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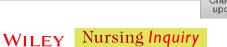
Re-conceptualizing the nursing metaparadigm: Articulating the philosophical ontology of the nursing discipline that orients inquiry and practice

Miriam Bender

Sue & Bill Gross School of
Nursing, University of California, Irvine,
Irvine, CA, USA

Correspondence
Miriam Bender, Sue & Bill Gross School of
Nursing, University of California, Irvine,
Irvine, CA, USA.
Email: miriamb@uci.edu

Jacqueline Fawcett's nursing metaparadigm—the domains of person, health, environment, and nursing—remains popular in nursing curricula, despite having been repeatedly challenged as a logical philosophy of nursing. Fawcett appropriated the word "metaparadigm" (indirectly) from Margaret Masterman and Thomas Kuhn as a *devise* that allowed her to organize then-current areas of nursing interest into a philosophical "hierarchy of knowledge," and thereby claim nursing inquiry and practice as rigorously "scientific." Scholars have consistently rejected the logic of Fawcett's metaparadigm, but have not yet proposed a substantially agreed-upon alternative. Through an analysis of articles introducing and critiquing Fawcett's metaparadigm, I argue for a re-conceptualized metaparadigm that articulates nursing's ontology. *What exists for the nursing discipline are not already-demarcated metaparadigm domains, but rather interdependent, dynamic relations that constitute people, including nurses, in their health/environment circumstance.* The nursing discipline aims to skillfully access this dynamic relationality as the basis for action and reflection to produce both positive health trajectories and knowledge that facilitates future action and reflection. Further inquiry into the onto-epistemology of nursing will produce a more robust understanding of nursing practice, science, and philosophy, and clarify its unique contribution to health and healthcare.

KEYWORDS
nursing knowledge, nursing theory, philosophy

1 | INTRODUCTION

The term "metaparadigm" was introduced to the nursing profession in the late 1970s. The first appearance was two papers by Margaret Hardy in 1978. Hardy defined a metaparadigm, based on Margaret Masterman's (1970) analysis of Kuhn's conceptualization in *The Structure of Scientific Revolutions* (1962/2012), as "a gestalt or total world view … that serves as a way of organizing perceptions" (Hardy, 1978a, pp. 38–39). Hardy's rationale for bringing Masterman/Kuhn's metaparadigm concept into nursing was to frame the nursing knowledge development process and show "where" the nursing discipline was on the Kuhnian paradigmatic trajectory. According to Hardy, nursing was at that time in the "pre-paradigm" stage, with multiple

"ill-defined perspectives" (1978a, p. 39), resulting in slow and "haphazard" knowledge development. Kuhn's paradigm and metaparadigm concept afforded Hardy a framing devise to reassure the nursing discipline that the confusion and haphazardness of the state of the nursing discipline at that time was not because nurse scholars lacked the necessary ability to develop empirically based knowledge, but because it was actually a normal and necessary paradigmatic stage, "all part of the evolutionary process that other disciplines have either experienced already or have yet to face" (1978a, p. 40).

A different articulation of the metaparadigm was introduced by Jacqueline Fawcett in her influential article *The Metaparadigm of Nursing: Present Status and Future Refinements* (Fawcett, 1984). Fawcett argued that the nursing discipline *did in fact* have an established focus,

"centered on just a few global concepts, and has always dealt with certain general themes" (Fawcett, 1984, p. 84). For Fawcett, the nursing discipline was emphatically not in a confused and haphazard state, but on the contrary, had reached a stage of structural clarity, with a unifying metaparadigm at the top, and multiple paradigms flowing from this metaparadigm that were doing the work of generating nursing theories and knowledge. What unified the nursing discipline, according to Fawcett, was four central concepts—person, environment, health, and nursing—and three specified relationships between the concepts: person–health, person–health–environment, and person–health–nursing (Fawcett, 1984).

Fawcett's definition of metaparadigm, not Hardy's, became dominant in the nursing discipline (Risjord, 2010). Most general nursing textbooks describe the four metaparadigm domains as defined by Fawcett in a mostly uncritical manner (e.g., Alligood, 2013; Black, 2016; Reed & Shearer, 2011). Fawcett's version has become one standardized basis for evaluating nursing models and theories (e.g., Fawcett & Desanto-Madeya, 2012; Lee, Vincent, & Finnegan, 2017) and continues to be cited uncritically in some nursing research (e.g., Alimohammadi, Taleghani, Mohammadi, & Akbarian, 2013; Lee & Calamaro, 2012). It even serves as a framework for National Institute of Nursing Research funded research on symptom science (Humphreys et al., 2014). However, this state of affairs is paradoxical, in that Fawcett's metaparadigm has been met with skepticism and outright challenge from philosophers of nursing since its initial publication, including numerous and robust critiques articulating the gaps in its logical structure and function (more on this later).

The fact that Fawcett's metaparadigm remains a popular heuristic to this day, despite repeated philosophical challenge, warrants further investigation. In this paper, I analyze the origins of the metaparadigm in the nursing literature to elucidate sources of this paradox. I then analyze critiques of the metaparadigm and alternative conceptualizations in the literature. Based on this analysis, I argue for a re-conceptualized nursing metaparadigm that re-activates Hardy's, and numerous other nursing scholars', understanding of metaparadigm as an ontology or worldview. The re-conceptualized metaparadigm articulates the primary assumption of how the nursing discipline orients in the world: What exists for nursing is not independent domains of person, health, and environment, but rather *interdependent relations* that dynamically constitute people in their health/environment circumstances, which comprises nursing's unique, fundamental point of access in the world. The nursing discipline aims to skillfully access this relationality as the basis for action and reflection to produce both positive health trajectories and knowledge that facilitates future action and reflection. This orientation makes nursing unique in the health disciplines. The following sections articulate the argument in more detail.

2 | THE ORIGINS OF THE NURSING METAPARADIGM

Margaret Hardy introduced the term "metaparadigm" to nursing in 1978 in a series of papers/book chapters written between 1978 and 1983 (Hardy, 1978a, 1978b, 1983). Hardy summarized the then-current state of nursing knowledge and concluded it was "chaotic" and "requires more systematic thought than it is receiving" (Hardy, 1983, p. 428). What she felt needed elucidating was the focus and domain of nursing: its common perspective and orientation as to the nature of nursing knowledge. Hardy argued this was needed because a common perspective is what would appropriately channel the work of nurse scholars, by structuring their theories and subsequent research. Hardy brought in Thomas Kuhn's concept of metaparadigm and paradigm to frame her argument. Hardy specifically cited Masterman's (1970) analysis of Kuhn's use of the word paradigm in *The Structure of Scientific Revolutions* (1962/Kuhn, 2012) to define metaparadigm. Masterman (1970) did the work of analyzing and explicating what Kuhn admitted as much to in *Second Thoughts on Paradigms* (Kuhn, 1977); that there were (at least) three conceptualizations of paradigm in *The Structure of Scientific Revolutions*. The first was as myth, or metaphysical speculation, or worldview, which Masterman labeled metaparadigm. The second was sociological in sense, a discipline's set of scientific habits, which Masterman labeled sociological paradigm. The third comprised a more concrete meaning in terms of tools, actual texts, instrumentation, illustration, etc., which Masterman labeled concrete paradigm. Based on Masterman's analysis, Hardy defined metaparadigm as "a gestalt, a global perspective, a total world view or cognitive orientation which is held by the majority of members of a discipline" (Hardy, 1983, p. 431). Hardy was clear, along with Masterman (1970) and Kuhn (1977), that a metaparadigm was an ontological orientation, not a knowledge claim; it was the way a discipline oriented to the world, which "profoundly affects the nature of the knowledge developed by a community" (Hardy, 1983, p. 432).

Hardy argued that the nursing discipline in the late 1970s and early 1980s was characterized by divergent beliefs, or metaparadigms, "which, although addressing the same range of phenomenon, usually describe and interpret these phenomenon in different ways" (Hardy, 1978b, p. 38). She equated this with a "pre-paradigm" state in the trajectory of the nursing discipline, a stage "with different, ill-defined perspectives that are heatedly argued and defended" (Hardy, 1978b, p. 39). Hardy felt this state of affairs was important to acknowledge, as it was the first step in rising above "the battleground and focus efforts and skills on developing sound nursing knowledge," which was accomplished by "being well informed in a substantive area and participating actively in both theory construction and research" (1978b, p. 40). Hardy suggested that theory building and testing, or even simply "loosely constructed theoretical notions," was the difficult yet constructive path toward developing "a predominant paradigm in nursing" (1978b, p. 40). This meant, to get from a pre-paradigmatic to paradigmatic discipline, nurse scholars needed to do the difficult work of building theory in a "poorly focused and unsystematic" landscape, that is without a metaparadigm to guide them. The implication seems to have been that continued efforts to develop and test theories would slowly do the work of creating systematic knowledge, from which concomitantly a metaparadigm would emerge, at which stage the nursing discipline would be

in the Kuhnian, full-paradigmatic stage—a discipline with "a special coherence which separates them from neighboring groups—and this special bond means they have a shared set of values and a common commitment which operates as they work together to achieve a common goal" (Hardy, 1983, p. 430). To be clear, Hardy felt in 1983 that the nursing discipline did not have a unified nursing metaparadigm.

2.1 | Fawcett's metaparadigm

Jacqueline Fawcett had other ideas about the state of nursing. Fawcett specifically cited Hardy as an author who "pointed out that most [nursing knowledge] work appears unfocused and uncoordinated" (1984, p. 84). She then argued vigorously *against* this view, stating that nursing "has always centered on just a few global concepts and has always dealt with certain general themes," and then went further, claiming "these central concepts and themes [are] … nursing's metaparadigm" (Fawcett, 1984, p. 84). Fawcett refuted Hardy by claiming the nursing discipline already had a unified nursing metaparadigm, which provided direction for theory development and signified "an important step in the evolution of a scholarly tradition for nursing" (1984, p. 85).

Fawcett did not cite Kuhn nor Masterman in her 1984 article. Instead, she qualified the use of the term metaparadigm through reference to Eckberg & Hill, 1979 article *The Paradigm Concept and Sociology: A Critical Review*, which was concerned with sociology's interpretation of Kuhn's paradigms. Eckberg and Hill utilized Masterman's, 1970 analysis to conclude: "We can agree with Masterman that paradigm refers to beliefs at three different levels. At the broadest level of generality (corresponding to what Masterman calls 'metaphysical paradigms', or 'metaparadigms') are unquestioned presuppositions … [that] do not direct ongoing, day-to-day research" (1979, p. 926, parentheses in original). Fawcett interpreted Eckberg and Hill's phrase "broadest level of generality" as "most global manner" (Fawcett, 1984, p. 84). But instead of interpreting these most global manners as unquestioned assumptions, as Eckberg and Hill defined them, Fawcett inexplicably equated them, in direct opposition to Kuhn (1977), Masterman (1970), and Eckberg and Hill (1979), with an empirically identified and abstracted set of explicit concepts and propositions that would actively direct ongoing nursing scholarship, that is a highly structured, abstract theory, rather than a set of unquestioned assumptions.

To construct this version of a metaparadigm, Fawcett appropriated the four concepts elucidated in Yura and Torres' (1975) efforts mapping curricular themes across accredited nursing programs in the United States into what they called "global concepts" of nursing: person, environment, health, and nursing. Fawcett cited Yura and Torres' work directly in her paper *The What of Theory Development* (1978), but did so only indirectly in the 1984 metaparadigm article via a reference to Flaskerud and Halloran (1980). What Yura and Torres did was collate "similarities, commonalities, and subgrouping[s]" (1975, p. 183) that were present in 50 nurse education program accreditation self-evaluation reports they analyzed. They named the overarching similarities "concepts," defining concept as "a general notion or a symbol" (1975, p. 182), even while admitting to a "state of confusion" (1975, p. 163) regarding a clear definition of "concept." Yura and Torres (1975)

also described the ambiguity and variability they found in each education program's articulation of their own core themes, along with substantial differences in the ways programs defined or described the "concepts" that Yura and Torres had created. In summary, the four "concepts" created by Yura and Torres were self-admittedly not scientific nor even precise concepts, but rather a broad set of "notions" that had some level of "popularity … based on the beliefs about professional nursing practice at this point in time" (1975, p. 185).

For her metaparadigm, Fawcett also utilized the work of Donaldson and Crowley in their seminal paper *The Discipline of Nursing* (1978). Donaldson and Crowley took a philosophical approach to answering the question of the central "conceptualizations and syntax of the [nursing] discipline" (1978, p. 114). The authors argued that the uniqueness of a discipline such as nursing "stems from its perspective rather than its object of enquiry or methodology" (Donaldson & Crowley, 1978, p. 115). Nursing scholarship was that which emanated from the unique nursing perspective, which they defined (more as the desired product of nursing rather than nursing itself) as the "healthy functioning of individuals in interaction with their environment" (Donaldson & Crowley, 1978, p. 116). They then listed three "conceptualizations" entailing this perspective: optimal functioning of human beings; patterns of human-environment; and processes by which health status are affected. Critically, they did not equate these conceptualizations with concepts. Rather, the conceptualizations asserted "what is of interest" to nursing (Donaldson & Crowley, 1978, p. 119), which influenced what got studied, and of which the products were nursing concepts, theories, and facts.

In summary, Fawcett appropriated a set of "notions" that were popular in nurse education curricula in the 1970s and interpreted them as "the central concepts of the discipline" (1984, p. 84). Fawcett then re-interpreted Donaldson and Crowley's conceptualizations of the nursing discipline as "three recurring themes" (Fawcett, 1984, p. 85). She then linked these "concepts" and "themes" through an analysis of the ways they had been articulated in then-current conceptual models of nursing, such as Newman's theory of health (1979), Orem's theory of self-care (1980), Roy and Robert's theory of person as adaptive system (1981), and King's theory of goal attainment (1981). Fawcett generated three major concept-theme linkages through this analysis: person–health; person–health–environment; and person–health–nursing. In contrast to Hardy, and Donaldson and Crowley, Fawcett (1996) was explicit in stating that her metaparadigm did *not* reflect a nursing perspective, nor the beliefs and values of nursing. Instead, she concluded that the four concepts, three themes, and three identified relationships between concepts and themes constituted in her metaparadigm were the "most abstract component in the structural hierarchy of knowledge of any discipline" (Fawcett, 1996, p. 94).

3 | CONTRASTING METAPARADIGM CONCEPTUALIZATIONS

While Hardy foregrounded an ontological, metaphysical, conceptualization of metaparadigm in her articles, Fawcett foregrounded

an epistemological "structural hierarchy of knowledge" (Fawcett, 1996, p. 94), with the metaparadigm situated at the highest "level" of knowledge. Fawcett explicitly chose not to define the metaparadigm as a set of assumptions or beliefs or worldview, but rather defined it as an already empirically identified and abstracted set of concepts and propositions that actively directed ongoing nursing scholarship. The question is why did Fawcett's conceptualization of metaparadigm become dominant over Hardy's?

There is the easy logic that if one needed to choose between a definition of one's discipline as: (a) "chaotic" and only in an embryonic stage of progression, with no unified worldview; or (b) with a substantial hierarchy of knowledge, including a top-of-pyramid metaparadigm as the fundamentally reduced statements expressing the pinnacle of nursing knowledge; the money is on choice b. On a more serious note, Risjord (2010) has conducted an extensive analysis of the history of nursing meta-theory and has made a very convincing argument that the philosophy of science norms in academia in the 1960s and 1970s had a profound influence on the first nursing academic scholars, whose numbers were small, and who had to continuously make the case for their discipline to their colleagues in mature academic fields. A small but evocative example of the arduous nature of the task can be felt in Gortner's, 1975 article *Research for a Practice Profession*, where she described a conversation with a Heart and Lung Institute scientific administrator about "what he thought nursing research was … beyond … how to make an impeccable-looking bed" (p. 196).

The default philosophy of science in these times was the "received view" of science, which was a set of assumptions and definitions about the products of scientific inquiry, which were equated with robust knowledge. Scientific knowledge in the received view was housed in theory (Suppe, 1972). Theories entailed the explanatory accounts of physical systems. Furthermore, the goal of a theoretical account of the world was a move toward more universal accounts of the world, with the pinnacle being "one great scientific theory into which all the intelligible phenomena of nature can be fitted, a unique, complete and deductively closed set of precise statements" (Cartwright, 1999, p. 16). Risjord (2010) showed, in a lengthy analysis that will not be detailed here, how Fawcett's metaparadigm was a product of the philosophical belief that nursing knowledge must be housed in a received view understanding of theory, in which there were levels of theory and only the most abstract theories determined the boundaries of a discipline. Risjord showed that Fawcett's work delineating nursing knowledge equated disciplinary knowledge with scientific knowledge, based on the assumptions of the received view of scientific knowledge. He (2010) argued convincingly that Fawcett oriented to the received view in her work developing the metaparadigm, which is why she framed it as a hierarchical knowledge achievement, a "unique" set of statements that comprised the structure of nursing knowledge, forever bounding its domains and distinguishing it from other academic disciplines.

It thus seems reasonable to assert that Fawcett's epistemologically oriented metaparadigm was taken up by nurse scholars over and above Hardy's ontologically oriented metaparadigm because Fawcett's version "fit" better with academic disciplinary norms at the time. But as critiques of Fawcett's metaparadigm make clear, the "fit" was only superficial; multiple analyses of Fawcett's metaparadigm over time have revealed its numerous logical flaws as a philosophy of nursing.

4 | CRITICISM OF FAWCETT'S METAPARADIGM

The critiques of Fawcett's metaparadigm were strong and abundant. William Cody (Fawcett, 1996) was emphatic in finding the metaparadigm "unreasonable" and defined the metaparadigm concepts as a "mantra" rather than a solid philosophical underpinning for the nursing discipline. Marilyn Rawnsley (Fawcett, 1996) provided a historical perspective in her critique. She mirrored Hardy in attributing the desire for something like the metaparadigm as a search for a substantive base for a discipline that was still struggling to defend itself at a time when there was not a consensus among nursing scholars about what the basis of the discipline was. Rawnsley, echoing Yura and Torres, highlighted the metaparadigm domains' utility as a global guide for nursing curricula, in that it "imparted an illusion of educational coherence across programs with disparate organizational structures and missions" (Fawcett, 1996, p. 103). But Rawnsley noted critically that the metaparadigm was severely flawed as a disciplinary knowledge meta-structure. Rawnsley agreed with Masterman and Hardy's definition of metaparadigm as a metaphysical set of beliefs that organizes perception, *and not a scientific notion*. Because of the metaphysical, nonscientific nature of metaparadigm, Rawnsley concluded that Fawcett's conceptualization of the metaparadigm domains as the empirically derived building blocks of nursing knowledge was not "viable," and, even more devastatingly, in an analysis echoed by other scholars as well (e.g., Basford & Slevin, 2003), concluded that even if they were re-interpreted as scientific theoretical constructs, they had not done the work of contributing to the generation of systematic nursing knowledge: "any relevance of productive nursing research agendas to the metaparadigm of person, health, nursing, and environment is retrospective, not prospective" (Fawcett, 1996, p. 103).

Sally Thorne and colleagues, in their paper *Nursing's Metaparadigm Concepts: Disimpacting The Debates* (1998), worked through the metaparadigm "concepts" to show how unstable they actually were, having been variably conceptualized by nursing scholars, many times in very conflicting ways. They also analyzed concepts that were not included in Fawcett's metaparadigm, yet were considered critical to the nursing discipline, such as caring. Thorne and colleagues' overall thesis was that Fawcett's metaparadigm was an attempt to force unity onto the nursing disciplinary terrain, but had not achieved that purpose, instead resulting in "divisiveness within theoretical nursing rather than to clearly define our mission and facilitate effective communication among nurses" (Thorne et al., 1998, p. 1265).

John Paley, in a 2006 book review of a textbook that continued to unproblematically assume the metaparadigm as the building block of

nursing knowledge, scathingly summarized Fawcett's metaparadigm as "four words—person, environment, health, and nursing—which just sit there, inert, like four garden gnomes. They say nothing, they do nothing. They make no claims, express no thoughts, represent no beliefs or assumptions" (Paley, 2006, p. 277). Mary Conway (1985) also conceded that Fawcett's metaparadigm provided no world view that would enable direction for the further development of the nursing discipline; that it provided no "road map." Janice Morse went as far as to question the "harm" Fawcett's metaparadigm might have done to "stunt" the growth of nursing knowledge development, rather than promote the growth of the discipline, as it insisted that all four "concepts" must be addressed in nursing scholarship for the product to be considered "nursing" knowledge, and hoped "nursing has now moved beyond this stage" (Morse, 2016, p. 26).

Suzie Hesook Kim, in her book *The Nature of Theoretical Thinking in Nursing*, was frank in stating "one of the major reasons for the apparent lack of a systematic view of nursing knowledge, I believe, is the continued use of the so-called four metaparadigm concepts … They are empty as boundary-specifying constructions, and are only useful in asking nursing scholars to formulate specific conceptual orientations for further theoretical thinking" (Kim, 2010, p. 14). Kim, like Paley, Thorne and others, found Fawcett's metaparadigm domains to be an unhelpful guide addressing how nursing knowledge should be generated and how each piece of knowledge contributed to the total system of nursing knowledge. Chick and Meleis's critique of Fawcett's metaparadigm concepts started first by asserting, correctly, that they were "the concern of scholars and researchers from many disciplines" (1986, p. 239) and therefore were not unique to nursing. The authors then concluded that Fawcett's metaparadigm concepts did not "help nurses decide what is a health problem and what are the healthcare priorities from a *nursing perspective*" (Chick & Meleis, 1986, p. 256, italics mine).

5 | REDEFINING WHAT A METAPARADIGM IS

What Fawcett wanted to delineate for the discipline was its unique boundaries from a *scientific* perspective, that is, to equate *the nursing perspective* with scientific concepts, which comprised the basis for all nursing knowledge, which was by virtue of its origin in empirically derived nursing concepts, unique and demarcated from other disciplines. Fawcett's metaparadigm was innovative, yet flawed, because it was constructed using philosophical assumptions *of what science was*, *not using philosophical assumptions of what nursing was*. Hardy initially appropriated Masterman/Kuhn's metaparadigm because it did the conceptual work of "placing" the nursing discipline on a well-defined, and thus easy to follow, "paradigmatic" trajectory toward cohesiveness, although she concluded that the trajectory goal of cohesiveness (or a metaparadigm) still eluded the nursing discipline. Fawcett rejected this argument and created an entirely new definition of metaparadigm, distinct from Kuhn and Masterman (and Hardy, and Eckberg & Hill), that aligned with received view scientific assumptions of disciplinary knowledge, to

situate the then-current nursing discipline on an equal footing with other academic disciplines *as a science*.

Hardy introduced Masterman/Kuhn's concept of metaparadigm to explicate what was *missing* from nursing; a philosophical account of its unique disciplinary coherence, describing that which *motivates* all nursing practice and inquiry. Fawcett reworked the concept of metaparadigm so that it became a structure that was able to house a number of existing areas of nursing inquiry (e.g., educational foci, models of nursing practice, theories of health) and by doing so, was supposed to generate disciplinary cohesiveness. The consistently valid critique against Fawcett's metaparadigm is that the invented structure, while able to superficially house multiple domains of nursing "under one roof," did nothing to address the original question about what the more fundamental "rationalization of practice" (Donaldson & Crowley, p. 115) was: What uniquely motivated all nursing practice and inquiry? It is important to be clear that the different *areas of inquiry* that were "housed" in Fawcett's metaparadigm were never questioned, which is why they remain uncritically accepted. What scholars have made explicit is that Fawcett's metaparadigm structure did not accomplish the goal of articulating a *coherent nursing philosophy* that describes the unique nursing perspective; the "gestalt or total world view … that serves as a way of organizing perceptions" (Hardy, 1978a, pp. 38–39).

6 | RE-CONCEPTUALIZING THE NURSING METAPARADIGM

A nursing metaparadigm that articulates the coherent, unique perspective of the nursing discipline must move beyond what is of *concern* to nursing, because the fundamental question is *why* these concerns, and not others? What motivates nursing to be concerned with what it has concerned itself with? Why does Parse (1992) consider person, environment and health as the concern of nursing? Why do Newman and Sime (1991) consider caring and the human health experience the concern of nursing? Why do nurse educators consider nursing, health, environment, and person the main foci for their nursing curricula (Yura & Torres, 1975)? An answer to this question can be found in a (very) brief synthesis of the underlying threads uniting the scholarship entailed in Fawcett's work and others.

Flaskerud and Halloran (1980) stated that "nurses manage *the interaction* between the patient and the environment to promote health or healing" (p. 4). Donaldson and Crowley (1978) were clear in stating the nursing perspective entailed conceptualizing health *functioning, patterning, and processes*. Yura and Torres (1975) in their analysis were clear that their concepts were not precisely delineated in the curricula they analyzed, noting significant overlap and *ambiguous boundaries*. Fawcett was determined as well to create *interdependent linkages* between her nursing domains, and did so using Donaldson and Crowley's conceptualizations of process and pattern to describe inter-relationships between person–health, person–health–environment, and person–health–nursing. Fawcett did not create a link between nursing and environment,

but Bender and Feldman (2015) were able to do so in their analysis of the nursing metaparadigm, arguing for the need to make visible the *interdependent relationships* between all metaparadigm domains as the critical starting point for understanding the dynamics of nursing. Meleis and Trangenstein (1994), in working to establish an appropriate framework for nursing that overcame the flaws of Fawcett's metaparadigm, developed the concept of transitions, which were about *processes and patterns* with the goal of a patient sense of well-being. They argued that "no other discipline has this *process orientation*" (Meleis & Trangenstein, 1994, p. 256). Davina Allen has contributed a wealth of insights into the work of nurses, showing how nurses "maintain an awareness of *different understandings* of the patient" and "shift attention from the individual to the organization and combine this clinical and organizational knowledge in *a distinctive professional gaze*" (2018, p. 40). Allen made visible, through her scholarship, how nurses, through their practice, *adjudicate relationships*, function as a "distributed memory system," and "bring about retrospective crystallization and prospective *translation* of the patient's identity" (2014, p. 135), among other practices.

7 | THE PRIMARY PERSPECTIVE OF THE NURSING DISCIPLINE

The common thread, implicitly yet unmistakably running through this admittedly brief survey of the nursing scholarship, is that nursing does not emerge through a concern with distinct domains or concepts, but rather through a unique understanding of dynamic relationships between them all. *What exists for the nursing discipline is not already-demarcated domains of nursing, person, health, and environment, but rather interdependent relations that constitute people, including nurses, in their health/environment circumstance, which comprises nursing's unique, fundamental point of access in the world*. Fawcett's metaparadigm domains are not sufficient as the fundamental perspective of nursing because they were considered *independent of their performance*. John Paley put it this way in his article analyzing Heidegger; relations are constitutive of the world, which comprises *a realism of practices, rather than a realism of objects* (Paley, 2006). This means, what exists is practice, and "practices are constitutive of both the self and social structures" (Paley, 1998, p. 822). Basically, nurses do not exist without patients and nursing practice does not exist without people having health/environment experiences.

What exists for nursing is a relation-sensing performance that continuously brings the concepts of nursing, person, environment, and health (among others) into being. Another way of putting it is that a nursing perspective that takes interdependence and relationality as its fundamental access point in the world means that what exists for nurses *is not deterministic*. There is no deterministic structure of nursing, no definitive theory of nursing that can be reduced to an algorithmic technology of nursing. As Holmes and Gastaldo (2004) put it, the nursing "perspective calls for a rejection of a 'pure' nursing essence, which simply does not exist …the definition of the essence of nursing cannot be fixed or static because the everyday manifestations of nursing are largely determined by contexts within which they are

exercised" (p. 264). By "context," we can substitute the practices that are constitutive of both the self, including nurses, and social structures, including patients with health concerns needing assistance. What exists for nurses is relationality, through which the world of nurses caring for patients in their health/environment circumstance emerges.

In their article *Accounting for Knowledgeable Practice*, Purkis and Ceci describe it, as nurses "making readings … thoroughly interpenetrated by the social" which then "become resources through which nurses accomplish their care" (2016, p. 19). What a nurse does is "take the social seriously … [a nurse] is [interested] in structures of relevance" (Purkis & Ceci, 2016, p. 20). This means, a nurse chooses a frame of reference as a way of making sense of what is presented, but always knows another frame of reference could be used instead, that it could show the circumstance in a very different light (Purkis & Ceci, 2016). Purkis and Ceci argue that this practice, this process of sensing what exists, recognizing the indeterminate nature of "what is presented" and generating a "structure of relevance," is the unique way nurses orient in the world—or more accurately generate the world—through which the enactment of nursing emerges. It is not that nurses "know things" about patients and their health and set about doing something about it, integrating this knowledge into their assessments and interventions. More fundamentally, nurses generate a world, picking and choosing from emergent relational patterns to continuously instantiate patients with health circumstances needing specific forms of nursing care—that is, nursing as a production, not a predefined construct.

A perfect empirical example of this is a cliché of nursing: Knowing a patient is deteriorating without being able to articulate why or how. Traditionally, this has been explained as an expert nurse using intuitive, embodied knowledge to make decisions in critical situations, in contrast to an objective, rational, linear decision-making process (Benner, 1984). The "data" used for this intuitive knowledge-work is a "grasp of the total situation" (Minick, 1995). What is now clear is that this "grasp" of the situation is the work of a nurse generating a reality where deterioration is the fundamental experience, a reality which is many times not seen by others on the clinical team. One nurse astutely described it as "you have … to be able to see the signs, *in order to perceive the things you need to perceive*" (Minnick, 1995, p. 309, italics mine). Relating this quote back to Purkis and Ceci (2016), the nurse recognized the need to "take readings" in order to create a "relevant structure," in this case a deteriorating patient, as the basis for nursing action—for example, convincing others on the team that a patient-with-deterioration exists in order to create an environment of concerted action, and starting interventions to improve health functioning.

8 | IMPLICATIONS OF THE RE-CONCEPTUALIZED NURSING METAPARADIGM

Reorienting to metaparadigm as unique perspective, or ontology, enables an understanding that what the nursing discipline traditionally describes as its core concerns, or core concepts—nursing/caring, person, environment, health—are actually the products achieved

via nurse's unique perspective or world view that serves as a way of organizing perceptions. This means nursing does not take the environment, for example, into account because it is an important determinant of health. Rather, the environment (in its myriad manifestations) emerges as an actionable entity for nursing because of its interdependent relationality in a patient's health experience; if it did not, it would not arise so consistently and nursing would not focus on it. The re-engaged nursing metaparadigm/perspective/ontology makes explicit a relation-sensing performance that brings nursing, person, environment, and health into being. This relation-sensing performance does not take what is present as given, but rather is a performance of sensing what relations to bring forward and what to leave out, at least for the moment. Nurses progress as nurses by becoming more skillful in this performance, through what Benner, Tanner, and Chesla (2009) have described as the novice-to-expert trajectory.

Orienting to the metaparadigm as the ontology of nursing overcomes the tricky paradox of "knowing" the metaparadigm domains are critical for nursing, while at the same time "knowing" that the way they have been traditionally conceptualized does not articulate the necessary logic of why and how they are so critical. I have, as Karen Barad puts it, examined the foundations of certain concepts and ideas to see "how contingency operates to secure the "foundations" of concepts we cannot live without" (Juelskjær & Schwennesen, 2012, p. 14). The metaparadigm domains have become "foundational" for the nursing discipline because through nurses' ontological orientation in the world, the "domains" continuously emerge as something to be engaged.

8.1 | Implications for nursing practice

Understanding the nursing metaparadigm as relationality opens up new possibilities for understanding nursing practice and inquiry. First, it describes, as Thorne puts it, what is "the distinctive "angle of vision" that nursing has always contributed to health and health-care … that, despite our diversity of roles and practice contexts, a unifying conceptual orientation [does] exist, and that it play[s] a vital role in shaping our actions, values, and distinctive expertise" (Thorne, 2015, p. 283). The nursing metaparadigm-as-ontology provides a logic of practice, a road map, that grounds and helps to makes sense of the incredible diversity seen in nursing practice and inquiry. Explicit acknowledgement of the unique nursing perspective will help to better understand the what and how of nursing practice, which may serve as the basis for new tools that help nurse clinicians and scholars to skillfully access this relationality as the basis for action and reflection that produces both positive health trajectories and knowledge that facilitates future action and reflection.

8.2 | Implications for nursing science

The main question is how knowledge generation is accomplished, because the re-conceptualized nursing metaparadigm blurs the distinction between ontology and epistemology in nursing. Or perhaps more concretely, it makes visible the difficulties defining nursing as

a science, a subject of enduring debate in the nursing literature. This debate has not yet produced an accepted nursing philosophy of science. As Risjord has put it, we are still "addressing a question that has pestered nursing scholars for decades: what is nursing science?" (Risjord, 2010, p. 220).

If nurses are constituting worlds—that what exists for nursing is a "process of becoming, of acquiring its definitiveness" (Sehgal, 2014, p. 195)—where is the dividing line between knowing what exists and the rules about how to gain knowledge about what exists? If nursing is an onto-epistemic discipline, how should one examine nursing's ontological relation-sensing performance, and what should the knowledge product comprise? A theory, a dataset, a narrative? If what exists for nursing is not deterministic, that is what exists are not enduring entities, then how precisely does one examine this, and can the findings be considered generalizable?

There are some hints in the existing literature. Bender and Elias (2017) have shown how traditionally described "ineffable" nursing concepts, such as esthetic knowing, can be systematically examined—not as a distinct scientific object, but rather as an agentic subject that can be related to through a process of inquiry, describing patterns and accounts that are revealing and actionable, if not "forever known." Bender (2018) has recently argued for a turn to models as an appropriate structure for nursing knowledge, in contrast to theory. This is because while theories traditionally articulate static, universal statements about the world, nursing engages the continuous, "messy" dynamics of patient/healthcare. Bender argues that models have the capacity to describe these dynamics and how they might be produced, without assuming they are produced the same way no matter what the conditions; that is, they are not deterministic or reductive (Bender, 2018). Further inquiry into the onto-epistemology of nursing is necessary to produce a more robust understanding of nursing knowledge, practice, science, and philosophy.

9 | CONCLUSION

There is one immediate implication of re-conceptualizing the nursing metaparadigm as the discipline's ontology—to understand that for nursing what exists is a relation-sensing performance that continuously brings the interrelations of nursing, person, environment, and health into being, through which the enactment of skilled nursing practice emerges. It helps to devise "elevator speeches" that can begin the work of articulating why nursing, even while it cannot deterministically define itself, is still so highly valued by society, for example, being considered the most trusted profession in the United States for 16 years in a row (Brenan, 2017). Put quite simply, nurses create worlds where they can make a difference—where they can make things better. Nurses may not often achieve that goal, and the question of "better for whom" is pertinent, but the process itself brings about situations where what is important at any moment in time—to the nurse, the patient, the family member, the interprofessional clinical team, the community, the policy arena—is made visible, and thereby actionable.

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ORCID

Miriam Bender http://orcid.org/0000-0003-2457-1652

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