural nursing perspective, is a dynamic experience of well-being that is culturally defined, valued, and practiced, which enables persons to live and die with dignity.

In addition to viewing the world as community, teaching and learning toward a global perspective asks us to seek out persons in the world whose culture and experiences differ from our own. Coming to know others on the common grounds of our humanity will first touch our souls and later inform our own perceptions of ourselves. Travel to foreign

places is one way of encouraging transcultural relationships. Immersion in the Namibian culture for 3 weeks has had a powerful influence on graduate students from Augustana and Augsburg Colleges in Sioux Falls, South Dakota, and Minneapolis who have taken a graduate course in the Republic of Namibia. On leaving the country, an American student expressed the following: "We're airborne [for home] flying over the huge Namibian landscape. Today there is so much more down there than there was 3 weeks ago. There is nothing like knowing names and faces to put earnestness in your prayers" (personal communication, January 2001).

Doris Lessing (1987) writes about the value of transcultural relationships in reflecting our own culture back to us:

> We are all of us, to some degree or another, brainwashed by the society we live in. We are able to see this when we travel to another country, and are able to catch a glimpse of our own country with foreign eyes. There is nothing much we can do about this except to remember it is so. Every one of us is part of the great comforting illusions, and part illusions, which every society uses to keep up its confidence in itself. These are hard to examine, and the best we can hope for is that a kindly friend from another culture will enable us to look at our culture with dispassionate eyes. (p. 33)

From a teaching-learning standpoint transcultural relationships will change us and our experience of the world. The broadening perspectives that others can offer us are invaluable to understanding ourselves as citizens and members of a global community.

The Principle of Peacemaking

The principle of peacemaking is a principle that speaks of respect for others and for the earth. Despite differences of beliefs and values, peacemaking assumes that people will honor each other's human dignity, that they will respect and use the resources of the earth fairly and responsibly, and that they will respect animals and other sentient life. Chinn (1995) writes of peace as both intent and process:

> Peace . . . requires conscious awareness of what happens in a group. Peace requires that you know what you do as an individual when you interact with others. Peace requires that you do what in your heart you know—that your chosen values guide your actions. Peace is the means and the end, the process and the product. (p. 2)

Teaching and learning peacemaking encourages reflection on "doing what we know" and "knowing what we do" (Chinn, 1995, p. 2). Within the discipline of nursing, there are numerous heroic individuals who have advocated for peace and practiced peace in wartime by caring for the wounded in the midst of wars. Boyle and Bunting (1998) ask that we remember their courage and draw strength and understanding from their exemplary living of their values. Nobel Peace Prize laureates also exemplify values well-lived. It has been my good fortune to teach in a private college where laureates are regular guests. Together with the Norwegian Nobel Institute, Augustana College and four other private colleges located in the northern plains and founded by Norwegian immigrants take turns hosting an annual Peace Prize Forum. The forums are opportunities for dialogue with Nobel Peace Prize laureates, American diplomats, leaders of peace organizations, students and faculty of the five colleges, and community members. In 2002, the Peace Prize Forum will be held at Augustana College in Sioux Falls, South Dakota. President Kim dae-Jung, 2001 Nobel laureate, will be our special guest. The principle of peacemaking as integral to and evidence of a global perspective is lived by all who participate in these peacemaking and peace-sharing dialogues. Teaching and learning peacemaking requires us to move beyond boundaries that separate us—boundaries of beliefs, culture, knowledge, language, space, and whatever might harm or dishonor human dignity.

The World as Classroom: Conclusions

As nursing practice accelerates beyond institutions and into homes, parishes, neighborhoods, schools, businesses, and homeless shelters, and to remote corners of the globe and to countless places where people live and work, nurses are being called on to respond to broader and more complex health concerns in increasingly diverse communities. At the same time, globalization is bombarding our lives with information, goods, services, and ideas at unprecedented rates. The teaching-learning principles of health, global-local connections, intentional caring, justice, challenging indifference, wholeness, transcultural and transnational relationships, and peacemaking (see Table 1) presented in this column move us toward viewing ourselves as vital and receptive citizens of the world. Not only is the world our classroom, it is fast becoming our practice arena as well. The greater our understanding of our practice in the relational context of globalization, the more competent we will be to discover and address health and human betterment in our global community.

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Rising to the Challenge in Practice With Persons Diagnosed With Alzheimer's Disease

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Is there any more challenging or interesting nursing practice than that affiliated with persons living with Alzheimer's disease or a related dementia? Persons diagnosed with dementia challenge nurses to create innovative patterns of care and service. Familiar ways of relating and of acting in community are radically different when some people live with dementia. This difference is an aspect of reality for members of a family and for staff on units that provide care to those diagnosed with dementia or Alzheimer's disease. The assumptions we make about shared culture, meaning, language, and experience shift in practice, and nurses, like other providers, are called on to create meaningful and helpful patterns out of a veneer of chaos and disparate meanings.

Finding ways to be with and support persons diagnosed with dementia, as well as providers of care, family members, and especially nurses is a major challenge for managers and leaders in modern healthcare facilities. Nurses require innovative ways of thinking and the courage to explore and invent novel ways of relating that uphold the basic value of human dignity. In this column by Jonas-Simpson, it is suggested that nurses can choose nursing theories that make a difference in practice with persons with dementia. Jonas-Simpson selected the human becoming theory in her own practice, and she challenges others to make commitments to human science approaches that ensure that the person with dementia is valued and respected.

From Silence to Voice: Knowledge, Values, and Beliefs Guiding Healthcare Practices With Persons Living With Dementia

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Author's Note: In this column, the phrase *Alzheimer's disease* is used, as is standard usage in the United States. In Canada, common usage is *Alzheimer disease*.

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> No matter what stage (of the disease) a person may be in, that prson is still in there, still alive and still craving what everyone else craves . . . acceptance, love and joy.
>
> —Marsha Penington, daughter of a mother diagnosed with Alzheimer's disease

I am still here! Hear my voice! I am a human being! Do not discount me! Do not ignore me! Nurses and other health pro-

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fessionals often hear pleas from others who want to be heard, taken seriously, and treated with respect and dignity. These pleas are particularly important when expressed by persons living with Alzheimer's disease (AD) and related dementias. What silences or gives voice to persons living with dementia? I believe it is our knowledge, values, and beliefs about human beings, as lived out in practice that either silences or gives voice to the meanings and concerns of persons living with dementia.

Persistent attitudes and stereotypes about persons living with dementia are silencing flow from specific knowledge, values, and beliefs. Evidence of these stereotypic attitudes are present in the following statements and quotes from the literature.

- "The Alzheimer's disease patients, in the early stages of the disease, continue to interact on the surface as if they were sentient beings. . . . This self is increasingly devoid of content" (Fontana & Smith, 1989, p. 36). And, "the 'content' of their actions becomes increasingly meaningless" (Fontana & Smith, 1989, p. 39);
- "At the final stages the patient may be assumed to have no real subjective awareness, no sense of self at all, and to be in this sense mentally 'dead' " (Jacques & Jackson, 2000, p. 99);
- "The self has slowly unraveled and 'unbecome' a self . . . where once there was a unique individual there is but emptiness (Fontana & Smith, 1989, p. 45);
- "Demented people have no sense of their own critical interests" (Dworkin, 1993, p. 232);
- "Demented people in the late stages have lost the capacity to recognize, appreciate or suffer indignity. . . . It is expensive, tedious and difficult to keep seriously demented patients clean, to assure them space for privacy, to give them the personal attention they often crave" (Dworkin, 1993, p. 234).

The attitudes accompanying these quotes are not only shocking—they are silencing. They silence the voices of persons living with dementia through suggesting a voice doesn't even exist or, if it does, it is discounted and unreliable due to the disease process. Staff working with persons living with dementia are given messages like those above to disregard the person and this disregard silences.

The predominant medical model perpetuates negative attitudes about people who live with dementia. Persons with dementia are often silenced by virtue of their diagnosis and through disregard of their every action and every word. I want to be clear that medical assessment, accurate diagnosis, symptom management, and research for effective rehabilitation, prevention, and cure are extremely valuable and essential for quality healthcare. It is, however, very disconcerting when the medical approach moves to assess a person's experience of living with dementia. When a person living with dementia tries to express something and there is no attempt to understand the meaning of the expression, the message to the person is one of disregard. The professional may accurately assess and diagnose the person with aphasia and may interpret the patient's language as vague, meaningless, "verbose and circuitous, running on with a semblance of fluency, yet incomplete and lacking coherence" (Appell, Kertesz, & Fisman, 1982, p. 74). However, without the attempt to understand the meanings behind the words, the person's voice is silenced. Consider the following examples. Seven persons living with dementia were observed for coping strategies and interviewed to learn about their "inner world" (Bahro, Silber, & Sunderland, 1995). After observing and interviewing, the authors commented on persons' abilities to cope. One man was assessed to be "capable of hearing the diagnosis of probable AD but *dissociated* any appropriate affect that would accompany this awareness. He also protected himself and assisted the process of *denial* by not asking questions about his condition" (p. 43). Rather than simply understanding and learning how this man lived with his diagnosis of AD, physicians judged him as being dissociating and in denial. The practice of describing people in terms of diagnoses diminishes dignity. An older woman who was also interviewed in the noted study indicated that she did not have more memory difficulties than other women her age, and she described her experience on the unit as being like "a nice holiday at a hotel." The authors assessed and judged her reality in the following way:

> This is a case of the early phase in the development of AD. The patient's *denial* was also reinforced by a distortion in her perception of reality; i.e., she experienced the clinical care unit as "a nice holiday at a hotel." (Bahro et al., 1995, p. 44)

This woman's reality and chosen meanings were discredited and judged as distorted. When healthcare providers focus solely on assessing the losses and deficits of persons, without attempting to understand the meaning of the experience as lived from the person's perspective, the person is silenced. Kitwood (1993) calls for a fundamental shift from seeing a person living with dementia as a "set of deficits, damages and problem behaviours awaiting systematic assessment and careful management" (p. 16) to seeing the person as a whole and primarily as a person first. Similarly, Cohen (1991) proposes,

> If we do not get to know our patient's experience of the illness beyond the results of medical, cognitive, and functional tests and assessments our clinical decisions will not represent patient needs equitably in the caring transactions that occur. . . . Our relationship, indeed our partnership with the patient is essential for the quality of their life and well-being. (p. 7).

The following examples from my practice show how hearing the person's voice can assist decision making even with persons who are considered severely impaired. One woman who lived with late stages of dementia was becoming increasingly restless and was experiencing a delirium. When asked how she was doing, she said, "Fire, fire, fire, burning, burn-

ing, burning" as she hit her groin, and it became apparent that she might be trying to express the reality of a urinary tract infection. When she was treated for this infection, her delirium subsided. She taught us how to care for her in the moment; her words were taken seriously. Another man who lived a delirium refused his medications because he believed they were killing him. This man was labeled as cognitively impaired, noncompliant, and paranoid. I was asked to see this man in my role as a nurse specialist to "convince" him to take his medications, especially his digoxin. He continued to say in Italian that the pills were killing him. Taking his concern seriously, on further investigation with a geriatrician it was discovered that this man's blood levels of digoxin had reached toxic levels. He was correct—his pills were killing him! If we had continued to discount his voice and his concerns, he might have died.

Along with facing others' expectations to be silent once diagnosed with a dementia comes the experience of feeling invisible. Jan Phillips (2000), a 50-year-old woman who has lived with early onset AD for 5 years, stated the following: "At diagnosis we are immediately discounted—our views are discredited because of Alzheimer disease. . . . You become invisible during most conversations." Adams and Clarke (1999) state that "buried beneath all these issues [related to dementia] is the actual person with dementia. These people have remained largely invisible to researchers, planners and practitioners" (p. 14). Although stereotypes remain, I would concur with Kitwood's (1997) statement,

> Dementia as a concept is losing its terrifying associations with the raving lunatic in the old-time asylum. It is being perceived as an understandable human condition, and those who are affected by it have begun to be recognized, welcomed, embraced and heard. (p. 133).

He cautions, however, that although the process of "personalization" is happening, it is happening slowly.

Amid the slow move to personalization, several authors from various disciplines have emerged who present persons living with dementia as valuable human beings deserving of dignity, worth, and voice (Acton, Mayhew, Hopkins, & Yauk, 1999; Adams & Clarke, 1999; Burgener & Dickerson-Putman, 1999; Cohen, 1991; Fiel 1993, Goldsmith, 1996; Gwyther, 1997; Innes, 2000; Keane, 1994; Kitwood, 1993, 1997; Kitwood & Bredin, 1992; Lyman, 1989; Mattice & Mitchell, 1990; Mitchell, 1994a; Mitchell & Kolodny, 2000; Parse, 1996; Phinney, 1998; Sabat, 1998; Sabat & Harre, 1992; Tappen, Williams, Fishman, & Touhy, 1999; Tappen, Williams-Burgess, Edelstein, Touhy, & Fishman, 1997). Values and beliefs about people who live with dementia are important, since they guide the way that nurses are with them—either to honor and hear or to silence and ignore expressions of personal realities. Treating a person as if he or she is a non-being, a non-person, leads to care that is paternalistic, task and disease-oriented, and functional rather than humanistic, person-centered, and quality enhancing.

Post (1995) states that "if we think that there can be no quality of life because of cognitive deficits, then we will probably not do the things that can enhance quality" (p. 28). Similarly Kitwood (1997) suggests that "the view that people lack insight, or even that they have ceased to be subjective beings, rationalized a lack of attention to their distress, and justified substituting to mere behaviour modification for true engagement" (p. 141). Also, Tappen et al. (1999) state that "failure to recognize the continuing awareness of self and the human experience of the person in the middle and late stages can lead to task-oriented care and low expectations for therapeutic intervention" (p. 121). Furthermore, Keane (1994) states that

> through science and medicine our historical response to dementia has been to its symptoms. The person is no longer a human being, but a set of "impairments" or negative "behaviour" requiring different creative strategies to "manage" or "contain." When successfully applied, this has been called "quality of care," but is there still a quality of life for the person left behind the disease? (p. 152)

Dementia and Human Becoming Theory

Keane (1994) suggests that "if we are to move forward in developing innovative treatments and therapies for the person with AD, we must develop a new paradigm of thought, one that views the persons (with the disease) from their perspective" (p. 151).

The human becoming perspective (Parse, 1998) is one that offers a theoretical lens that views persons with dementia from their perspective. This theoretical perspective is one that can facilitate the transformational shift that Keane (1994), Kitwood (1997), and others propose in the way we view and care for persons living with dementia. The human becoming school of thought focuses on personal meanings, relationships, and ways persons uniquely move beyond while living in the moment. It guides practice in a way that honors a human being's uniqueness and focuses on the person and not the disease while fostering dignity and quality of life. Just because persons live with diagnoses of dementia does not mean they all experience life in the same way. Thus, the belief that a person is unbecoming and increasingly void of content, as Fontana and Smith (1989) and others suggest, is the antithesis of human becoming beliefs, where humans are viewed as becoming and evolving uniquely, as mysteries and wonders to behold and cherish.

The principles of the human becoming theory construct a view that human becoming is "an ongoing changing process" (Parse, 1998, p. 34) experienced by all humans regardless of their situation or diagnosis. The first principle of this theory is that "structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (p. 35). This principle reflects how humans construct reality with the meanings of their past, present, and future all at once. From this principle, a practice process—*illuminating mean-*

ing—is specified to guide nurses to seek and value personal meanings and concerns, because these things enhance understanding of persons (Parse, 1998, p. 69). When we are in practice with persons living with dementia, then, we seek to understand the meanings the person is living and the reality he or she is constructing. Persons language their meanings, values, and what is known and important through words, symbols, moving–being still, and through their sounds and silences. Meanings are freely chosen (Parse, 1998). It is our limitation, not the person's, if we cannot understand the meanings the person has freely chosen in the situation.

Recall the woman whose reality was judged as being distorted when she described her experience on the unit as being like "a nice holiday at a hotel." From the human becoming perspective, her reality would be honored and respected as her unique meaning of her situation. Recall also Fontana and Smith's (1989) claim that the content of the "AD victim's" actions becomes increasingly meaningless. From a human becoming perspective, persons' actions and patterns of moving–being still are embedded in meaning. This was very clear to me as I played my flute for an older woman who lived with cognitive impairment and was dying. Her movements as I played the flute were those that happen when receiving communion during mass. Her moving–being still spoke her meanings and values, which were understood by those who loved her and encircled her in her final hours. Thus, I would agree with Kitwood (1997), who cautions that "as soon as people with dementia are seen as merely 'behaving' (in the sense of having meaningless body movements or verbalizations) an essential feature of their personhood is lost" (p. 87). Questions that enhance our learning about a person's meanings are, What is life like for you now? What is most important to you? and What do you mean? The intention alone to understand a person's meanings and what is important from their perspectives can change the way nurses are with others.

The second principle of the human becoming theory is "cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating" (Parse, 1998, p. 42). This principle describes how humans live their becoming in rhythmical, paradoxical ways. The practice process, *synchronizing rhythms*, emerges from this principle and guides a nurse to go with the flow of the person (Parse, 1998, p. 70). Persons living with dementia reveal and conceal their meanings and the persons they are becoming as they connect and separate with others, which is both enabling and limiting. Living with the many losses that come with dementia is limiting, but at the same time, many persons living with dementia speak about their new opportunities and freedoms. Consider the following quotation by Christine Boden (1998) from her book, *Who Will I Be When I Die?*

> Oliver Sacks said . . . that Alzheimer's sufferers don't lose their essential selves. True, maybe, but I know I have changed a lot already. I am more stretched out somehow, more linear, more step by step in my thoughts. I have lost that vibrancy, the buzz of interconnectedness, the excitement and focus I once had. I have lost the passion, the drive that once characterized me. I'm like a slow motion version of my old self—not physically, but mentally. It's not all bad, as I have more space in this linear mode to listen, to see, to appreciate clouds, leaves, flowers. . . . [The] unique essence of "me" is at my core, and this is what will remain with me to the end. I will be perhaps even more truly "me" than I have ever been. (pp. 49-50)

People have also described ways that they created new connections with others who live with dementia through support groups in the community, on the Internet (see www.DASN.org), or in long-term care communities. Going with the rhythms of the person means dwelling with the person's meanings and priorities *in tempo* with the ebb and flow of their speaking–being silent. For instance, one woman who lives with early onset dementia stated the following, "I can't change the rate at which my ears hear, but you can change the rate at which your voice speaks. In doing so, you shall give me back my ears." An example of going with the rhythm of personal meanings and priorities is found in an article by Mattice and Mitchell (1990) that describes a man who wished to go home to see his wife. This man's wife had died, but the nurse went with the man's meanings and hopes and asked, "What would you like to say to your wife if she were here?" He spoke about missing his wife and talked to the nurse about the memories of his marriage. The nurse went with the rhythm of this man's concerns; she did not orient him to her reality or tell him of his wife's death, nor did she distract him to get his mind off his wife. Synchronizing rhythms happens without words also as the nurse goes with the flow of the person's moving–being still. Having someone truly present with synchronizing rhythms can be sensed and felt explicitly and tacitly. Going with persons' rhythms honors their personal journeys and what is important to them.

The third principle of the human becoming theory is that "cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1998, p. 46). This principle describes the human desire and will to move beyond what is to what will be, while affirming one's being in the face of nonbeing. From this principle, a practice process, *mobilizing transcendence*, was inspired (Parse, 1998, p. 70). This process guides nurses to ask persons about their concerns, priorities, plans, hopes, and dreams. Persons are invited to discuss how to make their plans a reality or what might be helpful to them from their perspective.

Persons who live with dementia are often viewed as not having any hope, and yet when speaking to persons who live with dementia, hope is essential in moving on day to day. When I asked a man who lives with moderate dementia what he hoped for, he said, "Attention, all I want is a little attention." In receiving attention from others, this man's quality of life was enhanced because he was affirmed as a human being; attention helped him to go on. Finding ways to go on is powering, which is the affirming of being in light of possibility of disregard. Through the experience of receiving attention this man felt affirmed as a human being amid the threat of disregard.

The following examples from practice show how the values, beliefs, and principles of human becoming guide practice in ways that break the silence and invite voice to the meanings, concerns, and wishes of persons living with dementia. First consider the following quote by Morris Friedell, a man who has lived with early onset AD for almost 3 years.

> Well, what is to be done? In this world, to plead for understanding is not the way to get understanding—we do get antidepressants, but they are not the same. We can be inspired by Martin Luther King's message. First, we can refuse to move to the back of the bus, we can reclaim our dignity. Diana Friel McGowin is our Rosa Parks—she refused to be a victim, wrote *Living in the Labyrinth* and organized support groups. Second, we can understand and cherish each other. The outside world may think of us in terms of broken wires and lament that we can no longer tell what day it is, or count backwards from 100 by sevens. But we, many of us . . . can appreciate clouds, leaves, flowers as we never did before. And many of us can appreciate Michelangelo and Mahler as well. And we can encourage each other to create with our strengths. . . . So who is to say that our inability to memorize shopping lists defines the limits of our understanding? As the mind dims perchance the spirit brightens and the visions of shamans and prophets in ancient cultures may become ours. And we can tell the others and make them understand. (See http://members.aol.com/MorrisFF/Loneliness.html)

Friedell and several others who have written about personal journeys of living with dementia (Boden, 1998; McGowin, 1993; Rose, 1996; Synder, 1999), defy Fontana and Smith's (1989) view that "on close inspection ['AD victims'] reveal their emptiness behind the façade" (p. 40). The alternative is to consider that we could enhance our understanding of human becoming as it is lived in the face of many challenges. Friedell speaks about the potential to become more amid the losses that are experienced with dementia; he does not want to be defined by his limitations but to be open to who he is becoming with hope and to survive Alzheimer's disease with dignity (see http://members.aol.com/MorrisFF/Vision.html). Lyman (1998) states that

> Alzheimer's disease requires living courageously in a brave new world, not simply a world of "deficits" and "losses" but one that includes a new career for survivors: the daily work of recreating meaning and re-affirming the changed self. If we listen to the voices of people living with dementia we find that life continues with a sense of direction, if not clear destination. (p. 56)

We can learn from Friedell and others who live with dementia as fellow human beings who live day by day with courage amid many obstacles and limitations, but first we must value and honor their voices and break the deafening silence that comes with a diagnosis of dementia.

From a human becoming perspective, which is inherently person-centered, I have learned how to hear persons' voices through their words, sounds, and silences—even with those persons experiencing the later stages of dementia. Again, the human becoming theory is about *human becoming* regardless of the person's diagnosis or stage of illness. Consider this situation from my practice. Years ago, I was asked to see a 90-year-old woman who was calling out several times during the day and night. At this time in my practice I was required to conduct Mini Mental State Exams (MMSEs). This older woman scored 0. I felt uncomfortable administering this exam since I felt the test violated my nurse-person relationship. In an attempt to understand her, I had merely created a number that limited my view of her even further.

Although the intent of the MMSE tool is to diagnose and determine a person's level of cognitive impairment, a score often led me to make assumptions about the person, and I often placed a ceiling on the person's abilities. At the same time, I was learning about the human becoming theory, and I found myself challenged to view persons out of the diagnostic box. Could I see people with dementia as wondrous human beings who cocreate their meanings multidimensionally, who live in relationships with others and the world, and who continue on in unique ways amid adversity? I learned to ask persons different questions. Some of these questions were about their meanings and wishes. Knowing what date or time it was became less important for me when I realized they were not always important to the persons I cared for.

The human becoming theory taught me how to think differently, and so did the people living with cognitive impairment. One woman said to me, the day after I tested her on my name, "I don't know your name dear, but I know who you are and that is all that matters." With new knowledge, values, and beliefs I asked the woman who had been calling out and who had scored 0 on her MMSE, "What is life like for you now?" She said, "All I see is darkness and glare." In dwelling with her meanings and going with her flow I asked her what that meant. She said, "I think I am going to die." She didn't speak any further, but when this was shared with the staff and placed in the nursing notes, her calling out was no longer seen as a problem; rather, she was viewed as a woman who might be frightened of living her imminent death. The quality of her care was enhanced when she was seen differently and when voice was given to her meanings and concerns. The woman might have been silenced by an MMSE score of 0 alone, because, before I began to think about human beings differently, I would never have asked her what her life was like.

Several researchers have challenged the use of the MMSE as an indicator of abilities to answer open-ended questions about life and personal realities. These studies have shown, despite lower scores on the MMSE, how persons living with dementia are still able to speak about their concerns, meanings, and values (Acton et al., 1999; Burgener & Dickerson-Putman, 1999; Mozley, Huxley, Sutcliffe, Bagley, & Burns, 1999; Tappen et al., 1997, 1999). Being subjected to multiple tests can also be very upsetting to persons (Burgener & Dickerson-Putman, 1999; Lyman, 1989; Mitchell, 1994b). Burgener and Dickerson-Putman (1999) were surprised to learn about the negative effects neuropsychological testing

had on their research participants who live with dementia. Several of their participants agreed to be in the study if they did not have to be subjected to the tests they received in their clinic appointments, and many also requested several days to recover from their testing session prior to the researcher's assessment visits.

Listening with the intent to understand personal meanings while going with the person's flow and hopes is a premise of patient-centered care grounded in the human becoming theory; it honors a person's voice. Here it is important to note that the intention to understand is lived even when one does not understand what the person may be saying. Through one's intention to understand, a connection is made and felt by the other. One nurse who attended patient-centered care classes described how she lived the intent to understand what a man was telling her by listening even when she did not understand. She said this man followed her around the unit the rest of the day and that when it came time to give him care, he did not resist as he usually had in the past. Through listening with respect and with the intent to understand the man's meanings, the nurse experienced a difference in her relationship—her care was enhanced.

Consistent with a human becoming approach, Tappen et al. (1997) found that it was important to speak as an equal to someone living with dementia, which requires an attitude of humility on the part of the professional. When the ability to speak with words is lost, one's voice can still be heard and meanings can still be expressed as people live moment to moment. One woman who was unable to speak with words would make sounds if she was not facing the door during the evenings and nights and the window during the day. Her silences often spoke her contentment. I have witnessed how persons, when they can no longer speak with words, are enabled to express their voice through music as they drum, sing, and chime their meanings during music therapy sessions.

I witnessed one man who lay motionless on his bed, and when given the opportunity to drum in a music therapy session, decided to do so. His rhythms were very slow and then became faster. The music therapist and I went with his rhythm on other drums. The transforming was evident in his face as he smiled and his eyes brightened. Similarly, through art, persons express their meanings and give voice to their concerns and what is important in life through color, several mediums, and images.

Going with a person's meanings and rhythms means not assuming what a person is thinking. Assumptions can also be silencing. One day a woman called out on an acute medical unit, "Nurse, nurse, nurse." I walked in and asked Emma if I could help her. She said, "The dogs, they keep barking and barking." In the past I would have assumed that the dogs frightened her, and I would have tried to comfort her. I no longer assume and, in going with her reality, I asked, "What is it like to hear the dogs barking?" She said, "Oh, I feel safe when I hear the dogs barking. I know I am safe." She went on to talk about animals and how her father loved animals, and then she spoke more about her father. She eventually turned to me and said, "Thank you for stopping by." When asked if there was anything more I could do for her, she said, "No dear." As I walked out of her room, she shouted, "Now get that worm on the hook," and I thought maybe she was out on the dock fishing.

Persons in the later stages of dementia may connect and communicate meaning with their loved ones in different ways. One example is through the squeeze of a hand, which is evident in the following poem written by Dorothy Womack (see http://www.geocities.com/womack47.alzangels07.html), whose mother lived and died with AD. Dorothy wrote this poem for Marsha Penington, a friend whose mother was diagnosed with AD.

MOM'S LEGACY

She registers little, if any, at all
To those who would visit or take time to call
Her appearance is masklike—Her responses few
But I know she loves me—And I love her too.

People might wonder just why I believe
My mother's still "in there," because they don't see
The life of her spirit, encased in that shell
She's moving towards Heaven, where God's angels dwell.

I know in my heart that my mother's aware
When I come around her—I know she's "in there"—
For, just one moment—A miracle, grand—
I told her I loved her—And she squeezed my hand!

That moment spoke lifetimes that words could not say
It brought back good memories of much brighter days—
Although it was fleeting—Yet, ever so real—
My mother is "in there"—She knows, and she feels!

When her shell is discarded, and she can go free
I know she'll remember—and always love me—
For treasures that matter are those you can't see—
This is the value of Mom's Legacy . . . . . .

© 1999 Dorothy Womack
Written for Marsha Penington, an angel on earth . . .

This poem reflects how a daughter and mother transcended the tremendous losses of dementia to connect with each other. The belief that Marsha's mother was still there, still a person who was valued and cherished, created the openness to hear her voice through the squeeze of her hand.

Authors from several disciplines continue to call for a new humanistic paradigm. Similarly, persons living with dementia are calling for a new vision where they are no longer viewed as *victims* but as *survivors* of dementia (Raushi, 2000). In 2001, Morris Friedell (see http://members.aol.com/

MorrisFF/Vision.html) identified this new vision as *dementia survival with dignity*. The human becoming theory provides a knowledge base grounded in values and beliefs that enables healthcare professionals to rise to the challenge this new vision puts forth. It offers a lens to see the *person first* and shifts practices that *silence* to practices that honor *voice*.

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The Nurse Theorists: 21st-Century Updates—Imogene M. King

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Imogene M. King began to develop her conceptual framework and the theory of goal attainment at a time when nurses were striving to become professional practitioners and scientists. She deliberately developed a conceptual frame of reference for nursing as a precursor to a theory that explicates the "why" of nursing actions. King (1988) stated that the specific motivation to develop her conceptual framework was the need to select essential content for a new master's degree program in nursing. She explained,

> In 1963 as I worked with a faculty committee to develop a new master of science in nursing program, I was challenged by a question from a philosophy professor who was familiar with my undergraduate philosophy courses. He asked: "Imogene, have you or any nurses defined the 'nursing act'?" I perceived this to be a philosophical type question and my response was "Not that I know of, but first one needs to define a 'human act' because nurses and the clients they serve are first and foremost human beings." He chuckled and said that I had a good beginning and to continue to think about it. (King, 1997b, p. 15)

In 1964, King published her perception of the state of nursing knowledge and identified three major problems: the lack of a professional language, an antitheoretical bias, and the fact that the domain of nursing had not yet been identified.

King (1997b) explained the process she had used to develop her conceptual framework as follows:

> Initial thoughts were that the nursing act represents actions (not interventions) and a series of these actions represent nursing as a process. This led me to ask a few more questions, such as, where do nurses perform these acts and engage in this process? My next step was to conduct a comprehensive review of nursing literature [1923-1963]. My review revealed that multiple concepts were being discussed as essential knowledge used by nurses. . . . From this analysis multiple concepts were listed from which I selected those that represented broad conceptualizations of knowledge. This resulted in formulating my initial conceptual framework, which was published in *Nursing Research* [King, 1968]. [Then, I audited] three formal classes in systems research. Learning the language of systems helped me design my conceptual framework represented by three dynamic interacting systems. (p. 15)

Reading and course work led King (1971) to the literature of systems research and general system theory, and hence to a set of questions. The questions were: (a) What kinds of decisions are nurses required to make in the course of their roles and responsibilities? (b) What kind of information is essential for them to make decisions? (c) What are the alternatives in nursing situations? (d) What alternative courses of action do nurses have in making critical decisions about another individual's care, recovery, and health? and (e) What skills do nurses now perform and what knowledge is essential for nurses to make decisions about alternatives? (pp. 19-20).

In a recounting of the development of her conceptual framework, King (1990) explained, "After studying the research on General System Theory, I was able to synthesize my analysis of the nursing literature and my knowledge from other disciplines into a conceptual framework" (p. 74). Later, she explained that general system theory, as elaborated by von Bertalanffy (1968), "guides the study of organized complexity as whole systems . . . [and] guided me to focus on knowledge as an information processing, goal seeking, and decision making system (King, 1997a, pp. 19-20). King (1985) also commented that her perspective of nursing evolved in response to these questions: (a) What is the essence of nursing? and (b) What is the human act?

Elaborating on the origin of her conceptual framework, King (1971) explained, "Concepts that consistently appeared in nursing literature, in research findings, in speeches by nurses, and were observable in the world of nursing practice were identified and synthesized into a conceptual framework" (pp. 20-21). That synthesis resulted in selection of four universal ideas—social systems, health, perception, and interpersonal relations. King (1971) maintained that those ideas formed a conceptual framework that "suggests that the essential characteristics of nursing are those properties that have persisted in spite of environmental changes" (p. ix).

Keywords: King's conceptual system, nurse theorists, theory of goal attainment

Editor's Note: Any comments about this dialogue should be addressed to the Editor for possible inclusion in Letters to the Editor. For other information, contact Jacqueline Fawcett, RN, PhD, FAAN, P.O. Box 1156, Waldoboro, ME 04572; phone (207) 832-7398; E-mail: jacqueline.fawcett@umb.edu

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Furthermore, King (1992) stated that her early literature review revealed three major ideas about nursing.

> One idea was that nursing is complex because of the human variables found in nursing situations. . . . A second idea . . . was that nurses play different roles in health care organizations of varying sizes and organizational structure. Nurses are expected to perform many functions in these organizations. A third idea was that changes in society, changes in the role of women, and advancement in knowledge from research and technology have influenced changes in nursing. (pp. 19-20)

King identified several concepts for a conceptual framework in 1968. In 1971, the conceptual framework was presented in her book, *Toward A Theory for Nursing*. King then described refinements in the framework in her 1978 speech at the Second Annual Nurse Educator Conference. Further refinements in King's conceptual framework were presented in her 1981 book, *A Theory for Nursing: Systems, Concepts, Process*, in which the theory of goal attainment was introduced. Use of the conceptual framework and theory was demonstrated in a book about their application as guides for the development of curricula for community college and baccalaureate degree programs (King, 1986a), as well as in book chapters (King, 1986b, 1989, 1990, 1995a, 1995b) and a journal article (King, 1992). The evolution of King's conceptual framework and the derivation of the theory of goal attainment, within which a transaction process was designed, are supported by the members of the King International Nursing Group (KING), which was founded in 1998. The KING publishes a newsletter, *King's Systems Update*, and sponsors annual educational conferences.

I first interviewed Imogene M. King in November l988 in Tampa, Florida. That interview is part of *The Nurse Theorists: Portraits of Excellence* series of videotapes and compact discs (King, 1988). This column presents the edited transcript of a telephone interview I conducted with Imogene King on April 17, 2000.

JF: What do you think about the current state of the discipline of nursing?

IMK: I think that we have probably come to what I would call the adolescent stage, but I am concerned that graduate programs are not concentrating much on theory, especially the current nursing theories, and theory-testing in nursing. Instead, the programs seem to be concentrating on testing theories from other fields. I think that is sad. And so, I don't see the theory-research movement going forward unless something happens in terms of the faculty in the doctoral programs.

JF: What impact has that trend had on the discipline as a whole?

IMK: The result has been lack of development of knowledge for nursing. We still have small, isolated studies; very few nurses have programs of research. Unless we have programs of research, we are not going to develop nursing knowledge. If I were younger and still active, I would have started a program of research a long time ago.

JF: One could argue that some nurses are conducting programs of research, but there is little evidence of nursing theory [Fawcett, 2000]. Do you think that such work contributes at all to the discipline of nursing?

IMK: In some small way it does. I am thinking of the Episteme Awards given by Sigma Theta Tau International. An Episteme Award was given, for example, to Dorothy Brooten, who has conducted research for many years [e.g., Brooten, 1995; Brooten et al., 1986]. She developed knowledge that can be used to guide the care of low-birthweight infants but I do not understand what theory she was testing. Perhaps someone should try to develop a theory from Brooten's research findings.

We need to keep in mind that theories are not just those that are published with that label. For example, in the 1960s, I did a content analysis of concepts that were addressed in the nursing literature over a 20-year period. I then reconceptualized the concepts, which yielded the concepts in my conceptual framework [King, 1971, 1981]. Then, when I was thinking of developing a theory from my conceptual framework, I went to the research literature of the field in which the concept was originally studied. Perception, for example, has been studied in psychology for 100 years. Initially, the studies focused on sensory perception. By the mid-1950s, the focus had changed to interpersonal perception. I latched onto interpersonal perception as the basis for my concept of perception, which I think is basic knowledge for every nurse. Thus, I developed my concept of perception from the research literature in the field in which it was studied, in this case, psychology. In that sense, I think we can gain nursing knowledge from the knowledge of other fields.

JF: You were using what Myra Levine [1988] called adjunctive knowledge, that is, knowledge from a field related to nursing, and incorporated that knowledge into your own particular perspective in King's conceptual framework and the theory of goal attainment.

IMK: Yes, I did that because there was no research in nursing at the time that I could use. I do not believe that nurses cannot use knowledge from other fields. Knowledge is out there to know. But I do think that we must move forward and test our own theories. That means that we have to be more comfortable than we are now with critiques of our work, our ideas.

JF: Yes, we must realize that a critique of a person's work is not a critique of that person.

IMK: That is correct.

JF: How have King's conceptual framework and the theory of goal attainment contributed to the current state of the discipline of nursing?

IMK: I do not hear from our students, nor do I see in the literature, where nurses are teaching students about the original

formulations of general system theory [von Bertalanffy, 1968] as a philosophy of science that deals with wholeness. I see nursing literature that addresses a "systems approach," but the authors are not talking about this as a philosophy of science. There is no connection in the literature, as I read it, between general system theory as a philosophy of science that deals with wholeness and the so-called "systems approach."

I would like to mention three articles that provide explanations of how my conceptual framework and theory have contributed to the discipline of nursing. "King's Theory of Goal Attainment" [King, 1992] is a summary of everything I had done up to 1992. This article includes all of the diagrams about the framework and theory. "A Theory of Goal Attainment: Philosophical and Ethical Implications" [King, 1999] presents my analysis of the philosophical and ethical implications of my work. The third article, "A Transcultural Critique of Imogene King's Theory of Goal Attainment," by Pamela Husting, is the most beautiful paper I have ever read! Husting [1997] maintains that the theory of goal attainment is congruent with international and multicultural nursing and that use of the theory prevents cultural stereotypes.

JF: How should King's conceptual framework and the theory of goal attainment be used to guide nursing research? Do you agree that the researcher would look at the various concepts in the framework and theory and their connections and then derive studies that would test the concepts and their connection?

IMK: Yes. The framework and theory contain multiple concepts that can be used to develop theories. For example, Maureen Frey's dissertation and continued research about families in which children have a chronic illness have led to a theory of families, children, and chronic illness [Frey, 1995]. In addition, Christina Sieloff [1995] developed a theory of departmental power from my concept of power. Furthermore, Mary Killeen [1996] used my concept of perception to develop a theory related to patient satisfaction. Moreover, Wicks [1995] and Doornbos [1995] developed theories of family health, and Brooks and Thomas [1997] developed a theory of intrapersonal perceptual awareness.

JF: Are there any particular research methods or designs that should be used with King's conceptual framework and the theory of goal attainment?

IMK: There could be some qualitative, descriptive studies done. The objective would be to gather information that is not already available. It is important, however, that the qualitative methodology selected is in keeping with the problem to be studied and with the basic philosophic claims undergirding the framework and theory [see King, 1999; Whelton, 1999]. There is no particular research method for any theory, as the method used relates to the problem to be studied.

JF: How should King's conceptual framework and the theory of goal attainment be used in basic nursing education?

IMK: Daubenmire [1989] explained how my conceptual framework was used to develop an undergraduate curriculum at Ohio State University. It is important to point out that a theory cannot be used to develop a curriculum because a theory is too abstract and narrow. For example, the theory of goal attainment cannot be used to develop a curriculum because it is made up of just a few of the concepts of my conceptual framework. A broader conceptual framework can, however, be used to develop a curriculum. The faculty at Ohio State University developed the most beautiful undergraduate curriculum I had ever seen. The curriculum was developed using my conceptual framework. A grant allowed faculty time to study the research literature, so that each concept included in the curriculum was firmly grounded in research. Furthermore, the faculty built multiple aspects of the research process into the curriculum, such as participant and non-participant observation and statistics. In addition, the faculty selected team teaching as a major teaching-learning strategy. The students developed knowledge of each concept in the framework. Moreover, the faculty at Loyola University in Chicago used my conceptual framework to develop a graduate curriculum.

JF: Given the knowledge needed to use King's conceptual framework and the theory of goal attainment, what is the appropriate entry level for professional nursing?

IMK: I believe that it is impossible to teach the knowledge and the skills required for professional nursing in our existing 2-year, 3-year, and 4-year undergraduate programs. I have, therefore, said for the past several years that we need to establish entry-level, postbaccalaureate doctoral programs that do not have the research focus of the PhD degree but rather focus on practice and grant the Doctorate of Nursing [N.D.].

We have distorted the academic degrees; we have never resolved the whole educational system for nursing. We have Doctor of Nursing Science degree programs, which I understand are primarily to prepare nurses to function as practitioners. We have Doctor of Philosophy degree programs, which are supposed to prepare researchers. We also have Doctor of Nursing degree programs, which are postbaccalaureate programs that are supposed to prepare graduates for entry-level nursing practice; that degree is similar to the Doctor of Medicine degree.

We also need a group that Mildred Montag [1951, 1959] years ago called technicians; there is nothing derogatory about that term. Technicians, or technical nurses, can do things that only technicians know how to do and can do expertly.

JF: Do you support separate licensure for technical and professional nursing?

IMK: Absolutely.

JF: At what level should the technical nurse be educated?

IMK: When I think of a technician, I think of someone who has a certain amount of knowledge and is highly skilled in terms of that knowledge, such as the basic skills of nursing. I think that the required education can be accomplished in a 2-year associate degree program.

JF: Are King's conceptual framework and the theory of goal attainment appropriate as curriculum guides for both technical and professional nursing programs?

IMK: Oh, yes. Several years ago, I wrote a book about curriculum [King, 1986a], in which I demonstrated how to use my conceptual framework to develop an associate degree curriculum and a baccalaureate degree curriculum that were completely articulated. The central idea for the articulation was an advancement of knowledge and skills from one program to another, with each program based on the same conceptual framework.

In addition, inasmuch as health is the goal of my conceptual framework, the curriculum can focus on health. The selection of learning experiences, then, move the student from looking at the state of health to disturbances in the state of health, and back to health.

JF: How should King's conceptual framework and the theory of goal attainment be used to guide administration of nursing services? Could the conceptual framework and theory be used as the structure for nursing practice in a clinical agency?

IMK: Yes. Nurse administrators could easily use the transaction process, as described in the theory of goal attainment, when interacting and communicating with other nurses and other health professionals. The transaction process model is described as mutual goal-setting that leads to goal attainment. All individuals participate in decisions.

JF: Where should nursing be practiced?

IMK: Any place where there are people who need nursing care, that is, everyone who lives in a community.

JF: How should King's conceptual framework and the theory of goal attainment be used to guide nursing practice?

IMK: There are so many opportunities for health promotion wherever people are in their communities, regardless of the people's age and health state. Within the theory of goal attainment, I designed a transaction process model in which interacting individuals mutually set goals and agree on the means to use to attain the goals. The transaction process and knowledge of the relevant concepts of the theory are directly applicable in concrete nursing situations. Ninety-nine percent of the time, goals are achieved when this transaction process is used. Achievement of goals represents an outcome, and outcomes demonstrate evidence-based nursing practice. This is what makes my theory a middle-range theory.

JF: How else can King's conceptual framework and theory of goal attainment be used?

IMK: The framework, because it is based on general system theory, can be taken out of nursing. For example, families can be taught how to use the transaction process in their interactions, so that they are mutually setting goals with each other. A spouse can be taught to mutually set goals with his or her partner. A mother can be taught to mutually set goals with her children. Furthermore, the transaction process can be taught to teachers, who can mutually set goals with the students. The key is that my work is based on general system theory; this means that the whole system of interest is identified. The concepts of my framework and theory can be used with any system because the knowledge of the concepts relate to human beings and environment.

Furthermore, currently I am writing a keynote speech that I will present at a Teacher's College, Columbia University, research conference. The topic is global perspectives in nursing research. I am especially honored by the invitation because I am a graduate of the Teacher's College doctoral program.

Moreover, I wrote a chapter for Marilyn Parker's new book [see King, 2001]. In addition, I sent a paper on evidence-based practice to *Theoria: Journal of Nursing Theory*, which is published in Sweden. In this paper, I discussed the way we have changed words over time but not necessarily changed the meaning of the words [King, 2000]. For example, over the past 30 or 40 years, we have gone from quality nursing care, to effective nursing care, to quality assurance programs, to continuous quality care, to outcomes, and now to evidence-based practice. I regard all of these terms as related.

I went on to point out that the nursing literature has long indicated that the terms structure, process, and outcome represent a category system that is useful in developing a plan to implement a nursing care delivery system. I then offered my conceptual framework as the structure, my transaction process as the process, and goal attainment as the outcome. When goals set and goals attained are recorded in the permanent records of patients, the information is research data that can be used to demonstrate evidence-based practice. Retrospective studies of goal attainment also can be conducted. Multiple record forms and elaborate information are not needed to demonstrate evidence-based practice.

JF: Thank you so very much for agreeing to this interview. As always, it has been a pleasure to talk with you.

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An International Human Becoming Hermeneutic Study of Tom Hegg's *A Cup of Christmas Tea*

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This article seeks to contribute to human becoming theory and to nursing by providing an international human becoming hermeneutic study of Thomas Hegg's A Cup of Christmas Tea*. The human becoming hermeneutic method was used in this study to discover emergent meanings about human experiences. Guided by the method, the authors discovered three emergent meanings: honoring the cherished; communing with the was, is, and will be; and triumphing with new vision. These meanings were synthesized by the authors.* A Cup of Christmas Tea *is the story of the way triumphing with new vision arises with honoring the cherished in communing with the was, is, and will be. The conclusion for families and nurses is that by remaining open to all possibilities that exist in each now, moments of serendipitous togetherness can transform human trepidation and negative views of later life.*

A hermeneutic study of a work of literature is a rigorous dialogue with the text of that work aimed at discovering significant understanding about what it means to be human. Such understanding is critical if nursing science is to be concerned with the quality of human existence. Cody (1995) applied a hermeneutic method and Parse's (1981, 1998) human becoming theory to Walt Whitman's *Leaves of Grass* (1892/1983) and discovered valuable knowledge about the self and the world. Dwelling with lines of Whitman's poetry, such as "I will show that whatever happens to anybody, it may be turn'd to beautiful results . . . nothing can happen more beautiful than death" (cited in Cody, 1995, p. 287) and "I celebrate myself, and sing myself, and what I assume you shall assume, for every atom belonging to me as good belongs to you" (cited in Cody, 1995, p. 290). Cody interpreted Whitman's view of health as "contentment with the self as the who one is in the face of challenges and hardships. Death is beautiful, a natural continuation of life to be embraced with the same joy with which one celebrates life itself" (pp. 287-301).

Cody (1995) and Parse (1998) have explicated a method, similar to Gadamer's (1960) hermeneutic method, that provides a valuable avenue to understanding human experience and health for nursing. They suggest that if nursing is to be concerned about the quality of life, then the study of the humanities is as important as the study of the natural sciences. The purpose of this hermeneutic human becoming study is to better understand being human and contribute to the human becoming school of thought. It also seeks to exemplify a process of international nursing theory–based research. Five nurse researchers from three continents coauthored this report after conducting the study.

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A Cup of Christmas Tea

Thomas Hegg is a writer who lives in Eden Prairie, Minnesota. He, with illustrator Warren Hanson, published *A Cup of Christmas Tea* in 1982. According to W. Hanson (personal communication, 1999), Hegg was urged to publish his work by his church congregation after he read it to them. The lines of the poem are primarily the thoughts and feelings of a young man who receives an invitation from his great aunt to visit her for a chat and a cup of tea. The poem begins with the fairly common complaint about how traditions can lose their meaning in fast-paced, youth-centered materialistic societies but soon focuses on the young man's struggles regarding the request for a visit. The great aunt in relationship with her nephew demonstrates how generosity can triumph over skepticism, fear, illness, and time. The narrator's initial reluctance to visit his great aunt can be considered a kind of emptiness, which is fed by stereotyping (ageism) and reductionistic developmental theories. The story shows how a simple but gracious celebration of a cherished tradition can renew relationships, transfigure fears, and give respite to busy lives. The story suggests that new possibilities can arise when one remains open to the was, is, and will be.

The text provides little demographic data about the two characters in the story, except to reveal that the man has a brother and parents and that his parents encourage him to visit his great aunt. The man is described as living in the newer suburbs, whereas his great aunt lives in the older part of town, a common pattern in North America (Rybczynski, 1995). The title and the illustrations of the book suggest that this three-generation family celebrates Christmas with many traditional symbols and rituals. Later, the poem departs from these sentimental elements to reveal that the man makes the visit with considerable apprehension and reluctance but is joyfully surprised with the experience.

Method

Hermeneutics is a concept and method the significance of which has grown in contemporary thought and nursing. The term *hermeneutics* means interpretation, and it derives its meaning from the Greek word *hermaneuein* (*The American Heritage Talking Dictionary*, 1996), and hermeneutical efforts can be seen in the literature from ancient Greece (Vattimo, 1997). Use of hermeneutics expanded in Europe during and after the Protestant Reformation, at which time scholars, freed from a single, authoritative interpretation of reality (for example, papal authority in Roman Catholicism), sought to find a rigorous method to get at the meanings of religious literature. Hermeneutics is therefore deeply associated with modernity and, for some, the secularization of Western society. In effect, there are no facts, only interpretations (Vattimo, 1997). Hermeneutics usually includes a thorough study of the context of the work and the author's worldview. It considers the parts of a narrative in the context of the whole document and is seen as containing the meaning of the whole.

In the 19th century, philosophers such as Schleiermacher and Dilthey applied hermeneutic inquiry to nonsacred texts, including verbal and nonverbal productions, as well as historical and current sources. These efforts reflect the 19th-century challenge that all knowledge should follow the model of the physical sciences, which was increasingly dominating society. Dilthey sought to secure for literature and history a status that was on par with that of the natural sciences. Researchers using hermeneutics in the human sciences and human science–based nursing seek to explain, understand, or decipher texts as a way of understanding human beings (Palmer, 1969).

In the 20th century, Heidegger (1971) connects hermeneutics to his concern with ontology, which centers on the question of the meaning of being. Heidegger uses hermeneutics in his assault on the established arguments and conclusions of metaphysics, the branch of philosophy that studies ultimates (Vattimo, 1997). He sees interpretation as a rigorous method and something essential to what it is to be human. For Heidegger, to exist as a human being means to hold oneself open to all being. He links poetry to truth and describes genuine thinking as poetic thinking. He agrees with the German poet Hölderlin that "to be a poet in a destitute time means: to attend, singing, to the trace of the fugitive gods" (p. 94). The 20th century is considered destitute by Heidegger not only because of how the world has secularized, but because humans do not understand their own nature. For him, death in modern society has become an enigma, and the meaning of pain is no longer clear.

Gadamer (1960) applies hermeneutics to aesthetic, cultural, historical, and literary works. Like Heidegger, he stresses the historicity, finitude, truth, and value of poetic texts. He says that in world literature, there is something that transcends the time and "world" in which the work was written (p. 162). These traces of universal truths could only be brought back into lived experience by the process of understanding. Thus, he considers literature as a place where art and science merge. Gadamer further posits hermeneutics as a fusion of horizons. He sees a horizon as a way to look beyond the structures of meaning that remain unexamined to "see it better" (p. 305). The researcher participates in the fusion of the horizons by entering into the tradition of the text. In this work, the fusion of horizons is understanding the meaning of the text through the interpretation by the researchers. Parse and Gadamer (1998) agree that a rigorous process of interpretation of texts revises what is known about being human by dwelling with works of literature or art. Thus, this is seen as an appropriate research method of published works of literature for further developing the human becoming

theory and understanding individuals and families.

Cody (1995) used a hermeneutic method to study selected poems of Walt Whitman. He interpreted Whitman's poetry in light of Parse's (1981, 1998) human becoming theory. In the human becoming school of thought, the human-universe-health process is seen as a multidimensional unity. Human beings are seen as coparticipating with that which is given by knowing and choosing. The three principles of the human becoming theory are structuring meaning multidimensionally, cocreating rhythmical patterns of relating, and cotranscending with the possibles (Parse, 1998, p. 58). Nursing inquiry from such a perspective is focused on discovering the meaning of lived experiences.

Cody (1995) and R. R. Parse (personal communication, December 17, 1999) have explicated the three processes of the human becoming hermeneutic method as discoursing, interpreting, and understanding. Parse (personal communication, December 17, 1999) further explicated the method as discoursing with penetrating engaging, interpreting with quiescent beholding, and understanding with inspiring envisaging. In this study, the researchers actively engaged the text *A Cup of Christmas Tea* (Hegg, 1982) as open beings cocreating with the text. The human becoming hermeneutic method seeks to discover emergent meanings about human experiences, which contribute to knowledge and understanding to guide further research and practice (Parse, 1998, 2001).

Significance for Nursing Science

The purpose of a human becoming hermeneutic study is to gain understanding of human lived experiences related to health and to advance nursing science. The phenomena under study are lived experiences captured in the descriptions from published texts or artforms. In this study, five nurse researchers, three from the United States (Baumann, Carroll, Damgaard), one from Wales (Millar), and one from Australia (Welch), worked individually and collectively to explicate a new understanding of lived experiences related to personal health.

The Trajectory of the Study

The trajectory of the study of this text followed the three processes of the hermeneutic spiral: discoursing with penetrating engaging, interpreting with quiescent beholding, and understanding with inspiring envisaging (Parse, 2001). Cody (1995) views hermeneutics as a spiral, rather than a circle as described by Gadamer (1960), because the researcher progresses to new thinking about the meaning of lived experiences. These processes are seen as simultaneous. The penetrating engaging of the text by this group of researchers began with each researcher's sharing with the others images and meanings that arose as he or she read and reflected on Hegg's (1982, 1992) work. Guided by the human becoming theory, the researchers repeatedly returned to the text as they moved beyond the religious and cultural specifics in the story to explore the more universal experiences. The researchers recalled and shared their recollections of family visits and holidays. The nephew's concerns and feelings, and later joy, resonated with the researchers' own experiences of family and holidays. Each line of the poem was considered in the context of the whole story. One researcher (Damgaard) was able to meet with the illustrator of the story to discuss how the book evolved and gain information about the author and illustrator. Hanson said that he had an aunt in a nursing home when Hegg approached him and that this was part of the reason he agreed to do the illustrations for the book. First individually and then as a group the researchers moved through penetrating engaging with a quiescent beholding of the text and in inspiring envisaging discovered three emergent meanings: honoring the cherished; communing with the was, is, and will be; and triumphing with new vision.

Emergent Meanings

Honoring the Cherished

The researchers agreed that honoring the cherished was a significant emergent meaning of the text and one that reflected the first principle of human becoming theory: "structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (Parse, 1998, p. 35). Various passages from the text were seen as contributing to the meaning of honoring the cherished (see Table 1 for some quotations related to honoring the cherished). Extending an invitation for a visit during a holiday season was seen as honoring a person and a relationship. Likewise, the decision to accept an invitation and travel to make a visit is honoring, particularly when that process is difficult. Imaging, which is described in human becoming theory as a process of coming to know, was seen in the nephew's considerations of how his great aunt had been and how she might be now. According to the poem, he was aware that his "old Great Aunt" was housebound now because of a "mild stroke," and he assumed she had "gone downhill." The meaning of the term *old* in the nephew's early thoughts suggests that, for him, being of advanced age carries connotations of fragility and decline. His recorded thoughts suggest that he assumed that the person he once knew and enjoyed being with no longer existed; yet he cherished her. He feared that seeing her now would be for him "painful" and depressing.

According to the poem, his reasons not to go are eroded by "an acid rain of guilt" as he overcomes his reluctance and fear and makes the visit. His fears are quickly eased by his gracious aunt, and his visit is filled with great delight, in part because he sees how alive and gracious toward him his great aunt remains. He reexperiences the joy of the holiday and of the close loving relationship as he remembered them: "Like magic I was six again" (Hegg, 1982). He is surprised that she still has many objects that he loved when he was a

Table 1
Quotations Reflecting the Emergent Meaning of Honoring the Cherished

I got a letter from my old Great Aunt. It read: "Of course, I'll understand completely if you can't, but if you find you have some time, how wonderful if we could have a little chat and share a cup of Christmas tea."

I drove in from the suburbs to the older part of town.

The scent of candied oranges of cinnamon and pine, the antique wooden soldiers in their military line; The porcelain Nativity I'd always loved so much . . . the Dresden and the crystal I'd been told I mustn't touch.

And here, among old Christmas cards, so lovingly displayed, a special place of honor for the ones we kids had made.

And there, beside her rocking chair, the center of it all . . .

My Great Aunt stood and said how nice it was I'd come to call.

I lost the phoney breeziness I use when I get tense. She was still passionately interested in everything I did. She was positive. Encouraging. Like when I was a kid.

NOTE: From *A Cup of Christmas Tea* by T. Hegg and W. Hanson, 1982, Minneapolis, MN: Waldman House Press. Copyright © 1982 by T. Hess and W. Hanson. Reprinted with permission.

child, including cards he himself had made for her. The woman identified in the story as the great aunt honors and preserves this family's past and shows how sharing cherished traditions with loved ones can bring meaning to the present and hope for the future as the was, is, and will be are lived all at once. The ability to be fully and openly attentive to one's past, present, and future, all at once, is evident in this loving encounter. The attentive presence offered by the woman in Hegg's work also is honoring. She honors this young man by her keen interest in the details of his life, her insistence on being open: "She was still passionately interested in everything I did" (Hegg, 1982). From a human becoming perspective, this story suggests that the "magic" of living cherished holidays together with the meaning of family relies on individuals' freely choosing to value others, relationships, beliefs, and traditions.

Valuing in human becoming theory is another concept related to structuring meaning. It is described as a process of confirming–not-confirming cherished beliefs in light of one's personal worldview (Parse, 1998, p. 37). The paradoxical rhythm of confirming–not-confirming is seen in what one chooses to focus on in one's situation and relationships. These choices and their consequences become a part of one's being as a matrix of principles and ideas that helps one to hold firm in the face of illness, uncomfortable feelings, and distractions. The great aunt is choosing to be positive as she risks being disappointed by her great nephew. Her great nephew expresses his paradoxical rhythm of confirming–not-confirming his relationship by honoring the memories of his great aunt.

The third concept connected with structuring meaning in the human becoming theory is languaging. It represents words and gestures as well as silences and movements, often expressed in paradoxical patterns and rhythms. The text of *A Cup of Christmas Tea* contains only a few direct quotations. One of the most important is the letter sent by the great aunt: "Of course, I'll understand completely if you can't. But if you find you have some time, how wonderful if we could have a little chat and share a cup of Christmas tea" (Hegg, 1982). The graciousness of the invitation and the use of shared symbols and words is part of the languaging of meaning by the great aunt with her nephew as they come together to see each other anew. The silence and meanings behind the words, gestures, and symbols are in part a product of the reader's pace and style of reading, suggesting that languaging is always both unique for each person and shared with the other.

Communing With the Was, Is, and Will Be

The second emergent meaning discovered in the text is described here as communing with the was, is, and will be. *Communing*, as used here, denotes a special relation with, such as in the phrase, "communing with nature." In this story, the special relationship is between the chief characters and communing with the human-universe process and time. This communing is a special form of multidimensional relating. It is connected to the principle of human becoming, "cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating" (Parse, 1998, p. 42). Central to the story in *A Cup of Christmas Tea* is a loving process between two members of a family from different generations and parts of town. Like many cross-generational family visits, the one in this story is neither simple nor particularly easy as it spans the remembered, the now, and the unknown possibles. An invitation is a request that can be received with considerable trepidation. In the human becoming hermeneutic method, penetrating engaging, quiescent beholding, and inspiring envisaging arise with dwelling with the meaning in a text or artform. The text provides few details of the individuals involved and the family, and according to W. Hanson (personal communication, 1999), there are no drawings of characters in the book so that readers will be more inclined to reflect on their own experiences. Also not mentioned in the book or story is that Thomas Hegg, as he has disclosed to interviewers, suffers from periods of depression (Roberts, 1999). Perhaps this is intimated in the nephew's concern about what might arise from a visit and conversation with his great aunt.

The great aunt's stroke is in the now for the nephew, as is her pattern of walking and her use of a crutch and brace, yet he remembers her free of such aids. Part

Table 2
Quotations Reflecting the Emergent Meaning of Communing With the Was, Is, and Will Be

They said: "She'd love to see you. What a nice thing it would be . . . "
I remembered her as vigorous, as funny and as bright. I remembered Christmas Eves when she regaled us half the night.
Before my eyes and ears and nose was Christmas past . . . alive . . . intact.
Like magic, I was six again, deep in a Christmas spell, steeped in the million memories the boy inside knew well.
She listened very patiently, then smiled and said, "What's new?" Thoughts and words began to flow. I started making sense. I lost the phoney breeziness I use when I get tense. She was passionately interested in everything I did. She was positive. Encouraging. Like when I was a kid. Simple generalities still sent her into fits. She demanded the specifics. The particulars. The bits.
She spoke with utter candor, and with humor and good grace.
On wings of hospitality, she flew to brew the tea. I sat alone with feelings that I hadn't felt in years. . . . the impossibly good cookies she still somehow baked herself.

NOTE: From *A Cup of Christmas Tea* by T. Hegg and W. Hanson, 1982, Minneapolis, MN: Waldman House Press. Copyright © 1982 by T. Hess and W. Hanson. Reprinted with permission.

Table 3
Quotations Reflecting the Emergent Meaning of Triumphing With New Vision

Though housebound now, my folks had said it hadn't hurt her pride.
Then defying the reality of crutch and straightened knee . . .
And though her thick bifocals seemed to crack and spread her eyes, their milky and refracted depths lit up with young surprise.
Before my eyes and ears and nose was Christmas past . . . alive . . . intact.
Like magic, I was six again, deep in a Christmas spell . . .
But these rich, tactile memories became quite pale and thin, when measured by the Christmas my Great Aunt kept deep within. Her body halved and nearly spent, but my Great Aunt was whole. I saw a Christmas miracle . . . the triumph of a soul.

NOTE: From *A Cup of Christmas Tea* by T. Hegg and W. Hanson, 1982, Minneapolis, MN: Waldman House Press. Copyright © 1982 by T. Hess and W. Hanson. Reprinted with permission.

of the "enabling-limiting" (Parse, 1998) of communing with the was, is, and will be in this story is the great aunt's candor, encouragement, and insistence on hearing the "bits" of her great nephew's life (see Table 2 for additional quotations related to communion). These qualities move the conversation beyond "phoney breeziness" and allow the reunion that helps make "Christmas past . . . alive . . . intact" (Hegg, 1982). Communing with the was, is, and will be denotes a nonlinear experience of time, as serendipitous togetherness arises between two family members of different generations.

According to human becoming theory, rhythmicity includes the paradox of connecting-separating. In the text of Hegg's (1982) poem, there is not only the coming together of two people but also their separations—from other people, from other activities, and from previously held views. The text records the renewing of an "old relation," suggesting that the nephew has not visited for some time, yet in the middle of the visit he was "alone with feelings that I hadn't felt in years." The text invites the reader to further quiescent ponderings of cherished and not-so-cherished memories and experiences. Vanier (1998) has stated that nourishing encounters "can lead us into other gardens of life, into a new and deeper vulnerability, and into a new understanding of the universe . . . and the beauty and depth of each and every human being" (p. 68). He considers the later stages of life as "a journey toward communion" (Vanier, 1997, p. 124). Thus, communing with the was, is, and will be is significant in understanding human experiences.

Triumphing With New Vision

The third emergent meaning discovered in this hermeneutic study of Tom Hegg's (1982) work is triumphing with new vision. *A Cup of Christmas Tea* is seen here as a story about triumphing with new vision of a great aunt and her nephew (Parse, 1998). This emergent meaning reflects the third principle of the human becoming theory, "cotranscending with the possibles in powering unique ways of originating in the process of transforming" (Parse, 1998, p. 46).

Powering is described by Parse (1998) as the "pushing-resisting process of affirming-not affirming being in light of non-being" (p. 47). Powering in this story is seen in the great aunt's perseverance in the face of adversity and her ability to remain deeply interested in others (see Table 3 for quotations related to triumphing with new vision). It is also seen in the nephew's triumphing with new vision of seeing his great aunt differently without misconceptions and fear. The crutch in this story, as it was in Dickens's *A Christmas Carol* (1843/1997), can be seen as a symbol of that which challenges human beings but also that which can open them to deeper understandings and relationships with new possibilities. This view is counter to the popular view that a crutch is a symbol of decline and approaching death. In Sophocles' play *Oedipus the King*, Oedipus must answer a riddle: "What creature walks on four feet in the morning, two feet at noon, and three feet in the evening?" Oedipus survives death by correctly answering that it is a human being. The mistaken assumption of such a theory of human development, as well as of the nephew's preconception in Hegg's poem, is that human life is an individual cycle of growth and decline.

Sophocles and individual development theories fail to appreciate the interwoven aspects of human existence.

In the human becoming theory the concept of originating is seen as "inventing new ways of conforming-not conforming in the certainty-uncertainty of living" (Parse, 1998, p. 49). Triumphing with new vision in Hegg's (1982) story is that new possibilities arise at all ages and that aging should not be feared as a "going downhill." New possibilities for living, freedom, and generosity arise with time and experience: "Her body halved and nearly spent, but my Great Aunt was whole."

The last of the nine concepts in human becoming theory is transforming, which is described as "shifting the view of the familiar-unfamiliar, the changing of change in coconstituting anew in a deliberate way" (Parse, 1998, p. 51). Transforming can be seen in the ability of a loving relationship to give rise to triumphing with new vision seeing the familiar in a new light, such as perceiving the great aunt as still vital and whole, affirming being with the potential of nonbeing. The nephew's imagination comes alive again, banishing his skepticism about later life and illness, which had clouded his view earlier in the story. He now sees his great aunt as whole again, and his fears about visiting are now seen as unjustified. Later life is no longer associated only with decline and frailty, but with grace and warmth. Human generosity thus triumphs over fear and time.

The third process in the human becoming hermeneutic method is understanding through inspiring envisaging (R. R. Parse, personal communication, December 17, 1999). Dialoguing with Hegg's (1982) text and with each other, this international group of researchers discovered three emergent meanings about human experiences: honoring the cherished; communing with the was, is, and will be; and triumphing with new vision. When taken together, these meanings offer an understanding of Hegg's text. *A Cup of Christmas Tea* is the story of the way triumphing with new vision arises with honoring the cherished in communing with the was, is, and will be. This understanding is relevant across the cultures of the researchers, representing three continents (North America, Europe, and Australia) and three geographic areas of the United States (New York, Illinois, and South Dakota). The emergent meanings and understandings as synthesized can guide further nursing research. In particular, timelessness, which can arise in the celebration of cherished connections and holidays, is a phenomenon that requires further study.

Family relationships, particularly those beyond the immediate or nuclear family, in many modern societies are often distant and unaffirming. This hermeneutic study suggests that people cocreate their families and that their lives are shaped by the consequences of their choices about these connections and separations. Such choices bring new meaning, connections, and lifelong transformations and can reduce the number of people of all ages who are lonely, and yet have much to share.

The meaning of Tom Hegg's (1982) poem holds special significance for nursing, because nurses often receive "invitations" from their patients not only to do something for them but also be with them, and not unlike the great nephew, this request is often received with reservations and concerns. The authors of this hermeneutic study hold that when nurses are open to all of the possibilities with each person who invites them to "visit," then honoring the cherished; communing with the was, is, and will be; and triumphing with new vision can surface. This hermeneutic study suggests that many stories and poems such as this hold value for nursing science. The authors hold that the world's literature is a vast resource of knowledge and wisdom that can humanize modern healthcare. Hermeneutic nursing studies on literary works are needed to tap this source.

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Mexican American Family Survival, Continuity, and Growth: The Parental Perspective

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An ethnographic study using Roy's adaptation model was conducted among 23 Mexican American families in Hidalgo County, Texas, from 1994 to 1998. The purpose was to characterize the family goals of survival, continuity, and growth from the parental perspective during early family formation. Parents affirmed that being healthy, being a united couple, having supportive parents, having a steady job, and having civic harmony were essential characteristics of family survival. Family continuity was characterized by mothers doing tasks inside the house, fathers doing tasks outside the house, and both parents performing toddler and early childhood tasks. Family growth was characterized by having shared communication, growing in togetherness, planning ahead, exerting joint effort, and helping the child become part of the family.

Accurate data are needed about Mexican American family system goals for appropriate evaluation of outcomes achieved through nursing intervention (Castillo, 1996). Roy (1983) advises nurses to intervene in families by enhancing family processes of nurturing, support, and socialization, thereby helping families to achieve general goals of survival, continuity, and growth. The purpose of this part of the ethnographic longitudinal study reported here was to identify how Mexican American families in early family formation establish basic patterns for family survival, continuity, and growth. The research question was, What characterizes family survival, continuity, and growth in Mexican American families in early family formation? *Family survival* is defined as sustained organization of the family system. *Family continuity* is consistency of patterns in the family system over time. *Family growth* is change in the structure of the system allowing the family system to become more internally complex in adapting to changing needs of family members and changing relationships within the family. The change in structure of the family becomes more externally complex in responding to changes in the family environment. *Early family formation* spans the time from birth through the 4th year of life of the first child.

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Roy's Model of the Family as an Adaptive System

According to Roy (1983), the family is an adaptive system that responds to changes in the family environment, to changes in relationships within the family, and to changing needs of family members. The family adapts to these changes through family processes of nurturing, support, and socialization, thus achieving family goals of survival, continuity, and growth. Continual input to the family system comes through feedback mechanisms of member control and transactional patterns.

Roy's (1983) model of the family as an adaptive system has been used since 1994 to guide the research about Mexican American family transitions. During the first 10-month period of the study in 1994 to 1995, 26 Mexican American couples living in Hidalgo County, Texas, were followed from the third trimester of pregnancy until the firstborn child was 6 months old. This initial family study focused on parental concerns (Niska, Lia-Hoagberg, & Snyder, 1997), the meaning of family health (Niska, Snyder, & Lia-Hoagberg, 1999), and health-related decisions (Niska, Snyder, & Lia-Hoagberg, 1998). In 1996, the investigator returned for 8 weeks and interviewed 23 of the original 26 families to examine the distinctive nature of adaptive processes of nurturing, support, and socialization of the Mexican American family in early family formation (Niska, 1999b). The third part of the study, occurring from January to February 1998 and involving 25 of the original 26 families, investigated the similarity and acceptability of nursing interventions that enhance processes of nurturing, support, and socialization (Niska, 1999a) and also investigated basic patterns of survival, continuity, and growth within the family.

Related Literature

Roy's (1983) model of the family as an adaptive system references general system theory pioneered by Ludwig von Bertalanffy. Bertalanffy (1968) stated, "A system may be defined as a set of elements standing in interrelation among themselves and with the environment" (p. 252). Families are organized wholes. Bertalanffy wrote, "Characteristics of organization, whether of a living organism or a society, are notions like those of wholeness, growth, differentiation, hierarchical order, dominance, control, competition,

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etc." (p. 47). Whereas Bertalanffy cited a unitary conception of the world based on isomorphy of laws in different fields, such as biology, psychology, and sociology, he did not depart from regarding the individual person as the ultimate precept. He framed human society in terms of the achievements of the individual rather than viewing the individual as being "controlled by the laws of the superordinate whole" (p. 56).

Cultural communities invest family organizations with defined functions in childbearing, socialization of the young, sexual satisfaction of adults, and intimacy of family members. Family structure is the unique pattern of the family enacted to meet members' needs and to fit cultural precedents set for the family unit (Montgomery & Fewer, 1988). Montgomery and Fewer (1988) describe family patterns as sequences of interactions and sequences of transactions that become typical ways the system behaves.

Family health is a state of being and becoming an integrated and whole family (Roy, 1983). Roy states that the family is an adaptive system that responds to the changing needs of family members, to changes occurring within relationships within the family, and to changes in the family ecosystem. Adaptational processes of support, nurturing, and socialization operate within the family to facilitate family integration. General goals of the family system are survival, continuity, and growth. Feedback mechanisms of member control and transactional patterns provide ongoing input to the family system.

Roy (1983) indicated, "To make diagnoses related to family adaptation . . . family behavior can be observed as it relates to the general family goals of survival, continuity, and growth" (p. 275). Roy stated that family behavior being observed may parallel the individual adaptive modes in the following way: Family survival behavior may parallel the physiological mode of the individual, family continuity may be aligned with the role function mode, and family growth may be analogous to the self-concept mode of the individual. Transactional patterns of the family may parallel the interdependence mode, and member control processes of the family may be aligned with both physiological needs and role function modes of the individual.

Regarding the Roy adaptation model, Roy and Andrews (1999) state, "In this model, the major processes for coping are termed the regulator and cognator subsystems as they apply to individuals, and the stabilizer and innovator subsystems as applied to groups" (p. 37). Regarding the family, Roy and Andrews indicate,

> The *stabilizer subsystem* involves the established structure, values, and daily activities whereby participants accomplish the primary purpose of the group and contribute to common purposes of society. For example, within the family unit, specified members fulfill wage earning activities; others may be primarily responsible for nurturance and education of children. The family members possess values that influence the way in which they respond to their environment and fulfill their daily responsibilities to each other and society. (pp. 47-48)

In contrast to the stabilizer subsystem, the innovator subsystem is described as "the structures and processes for change and growth in human social systems" (p. 48).

Within the Roy adaptation model (Roy & Andrews, 1999), the four group modes are distinguished from the four individual modes. The physical mode for groups "pertains to the manner in which the collective human adaptive system manifests adaptation relative to basic operating resources, that is, participants, physical facilities, and fiscal resources" to achieve resource adequacy (p. 49). Roy and Andrews state, "Group identity is the relevant term to use for the second mode related to groups," allowing the group to achieve a basic need for identity integrity (p. 49). The group role function mode is directed toward achieving expected tasks with role clarity as a basic need of members of the group. Roy and Andrews state that for groups, the interdependence mode "pertains to the social context in which the group operates. This involves both private and public contacts both within the group and with those outside the group" (p. 50). Thus, the physical mode, group identity, role function, and interdependence of a group are assessed when studying a variety of human social systems, such as a family, a police department, a manufacturing plant, or a local community.

The Roy (1983) model of the family as an adaptive system is at a midrange level of conceptualization uniquely suited for describing the family system. Parallels exist between the midrange theory of the family as an adaptive system and the Roy adaptation model (Roy & Andrews, 1999). The parallels established by Roy integrating the family model and the individual model suggest that family survival may parallel group physical status, family continuity may be aligned with group role function, family growth may be analogous to group identity, and transactional processes may coincide with the interdependence of a group.

Method

A 170-square-mile area of Hidalgo County, Texas, was the setting for this longitudinal study. This rural area has a population of 12,352 persons (U.S. Bureau of the Census, 1991). From 1994 to 1995, data were gathered across 26 families. One family was lost to follow-up, and two families were working outside of the region during subsequent data collection, yielding 23 families with continuous data spanning 1994 to 1996. During the 3rd year of data collection in 1997 to 1998, 25 of the 26 families participated, but for purposes of this article only the data for the 23 families who have offered complete data sets from 1994 to 1998 will be reported.

During each of the three periods of data collection, the investigator lived within the research area with Mexican American families who were not study

participants. The investigator used Spradley's (1979, 1980) Developmental Research Sequence. Spradley advised using grand tour questions in interviewing and doing card-sorting tasks later in the process of data collection. In 1994, the investigator used grand tour questions asking participants to describe a typical day from dawn until dark. Based on participant responses, the investigator developed a set of 34 typical household tasks and 12 child care tasks. Each task was written on a 3 by 5 inch index card with English on one side and Spanish on the other side. In meeting with the mother and father, the investigator asked them to sort the cards, placing each card in one of four piles according to the family member who performed the given task (i.e., "Mother," "Father," "Both," or "Neither").

In the 2nd year of data collection, 11 age-related child care tasks were added, such as "Pick up the child's toys" or "Read a story." In the 3rd year, 5 age-related child care tasks were added, such as "Toilet train the child," "Dance with the child," or "Play soccer with the child."

In the second and third periods of data collection in 1996 and 1998, parents were also asked two grand tour questions: "What is essential for a family to survive nowadays?" and "What is essential for a family to grow?" Parental responses were audiotaped and transcribed verbatim in English or Spanish, giving participants fictitious names on all the transcripts. Names were changed to honor privacy. The investigator translated the Spanish conversations into English using the Tannen (1984) style of conversation analysis, working to retain cultural features in both the Spanish and English (Levinson, 1983; Sanchez, 1994; Schiffrin, 1987). A bilingual consultant verified the accuracy of English translations of the Spanish transcripts.

From the responses to these two questions, the investigator developed a frequency distribution of characteristics that families offered. The investigator cross-checked the commonality of each characteristic of family growth and of family survival by creating a card-sorting task including each characteristic written on a 5 by 8 inch index card with English on one side and Spanish on the other. A set of 9 index cards related to family survival and 10 index cards related to family growth were created that could be shuffled in random order. During a subsequent visit with the family, the investigator asked each family to read each card related to family survival and to sort the cards into two labeled stacks: (a) "Yes, it's essential for family survival," or (b) "No, it's not essential for family survival." The investigator then asked each family to read each card related to family growth and to sort the cards into two labeled stacks: (a) "Yes, it's essential for family growth" or (b) "No, it's not essential for family growth." These card-sorting tasks were recorded in a data display.

Analysis

Grand tour questions about family activities elicited data appropriate for doing card-sorting tasks about household and infant care activities during the infancy period. Inquiry and updating the infant care tasks permitted ongoing assessment of continuity in the gendered distribution of child care during the 2nd and 3rd years of the child's life. Data summarizing the gendered distribution of performance of child care tasks were analyzed in this study using frequency distributions and percentages. Parental conversations about family survival and family growth were analyzed by content analysis, locating repeating characteristics. Card-sorting tasks regarding characteristics of family survival and growth were summarized by frequencies and percentages.

Findings

Demographic Data

In 1998, maternal age ranged from 20 to 31 years with a mean of 24.4 years ($SD = 0.6$), and paternal age ranged from 23 to 36 years with a mean of 28 years ($SD = 0.8$). Firstborn children ranged in age from 31 to 44 months with a mean of 37.4 months ($SD = 4.4$). Nine second-born children ranged in age from 5 to 27 months with a mean of 12.5 months ($SD = 6.8$). One family had a third child aged 9 months. Maternal schooling was a mean of 11 years ($SD = 3.4$), and paternal schooling was a mean of 11.2 years ($SD = 2.8$). Only 7 mothers worked full-time outside the home. Seventeen fathers had full-time employment, 3 had part-time employment, and 5 were unemployed after returning from migrant labor. During the 3 years of data collection, mean family income in U.S. dollars was reported to be 7.69 thousand ($SD = 1.2$) from 1994 to 1995, 13.2 thousand ($SD = 3.0$) in 1996, and 13.5 thousand ($SD = 7.6$) from 1997 to 1998.

Family Survival

In response to the question, "What is essential for a family to survive nowadays?" families initially responded with the following: having secure employment ($n = 19$), receiving some government help ($n = 4$), being a united couple ($n = 3$), having a supportive family of origin ($n = 2$), being healthy ($n = 1$), having child care ($n = 1$), and having harmony in the civic community ($n = 1$). Parents described their struggles for family survival in terms of their needing to work. Timoteo, a carpenter, described how his family survived, stating,

> Trabajar, ahorrar, ahorrar,
> pues trabajando, ahorrar poquito lo más que se pueda
> porque pues a veces se acaba el trabajo,
> poquito carpentería,
> como pues las verduras, hay muchas verduras,
> está todo barato aquí,
> a veces nos ayudan las estampillas un poquito,
> así se vive bien,
> poquito, pero se vive por comer y todo,
> pero no para comprar casa ni nada.
>
> [Working, saving, saving,
> well working, saving, what little bit you are able,
> well, because at times the work stops,
> there's just a little carpentry,
> well, the vegetables, there are a lot of vegetables,

everything is cheap here,
at times they help us a little bit with food stamps,
at least this way one manages,
getting by, but one has food and all,
but not enough to buy a house or anything.]

Parents also described how family survival depended on their working together in harmony within the family. Oscar stated, "What does it take? Apart from the money, a lot of patience, a lot of understanding really." Miguel stated, "The struggle to survive for a family really is child care, you know; it's hard to find jobs; there's not much work here; the work that is here is not that . . . it's not that good . . . the work."

When doing the card-sorting task across all 23 families so that families could respond to what other families had suggested as essential for family survival (see Table 1), "Being healthy," "Being a united couple," and "Having supportive parents" were affirmed by all 23 families. Twenty-two families affirmed that "Having a steady job" and 21 families affirmed that "Having civic harmony" were essential for family survival. Fifteen families responded affirmatively to "Having safe child care" and 13 families to "Having affordable child care." Ranking lowest were "Both parents have to work" and "Receiving government help," with only 10 families selecting these two as essential for family survival.

In summary, more than 90% of the 23 families affirmed that being healthy, being a united couple, having supportive parents, having a steady job, and having civic harmony were essential for family survival.

Family Continuity

To uncover what characterizes family continuity, the investigator identified household tasks with a continual pattern of performance over the three data collection periods, that is, tasks performed by the mother over the 3 years, tasks performed by the father over the 3 years, tasks consistently performed by both parents all 3 years, and tasks performed by neither parent all 3 years (see Table 2). Tasks that neither parent performed over a 3-year period, such as using a baby-sitter, are included in tabulating continuity in households because continual omission of an activity constitutes a pattern of continuity in some cases as well as continual performance. For example, with respect to use of a baby-sitter, the tabulation includes the 7 families in which parents would not leave their infant or young child with a baby-sitter or day care provider. One additional family would use a baby-sitter, but only in the family home, thereby never taking the child to a location outside the family home. Similarly, families that never vacuumed were poor and they damp mopped plywood floors or cement floors; however, that activity was continual over 3 years. In tabulating across families, the percentages of families in which continual performance of household tasks occurred across all three data collection periods were as follows: sew/mend clothes, change the oil on the car/truck (n = 22, 96%); get a baby-sitter, iron clothes (n = 20, 87%); wash clothes, vacuum, feed the animals (n = 19, 83%); clean the kitchen, scrub the floor, fix lunches (n = 18, 78%); paint the outside of the house, wash the car/truck, cut the grass (n = 17, 74%); wash dishes (n = 16, 70%); trim trees/shrubs, clean inside the car/truck (n = 15, 65%); sweep the floor, fold dry clothes, paint inside of the house (n = 14, 61%); clean the rooms, make the beds, work in the garden (n = 13, 57%); set the table, shop for groceries, buy gas for car/truck, wash windows, and water trees/shrubs (n = 12, 52%). These 25 tasks of the 34 household tasks had a pattern of continuity in more than half of the families during the 3 years of data collection.

Table 1
Percentages of Families Affirming Certain Characteristics as Essential for Family Survival (N = 23)

Characteristic	n	%
Being healthy	23	100
Being a united couple	23	100
Having supportive parents	23	100
Having a steady job	22	96
Having civic harmony	21	91
Having safe child care	15	65
Having affordable child care	13	56
Both parents have to work	10	43
Receiving government help	10	43

With respect to the division of household tasks by gender, the investigator tabulated across families and noted the percentages of families in which the mother performed the tasks all 3 years: sew/mend clothes (n = 21, 91%); wash clothes (n = 19, 83%); iron clothes, scrub the floor, clean the kitchen (n = 18, 78%); fix lunches (n = 17, 74%); wash dishes (n = 16, 70%); and sweep the floor, fold dry clothes (n = 14, 61%). The percentages of families in which the father performed the household tasks across all three data collection periods were as follows: change the oil in the car/truck (n = 22, 96%); cut the grass, wash the car/truck (n = 16, 70%); clean inside the car/truck, paint the outside of the house (n = 14, 61%); and trim trees/shrubs (n = 12, 52%). With respect to household tasks shared by both parents over all 3 years, no tasks were shared by at least 50% of families. A division of household tasks by gender was the characteristic pattern that parents described.

Given these 34 household tasks, the range of tasks having continuity within families with respect to stability in performance of the task over the three periods of data collection ranged between 15 to 29 tasks that remained stable over a 3-year period. The mean number of stable tasks per family was 22 tasks (SD = 4.4), and the median number was 21 tasks per family. Not only was a divi-

Table 2
Number of Families Reporting Continuity in Household Task Performance Over 3 Years (*N* = 23)

Task	Mother	Father	Both	Neither
Change oil in car/truck	0	22	0	0
Sew/mend clothes	21	1	0	0
Get a baby-sitter	7	0	6	7
Iron clothes	18	0	1	1
Wash clothes	19	0	0	0
Vacuum	9	2	4	4
Feed the animals	1	9	5	4
Scrub the floor	18	0	0	0
Clean the kitchen	18	0	0	0
Fix lunches	17	0	0	0
Paint the outside of the house	0	14	3	0
Wash the car/truck	0	16	1	0
Cut the grass	0	16	1	0
Wash dishes	16	0	0	0
Trim trees/shrubs	0	12	0	3
Clean the inside of the car/truck	0	14	1	0
Sweep the floor	14	0	0	0
Fold dry clothes	14	0	0	0
Paint the inside of the house	0	7	4	3
Clean the rooms	11	0	2	0
Make the beds	11	0	2	0
Work in the garden	1	5	4	3
Set the table	10	0	2	0
Shop for groceries	1	0	11	0
Buy gas for car/truck	0	8	4	0
Water trees/shrubs	0	3	6	3
Wash windows	5	0	5	2
Go for the mail	3	3	5	0
Fix the toilet	3	8	0	0
Cook meals	10	0	0	0
Throw out the trash	1	4	5	0
Pay the bills	1	1	5	0
Return borrowed items	2	0	4	0
Plan the menu	4	0	1	0

Table 3
Child Care Tasks Among Families Who Maintained Continuity of Task Performance Over 3 Years (*N* = 23)

Basic Care Task	Mother	Father	Both	Neither
Hold the child	0	0	21	0
Make the child's bed	18	0	2	0
Go to Women, Infant, Children's Clinic	17	0	3	0
Choose which toys to buy	2	0	16	0
Go for a stroll with the child	2	0	11	0
Take the child to doctor	4	0	8	0
Rock the child	2	0	10	0
Change diapers	7	0	5	0
Go to public health clinic	5	0	6	0
Bathe the baby/child	5	0	3	0
Sing songs to baby/child	5	0	3	0
Get the bottle ready	4	0	2	0

sion of household tasks by gender prevalent across families, but also an average of 22 of the 34 household tasks showed continuity within families.

The investigator also identified which of the 12 basic child care tasks had a continual pattern of performance across families over the 3 years of data collection (see Table 3) and which of the 16 age-related child care tasks had a continual pattern over the years of data collection (see Table 4). The percentages of families with continual performance of basic child care tasks over 3 years were as follows: hold the child ($n = 21$, 91%); make the child's bed, go to Women, Infant, Children's Clinic (WIC) ($n = 20$, 87%); choose which toys to buy ($n = 18$, 78%); go for a stroll with the child ($n = 13$, 57%); and take the child to the doctor, rock the child, change diapers ($n = 12$, 52%). The percentages of families in which 16 age-related child care tasks had a continual pattern of performance over the years of data collection were as follows for each task: play with the child ($n = 22$, 96%); talk to the child, take child to a baby-sitter ($n = 20$, 87%); dance with the child, play catch with the child ($n = 19$, 83%); toilet train, listen to the child ($n = 18$, 78%); take the child for a ride in the car or truck ($n = 17$, 74%); cut up the child's food ($n = 16$, 70%); read the child a story, comfort the crying child, play soccer with the child, put the child to bed ($n = 15$, 65%); tell the child a story ($n = 13$, 57%); and put the child down to nap ($n = 12$, 52%).

With respect to the division by gender of child care tasks, the investigator identified which tasks were performed only by the mother in more than half of the families. Only the tasks of making the child's bed ($n = 13$, 57%) and taking the child to the WIC Clinic ($n = 12$, 52%) were performed exclusively by mothers in more than half of the families. No child care tasks were exclusively performed by fathers in more than half of the families. Child care tasks continually performed by both parents over the 3 years of data collection were the following: holding the child ($n = 21$, 91%) and choosing which

Table 4
Age-Related Care Tasks Among Families Who Maintained Continuity of Performance Over 3 Years (*N* = 23)

Age-Related Task	Mother	Father	Both	Neither
Play with the child	0	0	22	0
Talk to the child	0	0	20	0
Take the child to baby-sitter	4	1	7	8
Listen to the child	0	0	18	0
Take child on car/truck ride	0	2	15	0
Read the child a story	6	0	9	0
Comfort crying child	1	0	14	0
Put the child to bed	2	0	13	0
Tell the child a story	3	1	10	0
Put child down to nap	6	0	6	0
Pick up child's toys	3	0	5	0
Dance with the child	3	0	16	0
Play catch with the child	1	7	10	1
Cut up child's food	6	0	10	0
Play soccer with the child	1	3	10	1
Toilet train the child	11	0	7	0

toys to buy (*n* = 12, 52%). Age-related child care tasks performed by both parents over the years of data collection were the following: play with the child (*n* = 22, 96%); talk to the child (*n* = 20, 87%); listen to the child (*n* = 19, 83%); dance with the child (*n* = 16, 70%); comfort the crying child, take the child for a ride in the car or truck (*n* = 15, 65%); and put the child to bed (*n* = 13, 56%). In looking across families for continuity in the performance by gender of child care tasks, the prevailing pattern was the shared performance of child care.

Given the 28 child care tasks, the range of continuity within families ranged from 8 tasks per family to 23 tasks per family. The mean number of continuously performed tasks within a family was 17.3 (*SD* = 3.03). Parents described these structured patterns for the performance of child care tasks over time.

Family Growth

Parents described the following factors that contributed to family growth: exerting joint effort (*n* = 9), having shared communication (*n* = 5), using coping strategies (*n* = 3), relying on family values (*n* = 3), planning ahead (*n* = 2), gaining inspiration from children (*n* = 2), receiving professional guidance (*n* = 1), and having social contact with extended family (*n* = 1). Yasinia commented,

> La comunicación entre los dos,
> este, la unión entre,
> ah huh, la comunicación entre él y yo
> y que la niña, también, pues forma parte
> también en la familia,
> y como dice, la niña le da ánimos a trabajar y salir adelante.
>
> [The communication between us both,
> well, the union among,
> ah huh, the communication between him and me,
> and that the child becomes part of the family,
> and like they say, the child inspires him
> to work hard and get ahead.]

Oscar stated, "Learning, ah, what to do, ah, learning how to cope with what you have." Jaime stated, "I'd just say never give up, because for us right now, money is tight big time; we're hurting for money right now; but, like I tell my wife, we just, we'll get through, we've done it before." Marta found planning ahead to be important for family growth saying, "Yah, one has to plan ahead, so you know what you are going to do in the future." Soraida said family growth occurs through adhering to values, "With old family values, just following family values." Similarly, Yasinia commented, "Pues que crezcamos la familia junta y unida, uno de los deseos, verdad, que siempre haya respeto, apoyo, amor, verdad; es ese el deseo [Well that we as a family grow in unity and togetherness; that is one of the desires, right; that there may always be respect, helping each other, and love, right; that is the desire]." Ana stated that family growth depended on instilling in children the desire to belong to the extended family. Ana used the metaphor of the plant explaining, "Como si yo privo a mi hija de tener contacto con la familia, con el, con todo la familia que hay, y que yo no la llevo . . . allí la familia es está haciendo para abajo marchitándose en no tener contacto, en no tener éste con la familia [Like if I deprive my daughter of having contact with the relatives, with all the family that there is and I don't bring her . . . there the family wilts in losing contact, in not having contact with them]."

When doing a card-sorting task with all 23 families to clarify which characteristics were essential for family growth, all 23 families affirmed the essentialness of "Having shared communication," "Growing in togetherness," "Planning ahead," and "Helping the children become part of the family" (see Table 5). Of the 23 families, 22 affirmed as essential for family growth "Gaining inspiration from the children," "Relying on family values," and "Using coping strategies." Other highly affirmed characteristics were "Having social contact with extended family" and "Parents exerting joint effort." Ranking lowest was "Family receiving professional guidance."

By using the data obtained from doing card-sorting tasks about the gendered performance of household and child care tasks, the investigator obtained quantitative data about family growth. The investigator looked for changes from baseline performance of a task. For instance, the mother initially performed the following tasks in the 1st year, but then in subsequent years the father took over doing the task or shared in doing the task with the mother. The percentages of families in which fathers demonstrated this pattern of

Table 5
Percentages of Families Affirming Certain Characteristics as Essential for Family Growth (*N* = 23)

Characteristic	*n*	%
Having shared communication	23	100
Growing in togetherness	23	100
Planning ahead	23	100
Helping the children become part of the family	23	100
Gaining inspiration from children	22	96
Relying on family values	22	96
Using coping strategies	22	96
Having social contact with extended family	21	91
Parents exerting joint effort	20	91
Family receiving professional guidance	14	61

growth occurred with respect to the following types of household tasks: make the beds, pay the bills (*n* = 7, 30%); return borrowed items (*n* = 6, 26%); and clean the kitchen, plan the menu, cook meals, sweep the floor, wash the dishes (*n* = 5, 22%). Likewise, the percentages of families in which mothers demonstrated this pattern of growth in assuming or sharing tasks previously performed only by fathers occurred with respect to the following household tasks: throw out the trash (*n* = 9, 39%), go for the mail (*n* = 7, 30%), water trees and shrubs (*n* = 6, 26%), and work in the garden (*n* = 5, 22%).

The percentages of families showing growth by fathers with respect to the child care tasks occurred with the following tasks: picking up the child's toys (*n* = 12, 52%); getting the bottle ready (*n* = 10, 43%); giving the child a bath (*n* = 9, 39%); and putting the child down to nap, making the child's bed, going with the child to the public health clinic (*n* = 7, 30%). Whereas mothers had performed all these tasks initially, by subsequent data collection periods fathers shared in doing the tasks or took over the tasks, but only the task of picking up the child's toys was shared in at least 50% of the families.

Conclusions

This longitudinal study of basic patterns of Mexican American family survival, continuity, and growth yields some interesting results and suggests direction for future research. First, these 23 Mexican American family systems in early family formation linked family survival to being healthy, being a united couple, having supportive parents, and having a steady job with minimal dependence on the government for additional resources. This parental perspective of what is essential for family survival is consonant with indicators of positive adaptation in the physical mode offered by Roy and Andrews (1999), that is, adequate participant capability (being healthy, being a united couple), adequate monetary resources (having a steady job, both parents work, government help), availability of physical facilities (supportive parents), and operational resources (having safe child care, having affordable child care). Second, family continuity is pervasive with respect to the continual pattern of performance of 25 of the 34 household tasks grounding family life. Maternal continuity in the performance of household tasks focused on tasks done inside of the house, and paternal performance focused on tasks done outside of the house. Both parents performed basic and age-related child care tasks. The data obtained by doing card-sorting tasks shed light on one of the indicators of positive adaptation in the role function mode, role clarity; however, these categorical data do not provide understanding about other indicators, such as accountability in role performance and effective processes of role transition (Roy & Andrews, 1999). Third, essential characteristics for family growth were shared communication, growing in togetherness, planning ahead, and helping the child become part of the family. The parental perspective coincides with positive indicators of adaptation in the group identity mode (Roy & Andrews, 1999), that is, effective interpersonal relationships (having shared communication, helping children become part of the family, planning ahead, using coping strategies, exerting joint effort, and relying on family values), supportive culture (having social contact with the extended family), positive morale (gaining inspiration from the children and growing in togetherness), and group acceptance (family receiving professional guidance).

Roy's (1983) model of the family as an adaptive system is useful for understanding patterns of survival of the family unit, the continuity of the patterns of the family system, and the emergent structural growth that ensues as family members respond to needs of other family members and to changing relationships in the family. This study has characterized Mexican American family survival, continuity, and growth among families in early family formation. The longitudinal design provides depth of detail about gendered performance of specific tasks across time. In working with similar families in clinical situations using Roy's model of the family, nurses can be confident in using these characteristics of family survival, continuity, and family growth as a foundation to start their discussion with a family about existing family goals and expected outcomes of nursing interventions that enhance family nurturing, support, or socialization.

The next step in this longitudinal study of family transitions is to assess parental concerns about the firstborn children making the transition to the community school system. One way that parental concerns might be lessened is by having the nurse work with the family to enhance family socialization within the community school system. The ef-

fectiveness of the nurse's efforts to enhance family socialization could be evaluated by observing the effect on family outcomes of continuity and growth. The foundation provided by the current study characterizing family survival, continuity, and growth provides baseline parameters for that measurement.

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The Lived Experience of Contentment: A Study Using the Parse Research Method

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The purpose of this study was to answer the research question, What is the structure of the lived experience of contentment? The participants were 10 women volunteers. The Parse research method, a phenomenological-hermeneutic method, was used to uncover the meaning of contentment. The major finding of this study is the structure: Contentment is a satisfying calmness amid the arduous as resolute liberty arises with benevolent engagements. The structure provides knowledge about contentment and its connection to health and quality of life. It is discussed in relation to the principles and concepts of human becoming and in relation to how it can inform future research and practice.

Contentment is a human experience inextricably intertwined with feeling satisfied, tranquil, and happy (Pearsall & Trumble, 1995). It is a satisfaction, a chosen way of being with the moment, that arises in the context of feeling satisfied–not satisfied with activities or endeavors that are cherished. Contentment "requires being who you are—no more and no less" (R. A. Johnson & Ruhl, 1999, p. 48). The experience of contentment is important to human health and quality of life. Knowing more about it will shed light on the meaning of quality of life for persons being served by health professionals—thus, the purpose of this research study was to answer the research question, What is the structure of the lived experience of contentment? and, in so doing, provide new knowledge about contentment as an experience of health and quality of life to guide further research and practice.

The importance of contentment to persons' perspectives of their health and quality of life is clearly articulated in the literature. For instance, there are a number of sources in which the authors report that good health, active engagement in social activities (Carp & Christensen, 1986; Hegland, 1994; Jacob & Guarnaccia, 1997; C. L. Johnson & Barer, 1992; Markides & Martin, 1979; Meyers & Diener, 1995; Nilsson, Ekman, Ericsson, & Winblad, 1996), self-efficacy, subjective well-being, and life satisfaction (Jacob & Guarnaccia, 1997; Schmotkin & Hadari, 1996) are connected, and perhaps synonymous, with contentment (Jacob & Guarnaccia, 1997). As well, having "peace of mind" is thought to be important to retaining health (Nystrom & Andersson-Segesten, 1990) and achieving spiritual well-being and is believed to be characterized by an inner harmony and contentment with life (Young, 1993). The connection of contentment with *peace of mind* and *inner harmony* is similar to R. A. Johnson and Ruhl's (1999) view that contentment, an inner experience, is a way of feeling at home honoring what is. It is further supported by other theoretical literature that has associated contentment with serenity and tranquility (Glick, 1951), pleasure (Ekiken, 1913/1979), and financial security (Galbraith, 1992).

Recognition of the importance of contentment to health and quality of life is also evident if one considers the availability and frequent use of a wide variety of tools that include some measure of contentment in their assessment of quality of life, health, or life satisfaction (Darling & McKoy-Smith, 1993; McKoy, 1996; Schmotkin & Hadari, 1996; Tkachuk, 1995). Kane (1985) even suggests that contentment should be considered an ideal outcome for elderly people. Kane believes that older persons should be relatively content—stating that achieving contentment would diminish currently unacceptable rates of depression, suicide, loneliness, and anxiety among this age group. Kane's view is supported by many authors who have used level of contentment as a variable to assess positive affect in nursing home residents with Alzheimer's disease (Lawton, VanHaitsma, & Klapper, 1996), as a variable to address when assessing marital relationships (Moroi, 1990), and as a measure of depression (see, for example, Attala, Oetker, & McSweeney, 1995; Courts & Boyette, 1998; Demers & Lavoie, 1996). Kane's view is also supported by the work of Lerner and Gignac (1992), who contend that most elderly persons are content, since they "describe themselves as leading useful lives with surprisingly little anxiety or depression" (p. 322).

Only 11 studies were found in which the phenomenon of concern was contentment (Attala et al., 1995; Bylsma & Major, 1994; Courts & Boyette, 1998;

Keywords: contentment, human becoming theory, Parse method

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Demers & Lavoie, 1996; Hirsch & Hirsch, 1995; Karaku, 1995; Kovacs, 1996; Kriedler, Campbell, Lanik, Gray, & Conrad, 1994; Lindgren, Svardsudd, & Tibblin, 1994; Lloyd-Cobb & Dixon, 1995; Pardeck & Chung, 1995). The findings of these various studies suggest that people's contentment with their health is related to life situation (Bylsma & Major, 1994; Lindgren et al., 1994), ability to live independently (Kriedler et al., 1994; Nilsson et al., 1996; Schmotkin & Hadari, 1996), and level of depression (Attala et al., 1995; Courts & Boyette, 1998; Demers & Lavoie, 1996; Hirsch & Hirsch, 1995; Kovacs, 1996; Lloyd-Cobb & Dixon, 1995; Pardeck & Chung, 1995).

To date, only one qualitative study of the phenomenon contentment has been reported. Karaku (1995) used Giorgi's phenomenological method to increase understanding about and to develop a conceptualization of *psychological well-being*—defined for the study as the experience of feeling exceptionally good. Feeling exceptionally good was distinguished from ordinary well-being, which, from Karaku's view, is equivalent to contentment. The 5 participants were asked to write descriptions of one episode of exceptional well-being. One of the participants was also asked to write a contrasting description of feeling very content so that Karaku could contrast the situated structure of feeling very content with the situated structure of feeling exceptionally good. Although contrasting the situated structures of two different phenomena is not consistent with any phenomenological research method, Karaku was otherwise true to Giorgi's methodological specifications. Participants described their experiences of feeling exceptionally good using phrases such as these: a relaxation of unnecessary effort and tension, a sense of rightness, a joyful pleasure, an unimagined ecstatic bliss, a deeply calm relaxation, a pleasurable responsiveness, a sense of unity with others and situation, a sense of flowing unity, a feeling of being at home, a noted absence of negative thinking, a sense of lightness and buoyancy, and a feeling of being able to relax. They also described being more spontaneous and peaceful and feeling a sense of wonder and profoundness.

Karaku (1995) said "feeling very content," a similar but less intense experience than feeling exceptionally good, was described by 1 participant as a familiar friend—an ordinary and common experience grounded in a sense of trust and tolerance for uncertainty that is accompanied by the joy of being engaged in a situation in which one feels a sense of accomplishment while being connected to and supported by others. Referring to the participant's description, Karaku says,

> The episodes of contentment were always in the context of a project to teach Tai Chi. They were in situations of engaged action and involved a sense of accomplishment and completion. . . . True happiness is an underlying steady state of contentment. [Contentment] involves an easeful attunement to the present moment. [It involves] a contrast with . . . tensing and . . . struggling. (pp. 113-114)

Karaku's findings about contentment are similar to those that emerged in several studies guided by human becoming (Parse, 1981, 1998).

Contentment has been clearly illuminated in the findings of seven previous research studies in which human becoming was the nursing perspective guiding the investigation (Parse, 1993, 1994a, 1996, 1997b; Parse, Coyne, & Smith, 1985; Takahashi, 1999; Toikkanen & Muurinen, 1999). The findings of these qualitative research studies were descriptions of laughing your heart out (Parse, 1993), laughing and health (Parse, 1994a), quality of life (Parse, 1996), joy-sorrow (Parse, 1997b), health (Parse et al., 1985, pp. 27-37), and hope (Takahashi, 1999; Toikkanen & Muurinen, 1999). In all of these studies on lived experiences related to health, participants mentioned in some way the feeling of contentment.

For example, Parse (1993) conducted a phenomenological study to uncover a structural definition of laughing with 30 persons older than 65. The structural definition of laughing was this: Laughing is a buoyant immersion in the presence of unanticipated glimpsings, prompting harmonious integrity that surfaces anew in contemplative visioning. The common element, harmonious integrity, is related to contentment. Harmonious integrity

> is the sense of being in tune with others and the universe. It is the feeling of calm that arises through a satisfying experience. Laughing cocreates such an experience. . . . [It] is expressed by participants [in ideas] related to calmness, openness, and feeling more relaxed. (p. 42)

The descriptions of being in tune with others and the universe, and the idea of a "feeling of calm" arising with a satisfying experience, are similar to the descriptions given by the participants in Parse's (1994a) investigation of laughing and health—descriptions that led to the extraction of the core concept emerging with blissful contentment.

In the Parse method study to uncover the structure of the lived experience of laughing and health with 20 men and women older than 65 years of age, Parse (1994a) reported that the structure of the lived experience of laughing and health was this: a potent buoyant vitality sparked through mirthful engagements prompting an unburdening delight deflecting disheartenments while emerging with blissful contentment. The final concept of the structure, blissful contentment, is the "creating anew which tells and does not tell all-at-once about cherished beliefs. . . . The cherished beliefs lived in the contentment are the treasured meanings given to the situation" (p. 61).

> Participants described clearly the desire to laugh, which they said lifted their spirits and made them feel good, peaceful, and satisfied with life. In the desire [to laugh] are the revealed and concealed cherished beliefs that arise in creating the contentment. (p. 61)

These findings are similar to others reported by Parse (1996, 1997b).

Parse (1996) conducted a descriptive-exploratory study of the meaning of quality of life for persons with Alzhei-

mer's disease. Twenty-five people with mild to moderate Alzheimer's disease were asked to describe their quality of life. They all spoke about quality of life in ways reflective of the peacefulness and satisfaction that accompany contentment. The theme, contentment with the remembered and now affiliations arises amid the tedium of the commonplace,

> surfaced in discussions with all participants as they talked about how their lives now compared to how they used to be. Their conversations reflected an appreciation for family and old and new friends as they described the humdrum of everyday by sharing the details about unchanging routines. (p. 130)

Parse (1997b) conducted a phenomenological-hermeneutic Parse method study on the lived experience of joy-sorrow with 11 women older than age 65. The structure of the lived experience of joy-sorrow was found to be pleasure amid adversity, emerging in the cherished contentment of benevolent engagements. Cherished contentment, the second core concept in the structure of the lived experience of joy-sorrow, was described as "the gladness that emerges in accomplishing something that is treasured" (p. 85). The contentedness for the participants in Parse's study was

> the lightness of satisfactions that arose in considering the cherished of the moment while living the joys and sorrows of everydayness. What was cherished was clear in the choosings of the participants as they moved with activities that were fulfilling, confirming certain values and not confirming others. . . . The participants' descriptions reflected satisfactions with activities they chose . . . [and] while all participants suggested that joys and sorrows arose together in situations, they turned to activities they cherished in reaching contentment. (p. 85).

Parse et al. (1985) reported a phenomenological investigation of the lived experience of health. Following analysis of the descriptions given by 400 participants, a hypothetical definition of health was created: Health is harmony sparked by energy leading to plentitude. The participants' descriptive expressions that led to the extraction of the common element harmony support that harmony, for the participants in this study, is similar to the concept contentment. Participants spoke about "feeling all is going well," "feeling relaxed," experiencing a "sense of well-being," and being "happy, relaxed, and relieved." They described "being at ease," "feeling peaceful," "feeling light inside," and having a "general sense of everything right . . . a certain serenity."

Finally, findings from two Parse method studies on the lived experience of hope (Takahashi, 1999; Toikkanen & Muurinen, 1999) shed light on the phenomenon contentment. Takahashi (1999) reported that the structure of the lived experience of hope for 10 Japanese participants is an anticipation of expanding possibilities, while liberation amid arduous restriction arises with the contentment of desired accomplishments. The core concept, contentment of desired accomplishments, was said to incarnate the concept valuing. Similarly, Toikkanen and Muurinen (1999) reported that the lived experience of hope is persistent anticipation of contentment arising with the promise of nurturing affiliations, while inspiration emerges amid easing the arduous. The core concept, persistent anticipation of contentment, related to the interpretation that their 10 participants from Finland experienced hope in ways reflective of their actively seeking contentment—of wanting wishes to come true.

In summary, the phenomenon contentment was referred to in some way in each of the human becoming studies mentioned above. There are similarities in how contentment is alluded to in each of the reports. For instance, in several investigations (Parse, 1993, 1994a, 1996, 1997b; Parse et al., 1985) contentment surfaced as feeling calm, relaxed, at ease, good, or satisfied. In others, peacefulness and serenity were associated with feeling content (Parse, 1994a, 1996; Parse et al., 1985). In several of the studies, contentment was connected with participants' descriptions of the fulfillment and satisfaction arising with either achieving or striving for what they cherished (Parse, 1994a, 1997b; Takahashi, 1999; Toikkanen & Muurinen, 1999).

To date, there has been no work published that specifically studies contentment from a human becoming perspective, and there is no evidence of research to uncover the meaning of the lived experience of contentment, or to describe a structure of contentment, even though the research literature clearly points to its importance for health and quality of life. The knowledge gained from this research expands the human becoming theory and may be used to guide the research and practice of health professionals with persons in their homes and in healthcare settings.

Nursing Perspective

Human becoming is the nursing theory that guided this study (Parse, 1981, 1998). From this perspective, contentment is a feeling of peacefulness in the context of everyday struggles as meaning is structured with the cocreating rhythms of cotranscending with the possibles. Contentment is the speaking–being silent and moving–being still in the pushing-resisting of creating anew in light of the certainty-uncertainty of conforming–not conforming. The explicit-tacit of the familiar-unfamiliar is transformed through choosing tranquil ways of becoming in the moment that disclose-hide value priorities, as imaged projects affirm and do not affirm opportunities-restrictions. Contentment is a chosen way of being with the universe and important to health and quality of life.

Quality of life, from the human becoming perspective, is "what the person there living the life says it is" (Parse, 1994b, p. 17), and the individual and family are considered the experts on health (Parse, 1990, 1994b). Quality of life is what life is like for people. It is the "whatness . . . or the essence of life" (Parse, 1994b, p.17). It is about meaning and values, desires and dreams, rela-

tionships and plans, concerns and fears. Persons' experiences of quality of life guide decisions about health (Parse, 1990, 1994b).

The human becoming theory (Parse, 1981, 1998) posits the notion that each human being lives in unique ways. Contentment is the personal meaning that one gives to a situation in cocreating rhythms of relating while moving beyond the meaning moments of the now with the not-yet. Contentment is a universal lived experience that can be described by persons willing to share their experiences.

Participant Selection and Protection of Participants' Rights

This study was approved by an institutional review board for the protection of human participants. Participant selection involved inviting persons to participate in the study who were willing to speak about contentment—a universal lived experience of health that all individuals are able to describe. Ten women older than 65 agreed to participate. They were all persons who volunteer in community projects in a large metropolitan setting in North America. The participants met with the principal investigator in a convenient setting conducive to private discussion. They all signed a consent form, and standard measures were taken to protect their rights.

Method

The phenomenological-hermeneutic Parse research method (Parse, 1987, 1995, 1998, 2001) was used. This method is unique to the discipline of nursing, and it evolves from the ontology of the human becoming school of thought (Parse, 1981, 1987, 1992, 1995, 1997a, 1998)—the nursing perspective that guided this study. The purpose of the Parse research method is to discover the structure of universal lived experiences of health, such as contentment, through several processes.

Dialogical engagement is the unique researcher-participant dialogue that is not an interview but, rather, a true presence. The researcher, in true presence, engaged in a dialogue about contentment with each participant. The dialogues began with the researcher asking the participants to speak about their experiences of contentment. The researcher was then attentive to each participant's description. No other questions were asked, although participants were often encouraged to say more about some things or to speak about how something they said related to their experiences of contentment. The dialogues lasted from 30 to 60 minutes. They were audiotaped and transcribed to typed format for the extraction-synthesis process.

Extraction-synthesis is the process of moving the descriptions from the language of the participants across levels of abstraction to the language of science (Parse, 1987, 1990, 1992, 1995, 1997a, 1998). These transformational shifts in levels of abstraction occur through dwelling with the transcribed dialogues. Dwelling with is a way of centering during which the researcher becomes fully immersed in the description that was shared by the participant. For this study, the researcher spent time contemplating the transcribed dialogues about contentment—which required both reading the transcribed dialogues and listening to the dialogues on tape all at once. The researcher was immersed with the dialogue in the extraction-synthesis process (Parse, 1987, 1995). The extraction-synthesis process includes the following:

1. Constructing a story that captures the core ideas about contentment from each participant's dialogue.
2. Extracting-synthesizing essences from transcribed descriptions in the participants' language. The essences are succinct expressions of the core ideas about contentment described by the participants.
3. Synthesizing-extracting essences in the researcher's language. These essences are expressions of the core ideas conceptualized by the researcher at a higher level of abstraction.
4. Formulating a proposition from each participant's description. A proposition is a non-directional statement conceptualized by the researcher joining the core ideas of the essences. The essences arise directly from the participants' descriptions.
5. Extracting-synthesizing core concepts from the formulated propositions of all participants. Core concepts are ideas (written in phrases) that capture the central meaning of the propositions.
6. Synthesizing a structure of the lived experience from the core concepts. A structure is a statement conceptualized by the researcher joining the core concepts. The structure as evolved answers the research question, What is the structure of this lived experience? (Parse, 1998, p. 65)

Heuristic interpretation involves two processes: structural transposition and conceptual integration (Parse, 1987, 1998). Structural transposition is moving the structure of the lived experience up another level of abstraction. Conceptual integration further specifies the structure of the lived experience at the level of the theory. The finding of the study is the structure of the lived experience as discovered through the processes of dialogical engagement and extraction-synthesis (Parse, 1998).

In the next section, the stories of 3 of the 10 women participants, along with propositions for all of the participants (see Table 1), the core concepts, the structure, and the heuristic interpretation are presented (see Table 2).

Myra's Story

Myra, director of a non-profit organization, is married to a man who was going blind during their courtship and is now legally blind. She says, "We lost his sight together—and then we got married." Her first husband of 46 years died what she describes as a tragic death. She says her daughter, who lives at a great distance, is angry about her marriage, but her son, who also recently remarried, is close to her. Myra says, "Contentment is feeling good about life. . . . It is being OK where you are, no matter where you are. Contentment can be what you make yourself to be, what you make of your surroundings." She says,

"If you don't have pheasant under glass, enjoy peanut butter and jelly." She says she has "good things and bad things" but is very fortunate. She didn't realize how lonely she was until she was married again to a "dear and caring husband." She says, "To once again have somebody who cares, who knows when I come home, who cares when I come home—I feel that is contentment." Myra's 92-year-old mother is now in a nursing home and this is a "great stress," but "it is contentment because she is making this so easy. She talks about everything and cares about everything. Contentment is, I can handle it—what I have on my plate—and life is very lovely."

Essences: Participant's Language

1. Contentment is feeling good about life—being OK no matter where you are. It feels right; it is good to get up in the morning and go to sleep tired. It's what you make yourself to be. If you don't have pheasant under glass, enjoy peanut butter and jelly.
2. Contentment is having someone care about you, and caring about family and friends even though there are some stressful family situations.

Essences: Researcher's Language

1. Satisfaction arises with the fortifying liberty of appreciating everydayness.
2. Comfort emerges amid the arduous with benevolent affiliations.

Proposition

Contentment is satisfaction arising with the fortifying liberty of appreciating everydayness, as comfort emerges amid the arduous with benevolent affiliations.

Judith's Story

Judith has two children, her husband is dead, and she is now close to her brother and sister. Though she was sad about her husband's death and now about her daughter's depression, she is contented because she can keep on going. She says contentment "just runs through" her and she feels good and has a wonderful life. She believes that it is in the genes from her parents. She says contentment is exhilarating and gives her confidence to push away anything that is negative. She has many friends because she is a good listener. Judith says contentment is doing what she wants to do and she enjoys being alone but is not a loner. She is happy being an individual, not going along with what others do.

Essences: Participant's Language

1. Contentment is a good feeling about having a wonderful life. It is exhilarating and gives the participant confidence to push away anything negative and do what she wants to do.
2. Contentment is not going along with what others do, yet being close to friends and family.

Essences: Researcher's Language

1. Enlivening satisfaction emerges with resolute certitude in fortifying the now amid adversity.
2. Gladness arises with the prized liberty of intimate engagements.

Proposition

Contentment is an enlivening satisfaction emerging with resolute certitude in fortifying the now amid adversity, as gladness arises with the prized liberty of intimate engagements.

Marianne's Story

Marianne says contentment is waking up in the morning and being able to get out of bed without problems. She has had problems, a brain operation and the death of her husband, but she has learned to be content on her own and fill her life. She takes care of her grandson, quilts, goes to the spa, line dances, attends classes given by a psychologist, and has taken some modeling classes so she can "get up and speak to people." She says, "Contentment to me is just being able to move around and do things you have to do and get your house cleaned and wash the dishes and get the clothes going and that is good." Contentment is "happiness that you have in your life and when your house is all nice and clean and sparkling." Marianne walks, watches TV, and listens to music. She likes to cook: "Chicken soup is contentment." She is contented that her grandson says that she is his life. She meets with her four sisters at least once a year for a celebration. She says she thinks positive thoughts and tries not to think negatively—and that is contentment. To do what you want to do is wonderful contentment according to Marianne. She likes to watch the sun set over the river near her mobile home—"that's contentment—just a piece of heaven. Contentment is when you make a birthday cake for your kids, and they come out and sing 'Happy Birthday.' "

Essences: Participant's Language

1. Contentment is waking up and being able to do the things you have to do and want to do and not thinking negatively. It is watching the sun set over the river and the happiness that comes when the house is clean and sparkling.
2. Contentment is celebrating with her sisters and taking care of a grandson. It's singing "Happy Birthday" with the kids after making a cake.

Essences: Researcher's Language

1. Enlivening satisfaction arises amid potential adversity with the wonderment of prized liberty.
2. Gladness emerges with joyful intimate engagements.

Proposition

Contentment is an enlivening satisfaction arising amid potential adversity with the wonderment of prized liberty, as gladness emerges with joyful intimate engagements.

Discussion of Findings

The finding of this study is the structure: Contentment is a satisfying calmness amid the arduous as resolute liberty arises with benevolent engagements. The structural transposition is "Contentment is a fulfilling tranquility amid the disquieting as an unwavering reliance arises with solicitous involvements." The conceptual integration is "Contentment is valuing the powering of connecting-separating" (see Table 1).

Satisfying Calmness Amid the Arduous

The first core concept, satisfying calmness amid the arduous, arose as

Table 1
Propositions for All Participants

Participant	Proposition
Myra	Contentment is satisfaction arising with the fortifying liberty of appreciating everydayness, as comfort emerges amid the arduous with benevolent affiliations.
Joan	Contentment is a genuine calm amid the arduous, emerging with the joy of resolute liberty, as satisfaction arises with benevolent engagements.
Judith	Contentment is an enlivening satisfaction emerging with resolute certitude in fortifying the now amid adversity, as gladness arises with the prized liberty of intimate engagements.
Angela	Contentment is an uplifting satisfaction amid the arduous arising with liberating enterprises, as gladness emerges with cherished engagements.
Marianne	Contentment is an enlivening satisfaction arising amid potential adversity with the wonderment of prized liberty, as gladness emerges with joyful intimate engagements.
Janet	Contentment is joyful satisfaction emerging with enlivening engagements, as gladness arises with the liberty of gratifying pleasures amid remorse.
Jeanine	Contentment is a satisfaction emerging with the wholesome easiness of a liberating deliberateness, as gratifying enjoyment arises with the pleasure of intimate engagements amid unsure possibilities.
Elizabeth	Contentment is a gratifying calm amid adversity arising with spirited enterprises, as satisfaction emerges with the liberating benevolence of devoted engagements.
Anna	Contentment is a calm satisfaction arising with the liberty of rewarding benevolent engagements, as serene pleasure emerges with unencumbered ease.
Julie	Contentment is the liberating satisfaction arising with enlivening enterprises amid potential adversity, as calm surfaces with unique benevolent engagements.

participants spoke of feeling good and peaceful, even though there are stressful situations in everyday life. One participant said, "Contentment is a peaceful feeling," but she said she gets upset about things sometimes. Another participant said she lets upsetness slide by and relaxes and thinks of things that do not bother her. Another participant said she was content with her life, even when anticipating a drastic change in a relationship. Yet another participant said, "I am content . . . when everything is running smoothly." One person said being content is "accomplishing something worthwhile even if it may be difficult." Another illustration of satisfying calmness amid the arduous arose with a participant who said that contentment is exhilarating and gives her confidence to push away anything that is negative. These ideas from the participants' descriptions illustrate the structural transposition as a sense of fulfilling tranquility that arises amid disquieting situations in the confirming–not confirming of values. The conceptual integration of "satisfying calmness amid the arduous" as "valuing" sheds light on the meaning of choosing a cherished calmness even in the presence of obstacles. Valuing is a concept from the first principle of human becoming (Parse, 1998). It is the confirming–not confirming of cherished beliefs. From among myriad options people make choices that incarnate value priorities. These priorities are the structured meaning that confirms contentment as a satisfying calmness amid the arduous. For participants in this study, this satisfying calmness arose with a resolute liberty, which is the second core concept surfacing in the participants' descriptions.

Resolute Liberty

Resolute liberty, a determined independence, surfaced in all participants' descriptions of contentment. Participants were unwavering in affirming their self-reliance. Statements like "being able to do what I want to do" and "keeping busy on my own" were prevalent in the descriptions. One participant said, "I can handle it—what I have on my plate." Another participant said that being independent is most important to contentment. Another participant said she enjoys being alone and not going along with others. All of these statements show that for these participants, independence is important for contentment and thus to health and quality of life.

Resolute liberty is structurally transposed to *unwavering reliance* and conceptually integrated as *powering*. Powering, a concept from the third principle of human becoming, is the pushing-resisting rhythm of affirming–not-affirming being with non-being (Parse, 1998). Living being with non-being is incarnating the known of the now and the seeming unknown potential of the not-yet. The resolute liberty of contentment expressed by the participants in this study is affirming being through deliberately engaging in enterprises such as volunteer work, line dancing, cleaning, shoveling snow, playing cards, and others that illuminated their strong desire to promote their independence. The resolute liberty arose with benevolent engagements.

Benevolent Engagements

Benevolent engagements is the third core concept surfacing from the participants' descriptions. All participants described relationships with others when asked to talk about contentment. They told of being with their many friends, celebrating with sisters, taking care of their children, having loving and caring spouses or friends, helping family, and sharing with others. The participants' descriptions specified the engagements of contentment as benevolent, loving, and intimately close as they unfolded in

Table 2
Progressive Abstraction of the Core Concepts of the Lived Experience of Contentment

Core Concept	Structural Transposition	Conceptual Integration
Satisfying calmness amid the arduous	Fulfilling tranquility amid the disquieting	Valuing
Resolute liberty	Unwavering reliance	Powering
Benevolent engagements	Solicitous involvements	Connecting-separating

Structure
Contentment is a satisfying calmness amid the arduous as resolute liberty arises with benevolent engagements.

Structural transposition
Contentment is a fulfilling tranquility amid the disquieting as an unwavering reliance arises with penetrating involvements.

Conceptual integration
Contentment is valuing the powering of connecting-separating.

day-to-day happenings with others. The core concept benevolent engagements is structurally transposed as *solicitous involvements* and integrated conceptually as *connecting-separating*. Connecting-separating, a concept of the second principle of human becoming, is the paradoxical rhythm of being with and away from others, ideas, objects, and events (Parse, 1998). The participants spoke of being with and away from close others. Although they appreciated their time with others, they also liked being alone.

Findings and Related Literature

The finding of this study, the structure—contentment is a satisfying calmness amid the arduous as resolute liberty arises with benevolent engagements—contributes knowledge about contentment to the extant literature. Two of the core concepts surfacing from the participants' descriptions in some way arose in the literature on contentment. Satisfying calmness, for example, is alluded to in the theoretical literature (Allestree, 1677; Glick, 1951; Nystrom & Andersson-Segesten, 1990; Pearsall & Trumble, 1995; Young, 1993) that connects contentment with being abundantly satisfied (Allestree, 1677), serenity and tranquility (Glick, 1951), peace of mind (Glick, 1951; Nystrom & Andersson-Segesten, 1990), and inner harmony (Young, 1993). Contentment was also connected with ideas similar to satisfying calmness in several recent studies (Bylsma & Major, 1994; Karaku, 1995; Lindgren et al., 1994; Parse, 1993, 1994a, 1996, 1997b; Parse et al., 1985; Takahashi, 1999; Toikkanen & Muurinen, 1999). No literature specified "amid the arduous," but some authors (Attala et al., 1995; Courts & Boyette, 1998; Demers & Lavoie, 1996; Hirsch & Hirsch, 1995; Kane, 1985; Kovacs, 1996; Lawton et al., 1996; Lloyd-Cobb & Dixon, 1995; Pardeck & Chung, 1995) did say contentment is related to diminished chances of depression, loneliness, and anxiety.

The core concept benevolent engagements was alluded to in the theoretical literature on contentment (Hegland, 1994; Jacob & Guarnaccia, 1997; Markides & Martin, 1979; Meyers & Diener, 1995) and in some research studies (C. L. Johnson & Barer, 1992; Karaku, 1995; Kovacs, 1996), but not to the extent that it was described in this study. For example, in the Karaku (1995) study, participants described feeling exceptionally good as a sense of unity with others, which connects to some statements by participants in this study who talked about a sense of caring in relationships.

The concept resolute liberty was not explicitly found in the theoretical literature or the research literature on contentment. Three authors (Kriedler et al., 1994; Nilsson et al., 1996; Schmotkin & Hadari, 1996) did connect contentment with the ability to live independently; however, descriptions of contentment as the determination and resolve to live independently were not found. The participants in this study strongly indicated in their descriptions the importance of independence. Their unwavering self-reliance was expressed in the determination they had for carrying out activities and living alone.

New Knowledge

The unique knowledge about contentment found in this study follows:

1. Contentment is a satisfying calmness, but it is lived amid potential or remembered adversity.
2. Contentment arises with benevolent engagements with family and friends.
3. Resolute liberty, as an unwavering determination to be independent, is integral to contentment.

Recommendations

From the new knowledge and to further the line of inquiry on contentment related to health and quality of life, studies may be conducted on several phenomena, for example, feeling calm, feeling peaceful, feeling independent,

feeling dependent, and feeling alone. Research on these phenomena and others will expand understanding about human becoming.

Summary

This study on contentment with 10 women older than 65 years of age adds new knowledge to the general literature on contentment and its connection to health and quality of life and expands understanding of human becoming. The findings lay the foundation for further research on the essences of contentment. New knowledge about human experiences offers nurses and other health professionals ways to understand and be with people living their health and quality of life (Parse, 1981, 1998).

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Using Conceptual Models of Nursing to Guide Nursing Research: The Case of the Neuman Systems Model

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Conceptual models of nursing inform thinking and give meaning and direction to nursing research. The Neuman systems model is used to exemplify the following five steps, which provide specific direction for conceptual model–based research: (a) Develop a comprehensive understanding of the substantive content and research rules of the conceptual model, (b) review existing research guided by the conceptual model, (c) construct a conceptual-theoretical-empirical structure, (d) clearly communicate the conceptual-theoretical-empirical structure, and (e) conclude the report with an evaluation of the empirical adequacy of the middle-range theory and the credibility of the conceptual model.

The purpose of this article is to explain how a conceptual model can be used to guide nursing research, using the Neuman systems model (NSM) as the example. The article was motivated by a concern about the relative paucity of published research reports that include specification of the conceptual model that guided the study. The content of the article reflects our belief that it is impossible to conduct research in a conceptual vacuum, which is in keeping with Popper's (1965) statement that it is "absurd" (p. 46) to assume that theory development proceeds outside the context of a conceptual frame of reference. The article also reflects our belief that it is important to explicitly identify the conceptual context for every study. That belief is in keeping with Hempel's (1970) statement that "the specification of the model determines in part what consequences may be derived from the theory and, hence, what the theory can [describe,] explain or predict" (p. 157). Moreover, explicit identification of the conceptual model places the research within its intended intellectual and sociohistorical context (Lavee & Dollahite, 1991).

Definition and Functions of a Conceptual Model

A conceptual model is a set of relatively abstract and general concepts that address the phenomena of central interest to a discipline, the nonrelational propositions that broadly define those concepts, and the relational propositions that state relatively abstract and general linkages between two or more of the concepts (Fawcett, 2000). Each conceptual model provides a distinctive frame of reference—a "horizon of expectations" (Popper, 1965, p. 47)—and "a coherent, internally unified way of thinking about . . . events and processes" (Frank, 1968, p. 45). Thus, each conceptual model provides a different cognitive orientation or lens for viewing the phenomena that are within the domain of inquiry of a particular discipline. Each conceptual model also provides different epistemic and methodological rules about how the model can be used in the real world of research, including the following: the purposes to be fulfilled by the research; the phenomena to be studied; the nature of the problems to be studied; the source of the data (individuals, groups, animals, documents); the research designs, instruments, and procedures to be employed, as well as the settings in which data are to be gathered; the methods to be employed in reducing and analyzing the data; and the nature of contributions that the research will make to the advancement of knowledge (Laudan, 1981; Schlotfeldt, 1975).

Using a Conceptual Model to Guide Research

The discipline of nursing currently is informed by several widely recognized conceptual models (Fawcett, 2000). The researcher must select the one conceptual model that provides the desired context for the research. The NSM, for example, provides clear direction for the researcher who is interested in describing stressors; explaining the factors that influence reactions to those stressors; and testing the effects of primary, secondary, and tertiary prevention on stressor reactions within the context of a holistic, open systems perspective.

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Table 1
Using an Explicit Conceptual Model to Guide Research

Step Number	Explanation
1	Develop a comprehensive understanding of the substantive content and research rules of the conceptual model.
2	Review existing research guided by the conceptual model.
3	Construct a conceptual-theoretical-empirical structure.
	Select middle-range theory concepts that are in keeping with the content of the conceptual model.
	Select research methods that clearly reflect the content of the conceptual model.
4	Clearly communicate the conceptual-theoretical-empirical structure in written proposals and reports of study findings.
	Identify the conceptual model as the underlying guide for the study.
	Discuss the conceptual model in sufficient breadth and depth so that the relation of the model to the middle-range theory and the empirical research methods is clear.
	Clearly state the linkages between the relevant conceptual model concepts and the middle-range theory concepts.
	Clearly state the linkages between the relevant conceptual model concepts and propositions and the study aims and/or hypotheses.
	Present a diagram of the conceptual-theoretical-empirical structure for the study.
5	Conclude the report of research findings with an evaluation of the empirical adequacy of the middle-range theory that was generated or tested and the credibility of the conceptual model.

Once the researcher selects the conceptual model, five steps are followed to clearly and explicitly integrate that model into the research proposal and final report. Those steps are listed in Table 1.

Step 1

The first step in using an explicit conceptual model to guide research is development of a comprehensive understanding of the substantive content and research rules of that model.

Substantive Content

Understanding the substantive content of a conceptual model, including the concepts, the nonrelational propositions that define those concepts, and the relational propositions that link two or more concepts, is accomplished by reading all the primary source materials—books, book chapters, and journal articles—written by the author of the model. Careful reading is necessary because the concepts and propositions frequently are deeply embedded in the text. The substantive content of the NSM is presented in Table 2.

Research Rules

Ideally, the author of the conceptual model has specified the research rules. However, as Gibbs (1972) noted, that level of detail in the author's articulation of a conceptual model is rare. Thus, users of the conceptual model must extract the rules from the primary source materials and examine secondary sources for any rules that might have been formulated by others, based on their interpretations of the original work. The interpretations in the secondary sources should, of course, be evaluated critically. Drawing from primary and secondary sources, Fawcett (2000) formulated research rules for the NSM that include Gigliotti's (1997) proposal for specific statistics to test the NSM relational propositions (see Table 3).

Step 2

The second step in using an explicit conceptual model to guide research involves a review of the existing research that has been guided by a particular conceptual model. Citations to relevant research may be found in print and online databases, such as the *Cumulative Index to Nursing and Allied Health Literature, Index Medicus* (Medline), and *Dissertation Abstracts International*. In addition, citations to relevant research are available in secondary sources, such as Fawcett's (2000) book, or from societies and centers devoted to the study of particular conceptual models. For example, a bibliography of NSM-based research is available from the Neuman Systems Model Archives at Neumann College in Aston, Pennsylvania.

A review of the existing research guided by the conceptual model is important for three reasons. First, the research review points the way to the design of studies that will fill gaps in or extend knowledge. For example, in a recent review of the NSM-based research literature, Gigliotti (2001) noted that several NSM-based theory-generating studies revealed "what is" and pointed the way to theory-testing research. Theory-testing studies also point the way to additional research. For example, Glazer's (1984) NSM-based study revealed that the anxiety experienced by a pregnant woman's partner (a stressor for the woman) was positively related to the woman's own anxiety (invasion of her normal line of defense). A future study could focus on examination of the variables in the flexible line of defense that moderate the stressor. In sum, the research review facilitates the development of an organized program of research.

Second, the researcher can identify what is known about a particular conceptual model concept and how it is used in various studies. For example, several investigators have grouped stressors experienced by diverse populations within the NSM categories of intrapersonal, interpersonal, and extrapersonal stressors.

Third, a conceptual model–based literature review allows the researcher to identify the statistical techniques that have been used to test relations between two or more concepts of the model. Identification of the statistics used by other researchers to test relational prop-

Table 2
Overview of the Neuman Systems Model: Concepts, Nonrelational Propositions (Definitions), and Relational Propositions

Concept	Nonrelational Proposition
Client/client system	An individual, a family, a community, or a social issue, which is regarded as "a composite of variables (physiological, psychological, sociocultural, developmental and spiritual) . . . composed of a [central] core or basic structure of survival factors and surrounding protective concentric rings" (Neuman, 1995, p. 45).
Flexible line of defense	"A protective, accordion-like mechanism [concentric ring] that surrounds and protects the normal line of defense from invasion by stressors" (Neuman, 1995, p. 46).
Normal line of defense	The concentric ring that represents the client/client system's normal or usual wellness level (Neuman, 1995).
Lines of resistance	The concentric rings that represent "certain known and unknown internal and external resource factors [that] protect the basic structure [central core]" (Neuman, 1995, pp. 30, 46).
Central core	The basic structure of the client system that "consists of common survival factors, as well as unique individual characteristics . . . [and] basic system energy resources" (Neuman, 1995, p. 45).
Internal environment	"Consists of all forces or interactive influences internal to or contained solely within the boundaries of the defined client/client system" (Neuman, 1995, p. 31).
External environment	"Consists of all forces or interaction influences external to or existing outside the defined client/client system" (Neuman, 1995, p. 31).
Created environment	"An unconsciously developed protective environment that binds system energy and encompasses both the internal and external client environments" (Neuman, 1995, p. 45).
Stressors	"Tension producing stimuli or forces occurring both within the internal and external environmental boundaries of the client/client system" (Neuman, 1995, p. 23).
Intrapersonal	"Internal environmental forces occurring within the boundary of the client/client system" (Neuman, 1995, p. 23).
Interpersonal	"External environmental forces occurring outside the boundaries of the client/client system at proximal range" (Neuman, 1995, p. 23).
Extrapersonal	"External environmental interaction forces occurring outside the boundaries of the client/client system at distal range" (Neuman, 1995, p. 23).
Optimal system stability	"The best possible wellness state at any given time" (Neuman, 1995, p. 32).
Variances from wellness	Refers to "varying degrees of system instability" (Neuman, 1995, p. 33) or "the difference from the normal or usual wellness condition" (Neuman, 1995, p. 39).
Reconstitution	"Return and maintenance of [client] system stability, following treatment of stressor reaction, which may result in a higher or lower level of wellness than previously" (Neuman, 1995, p. 46).
Primary prevention as intervention	"Used for wellness retention, that is, to protect the client system normal line of defense or usual wellness state by strengthening the flexible line of defense. The goal is to promote client wellness by stress prevention and reduction of risk factors . . . [and to] reduce the possibility of stressor encounter or in some manner attempt to strengthen the client's flexible line of defense to decrease the possibility of a reaction" (Neuman, 1995, p. 33).
Secondary prevention as intervention	"Used for wellness attainment, that is, to protect the basic structure by strengthening the internal lines of resistance. The goal is to provide appropriate treatment of symptoms to attain optimal client system stability or wellness and energy conservation" (Neuman, 1995, p. 34).
Tertiary prevention as intervention	"Used for wellness maintenance, that is, to protect client system reconstitution or return to wellness following treatment [i.e., following secondary prevention as intervention]. . . . The goal is to maintain an optimal wellness level by supporting existing strengths and conserving client system energy" (Neuman, 1995, p. 35).
	Relational propositions
Stressors, flexible line of defense, and normal line of defense	
	"Each [stressor] differs in its potential for disturbing a client's usual stability level, or normal line of defense. The particular interrelationships of client variables [in the flexible line of defense] at any point in time can affect the degree to which a client is protected by the flexible line of defense against possible reaction to a single stressor or a combination of stressors" (Neuman, 1995, pp. 20-21).
	"When the . . . flexible line of defense is no longer capable of protecting the client/client system against an environmental stressor, the stressor breaks through the normal line of defense. The interrelationships of variables [in the flexible line of defense] determine the nature and degree of the system reaction . . . to the stressor" (Neuman, 1995, p. 21).
Stressors, normal line of defense, and lines of resistance	
	"[The lines of resistance] are activated when stressors have penetrated the normal line of defense, causing a reaction symptomatology" (Neuman, 1995, p. 46).
Normal line of defense, lines of resistance, and central core	
	"The lines of resistance protect the basic structure [central core]" (Neuman, 1995, p. 26).
	"Effectiveness of the lines of resistance in reversing reaction to stressors allows the system to reconstitute; ineffectiveness leads to energy depletion and death [central core response]" (Neuman, 1995, p. 30).

ositions of interest is an enormous aid to the researcher faced with the challenge of testing a complex model. Indeed, possibilities, as well as problems and pitfalls, can be uncovered during the review.

Step 3

The third step in using an explicit conceptual model to guide research in-

Table 3
Rules for Neuman Systems Model–Based Research

NSM Rules	Generic
Purpose of the research	To predict the effects of primary, secondary, and tertiary prevention interventions on retention, attainment, and maintenance of client system stability and to determine the cost, benefit, and utility of prevention interventions.
Phenomena of interest	The physiological, psychological, sociocultural, developmental, and spiritual variables; the properties of the central core of the client system; the properties of the flexible and normal lines of defense and the lines of resistance; the characteristics of the internal, external, and created environments; the characteristics of intrapersonal, interpersonal, and extrapersonal stressors; and the elements of primary, secondary, and tertiary prevention interventions.
Problems to be studied	Those dealing with the impact of stressors on client system stability with regard to physiological, psychological, sociocultural, developmental, and spiritual variables, as well as the lines of defense and resistance.
Source of data	Individuals, families, groups, communities, organizations, or collaborative relationships between two or more individuals.
Research methods	Inductive and deductive research designs, using qualitative and quantitative approaches and associated instrumentation. Data from the client system and the investigator, collected in inpatient, ambulatory, home, and community settings.
Data analysis	Data analysis techniques associated with both qualitative and quantitative methodologies; quantitative techniques should consider the flexible line of defense as a moderator variable and the lines of resistance as a mediator variable.
Contributions	Research findings advance understanding of the influence of prevention interventions on the relation between stressors and client system stability.

volves construction of a conceptual-theoretical-empirical (C-T-E) structure for the proposed study. Construction of the C-T-E structure is facilitated by listing all of the conceptual model concepts and propositions (see Table 2 for the NSM concepts and propositions).

The list of conceptual model concepts and propositions guides the review of the theoretical and empirical literature about the research topic and also provides direction for the potential expansion of that topic. Suppose, for example, that a researcher was interested in studying individuals' reactions to a stressor, such as a life-threatening disease. The NSM would direct the researcher to consider examining reactions within the context of the physiological, psychological, sociocultural, developmental, and spiritual variables. The NSM also would direct the researcher to examine the ability of the flexible line of defense to moderate the stressor and prevent invasion of the normal line of defense. Or, if the normal line of defense had already been invaded, the researcher would instead be directed to examine the ability of the lines of resistance to mediate or come between the initial stressor reaction and the central core reaction.

Thus, the conceptual model's concepts and propositions (the C of the C-T-E structure) direct the researcher to the relevant literature. The literature then is used as the basis for identification of the particular middle-range theory concepts that will be studied (the T of the C-T-E structure) and the empirical research methods (sample, research design, instruments, data collection procedures, and data analysis techniques) that operationalize the middle-range theory concepts (the E of the C-T-E structure).

In theory-generating studies, the conceptual model influences the research design by guiding the selection of empirical research methods and the interpretation of the new middle-range theory that emerges from the data. In this type of research, theory generation proceeds from the conceptual model directly to the empirical research methods (═). The data obtained from the empirical research methods then are analyzed and a new middle-range theory emerges (. . .) (see Figure 1).

The C-T-E structure for an NSM-based theory-generating study is illustrated in Figure 2. As can be seen, Cava (1992) used a semistructured interview guide, which she derived from the NSM Assessment and Intervention Guide (Neuman, 1989), to collect data. She then formulated a middle-range theory of coping strategies used by long-term cancer survivors from a content analysis of the data.

In theory-testing studies, the conceptual model influences the research design by guiding the derivation of the middle-range theory and the selection of the empirical research methods used to test that theory. Thus, theory testing proceeds from the relevant conceptual model concepts and propositions to the middle-range theory concepts and propositions (═) and then to the empirical research methods (. . .) (see Figure 3). The data obtained from the empirical research methods are analyzed by following the relevant conceptual model research rule, and the middle-range theory is supported or refuted.

The C-T-E structure for an NSM-based theory-testing study is illustrated in Figure 4. The diagram shows that Gigliotti (1999) linked selected NSM concepts to the concepts of a middle-range theory of the moderating effects of role involvement and social support on the perception of multiple role stress in mothers who were attending college. The study was designed to test the NSM relational proposition asserting that "the interrelationships of variables [in the flexible line of defense] determine the nature and degree of system reaction [to the stressor]" (Neuman, 1995, p. 21), using statistical techniques that permitted examination of moderator variables.

Step 4

The fourth step in using an explicit conceptual model to guide research is to

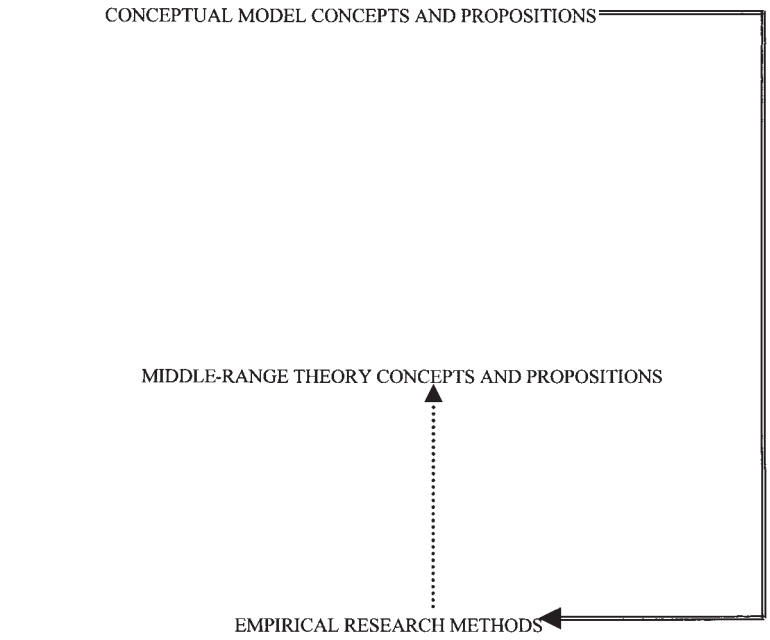

Figure 1. Conceptual-Theoretical-Empirical Structure for Theory Generation: From Conceptual Model to Empirical Research Methods to Middle-Range Theory

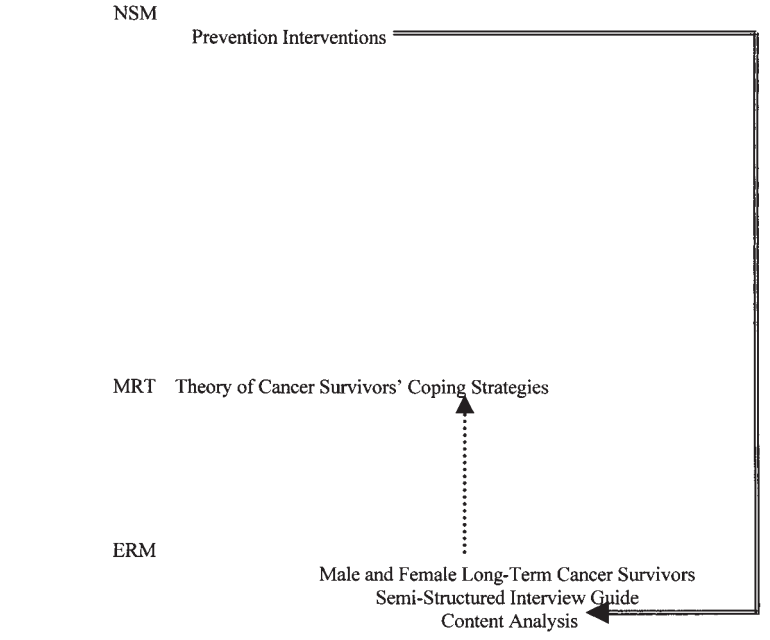

Figure 2. Conceptual-Theoretical-Empirical Structure for Cava's (1992) Research
NOTE: NSM = Neuman systems model; MRT = middle-range theory; ERM = empirical research methods.

clearly convey the C-T-E structure in any proposal for the study and in the final research report. That is accomplished by stating that an explicit conceptual model guides the study and providing an overview of the model that clarifies the relation between the content of the model and the study purpose. In addition, the linkages between the conceptual model concepts and the middle-range theory concepts are stated, as are the linkages between the relevant conceptual model propositions and the study aims, purposes, or hypotheses. A template for the narrative description of the C-T-E structure is given in Fawcett (1999). Inclusion of a diagram of the C-T-E structure for the study is a particularly effective way to illustrate the linkages of conceptual model, middle-range theory, and empirical research methods (see Figures 1-4).

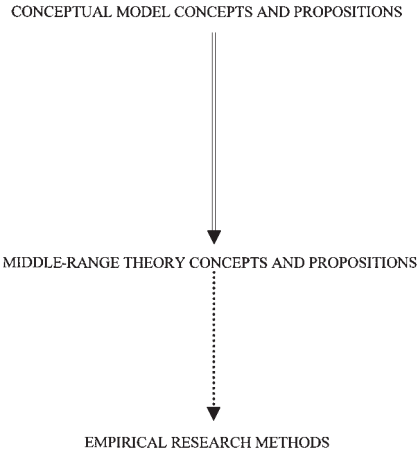

Figure 3. Conceptual-Theoretical-Empirical Structure for Theory Testing: From Conceptual Model to Middle-Range Theory to Empirical Research Methods

Step 5

The last step in using an explicit conceptual model to guide research is to conclude the report of research findings with an evaluation of the empirical adequacy of the middle-range theory that was generated or tested and the credibility of the conceptual model. The abstract and general nature of any conceptual model preclude direct empirical testing. The propositions of the conceptual model are instead tested indirectly through the empirical testing of the middle-range theory. If the findings of the research support the theory, it is likely that the conceptual model is credible. In the case of the NSM, for example, Glazer (1984) and Ali and Khalil (1989) found evidence that a strong flexible line of defense could ward off invasion of the normal line of defense by a stressor.

If, however, the research findings do not support the theory, both the empirical adequacy of the theory and the credi-

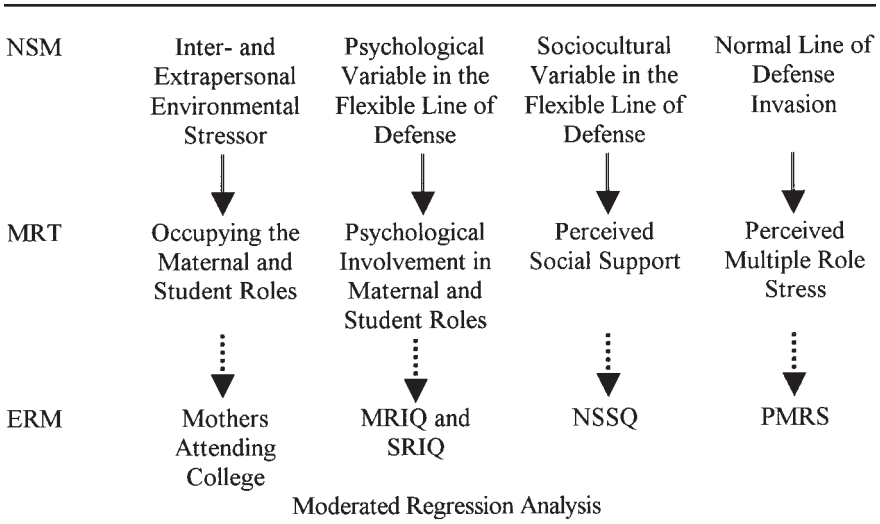

Figure 4. Conceptual-Theoretical-Empirical Structure for Gigliotti's (1999) Research
NOTE: NSM = Neuman systems model; MRT = middle-range theory; ERM = empirical research methods; MRIQ = Maternal Role Involvement Questionnaire (Gigliotti, 1999); SRIQ = Student Role Involvement Questionnaire (Gigliotti, 1999); NSSQ = Norbeck Social Support Questionnaire (Norbeck, Lindsey, & Carrieri, 1981, 1983); PMRS = Perceived Multiple Role Stress Scale (Gigliotti, 1999).

bility of the conceptual model must be questioned. If the credibility of the conceptual model is questioned, then serious consideration must be given to modifying its concepts and/or propositions. The willingness to consider modifying a conceptual model on the basis of empirical evidence prevents its treatment as "the truth" or as an ideology that should never be questioned. Indeed, Grant, Kinney, and Davis (1993) pointed out that "investigators must identify the strengths and weaknesses of a [conceptual] model and interpret data around a consistent frame of reference" (p. 55).

For example, Gigliotti (1999) failed to find the expected moderated relation between role involvement, social support, and multiple role stress in her NSM-based study. Looking at the concepts of the NSM once again, Gigliotti realized that she had failed to include the developmental variable as a component of the flexible line of defense. She therefore recommended that a revision of the middle-range theory should include maternal age as a correlate of multiple role stress experienced by mothers attending college.

Conclusion

Conceptual models provide discipline-specific frames of reference within which theory is developed. In particular, conceptual models are guides that inform thinking and provide direction for theory-generating and theory-testing research. Thus, a research report that does not include a discussion of the C-T-E structure provides an incomplete picture of the study. Indeed, the reader can only wonder about the intellectual and sociohistorical context of the study and only guess how the study advances disciplinary knowledge.

It is not sufficient, however, to merely state that a particular conceptual model guided the study or to provide only a general overview of the model. If followed, the five steps described in this article will provide sufficient specification of the integration of the conceptual model with all aspects of a study, from problem statement to the final report of the findings and their implications. Such specification enhances middle-range theory development and advances understanding of the credibility of conceptual models.

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Developing Perspectives on Korean Nursing Theory: The Influences of Taoism

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Nursing theory provides a systematic explanation and description of nursing phenomena. Western nursing theories have widely influenced Korean nursing. And yet, although nursing theory has universal aspects, the differences in philosophy and culture that are unique to each country need to be considered. This inquiry seeks to investigate the Korean cultural heritage, which integrates Confucianism, Buddhism, and Taoism, and how it provides a unique worldview of human beings, the universe, health, and nursing. Essential principles and therapies consistent with Taoist philosophy are also identified. This framework is proffered as the basis for establishing understanding between Korean nurses and patients.

In general, nursing theories describe, explain, and predict nursing phenomena. Thus, development of nursing theories is essential to the synthesis of knowledge and the advancement of nursing science. In the West, after Florence Nightingale established professional nursing, Orem, Rogers, Newman, Travelbee, Johnson, King, and others developed various nursing theories. Many views of nursing paradigms are currently in the Western nursing literature, both philosophic and scientific. For example, Newman, Sime, and Corcoran-Perry (1991) categorized paradigms as particulate-deterministic, interactive-integrative, and unitary-transformative, and Parse (1992) identified totality and simultaneity paradigms. The totality paradigm perspective views humans as made up of biological-psychological-social-spiritual parts; in other words, the person is seen as the sum of parts and as an entity that can be separated from the environment (Parse, 1992). Within the simultaneity paradigm, the human being is regarded as an open being in mutual process with the universe and freely choosing in situation, recognized by pattern or patterns of relating. Health is a process of becoming that is experienced and described by the person. The focus of nursing is quality of life from the person's perspective (Parse, 1992).

Notwithstanding Western nursing theory development, each nation has its own unique culture and philosophies, owing to its geography, environment, and type of society. If nursing science is to be established in Korea, nursing theory development should be based on a Korean understanding of reality. The major concepts of Western nursing theory include the person, society, environment, nursing, and health (Chinn & Kramer, 1995; Mariner-Tomey, 1994). In this article, a Korean understanding of the universe and the human being is presented. The human being is further classified into four categories of body, life, health, and illness. Finally, the author's view of nursing is presented.

Origins of the Korean Worldview

Korea is a country with a history of 5,000 years. Located in Asia, it has as neighbors China to the north and Japan to the northeast. The Indian poet Tagore (1929) calls it "the land of the morning calm," or "the light of the east." With this geographical location, Korea was greatly influenced by Indian Buddhism and by Chinese Taoism and Confucianism. In accepting foreign ideas and influences, Koreans have displayed talents for harmonizing and adapting them into their own way of thinking. For example, Buddhism was much more developed in Korea than in its native India.

Culture is formed through history. Human beings as individuals are determined not only genetically but also culturally, and this is why each person has his or her own characteristics. Likewise, groups and communities are constituted not only by biological conditions but also by culture and history. Thus, each society forms a specific cultural environment. In this respect, the question of the perspective on human beings can never be understood without the consideration of individuals as cultural entities and the cultural history of each society.

If the question "What is the human being?" is regarded as one of purely empirical fact, there is no reason to make the cultural peculiarity of each society an issue, in this world of universalized scientific knowledge. If, however, it is regarded as one of philosophy and ethics, great importance should be given to this question; moreover, it cannot be asked without considering the cultural form and tradition of the particular nation (So, 1985). Thus, the starting point for developing perspectives on Korean nursing theory is to understand the Eastern philosophies of Buddhism, Confucianism, and Taoism.

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Keywords: Korean nursing theory development, Taoist philosophy

Among the three philosophies, Taoism became the basis of the integrated philosophy that influences Koreans' daily lives. Tao was introduced to Korea by Chinese monks in 643 B.C. (Choi, 1978). In Korean philosophy, the metaphysical ultimate is Tao (in Korean, *Do*). Regarded as the source of the universe, Tao was called the *Great Ultimate*; moving from rest to activity and back to rest, it forms everything in the world. The Chinese philosopher Chou Lien Hsi (1017-1073) said that the Non-Ultimate is the Great Ultimate. Chu Hsi (1130-1200) explained this more concretely when he said that the Non-Ultimate does not exist apart from the Great Ultimate (Choi, 1978). Without reference to the Non-Ultimate, the Great Ultimate is just an existing thing and therefore cannot be considered as the source of everything. At the same time, the Non-Ultimate without the Great Ultimate is empty and cannot produce anything; therefore, the two can never be separated. The metaphysical Tao has no sound, no smell, and no shape or vestige: It exists beyond real things and is therefore called the Non-Ultimate (Choi, 1978).

What, then, is the relationship between Non-Being and Being? According to the Chinese philosopher Lao Tzu (604 ~ 531 B.C.), Tao essentially has no name and no shape—it is abstract and abstruse (Lau, 1963). The Tao is a metaphysical ultimate, and Non-Being can hardly be described or named; therefore, it is called Tao. These concepts, Tao and Non-Being, form a central core in Korean philosophy. Throughout Korean neo-Confucianism, such questions and their application to moral cultivation are addressed. Each philosopher discussed Tao under a different name; some called it *Principle* (*Li*) and others *Material Force*, but all philosophers were trying to describe the basis of existence and its application to everyday living.

Tao is also called One or Great (*Tae*). As the source of all things in the universe, it is One and, at the same time, absolutely unlimited. Tao as Non-Being is the source of all beings. It is never used up and is unlimitedly great. This concern for the shapeless, nonmaterial Tao characterizes Korean philosophy and is in sharp contrast to the materialistic character of Western European thought (Choi, 1978).

The Korean nursing community has largely adopted Western nursing theories. However, Western paradigms are not wholly applicable to Korean nursing, although there are many similarities and useful aspects. This author suggests a new perspective grounded on Taoism, which is the basis of life for Koreans. Chinn and Kramer (1995) identify four stages in the process for theory development: (a) creating conceptual meaning, (b) structuring and contextualizing theory, (c) generating and testing theoretic relationships, and (d) deliberately applying the theory. The inquiry here, part of the first stage of theory development, identifies, examines, and clarifies major concepts.

Major Concepts for Nursing Theory Development in Korea

Universe

In Taoist philosophy, the universe is the working of yang and yin. Yang is the positive or the male elements of being, whereas yin is the negative or female elements. In this philosophy, whole life is considered to be the circulation of yang and yin. All creation, then, is under the harmonious operation of yang and yin, and everything depends on their harmonious working.

An ancient Eastern book, *The Book of Changes* (*Chuyeok*, in Korean), says that all creation has the sky over its head and the earth under its feet (Wilhelm, 1977). At the beginning, the world was a mass of one unified *khi* (variously translated as energy, vigor, vitality, strength, force, spirits, stamina, or virility), which was chaos (or *Taeguk*) itself, and then it was separated into the sky on high and the earth below. The sky is pure yang (called *Keon*), and the earth is pure yin (called *Kon*). These terms, *Keon* and *Kon*, represent the properties of the sky and the earth. Because the powers of Keon are continuously working, all creatures are created and placed in order in the universe. Table 1 shows the basic correspondence of yang and yin.

Lao Tzu (Lau, 1963) seems to have understood the universe in a similar way when he said that the Tao—"The Way"—breeds the One; the One, the Two; the Two, the Three; and the Three, all creatures. To discover the nature of all creation, it is necessary to examine the meaning of the One, the Two, and the Three and the meaning of the Tao. The One represents the sky (universe), the one and sole being governing all things; the Two, the earth, is its counterpart, supporting all things; the Three, human beings, are the greatest masterpieces among all living things. Sky, earth, and human beings are called *samjae*, the three bases of the world.

All things are out of Non-Being or "emptiness," and Tao is emptiness itself; however, it is the emptiness that creates "existence." Because every creation is the interaction of yang and yin, Tao can be viewed as a chaotic state of yang and yin, called *Taeguk*. All things are dependent on yang and yin and work properly with the help of Tao. Tao is embodied in the form of the body, called *hyung*, and khi becomes the vital energy that enables the hyung—the embodied Tao—to work, to move, and to be alive. That is how all creatures come to have a body, hyung, and energy, khi. In other words, every creature has hyung, a vessel to contain khi.

To clarify the Taoist perspective of nursing presented in this article, it is necessary to examine the way things of the universe are classified systematically and to determine the basis of the classification. In particular, it is useful to compare categorization in the East and West. In the East, all things are first categorized into organic and non-organic substances and then are further classified according to their behaviors and styles of living. The organic are those thing that have both hyung and khi, whereas the non-organic have hyung only. In the West, however, a human being is considered an animal first

Table 1
Basic Correspondences of Yang and Yin

Yang	Yin	Yang	Yin
Sky	Earth	Blue	White
Sun	Moon	Red	Black
Fire	Water	Odd numbers	Even numbers
Day	Night	Spring	Autumn
Bright	Dark	Summer	Winter
Warm	Cool	Front	Rear
Hot	Cold	Outside	Inside
Dry	Damp	Go out	Come in
Man	Woman	Proceed	Recede
Male	Female	Open	Close
Up	Down	Scatter	Gather
Rise	Fall	Move	Stay
Float	Sink	Hard	Soft
Fast	Slow	Young	Old
Light	Heavy	Life	Death
Clear	Cloudy	East: Sunrise	West: Sunset
Round	Square	South: Facing the sun	North: Turning back on the sun
Convex	Concave		

SOURCE: Hong (1990).

and then, to discriminate the human from other animals, she or he is defined as a "thinking animal" to reflect the concept of humanity. In contrast, in the East, a human is considered first as an organism, having reason and the capacity to make something.

Eastern peoples understand human beings as the greatest beings on the earth, under the sky. Only human beings can think and feel. That is why humanity has been considered as one of the samjae (three bases) that help the growth and development of all things. Why are humans regarded as the most precious beings? The answer can be found in the fact that a human being has the most superior khi of yang and yin. The human shape is also the most beautiful because it is the vessel to contain khi and is formed after the sky and the earth, that is, Nature. A human being stands on his or her feet with head straight forward. Humans can pursue the endless, skyward ideal and, at the same time, explore the earth with their two firm feet.

Though both things and human beings have khi, the human is the only being who has boundless possibilities to be united with the universe or, through effort, to attain harmony with Tao because she or he possesses the superior khi of the world. To reiterate, a human and a thing are different from the beginning. Even though the human is an organic substance with inherent desires like other animals, she or he differs because of condensed, superior khi. Humans can understand the marvelous workings of the universe and are ethical beings with reason and sentiments. We are the only beings to understand the working of yang and yin with our minds and to feel the flow of all things with our hearts.

The universe endlessly changes by the cyclical movement of inner dynamic forces and is itself a unified, complete whole, composed of the networks of interrelated events and things. A being is defined by its function in this relationship and network and can have meaning only as a part of this whole. Western standards, which are quantitative and linear, are not adequate to measure this dynamic movement of yang and yin. In Eastern science, the principal standard is the reflected image of the whole universe, with each image having its own property. Nurses are expected to recognize the imbalance of the patient's condition using their perception and, thereby, to restore the balance and harmony of life.

The concept of universe is basic to understanding the human being in Taoism. Most existing nursing theories have used the term *environment* (Johnson, 1980; Neuman, 1982; Roy, 1984; Travelbee, 1966) or *society* (Levine, 1967), instead of *universe*, in explaining nursing's major concepts. Nightingale (1859/1969), too, regarded environment as a central concept and believed that external conditions like warmth, effluvia, noise, and light have enormous influence on the optimization of physical conditions for humans. Newman (1986) said that environment includes the universe and that environment and the person form a unitary pattern that is reflected in movement, space-time pattern, and consciousness. Apart from Parse (1992), few nursing theorists identify universe as a major concept.

The ancestors of Korea believed that true life is in the pursuit of the great ideal of uniting humans and universe. In the next section on human being, the author (a) defines human beings as the workings of Nature, (b) shows the relationships between humankind and Nature as the subject of nursing, (c) considers health as harmonization with Nature, and (d) examines the concept of illness.

Human Being

What Is the Body?

A human body is viewed as the union of yang and yin. The superior khi of the universe compels human beings to follow the law of one yang and one yin, or Tao. If so, how can we explain life, death, and birth? The answer is that life is created by the union of a man and a woman, which is regarded as the union of the sky and the earth. Men symbolize yang—the sky—and women, yin—the earth. Therefore, pregnancy is itself the union of yang and yin, the ideal.

A human being comes out of a human being through pregnancy. When one body has another within it, it is a sacred work and a painful one at the same time. As childbirth is a work to bring a new life into the world, it is a boundless delight as well as an end of suffering. It is worth noting that the ancient writings of the Dongeuibogam describe in detail the development of the human from the 1st month after fertilization until it is

separated from its mother, when it has completed itself (Hong, 1990). Whereas the essence of the universe is thrust into all creation, that of a human being who is born as a new life becomes the soul or spirit. Humans are the beings given the superior khi of the universe; therefore, they are different from other creatures. Individual human beings are also different from each other because each has khi of different qualities. In general, the birth of a human being follows the law of Nature that sky and earth unite their energies to create a life. Khi is filled up in the 9th month, when the placenta is completed. And then, a life begins in the 10th month, when khi is joined to the energy of the universe. The framework of a human being is the embodied Tao, hyung, a vessel to contain life.

In Eastern philosophy, the body is said to be built with four elements, distinguished from the five elements of the earth. In an ancient book of Buddhism, Buddha states that the elements of earth, air, fire, and water harmonize with one another to create muscles, bones, skin, and flesh of a human being. The muscles, bones, skin, and flesh belong to earth; the blood and the mucus belong to water; breath and body temperature belong to fire; and the soul and movement belong to air. So, if the air ceases to flow, khi would be cut; if the fire is gone, the body would get cold; if the water dries up, the blood would run dry; and if the earth disperses, the body would be dissolved. The correspondence of the five elements with the universe and human body is shown in Table 2; Figure 1 shows the relationships between the five elements.

Table 2
Correspondences of Five Elements With the Universe and the Human Body

Universe and Human Body	Five Elements				
	Wood	Fire	Earth	Metal	Water
Season	Spring	Summer	Late summer	Autumn	Winter
Development	Birth	Growth	Maturity	Withdrawal	Dormancy
Climate	Wind	Heat	Damp	Dryness	Cold
Direction	East	South	Center	West	North
Color	Green	Red	Yellow	White	Black
Value	Benevolence	Courtesy	Faith	Justice	Wisdom
Taste	Sour	Bitter	Sweet	Pungent	Salty
Internal organ	Liver	Heart	Spleen	Lung	Kidney
Digestive organ	Gallbladder	Small intestine	Stomach	Large intestine	Urinary bladder
Disposition	Anger	Excitement	Worry	Sadness	Fear
Sense organ	Eyes	Tongue	Mouth	Nose	Ears
Tissue	Sinews	Blood vessels	Flesh	Skin/body hair	Bones

SOURCE: Hong (1990).

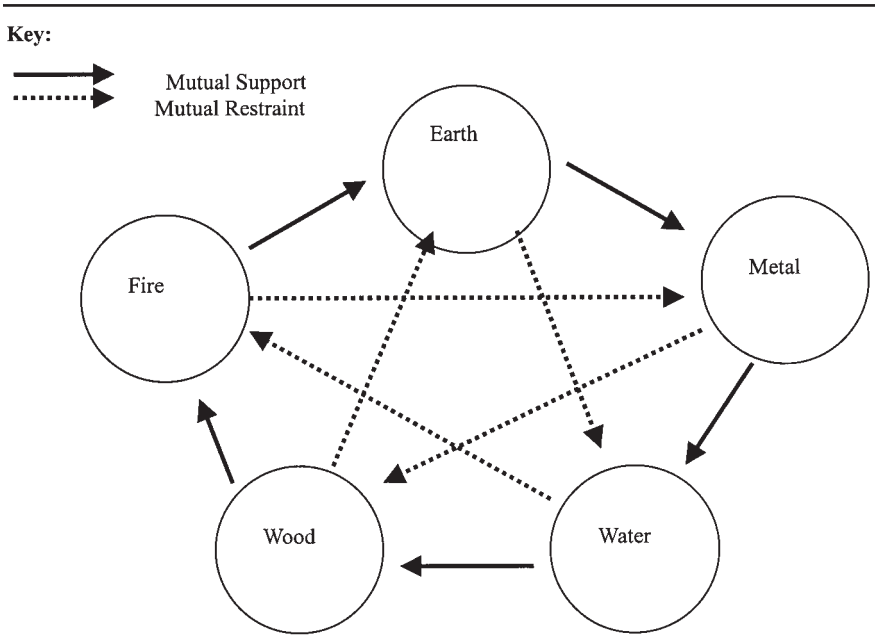

Figure 1. Relationship Between Five Elements: Mutual Support and Mutual Restraint

As noted, some nurse theorists view the individual as a system of physiological, psychological, and sociological parts (Henderson, 1978; Johnson, 1980; Levine, 1967; Neuman, 1982; Roy, 1984). And yet, Rogers (1987), Parse (1992), and Newman (1986) described humans as unitary beings, different from the sum of the parts. Koreans' cultural heritage has a similar, holistic view of a human being as a micro-universe of yang and yin, the five elements, and khi. However, Korean nursing education still concentrates on systems based on the natural sciences, rather than on a holistic view. This framework is quite distant from the Korean understanding of human being and, inevitably, causes a gap between practice and nursing theory and becomes the source of various problems.

What Is Life?

Life is the circulation of yang and yin. As noted earlier, humans are the supreme beings of all creation, and life is a temporary union of the four elements. The air makes possible the activities of the mind, whereas khi is the basis for the four elements. Therefore, air is considered the most supreme of the four elements. Khi is the source of life, and a life is the force of khi; that is, the length of one's life depends on khi. Likewise, the decline of khi is the cause of menopause. The body, hyung, is the vessel holding khi, and khi is the energy that

maintains hyung. Thus, the length of a person's life depends on the harmonization of hyung and khi.

The human being is an organism. What, then, makes a human being the supreme being, when other organisms also have hyung and khi? The answer is that only human beings possess *shin* (the soul or the spirit), which controls and manages the harmonized hyung and khi. Shin in turn cannot function without the circulation of *chung*, which refers to the mucus and the blood, and khi is the basis for the both shin and chung. To sum up, humans are the momentary union of the four elements as well as the organic relationship of the four components of hyung, khi, shin, and chung. Whereas hyung is considered yang, the other three are regarded as yin.

When the human body is regarded as the condensed lifeblood, life is redefined so that life and spirit are the substances of the human body, khi is the origin of life, and the main power to lead life is chung (mucus and blood) and shin (soul). Therefore, khi, chung, and shin are the life energy and the basic factors that control life. Hyung and khi work together and generate the spirit (shin) and blood and mucus (chung). Hyung, then, can be defined as the container of a life and chung, khi, and shin as the life itself. An ancient Eastern book compared a human body to a nation, in order to emphasize the organic relationship of each separate part. It divided the body into 12 parts. The heart was considered the dwelling place of the soul and, therefore, played the role of a monarch. The energy inside maintains life; it is called *sambo*, or "the three treasures," referring to chung, khi, and shin combined, to distinguish it from three physical organs (samjae) that are the three bases of the body. The life of a human being depends on the interaction of hyung, chung, khi, and shin. Hyung is created from khi and it holds khi; therefore, the basic principle for health is to properly take care not only of hyung but, also, of life. The subconcepts of chung, khi, and shin are summarized below.

1. Chung: These are the physical materials composing the body. Components include the following: hereditary factors and the reproduction system; blood generated from the essence of food absorbed and digested in stomach and intestines; nutrients inside the body, obtained from food; basic materials composing the skin, hair, tissue, muscle, bones, and internal organs; and all the liquid and mucus inside the body, such as saliva, sweat, tears, and urine.
2. Khi: This is present not only in all living matter but throughout the universe, keeping its flow, rhythms, cycles, changes, movement, and balance over all. It is energy that maintains life and physical, as well as mental, activities. Khi is classified into the inherited and the acquired. The former is from one's parents when one is born, and the latter is from food that we eat and air that we breathe. Profound changes take place in a human being's khi with changes in the weather and the cycle of the seasons.
3. Shin: This is the basis of one's disposition, thinking, and judgment, including reason and emotion. It is inherited from one's parents and controls the entire functioning of the body. Shin controls mental and emotional activities. It also controls the five senses, breathing, and the nervous system.

What Is Health?

Health is the harmony of yang and yin. To be healthy, the most important thing is the harmony of hyung (i.e., yang) and chung, khi, and shin (i.e., yin), where the former is the vessel holding the life and the latter the origin of life. Looking further into the three treasures described above, health necessitates harmony among shin (yang) and chung and khi (yin). In terms of khi, which is the main life force, the quality and the nature of hyung (this time, viewed as yin) and shin (yang) differ according to the state of khi—that is, whether it is clear or not.

The ideas presented here originated in the ancient writings of the Dongeuibogam (Choi, 1978), which gives people living in the age of science important clues to the ideal of health. In ancient times, models of the ideal human being were *chinyin* (a true man), *chiyin* (a man who reaches a certain truth), *seongyin* (a sage), and *hyeonyin* (a wise man). These characters, described below, may provide a useful clue to answer the question of what is the ideal of health.

Chinyin, true persons, are those who take the universe into their bodies and understand yang and yin. They breathe khi and keep shin. Their hyung, or flesh, is wholly integrated, and their span of life is as endless as the running of the universe.

Chiyin, persons who reach a certain truth, are those who keep Tao sound with humble and unspoiled goodness. They make yang and yin to be harmonized and genial, and they control the four seasons. They live in seclusion and cultivate chung. They can let their shin go around the entire world.

Seongyin, sagacious persons, follow the law of the eight winds and adjust their desires and enjoyments to match common customs. Seongyin have no trouble caused by anger. Their behavior and movements are in accordance with the world and the customs of their age. Outwardly, they do not exhaust their bodies with excessive working, and inwardly, they do not trouble their minds with worldly cares. And so, they do not ruin their bodies nor scatter their energy and spirit.

Hyeonyin, wise persons, are those who follow the sky and the earth, the sun and the moon. They can identify the stars and can manage yang and yin as they please. They can distinguish the four seasons, and they do their best to be united with Tao, as the ancient people did.

According to Tao, the harmony of yang and yin is the ideal of health. The way to get to this ideal is to recover simplicity by keeping one's mind and khi properly. The medical practitioners of ancient times were able to manage people's minds to prevent illness; however, those of today cannot manage people's minds but treat disease only. Still, for this author, the mind is the key. If human beings can manage their minds well, their minds shall be peaceful and their natures placid. Like the ancient wise

Table 3
The Management of Health Through the Seasons

Four Seasons	Management of Health	Four Ways (*Taos*)
Spring (wood, in the five elements): The season when the universe is animated and all creatures are prosperous.	Try to generate things like warm spring. Don't take but to give. Don't punish but to give a prize.	Tao of birth (watching for health, so as not to have any disease)
Summer (fire): The season when the *khi* of the universe associates with one another and all creation bear their fruits.	Don't have a furious mind. Make efforts to produce good fruits, keeping the blossoms healthy. Though you spend your khi, you should do it outdoors because your favorite things are there.	Tao of development
Autumn (metal): The season when the khi of sky is swift and bright to harvest all things.	Collect khi in your body. Make peace with the energy of autumn, and make clear the khi of the lungs.	Tao of withdrawal
Winter (water): The season when water freezes and the earth splits open.	Have a mind to get something. Avoid the cold and take warmth. Don't make yourself cold by exposing the skin.	Tao of dormancy

SOURCE: Hong (1990).

ones, they shall realize that all worldly affairs are meaningless, that working all day long is a delusion, that their own bodies are momentary, that all happiness and misery of life are nothing but bubbles, and that life and death are only a dream.

Once Korean people perceive this truth, they shall have clear minds and suffer no illnesses. Though they take no medicine, they will be well. Chiyin manage themselves before they get a disease, but today's healthcare professionals work only after a disease presents itself. Mind control and therapeutic treatment are two methods to handle disease, but there is only one origin of disease. And so, the point is to deal with disease through Tao.

Illness can also be examined with this approach. Though yang and yin are marvelous, they cannot work without khi. After all, the quickest way to achieve the ideal of health is to unite hyung and the "three treasures." For instance, one should cultivate khi, dismissing hyung, and develop shin, thinking no more of khi. If so, one would build up chung, disregarding shin, and then, the four will be united. The principle of unification of hyung and the three treasures is that one's mind is finally in accordance with the will of the universe. We can know when we achieve unification with the universe when the khi goes down to the abdomen and produces warm khi in our bodies.

The author understands environment in the context of the close ties between the universe and human beings, not separating the environment as an independent entity. In regard to khi, environment is the surroundings closely connected with human beings that have direct and indirect influences on health. Human beings are connected with Nature, as they are part of her. As for khi, the primary source of life, human beings' shin, is inseparably connected with the natural change of khi—the four khis. Thus, one of the essential conditions for health is to control shin flexibly in accordance with the change of khi in each season. Table 3 shows how to keep health in accordance with one's environment by following the natural way of the four seasons.

Korean traditions include many linked with health. Inasmuch as the four seasons reflect yang and yin in creation, a crucial point in maintaining health is to share the changes of living with all creation, promoting yang in spring and summer and yin in autumn and winter. When we realize this secret, we get spiritual awakening. By keeping certain conditions, we embody Tao in our daily lives. For example, in spring, one should get up early and go to bed late. In summer and autumn, one should get up earlier and go to bed later than in spring; in winter, one should get up later and go to bed earlier than in spring. One tends to lose chung and khi in summer, and so, one should keep the stomach warm by not having cold foods. Thus, one will not be struck with a disease, and his or her khi will be strengthened. Another Korean tradition is the use of massage to maintain good health and cure disease. The main principle is to help the circulation of chung and khi through the body's energy routes. Massage should especially include both sides of the nose, the eyes and forehead, the earlobes, the back of the head, and the waist. Rubbing the nose stimulates the gateway of breathing, and rubbing the forehead and eyes stimulates the brain. During self-massage, one sits quietly with closed eyes and a peaceful mind. One takes a deep breath and lets it out slowly, holding khi for a time. After massage, taking a deep breath again, one stands on both feet with head down and pulls the soles of the feet with the hands, keeping the knees as straight as possible.

A further health-promoting technique is *yangkhi* (to strengthen khi), a method for preserving khi. Some of its precepts are as follows: Lessen your words to cultivate internal energy. Control your sexual desires to cultivate energy and spirit. Don't enjoy rich food excessively to cultivate the energy of the blood. Swallow the essence (saliva) to cultivate khi of the body. Don't lose your temper to cultivate khi of the liver. Be cautious in choosing and eating your food to cultivate khi of stomach. Don't

overstrain your nerves to cultivate khi of mind.

Yangshin (to strengthen body and refine behavior) is yet another method for improving health. For instance, if people want to live long, they should frequently comb their hair, put their hands on their faces, and bite their teeth. Also, they should always swallow their saliva to refine their khi. When people talk too much, they lessen their khi, and when they have excessive joy, their shin will be let out. When they get angry frequently, they weaken the mind. If they have too much sorrow, they injure shin. Therefore, one must keep this in mind.

Yangseong (to control emotion and to improve the disposition) is a way of improving one's nature (*yang* means to raise and *seong* means one's nature). Following are cases that would hinder yangseong: pursuing fame and wealth; being exposed to joy and anger too frequently; appreciating only voice and countenance, as in appearance; and enjoying rich food. The following are forbidden for yangseong: The forbidden thing for a day is not to eat too much in the evening, the forbidden thing for a month is not to drink too much at the end of the month, and the forbidden thing for a year is not to go on a long journey in winter.

Essential to yangseong is the avoidance of excess: In terms of chung, frequent fatigue causes it to be scattered, and working too much reduces brilliance. Thinking a lot puts shin in danger. Too much care scatters one's mind, worrying too much makes one's mind uncomfortable, and excessive greed throws it into confusion. Working too much causes a tired look. Talking too much drives khi far away. Laughing too much harms the body. Enjoying pleasure too much causes excessive ideas, whereas having too much delight causes disorder. Having much anger causes all one's veins and khi to be wrong. When one has many favorite things, she or he is exhausted. And so, the essential point of yangseong is to make 12 excessive things into 12 simplified things. If one cannot do this, one shall lose Tao and khi, which is imprudent and harms health.

Another technique is used to put down the cardiac function to the lower abdomen, as follows: Look down your nose and let the tip of your nose meet your navel; this preserves khi and circulates water and fire smoothly, putting down fire, which gathered in the heart. And so, it keeps the mind. This method shares some ideas with *chamseonbeop* of Buddhism (the method of Zen with a sitting posture) and the method of traditional Indian meditation.

What Is Illness?

Illness is the loss of harmony and balance of the life rhythms. It is caused by attacks on the body by climatic forces and internal factors of the seven emotions, or having a poor diet or breaking the healthy and sound habits of living and proper manner. The main causes of illness are as follows: unbalance of khi; imbalance of the seven emotions, which cause illness not by external forces but by internal excess or lack of emotion; and habits not conforming to the law of nature. The forces that invade the body from the outside are wind, cold, heat, dampness, dryness, and fire. The seven emotions are anger, joy, worry, pensiveness, sadness, fear, and shock. The relationship between the emotions and the five internal organs is thus: When one is angry, the liver (wood) hurts and khi is raised up; when one is overjoyed, the heart (fire) hurts and khi is loosened. Worry hurts the spleen (earth) and blocks the flow of khi. Sadness hurts the lungs (metal), and khi is eaten up. And fear hurts the kidneys (water). Hence, these imbalances of yin, yang, and khi cause illness.

The Proposed Way for Korean Nursing

According to what has been discussed in this article, the goal of nursing in Korea is to bring out the harmony of yang and yin that each patient has inherited or acquired and to strengthen the patient's chung, khi, and shin. Rather than focusing on diseases, nursing should concentrate on life itself. In particular, to supplement insufficient energy and calm down the excessive, nurse practitioners should endeavor to maintain the balance of khi. And, to recover the health of patients, nurses should promote peace of mind, sound sleep, proper diet, and exercise. Because each human being is unique, nursing care should show subjective understanding of individual differences.

This traditional way of healthcare and nursing should not be understood as mere nursing techniques but, more broadly, as therapeutic nursing actions. A radical shift of conceptual paradigms was required for Korean nurse scholars and practitioners to apply Western theory-based nursing in Korea—disregarding one to get the other. In this author's opinion, absorbing and thus integrating traditional Korean nursing would be a good and useful way to further the development of Korean nursing science.

Employing alternative and complementary therapies, which are frequently conducted in Korea today, would advance efforts in this direction. These therapies have been developed on the ground that the khi of the universe is interconnected with that of human beings through the *kyungrak* (meridians), which are the pathways of khi and hyul. Therefore, they seek to restore the balance and harmony of yang and yin in the human body, for example, applying finger pressure therapy, acupuncture, and khi exercise therapy to kyungrak in the body. Such therapies help to keep the balance of khi by providing what is insufficient and calming down what is excessive. Also, dietary theories based on the principles of yang and yin and the five elements aim to restore the balance of the human body. Alternative therapies like these are part of daily life in Korea.

Conclusion

In Korean philosophy, the universe has its order of yang and yin; all creation

is continuously generated, grows and dies as the result of the harmonious operation of yang and yin. Among all creation, human beings alone are of the samjae (three bases of the world: sky, earth, and humanity), and they have a combined superior khi of yang and yin. Life itself is basically a condensed chung, khi, shin, and hyul; at the same time, it is only a transient gathering of the four elements of earth, air, fire, and water. Therefore, yang and yin, the two axes of the world, are the most crucial and fundamental concepts to explain the generation and demise of all creation. They help us to understand human beings in time and space; to discover the reality of their lives as organisms; and lastly, to observe the state of their health.

In this perspective, the following are assumed: (a) a human body is basically a union of yang and yin; (b) a human life is the circulation of chung, khi, and shin; and (c) human health is the harmonized coordination of yang and yin.

Because the health of human beings depends on the harmony of yang and yin, to be healthy, human beings should consider harmonization with Nature, as well as balanced human relationships in society. Moreover, it is crucial for nurses to view the patient as a whole rather than to merely treat the symptoms out of the context of the person who has the symptoms. Illness is not understood in terms of the pathology of isolated organs but, rather, as the disruption of normal, harmonious, complete living.

On the basis of the foregoing exploration of Taoist philosophy, the following conclusions are drawn for Korean nursing theory development. Inasmuch as human beings are part of Nature, yet are the most eminent microcosms among all creation, in Korean nursing, human beings should be understood with this philosophy rather than through application of Western nursing theory. Through common, fundamental sharing of philosophy, Korean patients and nurses can establish mutual trust and understanding.

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Are Nurses Advancing Nursing Knowledge?

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Not long ago while attending a scholarly lecture, I had the opportunity to engage in a recurring discussion with a colleague that focused on whether or not nurses need a nursing doctorate. We had opposing views. My colleague believes that doctoral preparation in a variety of disciplines is good for the profession. My view is the polar opposite, with the belief that nurses need to be grounded in nursing theory for the development of nursing science. Through such a process nursing knowledge will expand.

Reflecting on this discussion I was again faced with a conundrum of nursing. Why do we continue to have such discussions in the 21st century? As I speak with colleagues from other academic disciplines, the issue of obtaining advanced education outside of the discipline is not an issue. Each wants to have the grounding of his or her own discipline and to expand that branch of knowledge. Within interdisciplinary research teams, each member continues to seek the advancement or expansion of his or her own discipline.

It seems that nurses continue to look outside the discipline of nursing as a means of achieving greatness and recognition. The time has come for nurses to realize that the discipline will flourish only when the scholars within it have a grounding in nursing theory and pursue the betterment of nursing science. Nurses and nursing will not grow as a profession by hanging onto the coattails of other disciplines.

Yes, there are situations where doctoral study from a nursing perspective may not be available locally. With worldwide Internet capabilities, that is becoming less and less of an excuse not to pursue a nursing master's or doctoral degree. A number of universities in the United States have their entire master's and doctoral programs available through the Internet. Other universities have some courses available.

It is time for nurses to rethink the merit of engaging in advanced study outside of nursing. Those for whom we care deserve only the best and that is nurse scholars who have a firm understanding of the discipline of nursing.

Nurse scholars of French-speaking Quebec are taking the bold steps necessary to have a solid grounding in nursing theory. Advanced degree programs conducted in French are available in the region. The English versions of works of many nurse theorists have been translated into French for easier understanding by the students. In this column, Major and colleagues provide the reader with a historical perspective of nursing in Quebec and the development of knowledge from a nursing perspective.

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Nursing Knowledge in a Mostly French-Speaking Canadian Province: From Past to Present

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Quebec, an eastern central province of Canada, comprises more than 6 million French-speaking people and an English-speaking community of nearly half a million people. Nursing evolved differently in these two communities, as richly in one as in the other (Cohen, 2000). The purpose of this column is to describe the evolution of nursing knowledge in the French-speaking community of Quebec. Nursing here grew out of a tradition from France with the establishment by religious communities of the first hospitals in Quebec City (1639) and in Montreal (1642), two cities of the new settlement in America, so called la Nouvelle France. In this new French land, the Hospitaller Sisters, with the help of private funds, owned the properties, controlled the salubrity, hired physicians and apothecaries, and devoted themselves to caring for people. Unlike their counterpart in Europe, where wealthy people were cared for in their homes, the *Hôtels-Dieu* (acute care hospitals) would care for people from all classes of society, and the *hôpitaux généraux* (general hospitals) would assist the poor and disabled people (Lacourse, 1998).

Knowledge and Service

From the 1900s to the 1960s, the Hospitaller Sisters influenced the education and practice of all religious, secular, and, later on, professionally trained nurses. They were, along with a very few secular women, the most educated nurses, some of them having master's and doctoral degrees from the United States. Most nursing programs were offered in hospital schools; since 1934, others were offered at the Institut Marguerite d'Youville (IMY) (integrated into the Faculty of Nursing, University of Montreal in 1967) and at McGill University since 1920 (in English). At the time, nursing was close to a vocational model because of its dedication to patients and service to doctors. Christian values of compassion, charity, devotedness, and duty were embedded in the teaching of nursing, coupled with the precepts of biomedical science and hygiene. In the 1950s, a dictum from Sister Jeanne Forest, director of the IMY, summarized this merging of knowledge and service: *Mieux savoir pour mieux servir* [A better knowledge for a better service] (Petitat, 1989).

In the early 1960s, a secular influence grew in the health and educational institutions of Quebec. It became more obvious in 1970, when the hospital diploma programs moved to a new educational structure, called the *Collèges d'enseignement général et professionnel* (Colleges of General Education and Professional Training). Only a few Hospitaller Sisters moved to the new programs that were offered in colleges for the diploma level and in universities for the undergraduate level. The redesigned curriculum included more theoretical teaching and less experience in clinical settings.

Knowledge and a Nursing Perspective

Between 1970 and 2001, a tremendous effort was undertaken by teaching nurses to obtain higher education degrees for themselves and to develop undergraduate and graduate programs. Undergraduate programs began to spread, some with a basic curriculum, some with a post-RN curriculum, and some with both. Graduate programs in nursing became available in French, first in Montreal (1965) and Quebec City (1991), then in the regions (2000). In 1994, a joint doctoral program between McGill University and University of Montreal was offered. In the meantime, many nurses studied in other fields or disciplines in programs more available geographically, mainly master's and doctoral degrees in education, administration, anthropology, psychology, and sociology. These efforts led to a number of redesigned nursing programs and to the production of numerous written materials in French to improve the teaching-learning process. This written material was at first mostly translated from English (e.g., Henderson, 1969), then mostly original work written in French (e.g., Adam, 1979; Goulet, 1993; Kérouac, Pepin, Ducharme, Duquette, & Major, 1994). These works paral-

Keywords: nursing theory, Quebec nursing education, Quebec nursing practice, Quebec nursing research

leled some European books (Collière, 1982; Poletti, 1978) used for teaching nursing.

The interest in nursing conceptual and theoretical frameworks for education and practice can be traced to the early 1970s in the French-speaking community. Since Henderson's (1969) *Basic Principles of Nursing Care* was adopted by the International Council of Nurses (ICN) and translated into French by the Order of Nurses in Quebec (ONQ), it gained popularity in colleges, universities, hospitals, and community settings. Many articles and books were written insisting on the need for a conceptual model as the basis of practice, education, and research (Adam, 1985); formalizing Henderson's thoughts into a conceptual framework (Adam, 1979); and presenting the nursing process guided by that model (Phaneuf, 1986), as well as care for elderly people (Lauzon & Adam, 1996). Despite the fact that other models were taught in universities (e.g., Orem, Roy, Johnson, and Neuman), Henderson's model was quickly adopted by the colleges for its simplicity and transferability to nursing practice. In the 1980s and 1990s, many hospital and community-setting nurse managers set up committees and invited nurse leaders to assess different nursing conceptual or theoretical frameworks and to choose one that would guide their practices. The main criteria were availability of teaching material in French and resource people, length and cost of training with the model, and choice of a conceptual framework by nearby schools. Nearly two thirds of hospital and community settings chose Henderson's conceptual model, whereas those remaining chose Orem, Roy, or McGill (Sylvain & Lapointe, 1995). The McGill model, a family-oriented practice model developed in the 1970s by Moyra Allen and colleagues from the School of Nursing at McGill University (Gotlieb & Rowat, 1987), was adopted in the French-speaking nursing community only at the beginning of the 1990s. The McGill model is mainly used in community settings (*Centres locaux de services communautaires* [*CLSC*]) because it focuses on health promotion and a family development view of care that fosters individual and family strengths (Malo, Côté, Giguère, & O'Reilly, 1998).

As soon as a conceptual framework is translated into French and some teaching-learning material is available, Quebec nurse educators and practitioners develop a greater interest in that particular nursing conceptualization. Since the 1980s, some works of Roy, Orem, McGill, Leininger, Neuman, Rogers, and Watson have been translated into French (see www.bibl.ulaval.ca/ress/nursconc.html) from original texts or have been adapted for teaching-learning and, hence, have been chosen to guide nursing practice in various settings such as acute and long-term care, rehabilitation, and home care. The extent to which the nursing models and theories guide nursing practice in ways other than in a written philosophy statement and in nursing planning tools is unknown (Sylvain & Lapointe, 1995). Our observations indicate that the integration of a nursing way of thinking into one's practice is very much at the individual level and seems to be linked to nursing higher education. The integration of a nursing way of thinking into practice is certainly not matching the continuing education efforts made by nurse managers during the past 20 years; in some milieus, the model is applied mechanically, and in others it is dropped altogether. Meanwhile, the nursing process and nursing diagnoses gained some popularity as they were presented by their proponents as the hallmark of professional nursing (e.g., autonomous, efficient, and accountable, thus respectable) (Doyon, 1990; Phaneuf, 1986; Phaneuf & Grondin, 1994; Sylvain, 1994). More and more attention, however, has been paid to critics of the nursing process (Henderson, 1987) and nursing diagnosis (Mitchell & Santopinto, 1988). Indeed, the automatic systematization of care and the labeling of so-called nursing problems have been recognized as incongruent with the traditional nursing values of respect of and attention to the individual person. As long as the actual application of the nursing process and diagnosis is viewed as *the* way of planning care, the renewal of care practices most needed in today's healthcare system is less likely to happen. Nevertheless, the formal application of these processes is being challenged by the increased demands on nurses since the 1995 healthcare reform, the so-called *virage ambulatoire* (ambulatory drive-shift), in which person-centered care means an increased responsibility for the person, the family, and the community, coupled with the aim of efficiency and change in ways of delivering care.

Nursing Knowledge and *les Soins et Sciences Infirmières*

The translation of the word *nursing* is worth examining to understand the impact of language and human activities on the recent evolution of the nursing discipline in Quebec. Some nursing theory issues in education, practice, and research will then be considered. Up to the beginning of the 1980s, the word *nursing* was adopted as such, without translation into French, in the naming of schools (*écoles de* nursing), journals (*Nursing Québec*), curricula (*programme en* nursing), and research (*recherche en* nursing). The translation was and still is not easy because there is no noun in French to express the nursing profession. For example, for a while after using *soins et sciences infirmières* (nursing care and sciences) to translate nursing, the Faculty of Nursing of the University of Montreal settled for *Faculté des sciences infirmières*; after all, there was a *Faculté des sciences de l'éducation* (Faculty of Education Sciences) and science represents higher education. In turn, the colleges adopted *soins infirmiers* (nursing care) to designate the diploma program that is more oriented toward techniques. Whether this is the reason that soins infirmiers is often associated with the technical aspects of nursing by the general population remains a mystery. Interestingly, Kérouac et al. (1994) also translated *caring* as *soin*, this time in the singular form, when referring to the focus of nursing. Indeed, some French-speaking scholars (Collière, 1982; Saillant, 1999) maintain that *le soin* or *le prendre soin* is the

main focus of the discipline of nursing, and they are concerned by the fact that, although sharing this human activity with other disciplines, nurses do not claim it as their main object of interest. Legault (2000) proposed that *soins infirmiers* become associated with all levels of curricula, practice, and research in nursing so that the art of nursing, the meaning associated with the human encounter between the nurse and the person, be acknowledged and valued and that the word *science* be reserved for the activities related to inquiry. The discussion is still in process because the singular *soin* is more associated with the concept and the plural *soins* with practice.

Knowledge in Education, Research, and Practice

What knowledge do we teach? What knowledge do we create? and On what knowledge do we base our nursing practice? were major issues addressed in a nursing colloquium in May 2000, Les savoirs infirmiers au Québec: Bilan et perspectives (The Nursing Knowledge in Quebec: Statement and Perspectives) within the Association Canadienne-Française pour l'avancement des sciences (French Canadian Association for the Advancement of Sciences).

Knowledge Taught

For obvious reasons, at the university level, students are stimulated to create their understanding of the discipline of nursing, its ontology and epistemology. Two trends are becoming a public issue in teaching nursing at the undergraduate level. First, faculties increasingly are acknowledging the limits of the nursing process and nursing diagnosis as taught, without having at hand a replacement solution. They are becoming more aware, however, of the necessary congruency of nursing philosophy, curricula, and course content. Second, the ideas of Watson, Leininger, and Parse, as well as the McGill model, provide different views of the nurse, patient, and family relationships. Because scholarship comes with a commitment to an in-depth study of nursing theories and frameworks, this study could be facilitated through teaching-learning material that fits the chosen perspective; this material is urgently needed in French. At the graduate level, the trend is to be open to the substance of nursing beyond conceptual or theoretical models and to discussion of the various propositions that organize that substance.

Knowledge Created

A growing number of Quebec nurses plan their inquiry and research programs based on specific conceptual frameworks (Pepin et al., 1994) or take great care in presenting their studies as nursing studies and still shyly make the nursing voice heard within interdisciplinary research. Concomitantly, the center of interest for inquiry is in a process of clarification. Some nurses specify the nursing center of interest as caring in the human health experience (Kérouac et al., 1994; Newman, Sime, & Corcoran-Perry, 1991), and others as the human-health process or the non-pathologized experiences of human life related to health and illness with inquiry based on nursing theories and frameworks (Major, 2000). Others again want to focus on interdisciplinary care activities performed by nurses that stem from other disciplines' frameworks. Furthermore, some consider all research done by nurses as nursing research, whether in education, administration, or history.

As research funds are made more available for nurses, preferences are given by the administrators of these funds toward research on nursing care delivery or in solving pragmatic issues such as the nursing shortage. Without denying the importance of applied research, these orientations emphasize the denial of basic knowledge to be developed in the nursing discipline. Some may argue that nursing science is solely applied research from other disciplines, but others insist that basic nursing research will benefit applied research. Moreover, funding agencies foster interdisciplinary research programs. It is noteworthy that nurse researchers are welcomed as resources by interdisciplinary teams. It is less acknowledged that nurse researchers value nursing frameworks and are willing to develop methodologies congruent with these frameworks.

Knowledge Guiding Nursing Practice

A nursing perspective is not a product to apply but a way of living one's practice. A practice based on the criteria of other disciplines has the potential to diminish nursing. Already, the Canadian healthcare system is beginning to adjust to a nursing shortage: Lay care is praised, complete and detailed information on health is available on the World Wide Web, technological devices are designed to be user friendly, and networks regrouping people living with the same illness are growing and well-structured. Nursing must be clear to the population. The clarity comes from nursing schools of thought, the ones we have already or the ones to come. People want nurses to be there with them as they assess their situations, make difficult decisions, and implement and evaluate their interventions. People want nurses who listen to and regard what they say as important, who are resourceful persons who care for quality of life as defined by the person, and who are partners in the living of health experiences.

The evaluation of the relevance of nursing conceptual frameworks in practice is most needed, considering some observed current issues. First, increased responsibilities delegated by other disciplines and increased technological demands are reflected in a need for continuing education in biomedical knowledge; it is hoped that, with this knowledge, nurses will intuitively instill their values in the activities performed as delegated acts and that nurses will continue to make a difference for people. Second, and paradoxically, responsibilities are taken away from nurses by other healthcare professions, stressing the identification of the nature of nursing's core knowledge. Third, nurses in practice are very concerned about their place in the healthcare system, which is

more oriented toward efficacy and efficiency than toward respect of the person's value system.

Many successes in the healthcare system since the ambulatory drive-shift are attributed to nurses. In every instance, these innovations were created to help patients in decisions about use of healthcare services (e.g., *Service Info-Santé*, the Health Line, available 24 hours a day, 7 days a week) and to improve the ability of the patient with self-care activities (presurgery and postsurgery outpatient clinics, management of chronic illnesses in follow-up training sessions). Most of the time, these innovations were built without an explicit nursing framework, making it very difficult to evaluate with criteria set forth by nursing. The non-acknowledged aim of these innovations is revealed when healthcare policy decision makers (e.g., through research priorities) have nurses focus on increasing patient turnover (efficiency) and on controlling the follow-up of medical diagnosis and interventions (computerizing the data from all sources and controlling laboratory exam schedules, medication intake, and follow-up appointments with physicians), thus eliminating the nurse-person process based on nursing knowledge. Would nursing frameworks provide the roots needed by nurses to set standards for care, related to quality of life, along criteria defined by the people we serve and advocate these criteria to the healthcare policy decision makers? It would be much more difficult to shift the activities of nurses if we structured our own logic for care based on a nursing perspective.

Public awareness is another issue that engages health professionals in a new kind of activity. Web sites in French are becoming more and more available, and a Quebec government public policy has contributed funds to increase the number of connected Web home users. Experts are needed to discuss available choices as people clarify the importance and consequences of choices and orient their lives toward their values. Will nurses be ready? Nurses discuss concerns and priority issues with people on an everyday basis and share their knowledge. The Info-Santé structure is well designed to answer these needs. Yet, the mandate would have to be enlarged because nurses cannot actually accompany people in their decision-making process about their lived experiences of health but do assess the health situation, tell people what to do, and orient them into the healthcare system. Who can advocate for a mandate that acknowledges nursing's essential activity if not nurses who have a strong nursing theory base to guide their practice?

In conclusion, the nursing knowledge in Quebec is evolving from being good at making a reality based on what is thought by other disciplines to creating a reality on its own terms. What we create comes from what we think and what we are. Our challenge may lie in bringing to clarity what has been appearing "ordinary" and natural, that is, the human lived experiences of health and care; yet, that is what makes all the difference in the quality of life from the person's perspective. One may ask how nurses will present this perspective to other disciplines if they do not engage in scholarly work with this nursing perspective. Although the changing environmental context in this information era will continue to be high tech, nurses are developing knowledge based on human experiences related to health beyond diagnosis and value judgment. French-speaking Quebec nurses participate in clarifying and expressing the core of the nursing discipline that is true to their language. Hence, increasingly, the nursing knowledge base as nursing's raison d'être is being acknowledged by other disciplines and shared with them. Who said we were coming of age?

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Theoretical Thinking in Nursing

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The book under review in this issue is *The Nature of Theoretical Thinking in Nursing* (2nd ed.) by Hesook Suzie Kim. Dr. Kim is professor of nursing at the University of Rhode Island and professor at the Institute of Nursing Science, Faculty of Medicine, University of Oslo, Norway. Springer Publishing Company, New York, publishes this edition of the book. (The first edition of the book was published by Appleton-Century-Crofts in 1983.)

Reviews of Kim's book are provided by three nurse scholars who study and teach nursing theory. The first two reviewers are American scholars, Dr. Edna M. Menke and Dr. John R. Phillips. Dr. Menke is an associate professor at the College of Nursing, Ohio State University, and Dr. Phillips is an associate professor in the Division of Nursing at New York University. The third reviewer, Dr. F. Beryl Pilkington, is an assistant professor in the School of Nursing at York University, Toronto, Canada.

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The Nature of Theoretical Thinking in Nursing (2nd ed.)
by Hesook Suzie Kim
(New York: Springer, 2000)

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Almost 20 years ago, Kim's first book (1983) was published regarding a nursing typology to systematize nursing knowledge. According to Kim, the typology was a metaparadigm structure for nursing that could "be used to classify and posit concepts and phenomena within specified boundaries" (Kim, 2000, p. 7). Other nurse scholars had presented a metaparadigm regarding the concepts that were essential for nursing theories (Fawcett, 1984; Yura & Torres, 1975). Kim criticized the metaparadigm concepts of person, environment, health, and nursing as not being specific in delineating boundaries of phenomena for the discipline.

Kim is among a few nurse scholars who have continued to refine their conceptualizations of the discipline (Chinn & Kramer, 1999; Fawcett, 2000; Meleis, 1997; Parse, 1998; Watson, 1999). In the interim between the first and second editions of the book, Kim has been a prolific writer in the advancement of nursing knowledge. A seminal article related to this book was her revised typology of the four domains (Kim, 1987). Her initial domains were client, environment, and nursing action that became client, client-nurse, practice, and environment domains. She has kept the four domains and expanded on her ideology regarding nursing knowledge. She acknowledges that her ideas were "under baked" and later were refined from her experiences in teaching doctoral students and her own scholarly work. The purpose of the new edition is "to understand how conceptualizations and theoretical statements are developed and refined in nursing" (Kim, 2000, p. xii).

Some of the material is new and other parts of the book are the same as the original book. The first three chapters of the book provide an introduction, terminology related to theoretical thinking, and an introduction to her typology. The next four chapters are devoted to an in-depth discussion of each of the four domains. Chapter 8 provides examples of how concepts from the domains can be used to derive theoretical statements. Chapter 9 is totally new material as Kim presents her ideas regarding the nature of nursing epistemology in the context of pluralism that exists in nursing. She makes recommendations regarding what the discipline of nursing needs to do to advance theory development.

One of the strengths of chapter 2 is that it presents the terminology and the definitions that are important in theoretical development and analysis of knowledge in nursing. The reader knows how Kim is using this terminology in the book. Much of the terminology, including concept analysis and theory development, is based on classic works by sociological scholars that are congruent with her doctoral work in the discipline of sociology. She does provide some nursing examples of concept analysis and theory development. "Mesotheory" is introduced as a new level in the scope of nursing theories. It refers to a nursing theory that is less general than a grand theory but more general than a middle-range theory and is necessary to deal with a broad spectrum of phenomena in a domain. Kim includes King's theory of goal attainment, Newman's health as expansion of human consciousness, and Watson's theory of human care as examples of existing mesotheories. It is questionable whether there is a need for another level regarding the scope of a theory.

In chapter 3, most of the material does not go beyond the first edition of the book, except for the revised typology. She has made few changes in the client and environment domains, and the major areas of expansion are in relation to the nursing action and practice domains. In the first edition, she used *Picasso: Les Saltimbanques* as an example of how different disciplines can view the same phenomena differently; however, she does not extend her thinking in the second edition. Likewise, the same client scenario is used to illustrate derivation of theoretical concepts from a nursing perspective. As in the first edition, Kim contends that nursing is the most holistic level, and the four domains would be in a particularistic mode of conceptualization.

In chapter 4, Kim presents phenomena in the client domain from the nursing perspective. The difference in holistic and particularistic phenomena in this domain is at the unit of analysis. She argues that nursing should be concerned with human living and behaviors of health. There is little change in the material except for the use of the word *humans* rather than *man* that was in her original conceptualization. In the first edition, Kim delineated balance, process, configuration, and aggregation as types of conceptual ways of viewing man (humans) from a nursing perspective. She has expanded these types to include "experiencing" and "meaning-making" as part of human living that is based on existentialism, Husserlian phenomenology, and hermeneutics. A clinical situation is used to illustrate a conceptualization of humans that incorporates ontological positions that represent a move from focusing on doing things to the body to a more holistic perspective that integrates the human body, personhood and self, and human living. She contends that this portrays humanness and is the ontological concern of nursing with humanity. In addition, general models of health and some health conceptualizations by nurse theorists are included. As in the first edition, Kim advocates for developing middle-range theories about human life and health that ultimately could be used to

develop grand nursing theories. She omits discussing how meso-theory fits in her ideology of theory development.

Chapter 5 pertains to the client-nurse domain or phenomena arising out of encounters between client and nurse. Kim provides examples of three types of concepts: contact, communication, and interaction related to holistic and particularistic modes. She delineates the types of phenomena in relation to types of meaning-orientation, which are therapy, medium, and philosophy of care, and provides examples from nurse theorists. Overall, the nurse theorists are not presented in as much depth about client-nurse interactions compared to the client domain. Negotiation and client alliance are presented as examples of conceptual analysis and, not surprisingly, neither has been developed in as much depth as concepts in the client domain.

One of the strongest chapters in the book is chapter 6, which focuses on the practice domain or "nursing work." It includes concepts within the nurse and what the nurse does and experiences related to client care. Kim presents a framework for the practice domain that is much more definitive than any of the material presented in the other three domains. The framework is an expansion of her article pertaining to practice theories in nursing (Kim, 1994). She provides in-depth structures for the client and nurse as well as structures for nursing goals and nursing means. The major concepts in this domain are deliberative and enactment concepts and a holistic focus on the concepts. She contends that nurse theorists have not focused on this domain. She includes material related to nursing diagnosis that is related to her involvement with the North American Nursing Diagnostic Association but acknowledges that some nurse scholars do not perceive nursing diagnosis as advancing nursing knowledge. For conceptual analysis, Kim uses the concepts of clinical expertise and nursing aesthetics as examples.

Chapter 7 pertains to the environment domain, and the content is essentially the same as in the first edition. She does incorporate a small section on healthcare environment that is new and provides a few new examples of concepts for the domain. In chapter 8, Kim states, "Theory development for the domain of environment is not central to nursing in general" (p. 224). This might account for the few changes regarding the environment domain.

Chapter 8 is heuristic in providing how theoretical statements can be derived from within and between domains. Examples are provided of descriptive and explanatory theoretical statements. Most of the focus in nursing has been in the client domain phenomena. She contends that knowledge development in the client domain should be nursing theories and middle-range theories on phenomena dealing with humanity. For the client-nurse domain and the practice domain there has been less knowledge development or empirical testing of theoretical statements. She provides some examples of explanatory models that might be developed and tested.

The last chapter is Kim's metatheory of nursing epistemology, which is totally new. Kim contends that there needs to be a unifying framework for nursing epistemology rather than pluralism. In her framework, it is questionable whether it is a synthesis into a unifying epistemology or a pluralism of epistemological perspectives. It reflects some of her biases in regard to hermeneutics, general knowledge, and ethical/aesthetic knowledge and how they can be synthesized. There needs to be more scholarly dialogue about her framework. She acknowledges some nurse scholars who have made recommendations about the epistemological foundations but omits the work of others, for example, Chinn and Kramer (1999). It is questionable whether we should have an epistemological perspective versus multiple perspectives in terms of the phenomena in the discipline, as most human science disciplines have multiple epistemological perspectives. Thus, Kim's framework can be further explained in scholarly dialogue.

The book includes a glossary of terms that would be helpful to the beginning graduate student. On the other hand, the appendix of a synopsis of selected nursing theorists and conceptual models is not in depth and does not contribute to any new knowledge, as it is exactly the same as what is included in her edited work on nursing theories (Kim & Kollak, 1999).

Overall, the book contributes to nursing science in explicating the structure of the discipline. It is heuristic in presenting a typology and phenomena that can advance knowledge development within the discipline. Some nurse scholars and graduate students will find the book helpful in providing a synthesis of Kim's typology over almost two decades. Hopefully, the book will stimulate scholarly dialogue about knowledge development and advance the development of nursing knowledge.

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Each nurse needs nursing theoretical knowledge for education, practice, and research. Yet, content or courses about nursing models and theories have been eliminated or are being eliminated from the curriculum in some nursing programs. Can such actions be propelling the nursing profession toward the precipice of a theoretical disaster? How can nurses be reawakened to the necessity of theoretical thinking in nursing to prevent such a calamity? Such a reawakening is needed so nurses can avert what seems, again, to be a regression of nursing science to medical science with its stagnating effects on the advancement of nursing knowledge and nursing as a discipline.

Fortunately, there are nursing texts such as the second edition of Hesook Kim's book, *The Nature of Theoretical Thinking in Nursing*, that can establish further the primacy of nursing knowledge in the care of people in all dimensions of their life process. Kim notes the discipline of nursing must be recognized as a science and a profession. This requires, according to Kim, nurses who are able to synthesize scientific knowledge and technological advances to create nursing knowledge that provides understanding of people's wholeness, as well as their parts. Kim cogently points out that even though nursing has a rich body of knowledge, there is still a lack of specificity of its subject matter, which I see as a need to differentiate nursing knowledge from medical knowledge, particularly in the education of advanced practice nurses.

Kim (2000) makes clear in the "Introduction" that nurses need to focus on "knowledge that is directly related to understanding nursing practice and its relationship to clients and outcomes of practice" (p. 6). Moreover, Kim believes there needs to be a systematic and more coherent view of this knowledge, whose development has been impeded through the continued use of the metaparadigm of person, environment, health, and nursing. Therefore, Kim presents her four domains of client, client-nurse, practice, and environment as a "guide for delineating conceptual and theoretical issues regarding nursing's subject matter" (p. 7) to eliminate this impediment. Kim's book shows how this is accomplished from the perspective of her "world of nursing" (p. 7).

Chapter 2, "Terminology in Theoretical Thinking," confirms Kim's rich background in theory construction and theoretical analysis, which she presents in an understandable manner. Readers familiar with this diverse body of knowledge will note that Kim selected carefully the literature that supports her particular perspective of theoretical thinking. Terms such as *phenomenon*, *concept*, *theory*, *theoretical statement*, and *measurement of concept* are defined and supported with literature. An important section of this chapter is "Level of Conceptual Description and Analysis: Holistic and Particularistic Modes." These modes are used throughout the book to provide a significant component in Kim's structure for theoretical thinking. However, some readers may question whether Kim's level of concept description is truly holistic or particularistic, because they may hold a different view of holism. A comparison and contrast of Kim's perspective of the terminology of theoretical thinking with Fawcett's (2000) perspective of the structure and use of nursing knowledge will enrich one's understanding of the various dimensions of nursing science.

Chapter 3, "Conceptual Domains in Nursing: A Framework for Theoretical Analysis," presents a structure whereby nursing phenomena can be delineated, differentiated, and studied. The chapter begins with a scenario to show how nurses' conceptualization of a situation is different from other disciplines. This difference is illustrated through a presentation of how various viewers appreciate and understand a piece of art (Picasso's *The Entertainers*). Kim's discussion highlights how aspects of reality can be examined according to one's frame of reference, including whether one is using a holistic or particularistic analytic mode.

Kim uses the scenario to develop questions that can be used to explain and understand the situation from a nursing perspective. She progresses from these questions to a presentation of her four domains of client, client-nurse, practice, and environment, and she depicts how they are different from other metaparadigms of nursing. Each of her four domains is clearly defined and discussed, as well as the phenomena and concepts for each domain, which are illustrated through the use of tables. Types or phases of the phenomena and concepts are presented to aid conceptual and theoretical thinking about each of the four domains.

The content of the chapter then moves to the utility of the domains in theory development, both within and across the four domains. The potential of different types of relations is illustrated in a figure. Some readers may question Kim's idea that explanations within each domain are mainly particularistic whereas those across domains and in all of the four domains tend to be holistic. Kim (2000) states, "If we consider nursing as inclusive of all four domains, nursing as a general concept is at the most inclusive holistic level, while each domain is in a particularistic mode" (p. 54).

After clearly delineating the framework for theoretical thinking in nursing, Kim gives a detailed presentation of each

of the four domains in chapters 4 ("The Domain of Client"), 5 ("The Client-Nurse Domain"), 6 ("The Practice Domain of Nursing"), and 7 ("The Domain of Environment"). The aim and proposed content for each chapter are presented in an overview. The overview facilitates the reader's understanding of the major structure and the relevant theoretical concepts that describe the phenomena for each domain. It is important to emphasize, again, that the level of concept description—holistic and particularistic—plays a significant role in the conceptualization and theorizing necessary to the nature of theoretical thinking for each domain.

Each chapter contains literature that gives a general view of each domain before a nursing perspective is presented. Reference is made to nursing models/theories, with a discussion as to how specific nurse theorists view the phenomenon being discussed. To aid in understanding the nature of theoretical thinking, examples of concepts for each domain are presented from nursing perspectives. Frequently, the overall discussion derives more from a social science rather than a nursing science perspective.

A brief summary highlights the major ideas of each chapter. The overview and summary of each chapter help the reader to link previous content and the content that comes in the next chapter. This is a subtle strategy that emphasizes the integral nature of the content of the chapters and of the nature of theoretical thinking.

After presenting the framework for theoretical analysis and the substance of each of the domains, it is logical that Kim should present chapter 8, "Theory Development in Nursing." Because previous chapters dealt with concepts within each domain, Kim now shows how these concepts can be used to develop theoretical statements to create theory. As stated by Kim (2000), the "concepts and phenomena within each domain and across the domains are examined in order to indicate that relevant and critical relationships may be brought together in 'theories in nursing' and 'theories of nursing' " (p. 206). Kim discusses different models, which are displayed through figures, by which these theories can be constructed.

After presenting new ideas, Kim concludes her book with chapter 9, "Concluding Remarks: Issues in Theoretical Development in Nursing." The substance of this chapter is indicated by Kim's (2000) statement: "Now, we are at a stage where our development of scientific knowledge has to go beyond 'what nursing is all about' to 'what problems nursing knowledge can "take on" as its subject matter' " (p. 229).

The substance and issues of this chapter are indicated by subheadings such as "Identification of Subject Matter," "Conceptual Clarity," "Nursing Orientations or Philosophies," "Nursing Epistemology," and "Theory-Practice-Research Link." Kim (2000) emphasizes that the content of the book "focused on the nature of theoretical thinking rather than on the substance of theories" (p. 241). She states that nurses are responsible for the development of knowledge for the practice of nursing.

In summary, Kim has presented a framework for theoretical thinking in nursing that reflects her worldview of nursing. Nurses who have different worldviews of nursing can still use Kim's basic structure to examine their own worldviews and how theoretical thinking can be engendered within them. Kim can be lauded for providing a structure that reawakens nurses' enchantment with theoretical thinking in nursing. Throughout the book, the nature of her theoretical thinking in nursing is enriched by a logical presentation of the content, and the use of 13 tables and 16 figures provides clarity to an understanding of the content.

There are some concerns, however, about the content of the book. One concern is the emphasis on the social sciences, when nursing literature could have been used. This is noted particularly in the discussion of the phenomena and concepts of the domains where the body of nursing knowledge within nursing science could have been used to a greater degree. One gets the feeling that Kim may be grounded more in the social sciences than in nursing science. This orientation is reflected in the cited literature, which, by the way, tends to be old at times, including some nursing citations.

The most significant concern is Kim's use of Rogers' science of unitary human beings. Her presentation and discussion of it obfuscate a true understanding of Rogers' science. Even though Kim cites Rogers' later publications, she uses older terms and ideas, for example, *four-dimensionality* in some places rather than a consistent use of *pandimensionality*; *probabilistic* rather than *unpredictable*; and *interaction*, *interchange*, and *interpenetrate* for *mutual process*, as well as *organization* and *repatterning*, which Rogers stopped using a long time ago. In fact, some terms Kim presents as Rogerian are inconsistent with Rogers' science. Hopefully, the reader will go to the most recent Rogerian writings, those of Rogers and Rogerian scholars, to rectify this weakness of Kim's book. It behooves writers to use the most recent thinking and ideas of people or to make it clear why older ones are being used.

Kim is to be applauded for her concern about theoretical thinking in nursing. Hopefully, her book will help nurses to participate in creating knowledge that advances nursing science. However, nurses must continuously give glory to nursing rather than paying homage to other disciplines. Otherwise, they will quicken the pace toward the precipice of a theoretical disaster in nursing.

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The foregoing reviews of Kim's book have already addressed its structure and content. And so, in this review, I will further critique some of the ideas that are presented in it. To begin with a general evaluation of the book, I found Kim's book to be clearly written and well-edited. Throughout, Kim develops her ideas carefully and logically. Thus, it is a very readable book for its intended audience, graduate students and scholars.

In the preface of her book, Kim (2000) writes that its primary aim "is to offer a typology of conceptual domains that can be used to delineate theoretical elements essential to nursing" (p. xii). Her purpose "is not to show the adequacies and inadequacies of theories for nursing as a scientific theory, but to show how such theories are similar and different in their uses of abstraction, conceptualization, and subject matter" (p. xii). In other words, "the main emphasis is on the how to and the what of theoretical analysis in nursing" (p. xiii). In my view, Kim has been quite successful in accomplishing what she set out to do. The main criticisms that I raise relate to a remarkable statement that Kim makes in the introduction: "Starting with conceptualization as the first step in theory building, my intention is to begin theoretical thinking, freed from any specific theoretical bias or philosophical bent" (p. 8). And yet, Kim's "theoretical bias and philosophical bent" permeate every page of her book! Indeed, that is to be expected, given that Kim has earned a doctoral degree in sociology and, in order to do so, would necessarily have been "socialized" within that discipline. In fact, the very assumption that one can be "objective" or bias-free is characteristic of the postpositivist scientific tradition. Another telling indication of Kim's theoretical and philosophical bias follows her statement that "nursing practice encompasses both the scientific problem-solving orientation and the human-practice orientation" (p. 2). She goes on to suggest that

> the essential features of nursing knowledge required for practice must embrace the science of control and therapy as well as the science of understanding and care. This also means that nursing as a scientific discipline must delineate its specific nature as a human practice science, distinguished not only from the natural and social sciences, but also from the so-called human sciences. (p. 2)

The "science of control and therapy" worldview is one that is widely held in nursing; therefore, I would submit that, as a practical resource, this book would be most useful to those committed to nursing knowledge development within such a worldview. And yet, Kim's is not a universally accepted worldview in nursing; for instance, some scholars, myself included, situate themselves within the human science tradition (Mitchell & Cody, 1992; Parse, 1981, 1998; Watson, 1985).

Kim's theoretical and philosophical prejudice shows itself in the way that she analyzes concepts (and also, in her choice of concepts) under the domains in her typology (client, client-nurse, practice, and environment). For instance, after introducing each concept and defining it with reference to the literature, she presents a section in which she discusses its operationalization. Her assumption seems to be that measurement is the proper approach to research and subsequent knowledge development. And yet, measurement is not a feature of qualitative research, which is the principal methodology for knowledge development in the human science tradition (although measurement is the goal of qualitative research conducted in the postpositivist science tradition).

One bias that Kim does admit to is the belief "that theoretical development in nursing should allow universally applicable conceptual strategies, regardless of the specific ways nursing problems are classified" (p. xiii). However, to this reader, her analytic approach does not lend itself to all theoretical thinking in nursing. For example, viewing the "client-nurse domain" as separate from the "practice domain" does not make sense within Parse's (1998) human becoming school of thought, in which the client-nurse "domain" (or process) is identical to the practice domain. Indeed, Parse's (1987, 1998) practice methodology is specifically intended to guide the nurse-person process. Furthermore, within Parse's worldview, the domains of client and environment are inseparable. To her credit, Kim does recognize that some holistic perspectives, such as Rogers' (1980) model, do not view client and environment separately and, thus, are not congruent with her typology.

Kim's division of conceptualizations in nursing into *holistic* and *particularistic* modes is another area for critique. At first glance, this seems like a useful framework, not unlike those in the ample literature on paradigms in nursing. On closer examination, however, although Kim's (2000) examples of particularistic concepts (see Table 3.6, p. 54) are clearly just that, the examples of holistic concepts are arguably so. For example, under the client domain, Kim includes concepts like *adaptation*, *disability*, and *recidivism*. These concepts seem to focus on a specific aspect of clients' health or healthcare and, thus, do not reflect holism in the sense of an entire human life. Kim's notion of holism seems to epitomize the "totality paradigm" in Parse's (1987) schema of theoretical thinking in nursing. In contrast, in a simultaneity paradigm view (e.g., Parse, 1987; Rogers, 1980), "holism" would be interpreted to mean that humans are unitary beings in mutual process with the universe. Also with respect to "holism," Kim argues that viewing health as living is too broad a conceptualization to be useful, whereas that is exactly the way that Parse (1981, 1998) conceptualizes health—that is, as human becoming. Indeed, the World Health Organization has adopted a very broad definition of health, which could be said to encompass all of human life.

In chapter 6, Kim discusses "the practice domain of nursing." In this reader's opinion, much of what is currently considered to be the practice domain of nursing does not reflect unique nursing knowledge at all but, rather, is an eclectic combination of practical knowledge and knowledge from other disciplines, which nurses borrow and apply to perform specific roles in certain contexts. Kim (2000) touches on this reality when she observes that the nursing world seems "preoccupied with bringing into the core of nursing those actions that require competent use of technological instruments" (p. 131). Moreover, she notes that "all of what nurses do in ordinary nursing situations is not necessarily 'nursing,' and that nurses are neither scientific in all their acts nor able to make all their acts have nursing meaning" (p. 143). Here, I would argue that the science of nursing lies not in the practice of nursing, which is an art, but, rather, in its knowledge base.

When reading chapter 6, the overall impression is that Kim's conception of nursing practice is closely aligned with the diagnostic, biomedical model of healthcare. That is not unexpected, given that Kim has been actively involved with the American Nursing Diagnostic Association. The diagnostic "attitude" is an expert-driven approach to healthcare, in which the moral authority of the practitioner to assess, plan for, and intervene in the client's health situation is not questioned. For instance, one concept that Kim analyzes, without critique, is that of "compliance," even though some scholars have roundly criticized its use (e.g., Holm, 1993). An expert-driven conception of nursing practice is also evident in the assumption that knowledge development should be aimed toward explanation, prediction, and control. Nowhere in the book does Kim acknowledge the growing movement toward a client-centered approach in healthcare and what that means for knowledge development in nursing. Even though Kim (2000) gives lip service to "the science of understanding and care," she does not elaborate on it to the extent that she does "the science of control and therapy" (p. 2).

It is not until the last chapter of the book that Kim (2000) addresses the philosophical questions that surfaced at the outset, for this reader. It is here that Kim sets forth her understanding of nursing epistemology. Had this chapter come at the beginning, it would have served as a helpful context for reading the remainder of the book. In it, Kim identifies various "nursing orientations or philosophies" that have influenced nursing knowledge development, including postmodernism, existentialism, phenomenology, and empirical positivism. She states that such orientations "provide the general frameworks within which theories and research methodologies are developed in nursing" (p. 232). Interestingly, Kim advocates that these diverse philosophies be unified in a nursing epistemology, which she terms "a critical normative epistemology" (p. 235). This is a creative attempt to perhaps do the impossible, notwithstanding that there has been an ongoing call for such a unification of nursing science (for example, Reed, 1995).

For me, perhaps the most interesting feature of the book is the way that Kim has incorporated extant theoretical works in nursing in discussing her analytical typology. By so doing, she has helped to clarify the nature of theoretical thinking in nursing and has posited many ideas for further exploration and development. Overall, Kim's book is a cogent and scholarly work that is a worthy subject for further dialogue, in the interests of advancing nursing science.

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Letter to the Editor

I am perplexed as I read the July 2000 International Perspectives column by Sylvia Rodgers titled "The Role of Nursing Theory in Standards of Practice: A Canadian Perspective." There are three issues perplexing me. The first is related to the concept of theoretical pluralism. The second is related to the number of theoretical frameworks that nurses are expected to use in practice. The third is related to the role of nursing theory in standards of practice.

The author notes that the College of Nurses of Ontario adopted the concept of "theoretical pluralism" in modifying standards of practice in Ontario, Canada. Theoretical pluralism acknowledges and accepts the variations in nursing theories and frameworks (James & Dickoff, 1982). "Theoretical pluralism . . . permits the nurse to select and apply the theoretical model appropriate to the particular practice setting and client situation . . . [and] depth and breadth of knowledge of the individual nurse" (Rodgers, 2000, p. 261). I do think the concept of theoretical pluralism sounds great. I agree that nurses have to select an appropriate theoretical framework according to their client population, practice setting, and their own knowledge base. When selecting a theory for practice, we often place our own preference and knowledge base in priority. Nevertheless, when deciding whether a theory is appropriate for an individual client in a particular clinical setting one has to take the perspective of the client into account. The conceptual models that nurses use should be congruent with the perspective of the client. Due to the diversity of individual clients, because one theoretical framework is appropriate to one client does not mean that particular framework will be appropriate for another client. However, the real question here is, could a nurse apply one theory this minute and apply another one the next minute? Could a nurse actually practice theoretical pluralism? Dickoff and James (1989) questioned "how to live with multiplicity and difference without chaos, separatism, or ineffectiveness" (p. 98). Is it possible for nurses to integrate different theoretical models in practice?

Secondly, Rodgers (2000) contradicts herself throughout the article by suggesting that nurses should utilize one specific theoretical framework or multiple theoretical frameworks. On one hand, she points out that one of the indicators of the Professional Standards is that "each nurse uses nursing and other theoretical frameworks to plan and implement professional service" (Rodgers, 2000, p. 262, quoting from College of Nurses of Ontario, 1996, p. 9). On the other hand, the author states that nurses are expected to "identify a conceptual model for nursing practice" (p. 261) and "RNs are expected . . . to apply a consistent framework to decision-making" (p. 262). Rodgers (2000, p. 262) also quotes another indicator from the Professional Standards: "Each nurse provides a theory based rationale for decisions" (College of Nurses of Ontario, 2000, p. 8). My question to the author is, How can nurses use theoretical frameworks that are relevant to their practice and be expected to apply only a consistent framework at the same time? Does the author mean nurses should have the ability to apply at least a theory or a theoretical framework for their practice, but also be able to use more than one theoretical framework in nursing care? Or does the author mean that there can be only one conceptual model for a particular client population, but there can be more than one framework if the clients are different or practice settings are changed?

Finally, I think the title of this article is misleading. It is my impression that the author emphasized endlessly the importance of theories regardless of origin (i.e., nursing theories or theories from other disciplines in the standards of practice). For example, on page 262, she quotes, "Each nurse uses nursing and other theoretical frameworks to plan and implement professional service" (College of Nurses of Ontario, 1996, p. 9). She also states that a theory that includes "knowledge from nursing and related disciplines" (p. 262) provides nurses with the rationale for decision making. In addition, she states that competence in nursing is "related to the application of various theories including family, nursing, communication, and system theories" (p. 262). I agree that nurses apply theories and knowledge both within and outside the nursing discipline. If we think nurses use only nursing theory and knowledge to guide nursing practice, we must be kidding ourselves. It is obvious that the standards of practice in Ontario are based on both nursing and non-nursing theories, so why does the author specifically mention nursing in the title? Does the author want to emphasize nursing theory–guided practice? The American Academy of Nursing's Expert Panel on Nursing Theory–Guided Practice defined nursing theory–guided practice as "a human health service to society based on the discipline-specific knowledge articulated in the nursing frameworks and theories" (Parse et al., 2000, p. 177). However, if a standard of nursing practice is primarily based on the knowledge from other disciplines, is it still a standard of nursing practice?

I want to thank the author for inspiring my thinking, since often perplexity is an impetus for good thinking. I believe articles such as this one that stimulate thinking and discussion can advance nursing knowledge.

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