Canadian Journal of Nursing Research, 1999, Vol. 30, No. 4, 115–128

Clarifying the Nature of Conceptualizations about Nursing

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Les sciences infirmières, en tant que discipline, sont à un point crucial de leur évolution. La conceptualisation des sciences infirmières est élaborée et testée sans que l'on ait une conception claire de leur essence. Ainsi, la documentation sur le sujet a tendance à embrouiller plutôt qu'à clarifier la pensée. L'objectif du présent traité philosophique est de montrer qu'on pourrait obtenir une plus grande clarté en reconnaissant que les questions posées sur les diverses conceptions des sciences infirmières sont par essence philosophiques. On critique l'influence de Jacqueline Fawcett dans la mesure où la façon de reconnaître et d'agir en fonction du fait ci-haut mentionné permettrait de préciser la réflexion sur la question.

The discipline of nursing is at a crucial point in its development. Conceptualizations about nursing are being developed and tested without benefit of a clear conception as to their nature. Consequently, the nursing literature on the topic tends to confuse rather than clarify thought. The purpose of this philosophic treatise is to show that greater clarity could be achieved by acknowledging the fact that questions addressed in conceptions about nursing are philosophic in nature. The influential thought of Jacqueline Fawcett is critiqued with reference to how acknowledging and acting in terms of this fact would also lend parsimony to thought on the matter.

Introduction

During the past several decades, a dozen or more conceptualizations about nursing have been developed by nurse scholars such as Orem, Parse, and Henderson to guide nursing endeavours. It is clear, from various historical accounts (e.g., Chinn & Kramer, 1995; Meleis, 1991; Peplau, 1987; Whall, 1989), that the evolution of contemporary conceptualizations about nursing was precipitated by the pressing need to answer the question What is nursing? Nurse leaders correctly surmised that the development of nursing, as a discipline in its own right, awaited an answer to that question. The identification of *nursing* curricula, practice, and research was dependent on it; the circumstantial need to define the nature of nursing was intensified by the growing concern that nursing, as a science, was not developing theories of its own — that it could afford to neither continue to borrow theories from other sciences nor accumulate bits and pieces of unrelated information.

Originally published in *Canadian Journal of Nursing Research*, 1997, Vol. 29, No. 1, 97–110.

In the 1970s and 80s, nurse scholars' conceptualizations about nursing, and guidelines for analyzing and evaluating the conceptions, began to flood the nursing book market. Graduate nursing students began to earnestly study this literature and debate aspects of it. One debate has centred directly on the nature of conceptualizations about nursing. In Meleis's (1991) view, the distinctions that some nurse theorists have made among metaparadigm, conceptual model and framework, and theory, in deciding what to call conceptualizations about nursing, are "hair-splitting, unclear, and confusing at worst" (p. 16). Being of the view that these distinctions are not worth debating, Meleis takes the position — as do Chinn and Kramer (1995) — that conceptions about nursing are theories pure and simple. But Fawcett (1993, 1995) continues to insist on the importance of making these distinctions, and of distinguishing between those conceptions that are conceptual models or frameworks and those that are theories, in terms of level of abstractness. However, Uys (1987) correctly points out that theories can be just as abstract as conceptual models.

Given all that has transpired, it is amazing that the nursing literature on the nature of conceptions about nursing remains unclear and confusing. This philosophic treatise attempts to lend clarity to the matter. The thesis, simply put, is that our present confusion stems from a failure to recognize that the conceptions are philosophic in nature. It is defended, first, by revealing that conceptions about nursing have been generally and erroneously assumed by nurse scholars to be scientific in nature. Then taken up is the notion that they are philosophic in nature — more specifically that they are formal philosophies of nursing (i.e., philosophies of nursing having the form of a philosophic nursing theory). Finally, Fawcett's (1995) conception of the "structural hierarchy of contemporary nursing knowledge" (p. 6) is examined to demonstrate how tangled we have become in our attempts to clarify the nature of conceptions about nursing, and to show how we might extricate ourselves by properly conceiving of them as philosophic in nature.

Assumptions

The argument put forward in this treatise is grounded in, and is to be interpreted in light of, the commonsense philosophic position of *moderate* realism, which holds that reality exists outside and independent of the mind and is knowable. In its conception of modes of inquiry (as put forward by such moderate realist philosophers as Adler [1965], Maritain [1959], and Wallace [1983]), moderate realism reasonably makes a place for philosophy as a mode of inquiry capable of produc-

ing theories of the calibre that science, history, and mathematics do in terms of truth value.

Conceptualizations about Nursing as Scientific

There is ample evidence that nurse scholars have generally assumed that conceptions about nursing are scientific in nature. Consider the following examples from the nursing literature. Fitzpatrick and Whall (1989) speak of *indirectly* testing conceptualizations about nursing through investigative hypothesis-testing and using operational definitions — methods characteristic of science as a mode of inquiry. Fawcett (1993, 1995) does so as well with regard to conceptions that she deems to be models or grand theories, but she takes such thinking even further. She refers to the *direct* testing of conceptions about nursing (having, in her view, the form of a middle-range theory) through measurement and statistical procedures. Also, when Parse (1987), Meleis (1991), Barnum (1994), and Chinn and Kramer (1995) address conceptions about nursing as theories, they use terms characteristic of science — such as description, explanation, prediction, and phenomena. The assumption that conceptions about nursing are scientific in nature is also apparent in the numerous references, in the nursing literature, to these conceptions vis-à-vis sociology's notion of scientific grand and middle-range theories (e.g., Chinn & Kramer; Fawcett, 1993, 1995; Fitzpatrick & Whall; Kim, 1983, 1989; Meleis; Melia & Fawcett, 1986; Moody, 1990; Smith, 1992).

The problem in conceiving of conceptions about nursing as scientific is evident in the nature, scope, and object of science as opposed to philosophy as a mode of inquiry. In its inquiry, *science* seeks scientific theories, having the form of probable truth, about what is and happens in the world, grounding its inquiry in (and testing the results against) *special* experience — special in that the experience results from deliberate effort, conducting an investigation to observe phenomena (Adler, 1965). Thus description, explanation, and prediction of the phenomenal (i.e., that which is material and directly or indirectly observable) lie within the purview of science (Maritain, 1930, 1959; Wallace, 1983), giving science the power to attain know-that knowledge about the phenomenal as well as know-how knowledge — or knowledge of how to control phenomena to reach desired outcomes (Adler).

The nature of nursing per se (in the essential sense portrayed in nurse scholars' conceptions about nursing as what distinguishes nursing from other entities) is nonphenomenal (i.e., immaterial and nonobservable). As such, it is not amenable to study through science.

The question What is the essential nature of nursing? is a philosophic nursing question, not a scientific one (Kikuchi, 1992). It is to philosophic inquiry that we must turn for an answer to that question, the outcome of which would be (contrary to the thinking of Salsberry [1994]) a philosophy of nursing having the form of a philosophic nursing theory (Kikuchi & Simmons, 1994). What, then, is a philosophic nursing theory, and how is it attained? The answer, let it be kept in mind, is based in the moderate realist's conception of philosophy as a mode of inquiry.

Conceptualizations about Nursing as Philosophic

Maritain (1959) and Wallace (1983) distinguish between scientific, mathematic, and philosophic modes of inquiry, and their respective concepts, in terms of Aristotle's three degrees of abstraction from matter. Science, dealing with the material and directly or indirectly observable aspects of entities, operates at the first degree of abstraction, the closest, of the three, to matter and therefore the most concrete and least abstract. Philosophy, dealing with the immaterial and nonobservable aspects of entities, operates at the third degree, the furthest removed from matter and therefore the most abstract. Mathematics operates at the second degree. In other words, as the mind moves from the first to the third degree of abstraction it sheds more and more of the material aspects of the entity under study until, at the level of philosophic thought, only the immaterial aspects remain to be considered. Thus a theory at the philosophic level of thought consists of a compendious set of concepts and propositions that are more abstract and general in nature than those found in a scientific theory.

Also, at the level of philosophic thought, theories are developed using methods appropriate to it. Unlike science, which collects and then analyzes observational data at the first degree of abstraction, *philosophy* engages in armchair thinking at the third degree of abstraction. This thinking consists of reflection upon, and discursive analysis of, commonsense knowledge gained through *common* experience (as opposed to the *special* experience in which science is grounded). Commonsense knowledge and common experience are the basic knowledge and experience that all humans have by virtue of simply living and acting day to day, without making a deliberate effort to investigate anything (Adler, 1965). Further, in its inquiry, philosophy, like science, seeks theories, having the form of probable truth, about what is and happens in the world. Unlike science, however, it seeks knowledge of the immaterial or nonobservable aspects of that which exists in the world and knowledge of what we ought to do and seek in human life. Thus it does not

concern itself, as science does, with prediction or control of phenomena. Yet it alone has the power to provide us with the fundamental theoretical and practical knowledge to guide our human endeavours (Adler; Maritain, 1930, 1959; Wallace, 1983) — for example, knowledge of the essential nature of human beings and of moral standards.

From the foregoing explanation of the development of philosophic theories per se, it is clear that armchair thinking would be required to develop a philosophy of nursing having the form of a philosophic nursing theory. This thinking would consist of reflection upon, and discursive analysis of, that commonsense knowledge of nursing which nurses come to possess, not from engaging in extraordinary nursing activity but simply from engaging in everyday practice (i.e., that knowledge of nursing which comes from ordinary or common nursing experience). In other words, through reflection upon this knowledge, answers to philosophic nursing questions would be proposed and analyzed in a discursive manner to develop a philosophy of nursing having the form of a philosophic nursing theory. The established philosophy would consist of a compendious set of concepts and propositions that address philosophic nursing questions concerning the nature, scope, and object of nursing and of nursing knowledge; and of what ought to be done and sought in nursing — questions that nursing as a discipline is responsible for answering (Kikuchi, 1992; Schlotfeldt, 1992). Needless to say, the nursing philosophy so established would be a derived philosophy (Kreyche, 1959) — derived from the philosophic theories of the various branches of the discipline of philosophy (e.g., metaphysics; epistemology; philosophy of mind; philosophy of religion, ethics, and politics) developed in response to questions of a more basic nature that those branches are responsible for answering. Following is an example of how inquiry along these lines might proceed.

Suppose that the question What is the end-goal of nursing? were to be asked and that "quality of life," conceived as "a life befitting human beings," were proposed as a possible end-goal. Reflection on this answer might lead to the question What does such a life entail? Proposed answers would likely spawn other questions, such as: What conditions are required for quality of life, so defined, to exist? What are the consequences of it existing or not existing? How is it different from, or similar to, other things like it? If the inquiry were to be conducted properly, increasingly more penetrating questions would be asked in response to the ongoing analysis of proposed answers to questions already posed (Phenix, 1964). With this kind of cyclical asking and answering of questions, deeper penetration into the true nature of things — in this instance, into the end-goal of nursing — becomes possible.

Having considered the nature of a philosophic theory and of a philosophic nursing theory, and how they are attained, let us now see how greater clarity and parsimony of nursing thought could be achieved by properly conceiving of conceptions about nursing as philosophic in nature. Fawcett's (1993, 1995) conception of the structural hierarchy of contemporary nursing knowledge will be used to establish this point, because Fawcett has described it in sufficient detail to permit such an endeavour.

Fawcett's Structural Hierarchy of Nursing Knowledge

First, a synopsis of Fawcett's (1993, 1995) description of her conception of the structural hierarchy of contemporary nursing knowledge will be presented. The analysis will focus only on those aspects of Fawcett's work that are problematic in that they contain seeds of confusion regarding the nature of conceptions about nursing — seeds sown, it would seem, by virtue of the failure to see that the conceptions are philosophic rather than scientific in nature and the eclectical amalgamation of ideas. Direct quotations will be used, rather than paraphrasing, wherever it is crucial that Fawcett's ideas, and those of others that she uses, be conveyed accurately.

According to Fawcett (1993, 1995), the structural hierarchy of contemporary nursing knowledge has several components: a metaparadigm, philosophies, conceptual models, theories, and empirical indicators. The hierarchy descends from the metaparadigm (the most abstract) to the empirical indicators (the most concrete).

Metaparadigm

Fawcett (1995) states that the functions of a metaparadigm include that of summarizing a discipline's intellectual and social missions and placing a boundary on that discipline's subject matter. These functions are said to be reflected in the following four requirements of a metaparadigm: (1) it must identify a discipline's domain such that it is distinct from those of other disciplines, (2) it must parsimoniously encompass all phenomena of interest to a discipline, (3) it must be neutral in perspective, and (4) it must be international in scope and substance.

Fawcett (1995) identifies the central concepts of the nursing metaparadigm (the phenomena of interest to nursing) as person, environment, health, and nursing, based on four concepts induced from the conceptual frameworks of baccalaureate programs accredited by the National League for Nursing (NLN). The relationships among the

metaparadigm concepts, which Fawcett enunciates in four propositions, are based mainly on the work of Donaldson and Crowley (1978). Finally, Fawcett states that the metaparadigm cannot be tested empirically because there is no direct connection between it and empirical indicators but that it "should be defendable on the basis of dialogue and debate" (p. 30).

Philosophies

The second component of the structural hierarchy Fawcett (1993, 1995) identifies as "philosophies," describing the relationship of philosophies to the metaparadigm and conceptual models thus:

> Philosophies do not follow directly in line from the metaparadigm of the discipline, and they do not directly precede conceptual models. Rather, the metaparadigm of a discipline identifies the phenomena about which philosophical claims are made. The unique focus and content of each conceptual model then reflect the philosophical claims. (1995, p. 24)

Fawcett offers an example of that relationship: a philosophy's claim that all people are equal would be reflected in a conceptual model as nurse and patient being equal partners in health care. Fawcett (1993) outlines the substantive content of philosophies:

> Philosophies encompass ontological claims about the nature of human beings and the goal of the discipline, epistemic claims regarding how knowledge is developed, and ethical claims about what the members of a discipline should do (Salsberry, 1991). Different philosophies (world views) lead to different conceptualizations of the central concepts of a discipline and to different statements about the nature of the relationships among those concepts (Altman & Rogoff, 1987). (p. 8)

According to Fawcett (1995), one cannot empirically test philosophies, directly or indirectly, because there is no direct connection between philosophies and empirical indicators and because philosophies are statements of beliefs and values. They "should, however, be defendable on the basis of logic or through dialogue (Salsberry, 1991)" (p. 30).

In her guidelines for analyzing conceptual models of nursing, Fawcett (1995) suggests the following question be asked in relation to the philosophy component: "On what philosophical beliefs and values about nursing is the conceptual model based?" (p. 53). She proposes a similar question with regard to analyzing nursing theories (Fawcett, 1993, p. 36). Additionally, in describing how the components of the structural hierarchy of nursing knowledge might be "translated" in a

particular practice setting, she translates *philosophies* into *philosophy of nursing department* and *conceptual models* into *professional nursing perspective* (1995, p. 521).

Conceptual Models of Nursing

Fawcett (1995) refers to the third component of the structural hierarchy, conceptual models of nursing, as the "formal presentations of some nurses' private images of nursing" (p. 5) and as paradigmatic views of the metapaparadigm concepts (pp. 12–13). The term *conceptual model* she takes to be synonymous with *conceptual framework* (p. 2). Conceptualizations of nursing that Fawcett identifies as conceptual models include those of Johnson, King, Levine, Neuman, Orem, Rogers, and Roy. To clarify the purpose of conceptual models, Fawcett (1995) calls upon Dorothy Johnson.

> Johnson (1987) explained, "Conceptual models specify for nurses and society the mission and boundaries of the profession. They clarify the realm of nursing responsibility and accountability, and they allow the practitioner and/or the profession to document services and outcomes" (pp. 196–197). (p. 4)

Fawcett (1995) suggests that in analyzing a particular model, one should determine, among other things, how the metaparadigm concepts are defined and/or described and what is stated as the goal of nursing (p. 53).

According to Fawcett (1995), "conceptual models evolve from the empirical observations and intuitive insights of scholars and/or from deductions that creatively combine ideas from several fields of inquiry" (p. 3). Also, the concepts of a conceptual model are not directly observable "nor limited to any particular individual, group, situation, or event" (p. 2), because of their sheer abstractness and generality. Further, the conceptual model is empirically untestable, because there is no direct connection between a conceptual model and empirical indicators, but its credibility can be established indirectly (indirectly tested) by empirically testing middle-range theories derived from the model — theories whose concepts can be defined in measurable terms and from whose propositions empirically testable hypotheses of observable relationships can be derived (pp. 28–30).

Theories

Theories, the fourth component of the structural hierarchy, Fawcett (1993, 1995) believes are different from conceptual models in that they

are less abstract and comprehensive. She posits two kinds of theories: grand theories and middle-range theories. Grand theories are more abstract and comprehensive and, like conceptual models, empirically untestable except indirectly through the empirical testing of middle-range theories derived from them. According to Fawcett (1995), "grand theories are developed through thoughtful and insightful appraisal of existing ideas or creative intellectual leaps beyond existing knowledge" (pp. 24–25). Leininger's, Newman's, and Parse's conceptualizations of nursing Fawcett identifies as grand theories in nursing; those of Orlando, Peplau, and Watson she identifies as middle-range theories in nursing.

Empirical Indicators

The last component of the structural hierarchy Fawcett (1993, 1995) refers to as empirical indicators. "They are the actual instruments, experimental conditions, and procedures that are used to observe or measure the concepts of a middle-range theory" (1995, p. 29).

With the foregoing synopsis of Fawcett's (1993, 1995) conception of the structural hierarchy of contemporary nursing knowledge in mind, let us now see where the seeds of confusion lie and how they could be eliminated through properly conceiving of conceptions about nursing as philosophic in nature.

Fawcett's Conception: Eliminating the Seeds of Confusion

The confusion inherent in Fawcett's conception become apparent when one tries to distinguish between and among the components of her structural hierarchy, on the basis of her descriptions of them. Let us begin by considering the second component, philosophies, because the key to eliminating the seeds of confusion lies here. From Fawcett's (1993, 1995) description of what she refers to as philosophies, it is hard to get a handle on how, exactly, she conceives of this second component. At times it is portrayed as consisting of general philosophies — world views about basic matters; at other times as consisting of philosophies (views) of nursing (philosophic beliefs and values about nursing); at still other times it seems to consist of both general philosophies and philosophies of nursing. This ambiguity is complicated by the lack of clarity in how the beliefs and values about nursing contained in this component differ from those contained in the components that she refers to as conceptual models and theories.

When Fawcett asserts that (a) philosophies inform us of beliefs and values about nursing, its goal, and what its practitioners should do, and (b) conceptual models of nursing tell us of the mission and boundaries of the profession, its realm of responsibility and accountability, and its goal, then philosophies and conceptual models appear to be similar notions. Both seem to provide a nursing perspective. The water becomes murkier when one considers that conceptualizations deemed theories are also said to inform us of those matters seen as falling within the scope of philosophies and conceptual models. Further, Fawcett's (1995) description of how grand theories and conceptual models are developed reminds one of how philosophies are in fact developed.

Finally, the essential difference between philosophies and the metaparadigm becomes further obscured when one reflects on Fawcett's (1995) claim that (a) the metaparadigm identifies the domain of nursing; (b) philosophies are empirically untestable because there is no direct connection between them and empirical indicators and because they are statements of beliefs and values, but they should be defendable by means of dialogue and logic; and (c) the metaparadigm is empirically untestable because there is no direct connection between it and empirical indicators, but it should be defendable through dialogue and debate. Now, philosophies and the metaparadigm appear to be similar notions.

Fawcett could argue that philosophies and the metaparadigm are not alike because philosophies are *not* perspective-neutral (i.e., they are perspective-oriented) in that they are world views (Fawcett, 1993) and the metaparadigm is perspective-neutral (1995). But it is hard to see how the metaparadigm can possibly be perspective-neutral if philosophies are perspective-oriented. Given that there can be no presuppositionless conceptions (Martin, 1964), must the metaparadigm concepts and propositions (not to mention the conception of the metaparadigm qua metaparadigm) be grounded in and driven by some philosophy? If so, and if philosophies are perspective-oriented, then would there not be multiple perspective-oriented metaparadigms (and multiple perspective-oriented conceptions of the metaparadigm per se)? Further, it might be asked: how would it be possible to defend philosophies and the metaparadigm(s) in dialogue and on the basis of logic, as Fawcett (1995) prescribes, given that, in her conception, philosophies (being world views) would define truth in different ways, with some rejecting the principle of noncontradiction altogether?

That the preceding questions need to be addressed becomes readily apparent when one examines Fawcett's (1995) analysis of nurse scholars' revisions to her metaparadigm of nursing. Fawcett fails to provide

an adequate defence of her selection of the metaparadigm concepts and propositions and of her claim that the metaparadigm is perspective-neutral and international in scope and substance. In fact, what explanation she does provide (e.g., that the metaparadigm concepts are based on those induced from the conceptual frameworks of baccalaureate NLN-accredited programs), and an examination of the metaparadigm, would support the notion that her metaparadigm is *not* perspective-neutral. It contains a mixture of notions (e.g., "labeling," "intervention," "laws," "patterning," and "wholeness" [p. 7]), which are reflective of specific philosophies and conceptual models or theories of nursing.

Given the seeds of confusion contained in Fawcett's conception of the structural hierarchy of contemporary nursing knowledge, how can we better realize the potential of that structure, to benefit the discipline of nursing? Greater clarity, not to mention parsimony, of thought might be possible by properly conceiving of conceptions about nursing as philosophic in nature, making possible, in turn, the replacement of what Fawcett calls the metaparadigm of nursing, philosophies, and conceptual models and theories of nursing with philosophies of nursing having the form of a philosophic nursing theory. Such a proposal makes sense given that little, if anything, distinguishes the metaparadigm of nursing, philosophies, and conceptual models and theories of nursing in terms of a difference in kind. The distinction that Fawcett (1993, 1995) makes, in terms of levels of abstractness (and all that flows from it), is one of degree rather than of kind. Further, and most importantly, Fawcett attributes to each of them what is in fact a philosophic function: in one way or another, they all address nursing's philosophic questions — questions concerning the nature, scope, and object of nursing and of nursing knowledge, and of what ought to be done and sought in nursing.

With the proposed change, the structural hierarchy of nursing knowledge would consist of components of nursing knowledge (e.g., the science of nursing — scientific nursing theories about nursing phenomena developed using the scientific mode of inquiry and, where appropriate, what Fawcett [1993, 1995] refers to as empirical indicators — the art of nursing and the history of nursing), all grounded in the basic component, the philosophy of nursing. It should be noted that this change would require that philosophy be released from the domain of mere speculation or opinion and the confines of the nonempirical analytic realm of what Adler (1965) refers to as second-order philosophic questions — analytical questions about what has been put forward as knowledge by the various disciplines. Stated positively, this means we would need to acknowledge that (a) philosophic inquiry can also

provide us with answers to first-order philosophic questions about what is and happens in the world, and of what we ought to do and seek in human life; and (b) its answers are not only logically but empirically testable against common experience (Adler). Acting upon this acknowledgement would make possible the settling of important philosophic nursing issues, such as the nature of nursing, by empirical and logical means, and guard against treating philosophies of nursing as ideologies. In other words, philosophies of nursing in the form of a philosophic nursing theory would be testable against common nursing experience to determine their truth value.

Conclusion

The discipline of nursing is without a doubt at a crucial point in its development. Conceptualizations about nursing are being developed and tested without benefit of a clear conception as to their nature. Despite the ongoing remarkable efforts of such nurse scholars as Fawcett, the nursing literature still serves to confuse rather than clarify thought on this matter. Greater clarity could be achieved by recognizing that questions addressed in conceptions about nursing are philosophic nursing questions to which tenable answers in the form of a formal philosophy of nursing (a philosophic nursing theory) can be attained using the philosophic mode of inquiry (Kikuchi & Simmons, 1994). At a time when it is becoming increasingly important that we define the nature of nursing in a manner that is satisfactory not only to members of our own discipline but to those of other disciplines and to the public, surely it behooves us to clarify the nature of conceptions about nursing. Without such clarification we may continue to struggle in vain to define nursing and, in the process, lose all that we have come to cherish about nursing and seek to retain through definition.

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Acknowledgement

The author gratefully acknowledges the helpful comments made by Dr. Helen Simmons in her reading of drafts of this paper.