Theoretic diversity: Evolving paradigmatic issues in research and practice

Although research and practice differ in that one is the building of knowledge and the other the application of that knowledge, it is suggested herein that there are interesting parallels to explore between the evolving debate on research methods and the emerging theoretic debates on practice. On the basis of the Canadian experience and the trend toward adoption of a single-theory approach, the authors argue for theoretic diversity in nursing practice settings.

Lynn M. Nagle, BN, MScN
Doctoral Student
School of Nursing
University of Rochester
Rochester, New York

Gail J. Mitchell, BScN, MScN
Doctoral Student
School of Nursing
University of South Carolina
Columbia, South Carolina

AS THE FOUNDATION of nursing science pushes beyond familiar boundaries, discovery and innovation emerge to establish diversity in practice and research. The discipline of nursing is just beginning to authenticate new territory that incorporates a plurality of methods in research and practice. Over the past decade, nurses have witnessed a challenge to logical positivism as the "true" science, the rise of qualitative research as a credible way of doing science, and the either-or and beyond-the-methods debates of nurse researchers. Although research and practice differ in that one is the building of knowledge and the other the application of that knowledge, it is suggested herein that there are interesting parallels to explore between the evolving debate on research methods and the emerging theoretic debates on practice. Just as nurse authors have advocated coexistence of and respect for diverse research methods,[1] in this article we attempt to address the need for a peaceable coexistence of diverse theoretic views in practice settings. We offer a subjectively

Adv Nurs Sci 1991;14(1):17–25

realistic view of the implications of current theoretic trends in nursing practice. In addition, a prospective vision allows us to proffer some possible approaches for contending with, and allowing for, theoretical diversity. Albeit this is not an exhaustive discussion, we respectfully offer this discourse as a reminder that like research, nursing practice need not be bound by a single perspective.

DOMINANT METHODS IN PRACTICE AND RESEARCH

It is understandable that in the 1950s both research and practice approaches embraced the reductionistic methods of the biomedical model. The biomedical model is underpinned by a belief system that has been called the totality paradigm.[2] (In this article, the word *paradigm* refers to the general set of beliefs and values espoused in a particular worldview.) Logical empiricism is the scientific method of the totality paradigm and for a few hundred years was considered to be the only true science.[3] Nurse researchers were educated to accept the dominant method as the surest means to attain credibility as serious scientists.[4]

The totality paradigm conceptualizes the human being as the sum of biologic, psychological, social, and spiritual parts.[2] From this perspective, the person is a closed system in which adaptation and coping are viewed as successful responses to a changing environment. Because the individual is viewed in the totality paradigm as responding to environmental factors in cause-effect patterns, life experiences can be predicted and verified. Once causal relationships are determined, control is possible. Individual perceptions and differences are devalued in logical positivism as the researcher gleans out the hard facts of a reality separate from human experience.[4] Gortner maintained that generalizability is critical in the development of nursing science, because "the capacity to affect practice depends on this factor."[5(p4)] She cautioned that the threat of dehumanization is not sufficient cause to reject the value of control. Thus, early researchers focused on describing, explaining, predicting, and controlling from an objective, reductionistic viewpoint.

In a similar fashion, early practice approaches derived from the dominant paradigm of the biomedical model. The atheoretic nursing process may be considered the first systematized approach to be widely adopted in practice. Appearing in the late 1960s, the nursing process became a guiding framework for nursing practice. This now familiar four-step process extolls the same objective, reductionistic beliefs of the underlying totality paradigm. Nurses using this process are guided to assess the biologic, psychological, and social aspects of human beings for the purposes of identifying, predicting, and controlling human responses.

Early nurse theorists such as Roy and Orem maintained the status quo of objective reductionism by focusing on problems and defining health according to medical and/or societal norms. Although there was a definite attempt to broaden and clarify the conceptualization of nursing practice and the phenomena of interest, these theorists did not move beyond reductionistic norm models for guiding the nurse's interaction with human beings. Reductionistic models in practice, like quantitative methods in research, have enjoyed the primary position as the "true" way.

EMERGING METHODS IN RESEARCH AND PRACTICE

Leininger[6] was a pioneer in advancing the ethnoscience method as a valuable tool for nurse researchers. By the early 1980s, more and more nurses were defending the need for qualitative methods to explore complex human beings and their interrelationships with the environment.[7–11] These authors criticized the logistic, mechanistic method as being restrictive and meaningless for nursing practice focused on human beings. Many noted the lack of congruence between a discipline that called itself holistic while it studied the parts. Causality was rejected as the most hopeful way of gaining knowledge about the complex interrelationship of human beings and health. Cull-Wilby and Pepin[1] pointed out that, although nursing is a profession of human interaction and nurturing within a social context, it attempts to adhere to inappropriate methods to study its phenomena.

The goal of qualitative research methods is understanding and theory generation. Methods of research that are included in the qualitative category include ethnography, phenomenology, and the exploratory and case methods.[12] Qualitative methods are nonreductionistic, and they attempt to capture the patterns of meaning that reflect the human being's experience. In opposition to logical empiricism, reality is contextually grounded and a dynamic cocreation of the person–environment interrelationship.

The early 1980s witnessed the first challenges to practice approaches underpinned by the traditional totality paradigm. Griffin[13] was critical of both the systems approach and the nursing process as being authoritarian, judgmental, limiting, and disconnected from real-life relationships in practice settings. Hagey and McDonough[14] echoed similar warnings about the limitations and inherent values of the nursing process and subsequent labeling procedures. As did the challenges to quantitative research, these authors claimed that the objective reductionistic approach in practice was not congruent with nursing's humanistic mandate.

Rogers[15] was a pioneer for the practicing nurse when she introduced the concept of the unitary human being. This was the first theoretic guide for nursing activities that was focused on a nonparticulate human being who cannot be known by a study of the biopsychosocial parts. Parse[16] built on the concept of the unitary human being when she created the nursing theory, man–living–health. Incorporating tenets from existential phenomenology, Parse too rejected the beliefs and values of the totality paradigm as inappropriate for guiding practice with unitary human beings. In addition to the radically distinct concept of the unitary human being, Parse extended the distinctions by describing the individual as an active participant in life, freely choosing and cocreating health in the process of being and becoming. These views directly oppose those of the dominant totality paradigm and were further clarified by Parse[2] in the worldview called the simultaneity paradigm. Parse was the first theorist in the simultaneity paradigm to develop a specific practice method that

Parse was the first theorist in the simultaneity paradigm to develop a specific practice method that flowed from the ontological and epistemological principles of her theory.

flowed from the ontological and epistemological principles of her theory. Nurses applying Parse's theory represent one group of nurses challenging the present dominance of the traditional problem-based model as the best approach in practice.[17-19] Our own beliefs support the view that the reductionistic–controlling approach is restrictive and not reflective of the discipline's humanistic values.

IMPLICATIONS OF THE TRADITIONAL PARADIGM

In an effort to achieve a unified practice taxonomy and scientific base, many nurse leaders have advanced nursing diagnoses and/or single theoretic approaches grounded in the totality paradigm. However, to suggest that nurses must practice in accordance with a particular worldview has significant implications for the profession, individual nurses, and most important, the patient. Autonomy and creativity in nursing are most seriously impeded by the assumption that one theory or approach (from the totality paradigm) will promote professional practice.

In our opinion, the received view of the totality paradigm is philosophically inadequate and inappropriate for professional nursing practice. Neither the realities of nursing practice nor the complexities of the nurse–patient relationship are reflected by this theoretic stance. Nevertheless, administrative decisions to adopt theoretic approaches underpinned by prescriptive problem-based models are being driven by the need to meet the demands of accreditation boards and the profession's legislative bodies. Nurse administrators are being pressed to comply with requests for evidence of a theoretic base in practice and educational settings, and many have opted for the expedient single-theory approach. However, the single-theory stance is not only extremely restrictive to practitioners and patients, it is also blatantly paternalistic. Not all nurses are comfortable with diagnosing and trying to control human beings and their experiences.[19,20] Indeed, nurses may find themselves in situations where they are forced to practice according to values and beliefs that are incongruent with their personal ethical standards. Carper[21] noted the potential lack of congruence and moral conflict for nurses who have a professional mandate to control and manipulate, but who themselves believe that every human being is a unique, dynamic entity rather than a passive sum of parts.

"Paternalism arises out of removal of control from its legitimate source, the individual affected by the action, and giving control to another, the individual effecting the action."[22(p120)] Paternalism has been previously addressed by nurse authors in relation to the nurse–patient relationship and the health care system in general.[23,24] Yarling and McElmurry argued that current practice environments deny nurses "free exercise of moral agency."[25(p65)] Arguments against paternalistic practices are generally based on the need to enhance personal autonomy and recognize the inherently unique characteristics of individuals. From this viewpoint, mandating a single approach or theory for nurses may prove to be an unethical administrative practice with serious consequences. Such a decision is laden with the implicit assumption that one theoretic view will be consistent with all nursing approaches. This is not the case.

Nursing has long lamented the restraints imposed on autonomous practice by medicine and health care organizations. Yet, in view of current administrative decisions to

restrict nursing approaches, it would appear that nurses are becoming paternalistic unto themselves.

Dissatisfaction in nursing practice is a serious issue; being forced to practice in restricted ways further threatens nursing's professional existence. Other disciplines will continue to offer solutions for nursing's staffing shortages to guarantee that the medical aspects of our role are secure. The registered care technologist (RCT), a category proposed by physicians, may indeed be the answer to the nursing shortage if our focus remains limited to problems defined by the prescriptive biomedical model. It would appear that our own practice models—certainly those framed within the totality paradigm—reflect and perpetuate the image that nursing derives life from medicine—from "doing to" rather than "being with." Perhaps we have misconceptions about what nursing should be, but RCTs might provide more time for real nursing practice.

There can be little doubt that nurse researchers embrace multiple paradigms. Divergent belief systems are also a reality among nurses in practice. The question arises as to how service, licensing, and educational agencies can support and promote more than one approach so that the art and science of nursing can be enhanced. An assumption of sameness throughout practice, based on prescriptive principles, denies the diversity, art, and creative uniqueness of professional nursing.

BLENDING METHODS IN RESEARCH AND PRACTICE

The debates in research continue but have changed from lobbying for one method over the other to embracing pluralistic possibilities. The most recent debates focus on the appropriateness of using multiple methods in the same study versus keeping the methods separate and logically congruent with their respective philosophic underpinnings. Several researchers call for simultaneous exploration of phenomena by incorporating quantitative and qualitative methods in the same study.[26–29] They claim that, by a blending of multiple methods, depth and breadth will be added to the phenomenon under study. It is not, however, the phenomenon of concern or the research question that determines the possibility of combining methods but the ontological perspective of the researcher that decides how human beings and health are viewed.

The combining or blending of research methods has been critically challenged by those who believe it is not possible to incorporate research methods from two distinctly different paradigms into the same investigation.[30,31] Moccia[30] effectively challenged the proposed atheoretic assumption of researchers promoting blended methods. She claims that the very selection of the research question determines the theoretic bias of the researcher and that it is not possible simultaneously to embrace conflicting theoretic views. Choosing a research design is not a technical choice but an ethical, ideologic, and political activity.[30] Philips[31] supported this position in his opposition to blending methods. He contended that understanding and enhanced knowledge require that diverging methods be kept in their proper perspectives. Reality cannot be static and objective (quantitative view) and simultaneously dynamic and subjective (qualitative view).[31]

There are similar attempts to unite disparate paradigm values and beliefs in practice approaches. Perhaps the most blatant

incongruency is the North American Nursing Diagnosis Association's choice of the unitary human being as a guiding theoretic framework. The application of nursing diagnosis requires the objective reductionistic stance, yet the unitary person is clearly nonparticulate and cannot be known by studying the parts.[15] Despite this lack of logical congruence, there are continued efforts to make the two fit. As Hall and Allen[33] noted, it is not possible to embrace diverging beliefs; nurses either focus on applying science to the body for the purpose of controlling human responses, or they focus on health and the individual's interrelationship with the environment. Moccia[30] proposed that nurses in practice continue to predict and control that which is not controllable, or they seek to understand and assist people in developing potential that is uniquely their own. Another way that divergent values and beliefs are blended in practice is through the contention that reductionistic approaches can be made holistic through a summing of the parts. This belief is fallacious. The human being is more than that which is reflected in each single aspect of being,[2] and the parts do not reflect the life experiences of unitary human beings.

Another misguided belief is that individual nurses can be pluralists, choosing different theories to guide their actions depending on the patient's needs, problems, or medical diagnoses. This belief can be challenged on several fronts. First, the assumption that individual nurses can develop expertise in multiple theories is questionable. Such a claim trivializes both the complexity of different theoretic approaches with their specific terminology and the difficulty of the commitment to develop a practice truly guided by one cohesive set of scientific principles. Theory-based practice should not be construed as the selection of approaches on the basis of particular patient situations.

The second major flaw in the belief in the pluralistic nurse is that, even if it were possible to be an expert in multiple theories, nurses would have to select theories from either the totality or the simultaneity paradigm. Being underpinned by one belief system automatically excludes the other. To reiterate, it is not possible simultaneously to believe that human beings can be controlled and to believe that human beings are uncontrollable. Human beings either respond and adapt to the environment or they cocreate life in relationship with the environment. Patients' needs do not determine nurses' values and beliefs, and nurses cannot interchange belief systems on demand. Values and beliefs are shaped by life experiences and sustained or restructured over time through personal reflection and choice. A transformation in personal beliefs requires effort and a commitment to change ways of viewing and being with human beings.

It is not possible simultaneously to believe that human beings can be controlled and to believe that human beings are uncontrollable.

Advocates of the coexistence of research paradigms[1] and the triangulation of research methods[33] suggest that the complexity of nursing practice necessitates divergent and convergent approaches. Likewise, it is myopic and naive to suggest that a single-paradigm approach can adequately fulfill nursing's mandate to provide humanistic health-focused care to society. However, a multiple-theory approach or the use of coexisting paradigms in nursing practice raises many practical dilemmas. For example, how

does an organization accommodate variations in patient care documentation and the communication and valuing of different kinds of information? Furthermore, what are the implications for patients being cared for by many nurses using a variety of theoretic approaches? Finally, how can such diversity contribute to and enhance the development of nursing science? Dispensing with the single-paradigm approach would necessitate the development of nurse experts to guide the use of many theories in practice settings. Without minimizing the enormity of these issues, there is a need to explore innovative approaches to multiple-theory use in practice.

Clark and Yaros[26] proposed that one sees the blending of methodologies in practice through the art and science of nursing. This statement reflects the myth that "science" must be of the hard empiricist type while "art" reflects the soft science of qualitative methods. On close examination, this is not the case. Nurses guided by theories from divergent paradigms apply scientific principles that are congruent with their worldview. The application of any science may be viewed as art, but philosophic values and beliefs structure the art of nursing practice. The issue needing clarification is how this art differs for nurses guided by different theoretic perspectives. If research methods are value laden, surely the same claim can be extended to divergent practice approaches, yet there has been little exploration of the consequences of different theoretic approaches.[34]

COEXISTING PARADIGMS IN PRACTICE

Setting aside current popular views and traditions of nursing practice may facilitate the development of innovative approaches to the use of nursing theory. Because nursing practice and education are driven by the attainment of standards and constrained by organizational structures, perhaps these structures should be the starting point for a new view. The development of a philosophy that supports organizational needs yet does not undermine the practice of nursing in a paternalistic manner is imperative to this end. A philosophy of nursing that allows for different models of nursing practice within an institution will lay the foundation for the coexistence of paradigms.

Silva and Rothbart[35] addressed the transitional states of the philosophy of science and theory. They maintained that nursing theory development has lagged behind changing trends in the philosophy of science (ie, the movement away from the logical-positivist tradition). They also suggested that the appearance of nursing theories grounded in the existential-phenomenologist perspective[16,36] demonstrates a recognition that nursing science should not be bound solely by the traditions of logical positivism. As identified by several nurse authors,[9–11,33] traditional empirical methods have limited utility in the study of nursing phenomena. The single-paradigm approach to practice imposes similar limitations; to proceed with that approach denies a collaborative association between nurse researchers and practitioners guided by distinct belief systems.

Gortner's statement regarding research, "the profession surely can accommodate multiple paradigms,"[5(p6)] should also be applied to practice. It would behoove the profession to move beyond rigid practice environments, support diverse practice methodologies, and strive for the coexistence of paradigms. Such coexistence may bring a new richness to practice, accelerate the dis-

covery and testing of new nursing knowledge, and ultimately advance nursing science. It is in the interest of advancing professional practice and a unique scientific base that the coexistence of divergent theoretic views be supported and nurtured.

• • •

Despite a shift in the balance of methods and philosophies, the objective, reductionistic paradigm continues to dominate nursing activities in practice and research. Although qualitative research methods are recognized as legitimate, there are still barriers for funding and publication.[5,12] Nevertheless, the emergence of new approaches in nursing science has elicited important challenges and debates and contributed to mutual respect and understanding among nurse researchers. The same level of challenge and debate has begun to emerge in practice arenas. At the present time, many nurses consider the nursing process and the diagnosing of human responses as the only true approach in practice. Nursing associations and accrediting agencies in Canada and the United States continue to define and evaluate nursing practice according to the logistic, reductionistic approach of the nursing process.[3] Service and educational institutions continue to adopt the one-theory approach for guiding practice throughout entire hospitals and for the duration of the students' learning experiences. This blanket acceptance of one approach smothers creativity, scholarly inquiry, and growth. Therefore, an evaluation and expansion of existing standards of practice, curricula, accrediting criteria, and definitions of nursing would be timely and prudent for the profession. Incorporating practice approaches from divergent paradigms into these guiding structures will indubitably enhance practice and contribute to the evolution of our professional maturity.

REFERENCES

1. Cull-Wilby BL, Pepin JL. Towards a coexistence of paradigms in nursing knowledge development. *J Adv Nurs.* 1987;12:515–521.
2. Parse RR. *Man-Living-Health: A Theory of Nursing.* New York, NY: Wiley, 1981.
3. McHugh MK. Has nursing outgrown the nursing process? *Nursing 87.* 1987;9:50–51.
4. Bockman DF, Rieman DJ. Qualitative versus quantitative nursing research. *Holist Nurs Pract.* 1987;2:71–75.
5. Gortner SR. The history and philosophy of nursing science and research. *ANS.* 1987;5:1–8.
6. Leininger MM. Ethnoscience a promising approach to improve nursing practice. *Image Nurs Schol.* 1969;3:2–8.
7. Aamodt AM. Examining ethnography for nurse researchers. *West J Nurs Res.* 1982;4:209–221.
8. Knaack P. Phenomenological research. *West J Nurs Res.* 1984;6:107–114.
9. Omery A. Phenomenology; A method for nursing research. *ANS.* 1983;5:49–63.
10. Swanson JM, Chenitz WC. Why qualitative research in nursing? *Nurs Outlook.* 1982;30:241–245.
11. Tinkle MB, Beaton JL. Toward a new view of science: Implications for nursing research. *ANS.* 1983;5:27–36.
12. Parse RR. Qualitative research: Publishing and funding. *Nurs Sci Q.* 1989;2:1–2.
13. Griffin AP. Philosophy and nursing. *J Adv Nurs.* 1980;5:161–172.
14. Hagey RS, McDonough P. The problem of professional labelling. *Nurs Outlook.* 1984;32:151–157.
15. Rogers ME. *An Introduction to the Theoretical Basis of Nursing.* Philadelphia, Pa: Davis, 1970.
16. Parse RR. *Nursing Science: Major Paradigms, Theories and Critiques.* Philadelphia, Pa: W.B. Saunders, 1987.
17. Butler MJ. Family transformation: Parse's theory in practice. *Nurs Sci Q.* 1988;1:68–74.
18. Mitchell GJ. Man-living-health: The theory in practice. *Nurs Sci Q.* 1988;1:120–127.
19. Mitchell GJ, Santopinto MDA. An alternative to nursing diagnosis. *Can Nurse.* 1988;84:25–28.

20. Newman MA. Newman's theory of health as praxis. *Nurs Sci Q*. 1990;3:37–41.
21. Carper BA. Fundamental patterns of knowing in nursing. *ANS*. 1978;1:13–23.
22. Wright RA. *Human Values in Health Care: The Practice of Ethics*. New York, NY: McGraw-Hill, 1987.
23. Curtin L. The nurse as advocate: A philosophical foundation for nursing. *ANS*. 1979;1:1–10.
24. Gadow S. Basis of nursing ethics: Paternalism, consumerism or advocacy? *Hosp Prog*. 1983;64:62–78.
25. Yarling RR, McElmurry BJ. The moral foundation of nursing. *ANS*. 1986;8(2):63–73.
26. Clark PN, Yaros PS. Commentary: Transitions to new methodologies in nursing science. *Nurs Sci Q*. 1988;1:147–149.
27. Duffy ME. Methodological triangulation: A vehicle for merging quantitative and qualitative research methods. *Image J Nurs Schol*. 1987;19:130–133.
28. Haase JE, Myers ST. Reconciling paradigm assumptions of qualitative and quantitative research. *West J Nurs Res*. 1988;10:128–137.
29. Schultz P. Toward holistic inquiry in nursing: A proposal for synthesis of patterns and methods. *Sch Inq Nurs Pract* 1987;1:135–146.
30. Moccia P. A critique of compromise: Beyond the methods debate. *ANS*. 1988;10:1–9.
31. Philips JR. Research blenders. *Nurs Sci Q*. 1988;1:4–5.
32. Hall BA, Allen JD. Sharpening nursing's focus by focusing on health. *J Nurs Health Care*. 1986;7:315–320.
33. Munhall PL. Nursing philosophy and nursing research: In apposition or opposition. *Nurs Res*. 1982;31:178–181.
34. Yeo M. Integration of nursing theory and nursing ethics. *ANS*. 1989;11:33–42.
35. Silva MC, Rothbart D. An analysis of changing trends in philosophies of science on nursing theory development and testing. *ANS*. 1984;6:1–13.
36. Paterson JG, Zderad LT. *Humanistic Nursing*. New York, NY: Wiley, 1976.