Role of the specialties in nursing science

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QUESTIONS CAN BE raised regarding the need for specialties in nursing. First, will the specialties be viable beyond the present decade? Second, do the currently designated specialties fit the major paradigm of nursing science: person, environment, health status, and nursing action? The standards of practice for the five American Nurses' Association (ANA) Divisions on Nursing Practice have emphasized advanced study, expert competence, and increased autonomy, both in the work environment and in decision making.[1] In contrast, it is less clear what the specialties could or should be contributing to nursing science, specifically in the area of theory development and testing.

TRENDS IMPACTING ON SPECIALIZATION

It could be argued that there is conceptual movement away from specialization. Increasing numbers of nurses are making their implicit conceptions of nursing more

explicit, but none have addressed the roles of nurse specialists in their descriptions of person, environment, health status, and nursing action. Moreover, three major trends can be identified to support the position that the specialties are not in the forefront of theory development. These three trends are

1. defining nursing as a discipline separate from medicine,
2. educating entry-level generalists, and
3. developing conceptual frameworks.

Defining nursing apart from medicine

To establish an identity separate from medicine, nursing has defined itself as a discipline that focuses on human response to illness rather than illness per se, restortion of health that aims at higher level functioning than that prior to a current illness, and health promotion that considers health beliefs and values. Operationalizing a definition of nursing that moves away from a disease and body systems orientation has changed the focus, emphasis, outcomes, and knowledge base for nursing. Although nursing and medicine still enjoy some shared knowledge, perspectives of the two professions are clearly different. Medicine has become more specialized in an attempt to keep abreast of technological change and increased knowledge, whereas nursing has become more generalized and holistic in its approach to health care.

Educating entry-level generalists

As Ellis points out, "rejection of the body-systems perspective was forced by the identification of a burgeoning list of specific disease entities, the recognition of the impact of psychological and social factors in disease or in response to it, and by . . . affirmation of the obvious: patients are people."[2(p406)] Similarly, Stevens[3] discusses several educational ramifications of the "new" focus of nursing. In addition to the diversity of knowledge that students must synthesize in a short period of time, major units of study have been derived from different conceptual bases. For example, medical-surgical nursing was disease-based; psychiatric nursing, patient-based; and community health nursing, locus-based. Therefore, many schools determined that using speciality departments as the primary, organizing components of the curricula was no longer conducive to learning nor efficient for teaching. As a result, many nursing curricula now offer a series of concepts basic to nursing, along with the nursing process. These curricular designs vary greatly from school to school, even though they are commonly and loosely referred to as integrated curricula.

One of the outcomes of "integrating" the theoretical basis for nursing in this way is that the specialties are no longer clearly distinguishable. Although the movement away from compartmentalization has been beneficial for educating entry-level generalists, its impact on nursing specialties has not been positive. There are insufficient empirical data, but some suggest that this

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blending of nursing concepts makes the specialties less visible and therefore less viable alternatives for advanced study and practice.[4,5]

Integrated curricula constitute a major change in the educational process, and a number of other factors interactive with curricular design also have had an impact on obliterating the specialties. The shift of educational program control from hospitals to universities is one of these factors. As enrollment in diploma schools declined, the traditional admission policies of nonmarried status and age restrictions disappeared. Concurrently, as the image of nursing changed, schools of nursing experienced an influx of students in general and an increase of students with degrees in other fields in particular. Clinical placements were drastically altered to account for both large numbers of students and application of integrated content. Thus, "rotation" to such areas as operating room and emergency department, where specialty skills were modeled, was eliminated entirely.

Changing patterns of illness and increased knowledge and technology have also had an impact on both practice and education. Among these have been sharp reductions in the number of hospitalized sick children and psychiatric patients. As a result, student clinical experiences in these specialty areas have also been reduced, and in some schools, they have been eliminated.

Development of conceptual frameworks

The curricular changes, largely of the 1960s, were bold, considering that they were made based on the rudimentary definition of nursing by Henderson[6] and the problem-centered processes by Abdellah.[7] Transforming these early definitions into a knowledge base took a much longer time. For example, Johnson[8] published an article on the significance of nursing in 1961 and presented a paper on a model of nursing in 1968,[9] but it was not until the 1970s[10] that significant conceptualization of nursing appeared in writing. Rogers' conceptual framework[11] on unitary humans was published in 1970, and King's book[12] on nursing theory and Orem's book[13] on self-care were published in 1971. Roy's adaptation model[14] appeared in 1976, although her first book on conceptual models, edited with Riehl, was published in 1974.[15]

These conceptual systems have been in agreement on the unifying characteristics of person, environment, health status, and nursing action. Moreover, these conceptual systems provide direction for nursing practice and education as well as conveying to the public and other health care professionals the boundaries of nursing. Numerous articles describing practitioners' use and extension of these models have been published. In addition, school of nursing faculties are accepting various frameworks as bases for curriculum design. However, none of the conceptual systems have delineated the role of the specialties in theory development.

A POSITION IN SUPPORT OF SPECIALTIES

The social policy statement on nursing by the American Nurses' Association[1] presents a position in support of nursing specialties. Reflecting the belief that speciali-

zation constitutes a major advance in the discipline, the statement delineates the characteristics of specialization within the context of the nature and scope of nursing practice. According to the statement, the phenomena that are of concern to the discipline are human responses to actual or potential health problems. Nursing diagnoses and interventions address these responses in contrast to illness status per se. The statement includes a listing of general categories of human responses and suggests that a taxonomy of these phenomena be developed by the discipline.

Specialization is viewed as an indication that the profession has advanced to the stage of narrowing its focus on subsets of phenomena selected from the domain of nursing. The purpose of specialization is to refine nursing practice through nursing research based on in-depth understanding of specific phenomena. This point is summarized as follows:

> The effectiveness of the profession is increased when specialists are available to focus their efforts around a particular aspect of clinical nursing, to test application of newly available theory to conditions germane to that clinical aspect, to translate those theory applications into nursing approaches considered more useful than prevailing ones.[1(p25)]

However, the weakness of the ANA statement is its adherence to the belief that nursing is primarily an applied science. Thus, it emphasizes the *application* of a broad range of theories borrowed from other disciplines to understand subsets of phenomena, rather than the *generation* of nursing theories or the *adaptation* of borrowed theories and concepts for nursing practice. Similarly, although the ANA document emphasizes the use of theory to guide research on the effectiveness of nursing actions, it does not clearly link nursing research with theory generation or refinement. Thus, the statement supports the need for specialization in nursing to advance nursing practice, but it does not clearly delineate the contribution that nursing specialties can make to nursing science.

NURSING SPECIALTIES AND THEORY DEVELOPMENT

The viability of nursing specialties depends on their contribution to theory development in nursing. Recent discussions of this issue within the specialty of psychiatric/mental health nursing support this position. For example, two nursing leaders link documenting and testing the conceptual basis of psychiatric/mental health nursing practice to the growth of the specialty. Dumas[16] suggests that psychiatric/mental health nurses became "derailed" from this process after an initial productive period in the 1950s and early 1960s. As resources were expended primarily on role development in a variety of settings, documentation of the conceptual basis of practice in a systematic manner faltered. Similarly, O'Toole[17] stresses that the survival of the specialty within nursing depends on the development of theory that is relevant to practice and can be validated through systematic practice-oriented research.

Although there is no consensus in the literature as to whether the scope of nursing theories should be broad or limited, it appears that nursing specialties can best contribute to nursing science by generat-

ing and testing middle-range or limited-scope theories. General or grand theories of nursing may be useful in distinguishing the domain or boundaries of nursing from those of medicine and other disciplines, but limited-scope theories are more directly relevant for addressing practice concerns in a nursing specialty area.[3] The nursing literature increasingly supports the position that in a practice discipline, theory and research must be intimately related to practice. Theory generated by practice is used to guide practice once it is validated; in turn, theoretically based practice provides data for further theory refinement.[3]

If middle-range theory is selected, the major phenomena central to nursing theories (person, environment, health, and nursing action) can be used to distinguish between the foci for theory development and refinement among the various nursing specialties. A limited-scope practice theory is composed of a set of propositions regarding the relationships between concepts representative of at least two of these phenomena, one of which must be nursing actions.

However, the relative importance of the general phenomena and the nature of the corresponding concepts vary with the practice arena of the specialty. For example, one could argue that the mental health aspects of health are of primary concern to psychiatric/mental health nursing. When assessing the health status of clients, psychiatric/mental health nurses focus on identifying selected psychosocial factors interactive with mental and physiologic illness states. These factors can be classified as essentially intrapersonal (eg, self-efficacy), interpersonal (eg, interaction patterns), and systems variables (eg, social supports). Psychiatric/mental health nursing interventions focus on supporting or facilitating the development of intrapersonal, interpersonal, and system competencies (eg, coping strategies) to effect a positive outcome in the clients' health status.

The same general phenomena can be used to define a focus for theory development in other current nursing specialties as well as in newly emerging ones. For example, environmental stressors that impact on the health status of selected populations or communities may be of primary concern to community health nursing, and interventions may focus on developing system-level strategies to reduce selected stressors instead of on developing coping strategies of individuals or families. Hence, a limited-scope theory relevant to community health nursing practice would reflect this shift in emphasis. Moreover, as practice-relevant theory was developed and refined in each specialty, from its particular vantage point of these phenomena, the specialty would contribute to nursing science through both cumulative and didactic processes. This leads to the question of how middle-range theory is developed in the nursing specialties.

Theory development process

Practice theory can be derived either inductively or deductively.[3] Moreover, theory developed in other disciplines, such as the physical and behavioral sciences, can be *adapted* to nursing situations primarily through deductive processes. These two approaches to theory development are not mutually exclusive.

Because nursing is a practice discipline,

theories and concepts are frequently borrowed from other disciplines and imposed as guides for practice.[3,18] However, because professionals in other disciplines attempt to understand and explain some aspects of person, environment, and health from their own perspectives, borrowed concepts and theories of these phenomena must be *adapted* to the perspective of nursing. It is through this process of adaptation and synthesis that borrowed concepts become an integral aspect of nursing theory for practice.[18] Stevens[3] suggests that once theories have been adapted to nursing's perspective of these phenomena, they become *shared knowledge,* crossing discipline boundaries, rather than *borrowed* theories.

In the inductive method of theory development a specific phenomenon is identified and then related to the more general. Phenomena in the clinical practice arena are identified as a felt need or problem. The inductive approach enjoys current popularity because it is viewed as an effective method in the development of "practice-oriented theory." This approach is also commonly referred to as a step toward developing situation-producing theory, a term introduced into the nursing literature by Dickoff and James[19] in 1968. They propose that theory for clinical practice is identified in the clinical situation; practice theory is developed by *naming* the phenomena of interest, *relating* them, *predicting* what will work under what conditions, and *prescribing* according to the need.

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The inductive approach is also useful in naming and describing concepts that are uniquely embedded in nursing practice. The following example suggests the origin of a concept and traces its development over a 30-year period.

MUTUAL WITHDRAWAL AND INTERPERSONAL ATTRACTION

The concept of mutual withdrawal has been selected as an example of a phenomenon identified in a clinical nursing setting, as was first described by Tudor.[20] The concept can be viewed as originating *in* nursing rather than coming from a related discipline. Tudor noted that

> although a particular nurse may establish effective and satisfactory relations with a patient, this can easily be undone by what others do with the patient, by the formal and informal social structure on the ward, which tends to maintain the patient in his mental illness.[20(p11)]

Tudor's frustration with the "undoing" of the nurses' work in the social environment led her to formulate some hypotheses and to test them over a 6-month period as a participant observer. Tudor used the case study method to more thoroughly *describe* an as yet unnamed phenomenon.

The severely mentally ill patients were identified as study subjects based on the tendency of the hospital staff, in general, to avoid them. Likewise, Tudor noted that the dominant pattern of patient behavior was withdrawal. She hypothesized that this avoidance-withdrawal pattern was the major reason that patients did not get

better. Tudor's assumptions were that staff withdrawal → patient withdrawal from reality → further withdrawal of staff → maintenance of mental illness.

Tudor called this concept *mutual withdrawal* and isolated such variables as staff labeling of patients as "hopeless," "unresponsive," and "unable to tolerate closeness by staff." Tudor observed that these statements and attitudes prompted staff to label themselves as hopeless and as "failures." Finally, she noted that removing the personal approach from interaction with patients perpetuated the continued mutual withdrawal process. Further development of this concept took two decisive directions, focusing on the interaction (1) between patients and nurses and by nurse researchers/practitioners and (2) between the causality of mental illness and the psychotherapeutic environment,[21] which was a multidisciplinary undertaking.

Following what appeared to be a relevant and unique effort of theory development for psychiatric/mental health nursing, Tudor's work,[20] originally published in 1952, lay dormant until this significant paper was reprinted in 1970. In the last decade, Hall[22] and later Mitsunaga and Hall[23] have been instrumental in the major development of both inductive and deductive approaches to studying the nurse/patient relationship.

Hall[22] reported results from a field observation study in which patient participation and nonparticipation characteristics could still be clearly noted and documented even though 20 years had passed since Tudor's observations. Hall notes that hospital staff were drawn to patients who participated in their treatment and that nonparticipant patients were eventually discharged showing no apparent improvement. Hall's study differed from Tudor's in that it focused on both active and withdrawn behavior. Hall isolated and described behaviors of both participant and nonparticipant patients as follows:

- Participant patients were similar to staff assigned to the units.
- A mutual linking occurred early in hospitalization.
- Staff tended to spend more time with "active" patients.
- Unless patients could draw attention to themselves, they did not receive recognition that led to nurse/patient interactions.

The following year, Hall[24] presented a comprehensive review of the literature of interpersonal attraction and discussed some relevant variables *associated* with attraction such as liking, similarity, social desirability, reciprocity of liking, and proximity. It is important to note some relevant points in Hall's process. An attempt was made

- to start at level 1 of theory development (ie, to name and describe relevant phenomena under study);
- to borrow applicable concepts from other disciplines, such as sociology, without imposing them on practice;
- to develop relationships between relevant variables as they affect nursing;
- to begin to formulate researchable questions.

Ongoing research by Mitsunaga and Hall[23] indicates that relationships among additional variables have been identified and tested along with liking, respect, and social desirability involving nursing populations. These variables are compliance, degree of illness, and perceived quality of

care among a sample of medical-surgical patients. Moreover, several important ethical and educational issues have emerged as a result of this work, particularly in regard to the properties of the professional relationship.[25] Thus, the work of Mitsunaga and Hall also serves as a model for the development of the conceptual bases for psychiatric/mental health nursing because the interweaving of unique and shared concepts along with both inductive and deductive methods serves to identify new ways of defining the nurse/patient relationship. In this way, theory is not imposed on practice, but rather, serves as a scientific basis for practice.

The testing of the concept of interpersonal attraction in a medical-surgical nursing practice environment demonstrates the abstractness and generalizability of the concept. Nurses in medical-surgical nursing practice specialties can continue development of this concept from their *unique* focus. For example, how would quality of care be affected by the widespread adoption of a primary nursing model that requires one patient to be dependent on, and in frequent interaction with, one nurse, who may not like the patient? Answers to this and related research questions demonstrate the potential of middle-range theory as a basis for nursing practice.

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Although the viability of nursing specialties has been challenged during the last several decades, it appears that nursing science would be enriched by continued diversity. Specifically, the development of nursing science is enhanced when nurses in one or more of the specialties actively engage in middle-range theory development from the unique perspective of a specialty. Not only does such activity assist in documentation of the conceptual basis of the practice of various specialties, but their endeavors contribute to affirming the linkage between theory, research, and practice as integrated aspects of nursing science.

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