

# THEORETICAL NURSING: TODAY'S CHALLENGES, TOMORROW'S BRIDGES

Afaf I. Meleis

This article is based on an address delivered at celebrations commemorating the twenty-fifth anniversary of la Faculté des sciences infirmières at the Université de Montréal, Québec. A different version was originally prepared as a keynote address for the First Annual Theory Conference, the Catholic University of America, Washington, DC, in 1986.

In 1978, in Alma Ata, Russia, The World Health Organization (WHO) declared its commitment to health for all by the year 2000. It also recommended that the way to achieve this objective is through a strategy of primary health care. Nursing is a most significant force in bringing health to people of the world. Several strategies are necessary to realize the meaning of this declaration. One is the subject of today, the development of theoretical nursing through discovery, description or interpretation.

It is very apparent that there has been a renewed interest in describing nursing theoretically, and in systematically pursuing a developmental trajectory in nursing knowledge development. One has only to review the phenomenal increase in programs that are being developed nationally and internationally to appreciate knowledge development. Interest spans the gamut of practitioners, researchers, academicians and administrators. Examples are the university-based theory and theory development workshops; the focus of the Academy's annual meeting, in 1985, on knowledge development; and discussions on the relationship between theory and practice during the annual meetings of clinical specialists. When we review the content of these meetings as well as of some of the pertinent and leading practice and research journals, no doubt is left in the minds of nurse scientists and scholars that this is a time when there is a great deal of focus on theory and a genuine interest in the development of theoretical nursing. One may even surmise that, with the increase in research productivity and the increase in programs that prepare nurse scientists, the discipline of nursing may have reached a new milestone, somewhere between the stage of theory and the stage of scholarliness.

Afaf I. Meleis, Ph.D., F.A.A.N., is Professor and International Kellogg Fellow at the University of California School of Nursing, San Francisco, CA.

A quick review of stages of knowledge development reveals different foci at different times. The early focus was on practice, then it shifted to education and then to administration. The next shift was to research. Although research represented a definite attempt to develop nursing knowledge, completed research lacked a framework in which ideas and concepts could be connected; it was haphazard and scattered. It also lacked policy implications. Therefore, the most recent focus was on questions such as: what theories guide the development of nursing knowledge, and what types of theories are nurses attempting to develop?

Although these questions are still valid, new ones must be asked. The process of answering these may influence the process of knowledge development, as we begin moving toward a new decade.

## **The State of the Discipline**

### ***A defined domain***

The core of a discipline is its domain, or the territory for practice and investigation. The domain comprises central concepts, central concerns, focal areas of investigation, and the persons who engage in dealing with these concepts and questions (Toulmin, 1972). The domain of nursing has been explored by a number of theorists, beginning with Florence Nightingale. Different researchers have explored questions that they considered central to their practice or to their teaching. Clinicians have contributed different perspectives by providing necessary care to help patients recover, to keep them comfortable during uncomfortable procedures, to help decrease their suffering and, in some instances to help maintain their health. It is from all these areas and efforts, and from the wisdom of all involved, that the nursing domain began evolving.

The literature identifies central concepts and their interrelationships that are beginning to influence on-going research and theory development (Moccia, 1986). The concepts of health, environment and interactions have received more recent attention in the literature than they have had in the past. Self care and responses to health and illness situations are part of our repertoire (Donaldson & Crowley, 1978). We have claimed a territory for knowledge development.

There are some central theoretical propositions that have generated such related research questions. Some questions concern the client's patterns of responses to certain health/illness situations, and the nursing therapeutics that are most congruent with patients' needs and backgrounds. Some researchers have examined the environmental conditions that act as modifiers to the responses and the therapeutics (Chopoorian, 1986; Fawcett, 1983;

Flaskerud & Halloran, 1980; Meleis, 1986). Other questions examine the outcomes of nursing care and the factors that profoundly influence the decisions of clients and health care workers in promoting positive health care (Oberst, 1986).

Although we still have some distance to go in defining concepts, we must not continue to debate definitions, nor strive for global acceptance or consensus. We must engage in creating dynamic and working definitions that are based on clinical and empirical examples. It is then, perhaps, that consensus may emerge. We must begin to answer the discipline's central questions by being engaged in caring for clients or collaborating with clinicians who care for clients. That is, *if* we agree that engaging in care for clients is the essence of nursing!

### *Theoretical pluralism*

The complexities of human behaviours and interactions, and the dynamic nature of development and change make it imperative that we accept a pluralistic approach to theory development and utilization. There was a time, perhaps, when the goal for nurse theoreticians was to work toward the development and the acceptance of one nursing theory to guide our practice, education and research. Such a theory was expected to help by posing all the pertinent questions and would have provided a framework for all the pertinent answers. This belief is not as strong as it once was, and it has been replaced with questions on how to utilize different theories simultaneously to answer different questions; for example, clinicians are utilizing immune theories in conjunction with self-care and interaction theories.

One example of pluralism is a project that Juliene Lipson and I are currently working on. It involves the Middle Eastern immigrants to San Francisco that will serve as an example. The Mid East Siha project is designed to test theory, and to generate new theories that may help in answering some pressing questions related to the care of immigrants in the United States. We have used a symbolic interactionist approach to transition theory to articulate the research questions. These focus on the relationship between the immigrants' transition experiences and their health, and illness status. In selecting indicators of health, we were guided by the nursing domain's ontological orientation. This and the definition of health helped us in defining study variables and in focusing on questions of interest, such as consideration of the multidimensionality of health. Therefore, we have included the subjects' perceptions of health as a means of examining the individual meanings attributed to perceptions and experiences. We have also used Johnson's (1980) theory to develop a clinical assessment tool which is being used in the primary health care clinic attached to the project. We plan

to test the utility of the tool for identifying nursing care problems and for providing some direction for planning the necessary support for their care. We would not be able to carry on the clinical, and the research work for this project meaningfully, if we only used one theory.

### *Pluralistic philosophical approaches*

A third trend is toward greater exercise of pluralistic philosophic approaches. Liberal philosophy, which has helped in establishing the democratic tenets of North America, has been criticized as being gender, class and ethnically biased (Lather, 1986). Similarly, the empirical-analytical-logical paradigm for theory and research, which stressed measurable and testable hypotheses, objectivity in data gathering and data analyses, universality of findings, decontextuality of explanations and formalization through scientific principles, has been questioned and criticized (Munhall, 1982; Silva & Rothbart, 1984; Thompson, 1985; Watson, 1981). Historicists such as Silva and Rothbart (1984) emphasize the viewing of phenomena as being imbedded within a sociocultural context. Historicists also view the process of theory development in terms of a historical and value context (Chinn, 1985; Tinkle & Beaton, 1983). All truths, to historicists, are relative: there are always multiple truths, and application must be taken into account when considering research or theory.

Phenomenology examines the significance of meaning in understanding human behaviour; meanings for both the individual and the environment that result from transactions between the two. The aim of the phenomenologists and the historicists, in developing theories, is the development of examples that depict different patterns and trends that incorporate all the variables related to the phenomena. Another, more recent, perspective is that of feminist methodology, an approach which incorporates many of the ontological concerns of phenomenology and hermeneutics.

Nursing literature has debated the use of one paradigm or another. However, recent writing and sentiment among scholars is favorable to philosophical pluralism as the guide for theory development and research (Allen, Benner, & Diekelmann, 1986).

It is important for us to remember though, that, while our research tradition may have emerged from a fascination with the empirical-analytical-logical, neither theory development nor practice have adhered to this philosophical approach. Nursing practice literature is laden with examples that are based on experiential and contextual data. Indeed, without stating so, its authors have used phenomenological and hermeneutic approaches. These examples describe nurses as a group of clinicians in health care systems who are sensitive to gender and ethnic diversity. These examples could be the



bases for the development of descriptive theories of responses and prescriptive theories of care.

Perhaps it was in the attempt to develop our discipline scientifically that we may have opted for a philosophy that was derived more from the positivist paradigm; espousing objectivism, one truth and a reductionist approach to human beings and their environments. In other words, the focus on one paradigm may have been an artifact of the attitudes of a few who dominated the early scholarly development of the discipline. However, clinicians and theoreticians have had a hard time accepting one empirical positivist approach. Perhaps the use of different sets of philosophical principles by clinicians, by theorists and by researchers created the intellectual schism among them that has resulted in some isolation, and therefore the need for bridges to be constructed.

### **The Future**

Future trends in knowledge development will include shedding paternalism, viewing theory as a process, developing domain-focused theoretical formulations, using international nursing for the development of theory, and the development of an integrated approach to theory development.

#### ***Shedding paternalism***

Nursing has tended to be overshadowed and influenced by members of one or more disciplines. The tenets, the questions and the struggles of that parent discipline became the principles, the questions and the struggles of our own. Early on, medicine was the parent discipline. As we began to work toward intellectual independence we found replacements for medicine as that parent. Because I am a nurse sociologist, I have used, as an example, the influence of the discipline of sociology on nursing as an example.

Sociological theory had a number of profound and lasting influences on nursing knowledge. First, the conceptualization of an individual as a social being – as a member of a reference group, the behaviour of which influences and is being influenced by the social environment – evolved from this perspective. Therefore, properties, structure and function of the external factors are analyzed to help in understanding behaviours and actions. Sociological theories represent three major paradigms: conflict, interaction, and structure and functions. Nursing research and nursing theories that have evolved from sociological perspectives were based on one or more of these paradigms.

The sociological perspective has exerted a second major impact on nursing research. Modes of inquiry used in the development of sociological knowledge have been used extensively. For example, field methodology that was developed by Schatzman and Strauss (1973) grew out of a symbolic interactionist theory. Social processes inherent in death and dying or pain, in use of machinery in health care, in chronicity and drastic surgical procedures such as mastectomies have been elucidated by qualitative methods that have emerged from this approach to research. More recent writings in nursing theory and research challenge nurse researchers to use phenomenological and hermeneutic modes of inquiry in nursing research (Allen, et al., 1986).

Sociological theory has also influenced the writings of nurse metatheorists. These writers describe strategies for developing theories, discuss ways by which theories can be evaluated, and debate issues of validity in theory development. Nurse metatheorists have derived many of their ideas from metatheorists in sociology (Dubin, 1978; Hage, 1972; Merton, 1973).

In some ways this relationship may have created some unwarranted detours. These occurred because of a formalistic definition of theory as axiomatic, as only a product of empirical research and as a set of confirmed hypotheses. Research has come to be viewed by some as quantitative only, and as a necessary and sufficient prerequisite for the development of theory. More contemporary views of nursing theory include received and perceived views of nursing theory.

There are advantages and disadvantages in rebelling against one set of parents and quickly adopting another. As we look at the 1985-1986 debates in the literature, and observe the healthy philosophy of science discussions that are also occurring in other disciplines, are we co-opting and adopting a new set of parents with a new set of values? What if we put our energies and resources into dealing with the pressing questions related to the health and well-being of our clients, into developing some understanding of the diverse responses to healing and health promotion, and into much needed nursing therapeutics? What if we look within, to answer our own pressing questions? What kinds of nursing theories might we be developing? Would we then combine the intellectual maturity that is manifested in healthy criticism (Thompson, 1985) with a steady development of knowledge for nursing?

### *Theory as a process*

In a human science, where behaviour is dynamically shaped by social and physical environment, and where the environment is continuously being

influenced by humans, theory must also be equally dynamic and changing. Otherwise, we may find that its descriptive and explanatory powers diminish or become outdated, before it is even developed.

Natural and physical sciences have always managed to operate with completed theories; theories as outcomes – as end products. When new theories emerged that refuted older ones, older theories were then replaced. Kuhn (1970) described this as a revolution, the process of creation of new paradigms that replace the old ones. Human science will always have such theories-in-process. These are theories that denote a theoretical perspective; they are based on the discipline's ontological concerns and they evolve from accepted epistemological processes. They are based on assumptions that respect the totality of humans, the integration of human beings with their environment and the rights of human beings to participate in decisions related to their own life. Theories-in-process are an end-product, and not the means to an end; they are the process of conceptualizing a phenomenon, the process of understanding a clinical situation and the process of going beyond the data in a research project. They are defined as the analytical and interpretive phase, the phase that goes beyond data analysis, the phase that connects findings with the theoretical perspective. They identify underlying assumptions and relationships to domain concepts.

If we accept this view, theories-in-process would not be defined as incomplete. Instead, nursing as a human science will always be developing theories-in-process or dynamic theories that will not be relegated to a secondary status nor be regarded as a sign of a pre-paradigmatic discipline. They are, then, an indication that their parent discipline is a human science.

### *Domain-focused theoretical formulations*

A third trend is the shift from the philosophical and theoretical debates to considerations of practical developments in nursing (Meleis, 1987). Therefore, ontological and epistemological discussions would be grounded in nursing's central concepts and questions. Discussions of health, from a critical and phenomenological theory perspective (Allen, 1985), have created useful intellectual discourse. There is agreement within nursing on domain concepts, ontological beliefs, and epistemological approaches to knowledge development. There is also healthy diversity that will continue to exist. The ontological and epistemological areas should provide a framework for further theory development. It is therefore proposed, that theory development should focus on questions related to environments and individuals' responses to health and illness situations, and on ways by which we can render an effective nursing care that is gender, class and ethnically sensitive. Three conditions have been proposed to ensure the congruency and appropriateness of these theories with the holistic focus of nursing:

*Context:* The individual should be treated as a part of an environment and as being capable of having perceptions, meanings and interpretations of his or her own situation. Analysis of context allows a synthesis of the varied perspectives in the situation.

*Patterning:* Pattern is defined as "the configuration of relationships among elements of a particular phenomenon" (Crawford, 1982, p.3). Patterning takes us away from unidimensionality and single incident studies; away from developing theories based on manifested behaviours that are temporarily constrained. It is congruent with the human-clinical sciences because it considers repetitive responses within different conditions and situations. Considering patterns of responses allows the theorist to consider increasing complexity and diversity (Bramwell, 1984; Johnson, 1980; Rogers, 1970; Stevenson & Woods, 1986).

*Triangulation:* Triangulation is the use of multiple approaches to studying the same phenomenon (Denzin, 1978; Mitchell, 1986; Stevenson & Woods, 1986). These may be in the same study or in different studies. It is a method that relies on clinical observations, the experiences of clinicians, reviewing pertinent literature, reviewing previous theoretical formulations, selecting the phenomenon, labelling, defining concepts, and dealing with meaning and measurement issues.

### ***International Nursing***

Concern about the welfare of clients, as a prerequisite to the development of theory in a human science field, mandates a concern for the health of clients from different ethnic and socio-economic backgrounds. Therefore, theory development must accommodate such diversity. One way to ensure this is through a global approach to the development of theories. Researchers should collaborate with nurse theorists in different cultures to gain different perspectives of phenomena in our own countries and to discover worldwide concerns. There is a potential nursing power in the act of reciprocating in knowledge development; power that could influence nursing care world wide.

### ***Integrated approach to theory development***

The phases of knowledge development in nursing are graphically represented in nursing's educational institutions. There are research courses, theory courses, clinical courses, educational and administrative courses. What if we identify areas of specialization that are congruent with our ontological focus and that are based on the current levels of our epistemological growth, and what if we develop graduate seminars to represent these areas of specialization? The seminars would also be representative of nursing's mission and concerns. What if these substantive



areas are considered from clinical, research and theoretical perspectives? Furthermore, what if strategies of theory development are then considered within the context of the substantive issues that are being studied? Such an approach would decrease the divisions that exist among theory, research and practice. Integration would remove barriers in the very different processes inherent in theory and research that are essential for the development of knowledge in nursing (Lather, 1986).

### Challenges

There are many challenges that face us as we engage in the continuous process of knowledge development through the articulation of theories-in-process.

- . Stevenson and Woods (1986) presented the many ways nurses have specialized through the use of a number of conflicting models: a medical model, a life stage model, a time model, a health-illness model, and a mixed model. Which model represents nursing knowledge and what are the pressing questions in each area of specialization for which theories-in-process should be developed?

- . What are some of the strategies that could be used to encourage the development of theories-in-process, and how can researchers, clinicians, and theoreticians become engaged in such processes? Who should be charged with their development?

- . In what ways do theories-in-process respond to clients' health needs globally? In what ways do they help in explaining nursing care needs of our minority and immigrant clients?

- . How much of our energy, time and other resources should we devote to the elite and majority populations and how much should be allocated to the underserved populations?

- . What types and levels of dynamic theories should be developed? Should we promote the development of descriptive theories and prescriptive theories equally? Why, and what are the consequences of focusing on one or both types?

- . What are some of the strategies that could be used to combine analytical, empirical and reflective techniques in theory development?

- . What types of resources are needed for developing theories that are based on context, patterning and triangulation?

. In what ways and by what means can the myths that have separated theory, practice and research be dispelled?

. We have conceptualized self care as an outcome. What other outcomes are appropriate and congruent with the mission of nursing?

. How could we demystify theoretical nursing and stimulate the development of theory-in-process by clinicians and researchers, as well as by theoreticians? How can consumers be involved?

. What differences, if any, do theories-in-process make in health policies?

. What strategies in research and theory development could be used to ensure understanding of human responses and potential, without stifling growth and situational propensity for change?

### **Conclusion**

Our theoretical journey has been long. It started way back during the Islamic wars in Mecca and within the walls of Crimean cities in Turkey. Nurses have been ingenious in detouring obstacles, and in coming back on course. We have constructed many bridges on this journey. Some of these bridges have connected some areas of practice with research and theory. Some have been original and solid, like the Golden Gate Bridge, in San Francisco. Some have been replicas, such as the Golden Gate Bridge look-alike in Florianapolis, in Brazil; seemingly solid at the time of construction, it quickly became obsolete and ceased to meet the new demands of population increase on the island. A new bridge was constructed with more appropriate material and a more appropriate architectural approach. The bridges stand side by side, demonstrating the meanings of replication, obsolescence, and renewal. The Gotteberg Bridge, in Sweden, is a modified replica. The city's very needs, style, tradition, weather, and population directed the modifications.

We have built bridges, replicated some, and repaired others. We must continue on an international theoretical journey that will help our clients have more options and better access to health care, to cope with old and modern illnesses and to achieve the highest sense of well-being. The question is not: can we meet the challenges ahead of us? Nor is it: should we cross the bridges ahead of us? Rather, the questions are: which bridges should we build? And, which ones should we cross to continue the journey ahead of us, to continue a journey into the future of nursing knowledge?

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## RÉSUMÉ

### Le nursing théorique: les défis d'aujourd'hui, les ponts de demain

Lors de la première conférence dans le cadre du vingt-cinquième anniversaire de fondation de la Faculté des sciences infirmières, le professeur Meleis a prononcé une conférence intitulée: La théorie infirmière: les défis d'aujourd'hui et les ponts de demain.

Ce texte présente un résumé de cette conférence qui avait trois buts: analyser l'évolution de la théorie en sciences infirmières et les conditions qui ont influencé cette évolution; présenter les tendances futures; soulever des questions face aux défis devant nous.

La première partie trace les étapes du développement de la théorie en sciences infirmières et analyse brièvement deux approches: le pluralisme théorique et le pluralisme philosophique.

Dans la deuxième partie, l'auteur identifie cinq tendances futures: le rejet du paternalisme théorique de diverses disciplines, la théorie vue comme un processus dynamique plutôt que comme un résultat, l'élaboration de théories autour de concepts propres aux sciences infirmières, l'utilisation de connaissances multi-culturelles et internationales, l'approche intégrée dans le développement de la théorie.

En dernier lieu, le professeur Meleis soulève un ensemble de questions: Parmi les modèles choisis (modèle médical, modèle santé-maladie, etc) pour la spécialisation en sciences infirmières, lesquels représentent des connaissances propres à la discipline infirmière? Quelles stratégies facilitent le développement de la théorie vue comme un processus? Comment cette théorie répond-elle aux besoins des clientèles? Devons-nous promouvoir à la fois le développement de théories descriptives et de théories prescriptives? Quelles stratégies peuvent combiner les techniques analytiques, empiriques et réflexives dans le développement de la théorie?

Quels types de ressources sont nécessaires pour développer des théories basées sur le "patterning", la "contextuality" et la triangulation? Quels résultats chez la clientèle, autres que "la prise en charge", sont pertinents pour la discipline?

Comment détruire les mythes qui séparent la théorie, la pratique et la recherche infirmières?

En guise de conclusion, Meleis précise que la question fondamentale n'est pas de savoir si nous pouvons relever les défis, ni de savoir si nous devons traverser les ponts devant nous, les questions sont plutôt: quels ponts faut-il ériger et lesquels devons-nous traverser?