Commentary: The Development of Nursing Diagnosis and Theory

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A RECURRING dilemma inherent in the scientific process involves outcomes. Today's scientific outcomes are not only tentative, but they also contain limitations that are helpful in identifying rationales for altering or abandoning the method used. Mead views the scientific method as one of self-consciousness, a process of intelligence which is "continually adjusting itself to new situations ... continually changing its technique."[1(p290)] For Mead, scientific interpretation generates hypotheses upon which one acts, and continues to act, until exceptions are found. Then the cyclic activity of reconstructing or replacing such hypotheses is begun. The process is evolutionary.

NURSING DIAGNOSIS AS A THEORY DEVELOPMENT ACTIVITY

The focus of professional nursing's scientific activities on the concept of nursing diagnosis exemplifies this evolutionary process. Particularly in the last decade, the

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concept has been explored from a wide range of vantage points, both at a conceptual and a practical level. It has increasingly become an integral component in discussions addressing such diverse issues as nursing legislation, quality assurance, third party payment, nursing curriculum design, computerized health records and nursing peer review. While the formal efforts of the National Conferences on the Classification of Nursing Diagnoses most concretely demonstrate this concept exploration, a wide array of related explorations interact with this formal effort. They demonstrate repeatedly that the concept of nursing diagnosis impinges directly on both the theoretical and empirical bases of nursing science.

The generation and classification of nursing diagnoses has been described as a theory development activity.[2(p35-38),3(p77-78)] More specifically, the outcome of this activity is factor-isolating theory as described by Dickoff, James and Wiedenbach.[4] Theory development, as one mode of scientific activity, generates tentative hypotheses upon which one acts. However, as noted earlier, it also delineates new situations, the exceptions which raise new questions. Rapid progress in the scientific exploration of nursing diagnoses has not only enhanced the understanding of nursing but has also identified persisting quandaries that surround the concept of nursing diagnosis and subsequent theory development. Some of these quandaries are value issues.

VALUES AS MOTIVATORS OF HUMAN BEHAVIOR

A value is defined by Kluckhohn as "a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable which influences the selection from available modes, means, and ends of action."[5(p395)] It is a concept used by an individual or group to guide choices, to provide standards for evaluating behaviors. As Smith notes, values "pertain to the desirable, the preferable, rather than to the merely desired or preferred; to the realm of 'ought' rather than that of 'is' or 'want'."[6(p102)] Values are powerful motivators of human behavior.

Individual nurses and groups of nurses are behaviorally motivated by their values. Nursing as a profession has only recently actively engaged in the deliberate and conscious dialogue directed at value clarification.

Implicit Values in Nursing Diagnosis

No scientific activity is value free. The decision to engage in scientific activity is itself a choice based on values, as are one's focus and methodologies. Such values are often implicit. One researcher approaches pain focusing on subjective components while another focuses on physiological factors and a third combines both. All may enhance in different ways the understanding of pain.

The researchers' decisions may have been influenced by such variable factors as previous education and experience, available subjects and resources or funding limitations. These variables and unnamed others all have a value component. In addition, the personal values of the individual researcher influence decision making. All of these value factors may, however, remain implicit.

Theory development, as one mode of scientific activity, is a process clearly

influenced by values. Ellis, describing the characteristics of significant theories, contends that in such theories "implicit values are recognized and made explicit."[7(p221)] This is not only the least developed of Ellis' criteria, but the least explored factor in existing discussions of nursing theory. Nonetheless, its impact may be the most extensive and pervasive.

Nursing diagnosis and related theory contain many implicit values. These values can be recognized and made explicit, thus increasing the significance of the theory. This process of explication reveals some persisting quandaries in the theory and describes new situations which may require new approaches.

The Value of Holistic Nursing Care

Few values pervade professional nursing as completely as does the commitment to holistic nursing care. At both the conceptual and the practical level, this value informs nursing activities. It was an explicit focus of nursing's initial exploration of nursing theory.[7-9] As professionals, nurses are persistently committed to providing nursing care to the whole person, a goal that is far easier to value than to actualize.

The First National Conference on Classification of Nursing Diagnoses utilized a definition of nursing diagnosis as "the judgment or conclusion which occurs as a result of nursing assessment."[10(p70)] The conclusion is drawn from a data base generated by a nursing assessment. A wide array of nursing assessment guides or formats exists, all clearly demonstrating nursing's commitment to holistic care. Perhaps the most generally accepted guide, the American Nurses' Association (ANA) Standards of Nursing Practice lists 11 assessment parameters, several of which include subparameters, e.g., "cultural, religious, socioeconomic background."[11(p3)] The complexity and scope of this activity is self-evident and it implicitly reflects nursing's value of holistic nursing care.

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Nurses may, however, find themselves ill equipped to theoretically and empirically act on this value. This is not due so much to any real deficiency on the part of professional nursing but rather to the state of knowledge about complex judgments, the interaction of diverse human variables and the process of human decision making.

Existing clinical judgment paradigms are considered inefficient and inadequate for determining even one aspect of human experience, e.g., cognitive style or ethnic nutrition patterns. Diverse sets of human variables are minimally understood in terms of their interactions. There is, for example, little empirical information available which clarifies the interaction between persons' coping patterns and their health goals, ecological environments, interaction patterns or material resources. However, all of these parameters are included in nursing assessment. Finally, the act of drawing conclusions is itself a complex activity influenced by individual traits such as perception and self-concept.

Thus, while professional nursing may

place a high value on holistic care, the development of a factor-isolating theory which adequately reflects this value is likely—given the present level of knowledge—to have deficiencies. In the evolutionary scientific process, this is not a deterrent but a source of knowledge about the "new situation" to which adjustments must be made. Making the value explicit clarifies the demands of this adjustment.

The Value of Situation-Producing Theory

Much of the initial exploration of nursing theories was influenced by the concept of theory levels described by Dickoff et al.[4] As noted above, the development of theory based on nursing diagnosis exemplifies the lowest level in their discussion, i.e., factor-isolating theory. The highest level, situation-producing theory, was presented by Dickoff et al. as the goal toward which nursing should aspire. This is the theory which focuses on the kinds of situations viewed as worthy to be produced as well as identifying means and locales for producing such situations.[12] They clearly argue that nursing theory "must be theory at the most sophisticated level—namely a situation-producing theory."[4(p123)]

While the goal itself is uncontestable, the implicit value it communicates has influenced subsequent theory development. Because, as Smith observed, values deal with "oughts," professional nursing engages in a premature commitment to theories as situation producing. Because we value this level of theory, and "ought" to have it, we assume that indeed we do. Values can thus encourage us to view our theories as laws or dogmas.

The concept of nursing diagnosis has demonstrated serious knowledge base constraints inherent in describing the domain of nursing at the very basic factor-isolating level. These constraints become even more complex at increasingly higher levels of theory development. At the Third National Conference on Classification of Nursing Diagnoses, a group of theorists initiated efforts toward development of a conceptual schema which would provide a classificatory system for nursing diagnoses. The complexity of this task further substantiated nursing's knowledge base constraints at a factor-relating level of theory development.

Despite these experiences, we do engage in efforts toward situation-producing theories and we value the goal of achieving theory development at this level. The description of such theories offered earlier demonstrates that these theories deal with what is "deemed worthy to be produced." In the absence of scientific facts as a basis for identifying what is "deemed worthy," we may readily substitute personal values. Thus the activity of theory development at a situation-producing level will in part be predicated on the personal values of the theorist, specifically in regard to health, illness and the nature of humans.

Current nursing theory at a situation-producing level may emerge less from scientific fact than from the individual theorist's personal values about persons and their health experiences. Such value bases tend to be implicit, operating as assumptions in scholarly discourse. They may be minimally perceived as value postures.

These value postures vary among theo-

rists and their proponents. Value postures influence theory development and related scientific activities. One such activity, the generation and classification of nursing diagnoses, is thus directly influenced by value postures of individuals. Subsequently, diagnostic labels are conceptualized in terms of existing conceptual schema of nursing grounded in specific implicit values.

In principle, this diversity can be an enriching process, providing multiple viewpoints. If however, such situation-producing theories are viewed as law or dogma and values are not made explicit, the outcome, for the purposes of theory development of nursing diagnosis, becomes one of unyielding value conflict. The generation of a useful diagnostic taxonomy for nursing can thus be limited by unrecognized differences in values.

Values of Supporting Sciences

Because nursing is an applied science, it has its roots in a diverse number of basic sciences. As nursing assessment parameters demonstrate, these roots are numerous: anatomy, psychology, physiology, sociology, chemistry, anthropology and physics. This list is more indicative than exhaustive. The basic sciences constitute the foundation of the science of nursing.

The process of incorporating these basic sciences involves not only the incorporation of theoretical frameworks and empirical findings, but also the incorporation of values implicit in each discipline's scientific activities. These values vary. One need only compare research focusing on deviance with research focusing on renal function. Nonetheless, we incorporate, often unconsciously, the values implicit in the scientific activities of the basic sciences. These values, coupled with nursing's unique sets of implicit values, may further complicate our efforts toward describing the domain of nursing.

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The domains of the basic sciences, while perhaps more clearly delineated than nursing's, have been minimally interrelated—e.g., we know little about the interaction between physics and anthropology, although common sense tells us that there is such an interaction. In the exploration of such interactions, the variations in the basic sciences' value postures would conceivably become more overt. Nursing, in its efforts at theory development, experiences these conflicting value postures. It is perhaps most evident in the divergent value positions of nursing specialties—e.g., mental health nurses contend that they require their own unique theory of nursing and surgical nurses argue that only experimental research designs are appropriate to their field of study.

These value postures are largely unexplored. They can readily precipitate value conflicts which are, for the most part, unresolved. Their roots in the value disparities of the basic sciences are largely unrecognized.

Further confounding this situation is the tendency to incorporate the value conflicts of specific sciences: the nurture-nature controversy of psychology, the mind-body dichotomization of physiology, the self-society interaction dilemma of social

psychology. These further obfuscate our decision making.

The development of a theory of nursing diagnosis directly confronts this array of value issues. It is evidenced in the concept naming conflicts experienced by maternity nurses versus pediatric nurses in discussions about parenting. It is reflected in the specialized category system espoused by rehabilitation nurses discussing immobility. It is apparent in the dissonance experienced by hospital-based nurses in a discussion led by community health nurses proposing a nursing diagnosis focused on safety in the home. These and comparable phenomena are an integral component of the national conferences on nursing diagnoses and demonstrate the complexity of the value conflicts we confront. There are no easy answers, but an initial step involves making explicit the values which form the basis of our recurring differences.

Making Implicit Values Explicit

Hardy recently described nursing as a preparadigm science.[13] She utilizes Kuhn's description of the initial stage of scientific development, the preparadigm stage, where divergent approaches are made toward the same phenomena, generating divergent results.[14] The stage is one of confusion and unsystematic exploration and is characterized in nursing, as Hardy notes, by "different, ill-defined perspectives that are heatedly argued and defended.[11,13(p39)] This aptly describes the theory development of nursing diagnosis. Much of the argument and defense stems from identifiable value conflicts.

The choice to make implicit values explicit is itself a value choice, but one that is necessary to the growth of scientific knowledge. The generation and classification of nursing diagnoses is an embryonic theory with significant potential for the nursing profession. In the choice to explicate the values that confound, confuse or inhibit theory development, the nurse scientist may conceivably discover the new situations and new techniques that generate change. The development of a situation-producing theory focused on holistic nursing care and grounded in a unique synthesis of basic sciences is an ambitious scientific endeavor. Inattention to values can become a serious deterrent. Attention to values may be a source of scientific discovery.

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