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# The Future of Nursing: How Important is Discipline-Specific Knowledge? A Conversation with Jacqueline Fawcett

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## Abstract

Nurses have long attempted to secure a unique identity for the profession. Many scholars are now promoting an interdisciplinary framework for nursing practice. Fawcett is convinced that interdisciplinary practice poses a danger for nursing to lose its identity and cannot be successful if members of each discipline do not understand the conceptual models, practice, and research of their own discipline. Name and name interviewed JF about her views related to discipline-specific knowledge and nursing's future. We conclude that Fawcett's scientific foundation gives nursing the solidarity and power necessary to determine the unique internal goods of its practice.


Key words: discipline-specific content, nursing knowledge, Fawcett

# The Future of Nursing: How Important is Discipline-Specific Knowledge?
## A Conversation with Jacqueline Fawcett

Nurses' multiple roles and practice settings require that all registered nurses be educationally prepared to base their practice on complex nursing knowledge distinctive to the discipline. Over the past century, nurse leaders have attempted to secure a unique identity for the profession. At this time in nursing's professional history, there is a movement by many scholars to place increasing importance on nurses using an interdisciplinary framework (IOM, 2010; 2011). The shift away from nursing theory-guided practice is an intentional move led by nurse scholars, according to Milton (2011). Nurses collectively need to choose whether they will hold onto a

strong traditionalist practice or whether they will open their practice to more interdisciplinary ways of thinking and doing. Pamela Mitchell, President of the American Academy of Nursing, speaking at the 2009 Forum on the Future of Nursing, emphasized the need for an interdisciplinary framework and offered only one recommendation: "Academic institutions and health care organizations need to make a real commitment to interprofessional education that develops and sustains collaborative skills, both before and after licensure. The recommendation is not new...but let's make it real this time..." (p. 37).

Nurses may be reluctant to practice where role boundaries are ambiguous. Nurse leaders who remember

nursing's history may be averse to "giving away" anything unique to nursing or to allowing nursing practice to be blended with the practice of other disciplines. Milton (2011) was informed that nursing theories are "old and outdated." She countered that advancing this idea can lead to "lack of clarity of what [nursing] is, and who determines how nursing practice is defined" (p. 108).

Fawcett (personal communication, May 3, 2011) is convinced that true interdisciplinary practice cannot occur if the members of each discipline do not fully understand the conceptual models, theories, practice focus, and research methods of their own discipline. Nelson and Gordon (2004) argued that nurses have done

themselves a disservice by continually trying to reinvent the profession. How do nurse leaders reconcile emphasizing traditions from the past while moving the profession into the future? Although nurses want to hold onto elements that are uniquely *nursing*, the hierarchy of the increasingly interdisciplinary health care system is pulling nursing into interdisciplinary ways of designing nursing curricula for future practitioners.

Following the completion of their book, *book title*, to which Fawcett contributed two chapters, name and name (2011) had an opportunity to interview Jacqueline Fawcett (JF) about her vision of nursing at this crucial juncture in the discipline's history. This article contains a discussion of matters central to the discipline of nursing.

First, a brief background is presented from selected publications related to Fawcett's philosophical views on development of nursing knowledge.

***Fawcett's Position on Nursing Knowledge Development***

Although some of the theory terminology used in her early publications has evolved, Fawcett has remained unshakable in her position about what constitutes nursing knowledge related to theory generation and theory testing. Fawcett does not subscribe to the verification principle of positivism but instead to post-positivism, specifically Popper's (1963/2002) doctrine of principle of corroboration. Fawcett (Kahn & Fawcett, 1995) has aligned herself with Popper's thinking that, at the starting point of any hypotheses or theoretical statements, all

observations are viewed through an existing frame of reference with the prospect that many expectations are associated with it. Corroboration is a logical appraisal of the theory to determine whether the theory can stand up to this test. Corroboration can never equate with truth. Fawcett has taken seriously Popper's definition of corroboration, as evidenced by her use of the term *credible* as a evaluation gauge for determining the "goodness" of nursing conceptual models. A nursing conceptual model should be the beginning point of reference for nursing practice and ideally be credible with the philosophy of a nurse's own frame of reference and organization (Fawcett, 2005; name a, 2011).

Fawcett's *conceptual-theoretical-empirical* (C-T-E)

formalization is what many past theorists know as *theoretical substruction*. The fact that the C-T-E formalization can be theory-generating research (bottom-up) or theory-testing (top-down) research contradicts some scholars' views that Fawcett uses a reductionistic, positivistic approach (Fawcett & Downs, 1992).

***The Dialogue***

**JB and KR: What is your perspective of nursing knowledge?**

JF: I am convinced that one of the most central matters to the survival of the discipline of nursing is an understanding of the nature and structure of nursing knowledge. Over the many years of my nursing career, especially during the past three and one-half decades since I earned a PhD degree, I have come to think of

nursing knowledge first as a hierarchy and more recently as a holarchy. I now describe the structure of nursing knowledge as a holarchy made up of parts that are wholes in themselves. The parts are the metaparadigm of nursing, nursing philosophies, nursing conceptual models, nursing grand and middle-range theories, and empirical research methods. The most abstract is the metaparadigm, and the most concrete is the empirical methods (Fawcett, 2005).

I maintain that all nurses need to understand each part of the holarchy and to be much more explicit about their own philosophic beliefs about the concepts of the nursing metaparadigm—human beings, environment, health, and nursing. Every nurse must use an explicit nursing conceptual model and explicit nursing theories to

guide practical activities associated with nursing practice, research, education, and administration. Practical activities are performed using empirical methods.

When conducting research, the empirical methods include the study design, sample, instruments, data collection procedures, procedures for protecting human or animal participants, and the data analysis techniques (Fawcett & Garity, 2009). When practicing, the empirical methods are the patients, nursing practitioners, assessment formats, intervention protocols, equipment, and quality improvement strategies. When activities are in education, the empirical methods include students, teachers, the curriculum, and teaching and learning strategies used. In administration, the empirical methods

include staff nurses, patients, nurse administrators, and leadership strategies.

**JB and KR: Why is using nursing discipline-specific knowledge, in the form of explicit nursing conceptual models and theories, important?**

JF: The extant explicit nursing conceptual models and nursing theories are crucial to providing a rationale for what nurses do and why they do what they do. If nurses want to claim the rights and privileges of disciplinary status, they must acknowledge the already existing nursing knowledge and demonstrate how it guides practical activities. This is because a discipline has, by definition, a distinct body of knowledge. Similarly, a profession, by definition, has a distinct body of knowledge that is used in service to society.

Those nurses who decry the lack of nursing knowledge or refuse to use what already exists are indicating that nursing is no more than a trade. Yet, those same nurses want to be regarded as professionals and want to claim equal status with other members of the health care team or of academe who are members of other disciplines and professions. Perhaps those nurses who fail to acknowledge nursing knowledge want to be tradespersons along with physicians, who do not yet have any explicit or distinctive body of knowledge.

**JB and KR: The American Association of Colleges of Nursing (AACN; 2006, 2008) in the recent *Essentials* publications advocates a solid base in liberal education for nursing students. This type of education "provides broad exposure to multiple disciplines and ways of knowing" (2008, p. 11). The AACN goes so far as to say that DNP graduates should be prepared to "develop and evaluate new practice approaches based**

**on nursing theories and theories from other disciplines" (2006, p. 9). Do you believe there are any legitimate roles in nursing for non-nursing conceptual models and theories?**

JF: Yes, I do, but I do not think that those conceptual models and theories should be taught in nursing courses but rather in the courses of other disciplines. Nursing courses should focus on how non-nursing conceptual models and theories could be linked with nursing conceptual models and theories. Non-nursing models and theories can be shared knowledge for nursing, but only if they were found to be relevant to the nursing situation. For example, could Piaget's theory be linked to the cognator coping process of the Roy adaptation model so that nurses understand better how stimuli are processed at different stages of life or cognitive development?

**JB and KR: How do you reconcile an emphasis on discipline-specific knowledge in nursing with the Institute of Medicine's document *Health Professions Education: A Bridge to Quality* that calls for "more, not less, overlap and some fusion of roles" (Hundert & Wakefield, Preface, IOM, 2003, p. ix) among health care professions?**

JF: I cannot reconcile that statement, which I view as the death of nursing.

**JB and KR: This is an alarming outlook. Can you expand on your above comment?**

JF: Any overlap in or fusion of roles eliminates the need for articulation of the distinctive focus of each profession and, ultimately, may eliminate the need for a separate nursing program within a college or university. Perhaps the IOM would prefer generic health care workers, as Nagle (1999) pointed out could happen if nurses continued to reject distinctive nursing knowledge as the

basis for their work. However, I doubt that the members of the IO*M* would prefer that physicians be considered generic health care workers!

**JB and KR: Why do some nurses reject the very idea of nursing discipline-specific knowledge, in the form of explicit nursing conceptual models and theories?**

JF: The rejection of one's own body of knowledge is a behavior associated with oppression. Individuals who regard themselves as oppressed identify with the perceived oppressor rather than with colleagues that are thoughts to be oppressed. I view such oppressed behavior as exceptionally unfortunate yet easily overcome by making an effort to learn about nursing conceptual models and theories.

**JB and KR: What is the relationship between nursing discipline-specific knowledge, in the form of explicit**

**nursing conceptual models and theories and evidence-based nursing practice?**

JF: I regard theory as the best evidence for evidence-based nursing practice. Existing nursing conceptual models guide theory development, which encompasses theory-generation and theory-testing through conducting research, to produce evidence. Existing middle-range nursing theories are evidence. New nursing theories developed through research provide additional evidence.

**JB and KR: Please discuss your programs of nursing research and how those programs and findings have contributed to content-specificity in nursing.**

JF: I have conducted three major programs of research—one program of research, derived from Martha Rogers' conceptual system, addresses wives' and husbands' pregnancy-related experiences. Another program of

research, derived from Callista Roy's adaptation model, addresses women's responses to and perceptions of cesarean birth. The other program of research, also derived from Callista Roy's adaptation model, focuses on function during normal life transitions and serious illness. Each program of research has expanded the understanding of women's experience of childbearing. The theories generated and tested through the programs of research represent evidence for evidence-based practice, primarily in the form of comprehensive assessment tools, as well as intervention protocols. The theories could easily be incorporated into nursing curricula as nursing discipline-specific content.

**JB and KR: How do you see the future direction of nursing?**

JF: I am very concerned about the survival of nursing as a distinct discipline. We have multiple paths of entry into nursing practice and no willingness to distinguish roles of nurses who are prepared for practice in different types of programs. In particular, we refuse to distinguish between technical nursing and professional nursing.

I continue to be troubled by one examination for licensure as a registered nurse. How can it be, for example, that a graduate of an associate degree nursing program and a graduate of a baccalaureate degree program are equally qualified to practice nursing? Or, does the licensure examination reflect the "lowest common denominator" of knowledge? If that is so, what does that mean for patients?

I am convinced that the scope and depth of knowledge now needed to practice professional nursing requires post-baccalaureate education, specifically, the DNP degree. Think of how patients would benefit from being cared for by what we now call advanced practice nurses! When we finally realize the wisdom of entry into professional practice with DNP preparation, we can convert associate- and baccalaureate-degree programs into two progressive levels of pre-nursing education.

**JB and KR: What are your future aspirations for theory and research in contributing to discipline-specific knowledge given the direction with which nursing is moving?**

JF: I will continue to advocate for using nursing discipline-specific conceptual models and theories as the basis for all practical activities in nursing. I will

encourage and mentor nurses who want to develop evidence for nursing practice and other practical activities. I will not work directly with nurses who chose to contribute to other disciplines by using the conceptual models and theories of those other disciplines nor will I praise their efforts as contributions to advancement of nursing knowledge.

**JB and KR: What has given you the most satisfaction in your nursing career?**

JF: I have been exceptionally gratified by the number of nurses who have told me that my published work and presentations have facilitated their understanding of and pride in nursing as a discipline. I also am grateful for my many opportunities to mentor students and faculty colleagues, which has allowed me to give to others what

was given to me by my mentors.

***Conclusion***

Having a distinct body of knowledge with a scientific foundation gives nursing the solidarity and power necessary to determine the unique internal goods of its practice. Internal goods—those qualities of excellence that advance a practice—are determined and recognized only by the practitioners within a discipline (MacIntyre, 1984). To maintain the goods internal to the practice, nurses have a vested interest in preventing people outside of the discipline from judging the state and substance of nursing practice, thus directing its future. One of the internal goods of nursing is evidence derived from theory development and research. The

writers of this article believe that evidence-based practice is a mark of excellence, because it provides discipline-specific knowledge. Fawcett proposed this notion of a reciprocal relationship in 1992. The question of whether the discipline of nursing will survive, given the movement of nursing toward an interdisciplinary practice framework, is left for the reader to consider. Fawcett's voice is resonated by Milton's (2011) warning of danger for the discipline: "It is time for the scholars of nursing theories to rise up and participate in this global dialogue for the good of the discipline and for humankind" (p. 110).

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