THE MEANING OF HIGH-QUALITY NURSING CARE DERIVED FROM KING'S INTERACTING SYSTEMS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
University of Tennessee, Knoxville

Mary Ellen Gunther
May 2001

To the Graduate Council:

I am submitting herewith a dissertation written by Mary Ellen Gunther entitled "The Meaning of High-Quality Nursing Care as Derived from King's Interacting Systems." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

[redacted]

Martha R. Alligood, Major Professor

We have read this dissertation and recommend its acceptance:

[redacted]

David E. Lunge

[redacted]

Johnie Mozingo

[redacted]

Carol M. Seavor

[redacted]

Sandra P. Thomas

Accepted for the Council:

[redacted]

Interim Vice Provost and
Dean of The Graduate School

ACKNOWLEDGEMENTS

Amazing things have happened on this journey. I want to thank my committee members for their support and patience. I hope I have conveyed what they taught me, but any inaccuracies in interpretation are mine. I wish to express my appreciation to Dr. Jacqueline Fawcett who graciously allowed me to spend a week with her in Maine and helped me narrow and refine the focus of this study. I give special thanks to my mentors Jane A. Hudson and Dr. Martha R. Alligood.

I can never express enough thanks to my best friend, Michael Brotherton, who has lived with this work for the past three years. He taught me canasta, worked jigsaw puzzles, and took me dancing when I needed it the most. Thanks are due to my close friends Cynthia Markert, Kiki McDonald, Kevin Thomas, Kim Massey, Tim Shoen, and David Ballard for their continued encouragement and support.

This study was funded in part by a grant from Gamma Chi Chapter of Sigma Theta Tau International.

ABSTRACT

The purpose of this study is to conceptualize quality within a framework unique to nursing, King's Interacting Systems. Clarification of the concept within the metaparadigm and a nursing conceptual framework provides the understanding of the domain and scope of nursing necessary for professional autonomy. This differentiation fosters the continued development of the discipline as well as facilitating collaboration with medicine and other health care disciplines for the ultimate benefit of the patient.

Gadamer's philosophical hermeneutics involves a dialogical interaction between the whole and parts of the text and between the horizons of the text and the interpreter. In this research study, using dialogical interaction, King's (1981) A theory for nursing: Systems, concepts, process was approached with the question: What are the characteristics of high-quality nursing care? Using the framework of Fawcett's (1997) Structural Hierarchy of Contemporary Nursing Knowledge, the meaning and experience of high-quality nursing care is found in the metaparadigm relational proposition that nursing is concerned with the nursing actions or processes by which positive changes in the person's health status are effected.

Findings: Performed in an interpersonal field, nursing actions are influenced by the developmental level of the personal system of each participant as well as the conceptual characteristics of the larger social

system. Quality is an experiential judgment emerging from the nurse-patient interaction and reflects both the unique and shared values of the participants. As such it mirrors King's interaction-transaction model. Goal attainment provides measurable evidence of the quality of the nursing care provided.

Conclusion: Empathic understanding, requiring the nurse's self-awareness and perceptual accuracy, guides communication during the nurse-patient interaction aimed at mutual decision-making regarding actions leading to goal attainment. Role and power influence mutuality, an interdependence of nurse and patient, in decision-making. Goals and subsequent actions are reflections of the patient's values manifested through nursing interventions.

Application: The fusion of the horizons of the text and the interpreter's situation in today's health care environment results in a theory of high-quality nursing care from which specific empirical indicators may be developed. The theory supports the baccalaureate degree as entry level for professional nursing with recommendations regarding curriculum content; supports differentiated practice care delivery models; and identifies future research questions and problems.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

The industrialization of health care services, demonstrated by an emphasis on competitive costs, places increasing importance on the quality of such care. Used as an adjective to describe the degree of the excellence of products or services, *quality* can range from low (or non-existent) to high. People frequently assume that the use of the single descriptive word *quality* without a continuum-locating modifier indicates a high degree of excellence for while cost is a clearly quantifiable variable, quality is not. The Agency for Health Care Research and Quality (AHRQ) stated: "At its most basic level, high-quality care is doing the right thing, at the right time, in the right way, for the right person" (Simpson, Osborne, & Eisenberg, 1999, p.470). The authors immediately acknowledged that for this definition to have meaning, the adjective *right* must be defined.

The problem lies in the fact that quality is not a single, homogenous variable, but rather a complex construct incorporating values, beliefs, and attitudes of individuals involved in a health care interaction. For nursing, this is compounded by the fact that the quality of care is (1) intangible, manifested and verified by the patient's experience; (2) of an ever-changing nature dependent on the specific care giver and patient needs; and (3) difficult to control as production and consumption are inseparable (Jun,

Peterson & Zsidisin, 1998, p. 83). Nursing's claim to be a profession becomes more tenuous if it cannot articulate what characterizes excellent care and, consequently, continues to have difficulty in defining the role it plays in health care.

A discipline-specific definition of high-quality care is essential for nursing to (1) balance rights and responsibilities; (2) establish and maintain legitimate professional autonomy; and, most importantly, (3) clearly define the scope of nursing in such a way that it can be communicated and understood. Nurses claim "the right to provide clinically appropriate, humane, sensitive care" (Friedman, 1988, p. 259) while patients claim the right to receive "good-quality care" (Redfern & Norman, 1990, p. 261). Friedman (1988) predicted a "bleak and threatening future" for health care providers who "do not take up quality as a personal cause . . . because it is an inherent part of their pact with society" (p.263). Being the largest group of both providers and overseers of care, nurses are morally responsible and legally liable for its quality (Blouin & Brent, 1998; Glen, 1998a; Hogston, 1995a).

This responsibility incorporates validating the worth of the profession by measuring the impact of nursing interventions on patients' health (Higgins, McCaughan, Griffiths & Carr-Hill, 1992; Westfall, 1984). Because regulatory and government agencies now focus more on outcome than process evaluation, nursing's professional autonomy is threatened by the lack of

evidence specifically linking nursing care to health status (Mitchell, Ferketich, Jennings & American Academy of Nursing Expert Panel on Quality Health Care, 1998). As Redfern and Norman (1990) warned:

> It is not too fanciful to conceive of health economists and other experts constructing cost-effective packages of nursing care for patients who fall into predefined medical categories – severely curtailing autonomy of clinical nurses to plan care on an individual basis (p. 261).

On a more abstract and more vital level, the way nursing defines quality determines the very definition of nursing (Coulon, Mok, Krause & Anderson, 1996; Glen, 1998a). Before mentioning standards or degrees of excellence, the dictionary defines quality as an inherent, distinguishing and essential nature (Encarta World English Dictionary, 1999). Quality then refers to the scope of nursing – its view of reality, its place in and relationship with society, and its unique knowledge base. Ironically, the only overt conceptual analysis of the construct *quality* found in the nursing literature is based in a framework adopted from medicine (Atree, 1993). While the model used does address multifaceted dimensions of care (structure-process-outcome), it is not grounded in the primary concepts comprising nursing (person, environment, health, nursing). As Fawcett (1993a) noted: nursing focuses on the wholeness or health of *humans*, whereas medicine focuses on the identification and treatment of *disease* (emphasis added). Chinn

(1983) translated this difference into practice stating:

> Medicine focuses on surgical and pharmacologic interventions, with interpersonal interactions being an adjunct to these interventions. In contrast, technical interventions are viewed in nursing as being adjunct to the primary interpersonal interactions (p. 397).

Inquiry into the nature of quality can be said to be both an ontological and epistemological venture as it is a study of the nature of nursing and of nursing knowledge. As such, it explores the substantive (conceptual) and syntactical (methodological) structures of the construct. The substantive structure specifies representative conceptual elements of the phenomenon, while syntactical structures assist in validation as they incorporate accepted ways of knowing, that is, empirics, ethics, aesthetics, and personal knowledge (Carper, 1992). Ironically, Mahon (1996), couching a concept analysis of the quality outcome indicator *patient satisfaction* in Donabedian's model, noted the essential nature of a conceptual framework to any research:

> Most important for future research is the identification of the conceptual framework that will hold the study together. From this come identification and definition of the facets or constructs . . . to be measured, and variables for testing. When a study omits identifying concepts or theories, and proceeds directly to definition or variables, the study loses viability for further use (p. 1246).

Yet, a review of nursing literature reveals that when it comes to clarifying the construct *quality*, nurse researchers and theorists have failed to recognize the importance of exploring their discipline's unique knowledge base: nursing's conceptual models and theories.

In a review of selected articles from 1957-1978 aimed at defining high-quality care, Chance (1980) noted that frameworks developed by economics, management science, medicine, and philosophy guided nurse theorists and researchers. In the same review Chance (1980) cited only two instances of the use of nursing knowledge: outcome categories derived from Orem's self-care model and the use of Johnson's behavioral system to define high-quality care as an absence of complications. Despite an increasing emphasis on quality of care evidenced by a rapidly growing body of literature, the derivation of grand or middle-range theories of quality from nursing knowledge remains rare. In more recent literature, the use of nursing knowledge to identify and define high-quality nursing care included only King's goal attainment theory (Larrabee, Engle, & Tolley, 1995; Sowell & Lowenstein, 1994), Henderson's definition of nursing (Pierce, 1997), and Neuman's five interdependent dynamic variables (Clark, Cross, Deane, & Lowry, 1991). Because the majority of frameworks used to analyze the construct and develop theories are based in disciplines other than nursing, nurses have yet to agree on the defining dimensions of quality or how they

should be measured. The meaning of high-quality nursing care remains elusive because nurse scholars overlook or fail to recognize the significance of Chance's (1982) observation: "Professional accountability or quality of care is directly linked to the use of nursing knowledge" (p. 63).

Purpose of the Study

Manifested through a historical concern with the health of society, nursing claims the health and wholeness of humans in interaction with the environment as its domain. Thus, the experience of quality emerging from this interaction clarifies its meaning in the discipline's domain. Models borrowed from other disciplines do not lend themselves to clarification of the construct quality as it pertains to nursing because they de-emphasize the wholeness of the person-environment interaction. The purpose of this study is to reconceptualize high-quality nursing care within a framework unique to nursing.

Development of Nursing Knowledge

Knowledge is commonly defined as a general awareness or possession of information, facts, ideas, truths or principles and an understanding of the same gained through experience or study (Encarta World English Dictionary, 1999). Benoliel (1987) stated that *nursing knowledge* is the organization of the discipline-specific concepts, theories, and ideas found in textbooks and monographs, while *knowing* is the

individual nurse's perceptual awareness of situational complexities. Alligood (1997) identified four distinct although overlapping eras of nursing knowledge development beginning in the 1920s with each era lasting approximately twenty years. Named for their predominant activity, they are the (1) Curriculum Era (1920s-1930s); (2) the Research Era (1940s-1950s); (3) the Graduate Education Era (1960s-1970s); and (4) the Theory Era (1980s-1990s). Preceding the twentieth-century eras identified by Alligood (1997) is the time span that overlaps, if not encompasses, the Curriculum Era – the Nightingale Era beginning in the 1860s.

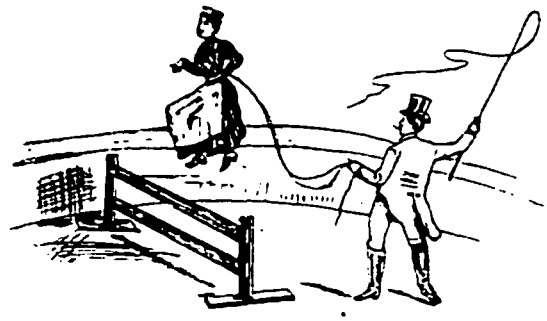
Nightingale and Curriculum Eras

Florence Nightingale's historical mission to the Crimean War battlefield removed nursing from the realm of religious orders and placed it firmly within the social history of women. In Notes on Nursing: What It Is and What It Is Not she stated that since "every woman . . . has, at one time or another of her life, charge of the personal health of somebody . . . every woman is a nurse" (Nightingale, 1859, Preface). Rutty (1998) was later to describe the nursing knowledge of this Era as embedded in the "intuitive, experiential, silent knowledge . . . women brought to nursing" (p.246). Of equal importance to the future of nursing, but seldom recognized even today, was Nightingale's (1859) assertion that this knowledge is "distinct from medicine" (Preface) being concerned with the knowledge and management of the interaction

between the person and the environment (Alligood & Choi, 1998; Chinn & Kramer, 1998). Attempts to improve and assure the quality of nursing care began with Nightingale's collection and analysis of data regarding wound infections and mortality rates during the Crimean War. Her actions led to regular evaluations of hospital medical and nursing care. These statistical analyses placed an emphasis on empirical research that dominated until the late twentieth century.

The nursing leaders of these two Eras planted the seeds of the everlasting debate regarding the appropriate educational preparation of nurses. The feminine attribute of silent intuition and the belief that nurses learn by doing formed their training into an apprenticeship consisting primarily of delegated tasks based on the rules, principles and traditions of medicine (Chinn & Kramer, 1998). Those nursing leaders who viewed nursing as more than a craft never lost sight of the fact that their practice was different from that of medicine and competed for control of nurse training. Unfortunately, they competed mostly with each other. Baer (1985) noted that different nursing leaders advocated different training methods reflecting their own ideals and each fought for acceptance by the larger nursing community.

In a social climate favoring male-domination, physicians and hospital administrators took increasing control of nurses' training (Figure 1-1).



"A TRAINED NURSE."

A medical student's conception of "a trained nurse," 1895.

Figure 1-1. A medical student's conception of a "trained nurse," 1895

Source: The advance of American nursing, (p. 145), by P. A. Kalisch and B. J. Kalisch, 1995, Philadelphia, J. B. Lippincott.

Physicians wanted trainees (and graduates) to obey - not think about - their orders. Hospital administrators, interested in keeping labor costs low, wanted the students at the bedside doing the work, not sitting in classrooms learning. Few graduates of the programs were hired by hospitals to oversee the work of the trainees. The isolation of home-based private duty rapidly diluted the socialization into nursing produced during training (Malosh, 1982).

Most applicants accepted into training were drawn from the working class. Once graduated and working private duty, their place in society

became ambiguous for they were considered neither family member nor servant. On the other hand, nurses being groomed for leadership positions were recruited from the better-educated richer classes. When these leaders advocated more education for trainees and graduates, they met great resistance from the larger body of graduate and student nurses who could not afford (or did not want) more education. They charged the leaders and the professional organizations with elitism, arguing that the heart of nursing was in the craft of technical skills. Worried that more education would erode their power base, physicians supported the technical role. Rather than facilitating further education through bridge programs for diploma nurses, nursing leaders decided to wait them out, thinking that as the diploma nurses left the workforce for marriage or retirement, they could be replaced with younger college-educated women. As Malosh (1982) mourned:

> Embroiled in conflict over professionalization, both leaders and their opponents lost sight of the larger meaning of women's education. Both could have learned from the counsel of Lavinia Dock, an early nursing leader, suffragist, and feminist, who wrote in 1901: "The thing of real importance is not that nurses should be taught less, but that all women should be taught more" (p. 76).

Nursing leaders who aligned themselves with physicians and administrators pushed for the continuation of the apprenticeship model. Hence, although

universally based in the biomedical model, the elements and outcomes of training depended on its location. Walker (1971, p. 430) identified two views of nursing knowledge: (1) a conglomeration of basic science knowledge and (2) the deliberate focusing of those facts on pertinent nursing endeavors. Nursing leaders advocating baccalaureate education in nursing settled for emphasizing the standardization of *what* nurses needed to know (Alligood, 1997) and *how* to teach it (Meleis, 1983).

Research Era

Although strongly influenced by post-World War II advances in biomedical science and role changes prompted by increased use of technology, nurses never completely lost sight of the fact that their practice was distinct from that of physicians. They also witnessed how successful use of the scientific method and empirical knowledge increased and legitimized the status of medicine and other disciplines (Edwards, 1999). This "received view" of empirical exploration - what Kidd and Morrison (1988) labeled "learning through listening to others" (p. 222) - and their exposure to the basic and behavioral sciences in their education and practice prompted the organization of pertinent concepts into the beginnings of a unique body of nursing knowledge (Chinn & Kramer, 1998; Rutty, 1998). Collaborating in conducting studies with experienced researchers from other disciplines, nurses discovered information about themselves as a group. Enthralled with

the success of the method, nurses placed primary emphasis on the process rather than the content of the studies (Alligood, 1997; Meleis, 1983). By the end of the Research Era, nursing had incorporated enough borrowed knowledge from the physical, biological, and behavioral sciences to begin the move from vocation to profession (Abdellah, 1969; Alligood, 1997). In practice, this empirical knowledge contributed to the rise of holistic nursing in which individualized care plans and the nurse-patient relationship were "considered instrumental in resolving the patients' problems and became part of the professional definition of nursing" (Boschma, 1994, p. 328).

Graduate Education Era

This transition from vocation to profession required a clearer identification of nursing's contribution to health care. At a 1962 World Health Organization (WHO) meeting in Japan, nurse administrators found it beyond their capabilities to define "quality nursing" and settled for stating: "Quality nursing care is concerned with health as well as with sickness, and with the patient as a person. It emphasizes action and initiative on the part of the patient" (Cameron, 1963, p. 23). A year later Fiesel (1963), a WHO advisor to Thailand, expanded this to say:

> Quality nursing is adapted to the needs of the patient; it is personalized and individualized care, and is concerned with the patient

> as a person and not only as a disease entity. Quality nursing is patient centered and the patient's needs become the nurse's command (p. 41).

The idea that the definition of a discipline and the definition of quality are connected was not unique to nursing. Donabedian (1980) noted that a primary step in his attempt to define quality in medical care was the need to first define "Medicine." His model for assessing the quality of medical care, first published in 1966, identified two major components of quality in medical management: technical competence and interpersonal relationships. A favorable balance of risks and benefits measured the technical component, while evaluation of interpersonal relationships involved societal values, professional ethics, and patient expectations (Donabedian, 1980). Refining these general principles led to a measurement approach (structure-process-outcome) capable of yielding empirical indicators. It is the relationships between and among these measurable indicators that facilitated research into the definition of quality. As Donabedian (1980) explained:

> the structural characteristics of the settings in which care takes place have a propensity to influence the process of care so that its quality is diminished or enhanced. Similarly, changes in the process of care, including variations in its quality, will influence the effect of care on health status . . . (p. 84).

In this model structural elements or variables include environmental factors, the physical plant and equipment, organizational hierarchy and culture, as well as monetary and human resources. Process elements relate to the interventions aimed at meeting the patients' physical and psychosocial needs. Falling within the category of outcome measurement are changes in health status and behavior as well as provider and recipient satisfaction with care rendered and received. Although devised specifically to measure the quality of medical care, Donabedian's model has been adopted by health care administrators and non-physician providers, including nurses, in their attempts to measure, control, assure, and improve quality of care.

The founding of the Joint Commission for Accreditation of Hospitals in 1952, publication of Donabedian's model, and the onset of federal funding (Medicare, Medicaid) resulted in formalization of practice standards aimed at increasing provider accountability. Quality Assurance (QA), a planned and systematic process for monitoring and evaluating patient care, primarily evolved into periodic audits of functions, activities, or treatments deemed essential to providing quality care (Roberts & Walczak, 1984). Examples of audits include reviews of documentation of the providers' planning of care, compliance with the policies of medication administration as judged by the number of errors and omissions, successful prevention of hospital-acquired

infections, and cardiopulmonary resuscitation outcomes. Thus quality was defined operationally in terms of these measurable processes and outcomes. As Kitson (1986) remarked: "The effectiveness of this system rests with the assumption that most practitioners know how to provide a quality service and can describe its main components" (p. 32). In practice, quality assurance led only to the identification of "bad apples," blaming individual health care providers for measured variances of actual performance from the standardized desired performance (Berman, 1995; Goonan & Jordan, 1992).

Wanting to articulate nursing's contributions to health care, nurse researchers and scholars began to hunger for advanced academic programs lying solely within their discipline. There was an explosion of interest in furthering nursing science through a commitment to the central goals and functions of nursing that required knowledge not provided by medicine or other disciplines. With advanced education and continued success in quantitative research methods came the realization that no theoretical content had been circumscribed as unique to nursing (Norris, 1964). Phillips (1977) explained how the lack of discipline-specific conceptualizations impedes knowledge development:

> The evolution of nursing science as any young science is dependent upon knowledge borrowed from other disciplines. There will always be a core of knowledge which will be used by all the sciences.

> However, the process of borrowing theories and models from other disciplines has hampered nurses in learning how to ask questions which are of specific concern to nursing or in conceptualizing how the borrowed knowledge is to be used to generate theory to expand nursing science (p. 4).

Following the 1965 American Nurses Association's formal identification of the need for nursing theory development, national conferences addressed theory development, the state of nursing science, and what content needed to be included in nursing doctoral programs (Silva & Rothbart, 1984). Within ten years the number of nursing doctoral programs mushroomed from 3 to 21 (Alligood, 1997). At the same time master's degree nursing programs matured in both professional status and quality.

Theory Era

The expansion of discipline-specific academic programs facilitated the shift in emphasis from research methods to theory development. Fawcett (1983) identified four hallmarks of success from previous eras that catapulted nursing into the Theory Era: (1) identification of nursing's metaparadigm; (2) publication of conceptual models specific to nursing; (3) derivation of unique nursing theories from these conceptual models; and (4) development of theories shared with other disciplines. Simultaneous with the development of a unique theoretical framework, nurse scholars moved into the area of

metatheory: the systematic assessment of nursing science regarding the degree of maturity, comprehensiveness, and completeness of knowledge development (Kim, 1997). To get a feeling for the overwhelming amount of work done in this area one need only look through anthologies like Nicoll's (1986) Perspectives on Nursing Theory; Omery, Kasper, and Page's (1995) In Search of Nursing Science; Kenney's (1996) Philosophical and Theoretical Perspectives for Advanced Nursing Practice; and Polifroni and Welch's (1999) Perspectives on Philosophy of Science in Nursing.

A concurrent increased emphasis on the management of overall health care quality did not substantially contribute to nursing's search for a discipline-specific definition. In the early 1980s regulatory agencies began to stress the need for corrective action to follow identification of unmet standards. The emphasis shifted from blaming individual performers to understanding the causes of variances and correcting the processes involved in delivering care (Berman, 1995). Quality Improvement (QI) programs analyzed structure and process failures and inefficiencies, thus allowing a systems approach to identification of and plans for achieving desired clinical, functional, and perceived outcomes (Goonan & Jordan, 1992). Crosby (1980) explained quality management as a "systematic way of guaranteeing that organized activities happen the way they are planned" and a "management discipline concerned with preventing problems from occurring by creating the

attitudes and controls that make prevention possible" (p. 19).

The mechanistic worldview epitomized by this linear model replete with causality and thus, predictability proposed that the whole is no more than a sum of the parts. Deming, a world-renowned statistician, theorized that over 90% of variances in quality could be attributed to systems over which workers had no control. The less variation in and among these parts, the better the whole. For Deming, quality equaled uniformity resulting in customer loyalty and thus profit (Aguayo, 1990). The industrial QA/QI model presented difficulties when translated to health care for the simple reason that it took the focus off the person and put it on the process. It de-emphasized the individual variation of the person-environment interaction and the fact that perception of quality depends on the individual person's experience. The QA/QI model does not take into account that it is from this subjective experience that quality emerges. De-emphasis of the wholeness of the person-environment interaction hindered clarification of the construct quality as it pertains to nursing. Ambiguity of the perception of quality itself kept the study of this interaction on the conceptual level with dilute effects on nursing practice. As recently as 1999, Edwards stated that there is still "no consensus regarding what practices constitute examples of 'good nursing'" (p. 568).

Relevant to this lack of consensus and significant to this study is the

fact that the most recent development of nursing knowledge shifts the emphasis from epistemology to ontology. This shift resulted from a growing recognition of the limitations of the scientific method with its emphasis on empirical knowledge and devaluation of esthetic, ethical, and personal knowledge (Chinn, 1985). Wainwright (1997) clearly explained the difference: *ontology* is what exists; *epistemology* is how we know about it; and methodology is concerned with the philosophical assumptions underlying our research strategies. Conducting research within a specific nursing model requires congruence between the philosophical assumptions of the research methodology and the philosophical assumptions (worldview) of the model. According to Fry (1992) ontological issues involve discussions of whether nursing is a science, an art, or a presence while epistemological questions revolve around the ways the nurse knows and the structure of knowledge.

Fawcett's Theory of the Structure of Knowledge

Recognizing that observations are made within a conceptual and sociohistorical frame of reference and therefore, place value on all ways of knowing, Fawcett (1997b), a renowned and prolific nurse metatheorist, advanced an epistemological structural hierarchy for nursing knowledge development. (Figure 1-2). Her earlier view of the literature on theory development revealed a consensus regarding the central concepts of interest to nursing: person, environment, health, and nursing (Fawcett, 1984). These

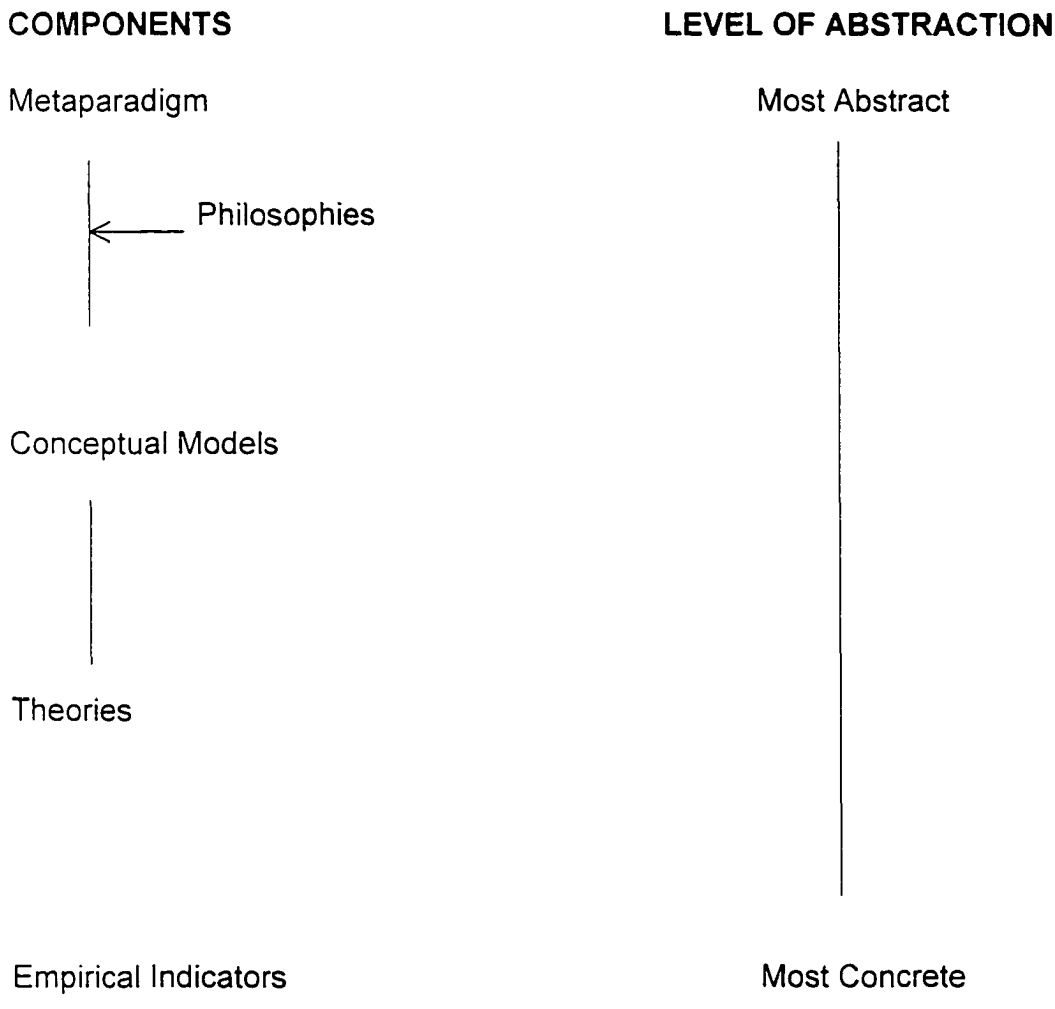


Figure 1-2. The Structural Hierarchy of Contemporary Nursing Knowledge: Components and Levels of Abstraction.

Source. From The language of nursing theory and metatheory, (p. 11), by I. M. King & J. Fawcett, 1997, Indianopolis, Sigma Theta Tau.

global concepts comprise the metaparadigm of nursing. Beliefs about the relationships between and among these concepts reveal ontological and epistemological worldviews reflected in the discipline's conceptual models. At the most abstract level, the metaparadigm delineates the scope and boundaries of the discipline through identification of central global concepts as well as propositions regarding their relationships. These propositions state that the discipline of nursing is concerned with: (1) the principles and laws that govern the life process, well-being, and optimal functioning of human beings, sick or well; (2) the patterning of human behavior in interaction with the environment in both normal and critical situations; (3) the nursing actions or processes by which positive changes in the person's health status are effected; and (4) the wholeness or health of human beings in continuous interaction with the environment (Fawcett, 1995, p. 7).

Metaparadigm

A paradigm, as defined by Kuhn (1970), is a model or example that defines legitimate research problems and methods for a discipline. It is a way of looking at the subject, a perspective, a worldview (Menke, 1990; Newman, 1990). Powers and Knapp (1990) defined a paradigm as an organizing framework containing "concepts, theories, assumptions, beliefs, values, and principles that form a way for a discipline to interpret the subject matter with which it is concerned" (p. 102). According to Fawcett (1995) a metaparadigm

identifies a discipline's specific domain in a parsimonious, perspective-neutral manner that is international in scope and substance. It is not as concrete or specific as a worldview. It identifies the discipline's phenomena of interest providing only broad abstract definitions. Philosophical stances, assumptions, and statements flow from the relationships between and among these central concepts to form the basis for conceptual models and subsequent theories. A metaparadigm contains a discipline's paradigms (worldviews or disciplinary matrices). As Ellis (1982) explained:

> It is an abstraction useful for ordering and developing knowledge . . . It describes the key elements or concepts that in combination create a perspective that defines the phenomena that are of some interest for some purpose such as practice or research and theory development (p. 406).

While at first appearing simpler than a paradigm, it is actually on a higher level of complexity because it contains all possibilities. Those who call for greater specificity of the metaparadigm miss this point.

Determining the subject matter for research in the discipline of nursing began with Nightingale's 1859 Notes on Nursing and continues today with theories derived from conceptual models. These models, shaped by philosophy, give evidence to the metaparadigm. From the early 1950s through the 1970s, nurse scholars concentrated on developing a body of

knowledge unique to the discipline. Analyzing the curricula, research, and philosophical literature of this period led nurse metatheorists of the late 1970s and early 1980s to the identification of the focus of nursing (Carper, 1992; Meleis, 1986). As Flaskerud and Halloran (1980) noted: "There is a consensus among nursing theorists on what nurses do, and it has not changed dramatically since Nightingale defined it" (p. 4). Their conceptualization of nursing supported Donaldson and Crowley's statement that "nursing studies the wholeness or health of humans, recognizing that humans are in continuous interaction with their environments. Nursing's perspective evolves from the practical aim of optimizing human environments for health" (p. 119). Growing consensus among the philosophers and theorists of nursing led to Fawcett's (1984) formal presentation of the metaparadigm concepts: person, environment, health, and nursing.

Kuhn (1970) noted that a period of normal science occurs when the community of scholars within a discipline identifies a foundation for further research with the acquisition of such a foundation denoting maturity. He went on to state: "In paradigm choice, there is no standard higher than the assent of the relevant community" (Kuhn, 1970, p. 94). Initially it appeared that this consensus existed in nursing. Deets (1990) reminisced:

> Books on the nursing process were revised to include the four concepts if they were not already there, or to make the concepts

> more prominent if they had been previously considered. The authors who purported to deal with nursing theory also revised their work to illustrate how it addressed the four concepts if they had not previously done so (p. 149).

Of course, not everyone agreed then nor does everyone subscribe to this conceptualization of the metaparadigm now. The main arguments against acceptance involve lack of commonality in definitions and utility (Brodie, 1984; Deets; 1990; Newman, Sime, & Corcoran-Perry, 1991). Fawcett (1984) addressed these objections by pointing out that most disciplines have more than one subculture and that these subcultures are more restrictive than the metaparadigm. In support of multiple paradigms within a single discipline, Kuhn (1970) warned that reaching consensus regarding a paradigm is not the same as determining shared rules. In other words, a metaparadigm can mean different things to different groups of scholars within a discipline without negating its validity. In a later work, Kuhn (1977) replaced the word paradigm with "disciplinary matrix" defined as a "common possession of ordered elements of various sorts requiring specification" (p. 297). Menke (1990) reminded us that "implicit in the metaparadigm is the notion that there are existing paradigms or disciplinary matrices that are the nursing models" (p. 208).

Newman (1990), who defined paradigm as a worldview, postulated

that the major questions to be answered by nursing had something to do with health, but "the way the question is asked and the answers we get . . depend(s) on which paradigm of health is in place" (p. 234). This early argument about concept definition flowed from the discipline's adherence to an empirical, reductionistic view of science. It reflected back to a time when nurse scholars believed that they could and would find one theory to guide all practice and research (Gortner, 1983; Meleis, 1983; Menke, 1990). As the syntactical structure of nursing expanded to value both qualitative and quantitative research methods, as well as differing worldviews, and shifted from focusing on epistemology to focusing on ontology, diversity became more acceptable, and to some, preferable.

Another issue that falls within the topic of disciplinary matrices involves whether or not the four concepts are the correct ones. Conway (1985) objected to the inclusion of *nursing* within the metaparadigm on the basis that the discipline itself could not be a concept. The issue here is the general definition of a concept: is *nursing* a series of actions or a discipline in which knowledge is developed? In 1980 Flaskerud and Halloran directed: "Nursing theory must include the concept of nursing . . . must explain and predict how nursing actions affect or interrelate with other concepts to produce a desired patient outcome" (p. 3). Fawcett (1984) spoke of the relationships among *person*, *health*, and *nursing* as a process by which change is effected"

(p. 85). In 1992 she stated that *nursing* refers to actions taken by nurses. In 1995 she presented four propositions based on the relationships among the concepts stating, "the discipline of nursing is concerned with the nursing actions or processes by which positive changes in health status are effected" (p. 7). Consensus regards the metaparadigm concept *nursing* as a process which when interacting with the other three concepts allows the discipline to claim the knowledge as unique.

There was a move in the 1990s to include the concept *caring* in the metaparadigm. But as Fawcett (1995) pointed out, *caring* violates the requirement of a metaparadigm by not being perspective-neutral and international in scope. Even more telling is its failure to represent phenomena in a parsimonious manner. Content analysis of definitions of *caring* found within the nursing literature identified five categories in which this concept resides: (1) human trait; (2) moral imperative; (3) affect; (4) interpersonal relationship; and (5) therapeutic intervention (Morse, Solberg, Neander, Bottorff, & Johnson, 1990). The concept of *caring* lies within the broader metaparadigm concepts of *person* or *nursing*, its use being dependent on the theorists' worldview. In this sense, *caring* belongs to several subcultures, but not as a central concept.

Critics and proponents of the metaparadigm have asked: What contributions will it make to the discipline? Clearly explaining its purpose,

Rogers (1970) wrote:

> Science is concerned with meanings rather than facts. A conceptual framework of reference is an indispensable prerequisite to the ordering of knowledge and to the formulation of meaningful propositions. An organized system of concepts further provides a repository for experiential observations which can enrich the conceptual system in the continuing search for systematic relationships among a range of phenomena (p. 83).

Although agreeing with Donaldson and Crowley (1978) that the discipline of nursing must be connected to and defined by social relevance, Newman et al. (1991) denied that the proposed metaparadigm concepts were related and stated that the lack of such a relationship prevented their raising the "philosophic issues or scientific questions that stimulate inquiry" (p. 2). Yet nurse theorists and researchers continue to discover patterns of interaction and complementary relationships between and among the concepts.

Although the metaparadigm itself cannot be tested empirically, it can and does give rise to philosophy and theory by examination and explication of the individual concepts and their relationship to each other within a particular worldview. Along these same lines, the concepts create a structure in which to conduct valid analyses of existing and proposed nursing models and theories (Fawcett, 1995). Kuhn (1970) identified the search function of

paradigms through articulation of the types of phenomena used in theory development. He defined the type most relevant to this discussion as "those whose nature is indicated by existing paradigms but whose details can be understood only through further theory articulation" (p. 97).

Identification of the metaparadigm of nursing resulted from extensive analysis of work produced by the discipline's scholars in the process of developing nursing knowledge. It did not originate in the mind of any one individual or group, but rather developed through consensus regarding patterns and themes. The concepts are global, inclusive, and perspective-neutral. The usefulness of the metaparadigm includes its functions as a standard tool for analysis of existing and future models and theories, as well as a source of further philosophical and theoretical exploration of the concepts. The commitment to the metaparadigm indicated by the degree of consensus regarding its components denotes that the discipline is maturing and creating a body of normal science (Kuhn, 1970). Paradigms may shift, but the metaparadigm continues to be relevant.

Conceptual Models

Conceptual models reflect the ontological and epistemological claims about the nature of the central concepts and their relationships. These claims outline beliefs about the nature of human beings and their interactions with the environment as well as beliefs about how knowledge develops. Analyzing

the literature detailing the evolution of nursing's worldviews led Fawcett (1993b) to a parsimonious set of three (Figure 1-3): (1) the reaction action worldview; (2) the reciprocal interaction worldview; and (3) the simultaneous worldview.

Derived from the focus of the metaparadigm and guided by a philosophic worldview, a conceptual model is a set of concepts and propositions that provides a distinctive perspective, but whose abstractness and global nature precludes direct empirical observation and testing (Fawcett, 1992). Reflecting a "philosophic stance, cognitive orientation, research tradition, and practice tradition of a particular group of scholars" (Fawcett, 1992, p. 102), conceptual models become the "logical nuclei for communities of scientists" (Fawcett, 1984, p. 86). With a focus on an approximation of reality and a systematic structure, a conceptual model tells these nurse scientists how to observe and interpret the phenomena identified in the metaparadigm (Fawcett, 1995).

Although nursing conceptual models have existed since 1859 when Florence Nightingale published Notes on Nursing: What It Is and What It Is Not, it was not until the 1970s that the explicit label *conceptual model* was applied to varying perspectives of nursing. Fawcett (1995) identified seven conceptual models for nursing: (1) Johnson's Behavioral System Model; (2) King's General Systems Framework; (3) Levine's Conservation Model;

The Reaction Worldview

Human beings are bio-psycho-social spiritual beings.
Human beings react to external environmental stimuli in a linear, causal manner.
Change occurs only for survival, as a consequence of predictable and controllable antecedent conditions.
Only objective phenomena that can be isolated, defined, observed, and measured are studied.

The Reciprocal Interaction Worldview

Human beings are holistic.
Parts are viewed only in the context of the whole.
Human beings are active.
Interactions between human beings and their environments are reciprocal.
Reality is multidimensional, context-dependent, and relative.
Change is a function of multiple antecedent factors.
Change is probabilistic and may be continuous or only for survival.
Both objective and subjective phenomena are studied through quantitative and qualitative methods of inquiry.
Emphasis is placed on empirical observations, methodological controls, and inferential statistical analysis.

The Simultaneous Action Worldview

Unitary human beings are identified by pattern.
Human beings are in mutual rhythmical interchange with their environment
Human beings change continuously, evolving as self-organizing fields.
Change is unidirectional and unpredictable as human beings move through stages of organization and disorganization to more complex organization.
Phenomena of interest are personal becoming and pattern recognition.

Figure 1-3. Characteristics of Nursing's Worldviews

Source. From "From a plethora of paradigms to parsimony in worldviews" by J. Fawcett, 1993, Nursing Science Quarterly, 6(2), p. 58.

(4) Neuman's Systems Model; (5) Orem's Self-Care Framework; (6) Rogers' Science of Unitary Human Beings; and (7) Roy's Adaptation Model (Table 1-1). Constructed between 1959 and 1982, the models are products of synthesis of knowledge from other disciplines, interpretations of nursing literature, and reflection on the personal nursing experiences of the authors. They are the classics of nursing scholarship embodying the traditions of the profession. Even though these nursing conceptual models are derived from one metaparadigm, they are the discipline's paradigms or "incommensurable

Table 1-1. Chronology of major nurse theorists and their views on nursing

	Theorist	**Nursing is a(n)**
1959	Dorothy Johnson	- Humanistic art and science
1967	Myra E. Levine	- Therapeutic intervention - Science
1970	Martha Rogers	- Humanistic art and science - Interpersonal process
1971	Dorothea E. Orem	- Humanistic art and science
1971	Imogene M. King	- Interpersonal process
1976	Callista Roy	- Science
1982	Betty Neuman	- Therapeutic intervention

Source. Adapted from "Theoretical perspectives of nursing: A review of the literature," by P. A. Hilton, 1997, Journal of Advanced Nursing, 26, 1211-1220.

ways of seeing the world" (Kuhn, 1970). As such, each model determines the meaning of its constituent concepts and no two models can assign the exact same meaning to a term (Suppe & Jacox, 1985). While the models cannot be reduced to one neutral language, they do deal with the same domain. Thus, the meaning of the concepts can be compared and contrasted through interpretive translations (Kegley, 1995). This interpretative translation, or the interactive production of meaning, is the core strategy of hermeneutics, which primarily focuses on texts as the object of research (Allen, 1995). Indeed, Reeder (1988) notes that one definition of hermeneutics "emphasizes dialogue between worlds that are incommensurable and thus, require translation" (p. 196).

Significance

Conceptualizing quality within nursing's incommensurable worlds provides a discipline-specific definition essential for nursing to (1) balance rights and responsibilities; (2) establish and maintain legitimate professional autonomy; and, most importantly, (3) clearly define the scope of nursing in such a way that it can be recognized, communicated, and understood. Because the frameworks used to analyze the concept are based in disciplines other than nursing, nurse researchers and practitioners have yet to agree on the defining dimensions of quality or how they should be measured as evidenced by the diversity of instruments and lack of replicated

studies. The meaning of high-quality care as it pertains to nursing remains elusive despite the fact that the person-environment interaction is well defined in nursing conceptual models.

Clarification of concepts using a nursing lens allows rigorous development of nursing knowledge with logical implications regarding the discipline's role in providing health care as it explicates what nurses know and why they do what they do (Fawcett, 1997a; Reed & Ground, 1997). By conceptualizing high-quality care within a nursing framework, nursing knowledge is differentiated from that of medicine, resulting in theoretical and practical clarity necessary for the discipline's survival and growth. This differentiation fosters the continued development of the discipline as well as facilitating collaboration with medicine and other health care disciplines for the benefit of the individual patient. Finally, clarification of the concept within the metaparadigm and conceptual models provides the understanding of the domain and scope of nursing necessary for professional autonomy.

CHAPTER TWO

DEFINING QUALITY: A REVIEW OF THE LITERATURE

Because the purpose of this study is to conceptualize high-quality nursing care, the purpose of this literature review is three-fold: (1) to ascertain the state of the science, that is, how nurse researchers answer the question "What is high-quality nursing care?"; (2) what models have been developed to guide future research; and (3) to support this study's assumption that the inquiry into the nature of quality is a study of the nature of nursing knowledge. Criteria for inclusion in this literature review consisted of the explicit purpose of defining quality or a statement of the specific use or development of a model or theory.

A search of all years of the computer base CINAHL identified both conceptual and research articles addressing the question: "What is high-quality nursing care?" A descendancy search of reference lists and bibliographies published with these articles revealed further sources. A hand search then was conducted on all volumes of select journals noted to publish a high number of such articles. These journals included Image: The Journal of Nursing Scholarship; Journal of Advanced Nursing; Journal of Nursing Administration; and Nursing Economics. In the course of this review, the researcher found that the same technique had been used on at least three previous occasions (Chance, 1980; Lang & Clinton, 1984; Redfern & Norman,

1990) to summarize nursing research aimed at defining high-quality nursing care. In addition, the American Nurses' Association published a synopsis of 158 articles focusing on specific aspects of nursing quality measurement (Rantz, 1995). Although these articles were collected and read, this review emphasizes literature published after 1988 with the inclusion of some foundational literature of earlier years. Articles from health administration or quality management journals were included if the primary author was identified as a nurse.

Nursing Research

The elusive nature of the definition of quality has long been noted. In 1963 Cameron reported the inability of nurse administrators to define quality as it pertains to nursing. Almost 30 years later, Frost (1992) noted:

> From a research perspective, there is a need to develop methods to measure quality care and outcomes of quality care. Beginning studies that identify how a variety of vested individuals and groups define quality care can provide a basis not only for instrument development but also for refinement of the definition of quality (p. 67).

The following review of the literature revealed three perspectives from which this construct has been studied: (1) from the perspective of a selected framework; (2) from the perspective of the patient; and (3) from the perspective of the nurse.

Perspective of Frameworks

Despite a professed philosophy of holism and humanism, nursing has relied heavily on Donabedian's industrially-derived structure-process-outcome model even though an analysis of the construct conducted within this framework noted that no unequivocal application or interpretation of quality emerges (Attree, 1993). Furthermore, despite the belief that these elements are highly interrelated, published studies seldom have shown a relationship among all three elements. Structural elements or variables included environmental factors, the physical plant and equipment, organizational hierarchy and culture, as well as monetary and human resources. In recent nursing studies, these elements included the "hotel aspects" of the hospital, such as noise levels, cleanliness, food service, and parking (Doering, 1983; Komarek, 1996) along with the availability, type, and quantity of nurses (Eriksen, 1988; Hogston, 1995b; Leveck & Jones, 1996; Minnick, Roberts, Young, Kleinpell, & Mercantonio; 1997; Strzalka & Havens, 1996).

Process elements relate to the delivery of nursing interventions aimed at meeting the patients' physical and psychosocial needs. Such variables included interpersonal skills (Leino-Kilpi & Vuorenheimo, 1993; Meister & Boyle, 1996; Ming Ho Lau & Mackenzie, 1996), roles of providers (Hogston, 1995b), and technical competence (Beaudin & Pelletier, 1996; Clark, Pokorny, & Brown, 1996; Eriksen, 1988; Leinonen, Leino-Kilpi, & Katajisto,

1996; Meister & Boyle, 1996). Past nursing literature extended outcome elements from the patient's physiologic status post-intervention to the degree of compliance with prescribed regimens and behavioral changes (Ventura, Fox, Corley, & Mercurio, 1982). Adverse occurrences such as medication errors, patient falls, skin breakdown, nosocomial infection rates, and death were identified as negative indicators of quality (Reed, Blegen, & Goode, 1998). Using these negative indicators in a work redesign study, Grillo-Peck and Risner (1995) concluded, "that reassignment of tasks to nonprofessional caregivers did not show a decline in quality related to patient procedures" (p. 371). Lynn and Moore (1997) found these adverse occurrences, along with traditional volume indicators (such as length of stay), unreliable as they primarily reflected the thoroughness of documentation and whole system efficiency, thus, "hav(ing) little in common with either patients' or nurses' perceptions of quality care" (p. 191).

Also considered within the category of outcome measurement was provider and recipient satisfaction with care rendered and received. However, satisfaction data were collected using a multitude of non-standardized survey tools that rarely considered the patients' perspective. Furthermore, these tools underwent minimal psychometric testing and provided no empirical link between resulting data and perceptions of quality (Lynn & Moore, 1997). In light of these findings, it would seem that such indicators cannot be used to

define the essential nature of nursing.

Using an economic-focused model of the Donabedian framework, researchers investigated how input (money and labor) changed output (satisfaction, compliance, health). This approach resulted in studies that positively linked quality and efficacy with cost and outcomes (Irvine, Sidani, & Hall, 1998a; Jones, 1991). In this arena, quality "encompasses the elimination of costly, unnecessary or inappropriate services while providing better clinical outcomes, fewer avoidable complications, and higher client satisfaction" (Meisenheimer, 1991, p. 41).

Perspective of Patients

From the patients' perspective, quality emerged from their interaction with their nurses. Patients evaluated the nurses' attitudes and interpersonal behaviors when judging how closely their experience matched their expectations. Expectations were specific to the individual and influenced by that individual's values, ethnic and cultural background, as well as past experience with the health care system (Greeneich, 1993; Larrabee et al., 1995; Larsson & Larsson, 1999; Minnick et al., 1997; Nash et al., 1994; Peters, 1995). Moreover, media coverage of rising costs and diminishing resources as well as discussion of the ethics of managed care greatly influenced contemporary patient expectations (Peters, 1995). However, using the results of patient satisfaction surveys as a measurable indicator of quality

nursing care may not be reliable because of the patients' desire to please, their dependence on the system and its providers, fear of reprisals, ignorance of different standards, or low expectations (Al-Kandari & Ogundeyin, 1998; Pearson, Durant, & Punton, 1989). An additional weakness inherent in surveys consists of their being composed by providers and thus reflecting only their criteria for defining high-quality care.

Providers identified technical competence as essential to high-quality nursing care. However, recipients of the care considered competence a given. Hence, it was not always a factor in their evaluation of the quality of care they receive (Beaudin & Pelletier, 1996; Clark et al., 1996; Doering, 1983; Eriksen, 1988; Joiner, 1996; Meister & Boyle, 1996; Varholak & Korwan, 1995; Ventura et al., 1982). In a related phenomenological study, Riemen (1986) discovered "not once was an ill-performed technical procedure mentioned as non-caring" (p. 33). Indeed, provider emphasis on this aspect of care actually diminished the perceived quality of care (Price, 1993). From the patient's perspective, the nurses' attitudes and interpersonal behaviors most affected perceptions of high-quality care. That is, the perceived quality of care increased when the nurse paid attention to the patients' concerns and anticipated their needs within a relationship marked by mutual respect and trust (Abramowitz, Cote, & Berry, 1987; Leinonen et al., 1996; Meister & Boyle, 1996; Ming Ho Lau & Mackenzie, 1996; Oermann,

1999; Price, 1993).

A highly valued nurse behavior was the ability and willingness to communicate with the patient and family (Doering, 1983; Leino-Kilpi & Vuorenheimo, 1993; Meister & Boyle, 1993; Ming Ho Lau & Mackenzie, 1996). Desired communication included receiving information (i.e., listening) as well as imparting information. Indeed, for some patients listening was more important because they expected and preferred to hear medical details from physicians (Leino-Kilpi & Vuorenheimo, 1993; Price, 1993). From a study conducted in an ambulatory setting, Oermann and Templin (2000) concluded that while patients expected their physicians to explain their illness and treatment, they expected to receive health teaching from nurses. Their analysis of the data from that study indicated an inverse relationship between education/economic class and the value placed on such teaching. That is, the more limited the educational level and income, the higher the value the patient placed on the nurse's teaching role. Other attributes of the nurse valued by patients included (1) empathy (Hart, 1996; Joiner, 1996; Meister & Boyle, 1996; Price, 1993); (2) reliability (Hart, 1996; Jun et al., 1998; Ming Ho Lau & Mackenzie, 1996); (3) responsiveness (Hart, 1996; Joiner, 1996; Jun et al., 1998); and (4) caring (Eriksen, 1988; Joiner, 1996; Jun et al., 1998; Ludwig-Beymer et al., 1993).

Perspective of Nurses

Reflecting some of the same interpersonal behaviors noted by the

patients, nurses cited the ability to act in the best interest of the patients by meeting their spoken and unspoken needs as the primary indicator of quality (Coulon et al., 1996; Williams, A. M., 1998). In a recent qualitative study, nurse leaders easily defined quality as nurses anticipating patient expectations and performing activities that resulted in a difference in patients' lives (Williams, R. P., 1998). Thus, nurses defined high-quality care by the success of their interventions, not the attributes of the interaction.

Not only did the two populations define and evaluate different dimensions of quality in these studies, the nurses often were mistaken in their identification of what dimensions patients valued (Larrabee et al., 1995; Lynn & McMillen, 1999; Meister & Boyle, 1996; Young, Minnick, & Mercantonio, 1996). Lynn and McMillen (1999) found that nurses consistently underestimated the importance of the physical environment, psychological aspects of care, and their own professionalism (defined as dedication and efficiency) on the patients' perception of quality. Nurses were more interested in changes in physiological status and acquisition of disease/treatment-specific knowledge than in patient satisfaction. Pierce (1997) concluded that quality was "directly dependent on the knowledge, skills, abilities, efforts, and motivations of the patient" (p. 60).

Personal, professional, and organizational variables influenced the nurses' selection of prerequisites for quality care. Necessary personal

attributes included dedication, cheerfulness, tact, commitment, confidence, sincerity, humility, empathy, subtlety, and compassion (Coulon et al., 1996). Nurse-valued behaviors included professionalism exhibited through compliance with practice standards and technical competence as well as demonstrations of caring and communication skills (Coulon et al., 1996; Hogston, 1995b; Lynn & McMillen, 1999; Williams, A. M., 1998; Williams, R. P., 1998). Several researchers concluded that quality was dependent on the amount of time available for nurses to interact with patients (Leveck & Jones, 1996; Rudolph & Hill, 1994; Strzalka & Havens, 1996). The less time available, the more stress the nurse experienced. More stress equated with lower quality care as it negatively affected the nurse's personality and competence thus compromising the effectiveness of interventions (Hogston, 1995b; Leveck & Jones, 1996; Williams, A. M., 1998). For some nurses, high-quality care was inextricably linked to maintaining continuity throughout multiple episodes of care (Duffield, Donoghue, & Pelletier, 1996; Williams, R. P., 1998).

In a review of selected journal articles aimed at defining high-quality care published from 1957 through 1978, Chance (1980) noted frameworks developed by economics, management science, medicine, and philosophy guided nurse theorists and researchers. A later review of 164 articles published in nursing journals between 1974 and 1982 noted: "Most of the

studies about assessment of quality assurance were at the conceptual level, the development of models and standards, instrument development, and the single case or institution and noncomparative study" (Land & Clinton, 1984, p. 152). The reviewers noted that the ambiguity of the perception of quality itself kept the work on the conceptual rather than the practice level. More recently, Frost (1992) concluded: "In that quality is a multifaceted concept, the current use of patient satisfaction, documentation of technical skills performed, and physical outcomes are not equivalent with quality care, but merely aspects of this concept" (p. 67).

Summary of Nursing Research

The following conclusions are offered from the review conducted and summarized above by this author. First, despite a professed philosophy of humanistic holism, nursing relies heavily on Donabedian's industrial model developed disregarding the fact that it fails to provide either an explicit definition of or definitive criteria for quality (Attree, 1993). Second, from the patients' perspective, quality emerged from their interactions with their nurses. Patients evaluated the nurses' attitudes and interpersonal behaviors when judging how closely their experience matched their expectations. Third, nurses judged quality by their ability to act in the best interest of the patients by meeting their spoken and unspoken needs as evidenced by the success of nursing interventions. Moreover, frequently used outcome indicators (such as

adverse occurrences and cost-benefit analyses) are not solely and directly related to nursing interventions and, therefore, are not discipline-specific. While such indicators may demonstrate whole system efficiency, defining high-quality nursing care requires that the nursing actions positively affecting the patients' health status be identified within a framework congruent with the discipline's ontology. In other words, the definition of high-quality care emerges from an interpretation of the discipline's conceptual models.

Models and Theories

Fawcett's (1989, 1993) analysis and evaluation method was employed while reviewing the explicit models and theories found in the contemporary professional literature. Such a process begins with understanding the difference between a model and a theory. A conceptual model is "an abstract and general system of concepts and propositions" while a theory "deals with one or more relatively specific and concrete concepts and propositions" (Fawcett, 1989, p. 27). The purpose of the theory, along with its level of abstraction, determines whether the latter is a grand theory or a middle-range theory. Analysis of a model targets its origins, unique focus, and content; while evaluation of the same focuses on comprehensiveness, logical congruence, theory-generating ability, and credibility (Fawcett, 1989). Analysis of a theory examines its scope, context, and content; while evaluation considers internal consistency, parsimony, and testability along

with empirical and pragmatic adequacy (Fawcett, 1993). The context of theories includes the relational statements regarding the metaparadigm concepts (person, environment, health, nursing); philosophical assumptions; and worldviews. Content identifies other concepts and propositions of importance to the theory.

Structure-Process-Outcome Framework

By far the framework used most frequently in defining high-quality nursing care is that of the structure-process-outcome model adapted from systems theory and industrial management to medical practice. Although referred to as a "model, " this framework more closely fits Fawcett's definition of a grand theory. In it, Donabedian (1980) identified two major components of quality in medical management: technical competence and interpersonal relationships. These general principles are refined further to the measurement approach (structure-process-outcome) capable of yielding empirical indicators. It is the relationships between and among these measurable indicators that facilitate research into the definition of quality. Although there is an abundance of nursing literature reporting research of the relationships among structure-process-outcome, this aspect of the literature review focuses on explicit instances of efforts made to reconceptualize the concepts for nursing.

While Nielsen (1992) accepted Donabedian's framework, she felt it lacked the moral and caring dimension most important to nursing. The

purpose (significance) of the model was "to provide a starting point and common ground for the development of nursing knowledge related to the phenomena of quality of care" (Nielsen, 1992, p. 65). Using Meleis' method of theory development combined with concept analysis techniques, Nielsen worked within this framework to develop a nursing practice grand theory based on her clinical observations and extant literature. Philosophical assumptions supported by the literature included: (1) all health care workers want to provide quality care; (2) quality is value-based; (3) quality is not inherent, but rather learned and managed; (4) quality is measurable; and (5) quality reflects consumer expectations. Although Nielsen did not specifically refer to the metaparadigm, all four concepts were addressed within operational definitions: patients/clients (person), environment, outcomes (health), and processes for delivery of care/caring (nursing). The theory itself never was explicitly voiced despite the fact that propositions regarding relationships among the concepts were clear, concise, logically stated, and testable. Use of the concept analysis techniques provided "descriptive . . . salient relational statements associated with the concepts of quality of care . . . occasional value statements, attributes, and anecdotal examples" (Nielsen, 1992, p. 68).

In 1993, Attree published a concept analysis of quality as it pertains to contemporary nursing based entirely within Donabedian's framework using

structure-process-outcome as "predetermined elements against which aspects of service are compared" (p. 361). Having laid this groundwork, Attree (1996) followed with a proposed conceptual model of quality health care. Elements of the model included: (1) structure-process-outcome criteria; (2) perspectives (professional, managerial, social); (3) context/environment; and (4) time/era. For nursing, identified as a professional subgroup, a supporting literature review revealed that the focus was placed on the process of providing care with some attention paid to outcomes. Relationships between the attributes of quality, defined in the earlier publication, and perspectives of quality were proposed. Attree (1996) noted: "When mapped against each other no single criterion/attribute was identified as common to each perspective . . . where these criteria corresponded, variations of emphasis on different dimensions, rather than substance, were recognized" (p. 22). Therefore, she concluded "a single criterion which could function as a composite indicator of 'Quality Care' does not exist" (Attree, 1996, p. 24).

Another nursing theory emerging from Donabedian's work is the Nursing Role Effectiveness Model of Irvine, Sidani and Hall (1998a). This theory proposed specific relationships of the independent, dependent, and interdependent roles of the nurse with patient outcomes and cost. Structural variables of the nurse (experience, knowledge, skills), organization (staff mix,

workload, assignment pattern), and patient (health status, severity, morbidity) were clearly stated. Process variables involved the independent, dependent, and interdependent roles of the nurse. Nurse-sensitive outcome variables gleaned from contemporary nursing literature were placed in six categories: (1) preventing complications; (2) clinical outcomes (symptom management); (3) knowledge of disease and treatment; (4) functional health outcomes; (5) patient satisfaction; and (6) cost (Irvine et al., 1998a). Stated relational propositions included:

> (1) Nursing's capacity to engage effectively in the independent, dependent, and interdependent role functions is influenced by individual nurse variables, patient variables, and organizational structural variables. (2) Nurse, patient, and system structural variables have a direct effect on clinical, functional, satisfaction, and cost outcomes. (3) Nurses' independent role function can have a direct effect on clinical, functional, satisfaction, and cost outcomes (Irvine et al., 1998a, p. 61).

In a follow-up article (Irvine et al., 1998b), the authors demonstrated how the theory guides both the selection of indicators for quality improvement programs and the evaluation of the effectiveness of newly designed nursing roles. As such, it demonstrated both empirical and pragmatic adequacy.

On a higher level of abstraction lies the Quality Health Outcomes

Model developed by Mitchell, Ferketich, and Jennings in conjunction with the American Academy of Nursing Expert Panel on Quality Health Care (1998). The model was another modification of what the authors termed the "time-honored structure-process-outcome framework" (Mitchell et al., 1998, p. 44) decreasing the linearity of the original by emphasizing the importance of feedback. The authors proposed six research questions and noted that the model was "sufficiently broad (a) to guide development of databases for quality improvement and outcomes management, (b) to suggest key variables in clinical intervention research, and (c) to provide a framework for outcomes research and management" (Mitchell et al., 1998, p. 43). Although the stated need to make the structure-process-outcome model more dynamic and less linear reflected an attempt to embrace nursing's philosophical stance, it also pointed out an implicit awareness of model inadequacy. There was no explicit referral to the metaparadigm concepts and no relational propositions included in their proposal.

Competence and Interaction Theories

Although Donabedian (1980) mentions interpersonal relationships as a component of quality, Fosbinder (1994) did not mention his model in what she described as an emerging descriptive theory of interpersonal competence. She used a review of medical, nursing, psychology, and sociology journals combined with an ethnographic study to link the definition of quality to a

theory of interpersonal competence. Constant comparison of the interview and observation data yielded four categories of nurse attributes displayed in interaction and valued by the patients: (1) translating (interpreting and providing information); (2) getting to know you (humor and sharing personal information); (3) establishing trust; and (4) going the extra mile (Fosbinder, 1994, p. 1087). Although not stated clearly as such, the propositions resulting from this study were: (1) the patient's perceptions of quality care are related to interpersonal relationships, and (2) personal interactions between caregivers and patients significantly influence patient satisfaction. The small study sample accompanied by homogeneous characteristics (race, age, education) among the participants did not permit generalization to a larger population.

Kasch (1985) suggested that existing nursing models link theory, research, and practice more closely together by viewing nursing action as a form of social interaction. This organismic, symbolic interactionist theory assumed (1) every person has a unique pattern of knowledge and experience; (2) effective social interaction depends on the capacity of a person to understand the viewpoint of another; and (3) mutual goal attainment depends on negotiation (Kasch, 1985, p. 226). Kasch (1985) believed that nursing was primarily a communicative function: (1) eliciting and providing information; (2) influencing attitudes, beliefs, and actions; (3) comforting and

supporting; and (4) building functional relationships (p. 228). The theory proposed that conceptualizing nursing action as a process of social interaction leads to prescriptive middle-range theories of negotiation and goal attainment that may or may not be incorporated into existing models.

Glen (1998a), linking interaction and competence theories, stated: "Quality cannot be assessed in terms of performance referenced criteria, but only in terms of personal qualities displayed in the performance" (p. 41). Assuming that (1) nursing is essentially transactional and (2) performance is affected by emotional and motivational states, she proposed that competence involves the development of states appropriate to the nursing task. Her theory emphasized the metaparadigm concepts of person and nursing. It is the realization of human values in social transactions between and among people that defines quality and different definitions of quality determine different definitions of nursing. Four such definitions were derived: nursing as (1) labor, (2) a craft, (3) a profession, and (4) an art. Glen (1998b) later combined this theory with Harre's model of personal and professional identity to propose that professional learning is "a process of individualization and independent thinking and practice within changing professional or social contexts" (p. 100). The four types of nursing defined earlier were linked with observable behaviors in the belief that the key to quality nursing care was advancement to the practice of the art of nursing through personal development.

Ethical Frameworks

Larrabee (1996) used the results of her qualitative research into patients' perceptions of quality (Larrabee et al., 1995) and her professional experiences to propose a holistic framework to define quality. In this model, expectations and perceived outcomes define quality based on their value to the individual: "Quality is defined as the presence of socially acceptable, desired attributes within the multifaceted holistic experience of being and doing" (Larrabee, 1996, p. 356). Quality (1) is value-laden; (2) is empirically measurable as "perceived quality"; (3) has degrees of desirability; and (4) is influenced by role (Larrabee, 1996, p. 356). Propositions demonstrated the relationship and interactions among beneficence, value, prudence, and justice. Larrabee's work fits Fawcett's criteria for a conceptual model being "broad enough to engender middle-range theories for nursing and health care" (Larrabee, 1996, p. 357). Although she did not state explicitly that the model guided her, Williams (R. P.) used Larrabee's defining characteristics to support the following definition of quality arising from a 1998 qualitative study:

> Quality nursing focuses on the patient as a unique individual with specific needs. It is care provided by nurses with clinical competence and expertise. This care must meet patients' needs at or above accepted standards. Quality nursing equips patients with knowledge and ultimately makes a difference in their lives (p. 263).

Nursing Conceptual Models

Reports of derivation of grand or middle-range theories of quality from nursing's seven recognized conceptual models are rare. Chance's (1980) review of selected literature cited outcome categories based on Orem's self-care model and the use of Johnson's behavioral system to define quality as an absence of complications. In more recent work, King's goal attainment theory (Larrabee et al., 1995; Sowell & Lowenstein, 1994) and Henderson's definition of nursing (Pierce, 1997) illustrated components of quality nursing care. Clark, Cross, Deane and Lowry (1991) incorporated Neuman's five interdependent dynamic variables (physiologic, psychologic, sociocultural, developmental, spiritual) in a theory proposing the need to address spirituality when defining quality.

Summary

The literature review revealed that nurse theorists have equated defining quality with defining nursing itself as evidenced by their discussions of the person-environment interaction and its relationship with nursing activities. Those guided by Donabedian's model found it necessary to incorporate significant modifications to attempt philosophical congruence with the discipline's ontology. These observations support the need for interpretation of quality within the structure of the nursing metaparadigm and conceptual models.

Implications

Because the frameworks used to analyze the concept and develop theories have been based in disciplines other than nursing, nurses have yet to agree on the defining dimensions of quality or how they should be measured. Thus the meaning of quality as it pertains to nursing remains elusive despite the fact that the person-environment interaction is well defined in nursing theory. As stated above, inquiry into the nature of quality is an ontological and epistemological venture as it studies the nature of nursing and of nursing knowledge. Therefore, it becomes the work of nurse philosophers to systematically order the discipline's beliefs through clarification of concepts and description of practice actions.

CHAPTER THREE

THE HERMENEUTIC PROCESS

Manifested through a historical concern with the health of society, nursing claims the health and wholeness of humans in interaction with the environment as its domain. Thus, the experience of quality emerging from this interaction clarifies its meaning in the discipline's domain. The purpose of this study is to reconceptualize high-quality nursing care within a framework unique to nursing. The inquiry into the nature of quality is an ontological and epistemological venture as it studies the nature of nursing and of nursing knowledge. Because nursing is capable of accommodating both science and human values, nurse researchers have the tools of philosophical inquiry as well as empirics to answer those questions about truth and reality unexplained by traditional science (Kikuchi, 1992; Watson, 1995).

Philosophy

Philosophy is the study of the nature of reality (metaphysics), the meaning of existence (ontology), the nature of knowledge (epistemology), the formal rules of thought (logic), the standards of behavior (ethics), and the criteria of beauty (esthetics) (Edgerton, 1988; Quinton, 1995). Metaphysics (the ultimate nature of things) and ontology (claims regarding the nature and structure of being) are so closely identified as to be synonymous, whereas epistemology is concerned with the origin and structure of knowledge

(Rawnsley, 1998). To philosophize, or *do* philosophy, is to engage in rational systematic reflection about the nature of the world, the justification of our beliefs, and the conduct of our lives to satisfy our intellectual desire for integrated understanding (Fry, 1992; Gaut, 1985; Quinton, 1995; Sarter, 1988). Oxford philosopher Quinton explained the role of philosophy within a discipline:

> Whenever there is a large idea whose meaning is in some way indeterminate or controversial, so that large statements in which it occurs are hard to support or undermine and stand in unclear logical relations to other beliefs we are comparatively clear about, there is opportunity and point for philosophical reflection (p. 670).

Within philosophy exist specialized disciplines devoted to the pursuit of knowledge in specified fields from within their own ontological and epistemological worldviews. One such field is the philosophy of science and one such worldview is empiricism encompassing positivism and post-positivism. Positivism is the belief that reality consists only of discrete, observable, measurable, and verifiable phenomena independent of personal opinion or perception. A foundationalist epistemology, this "received view" only allows scientific statements based on experience (observation) and confirmed by sensory data (experimentation). Verification allows science to progress toward one certain truth. Trademarks of this worldview are objectivity, causality, induction, and predictability. The spatio-temporal

structure of scientific knowledge is linear and sequential: later theories incorporate earlier ones and "justified truth (is) built upon justified truth" (Kegley, 1995, p. 45). Just as new theories build on old ones, so all science ultimately can be reduced to physics and chemistry (Suppe & Jacox, 1985).

Dominant from the time of Bacon's (1620) introduction of empirical induction until the 1950s, positivism has given way to post-positivism, a worldview that accepts the existence of unobservable phenomena. The ultimate goal of science is not restricted to objective explanation, but includes understanding through description and deduction (Weiss, 1995). Total objectivity is impossible since all scientific statements include the beliefs and values fundamental to individual perception. Therefore, meaning (as well as research problems and questions) depends on theoretical assumptions influenced by and contingent on the context of given circumstances. That contexts differ leads to a plurality of theories Kuhn (1970) described as "incommensurable ways of seeing the world and practicing science in it" (p. 4). Kuhn disputed the positivistic belief that science builds toward an ultimate truth by adding new theories to old ones. Rather, he asserted that revolutions disrupt periods of "natural science" and replace the prevailing paradigm with totally different and transformative paradigms. Growth occurs through changes in a discipline's perspective and practice. Although there needs to be a consensus regarding the basic domain of a discipline, different

conceptualizations may coexist and be compared without being translated into a neutral language (Kegley, 1995).

Hermeneutics

A branch of philosophy named for Hermes the messenger of the Greek gods, hermeneutics began with the allegorical interpretation of Greek myths and proceeded into Biblical Scripture interpretation (Bruns, 1992; Grondin, 1994). The same technique was used following the Protestant Reformation to determine the accurate interpretation of the Holy Word. Palmer (1969) provided six modern definitions (or approaches to) hermeneutics: (1) biblical exegesis; (2) a general philological methodology; (3) the science of all linguistic understanding; (4) a methodological foundation of historical consciousness; (5) the phenomenology of existence and existential understanding; and (6) a system used to reach the meaning behind myths and symbols. Of the three strong influences on modern hermeneutics, two (Scheielermacher and Dilthey) are concerned with epistemology while one (Heidegger) refined understanding ontologically.

Both Scheielermacher (1768-1834) and Dilthey (1833-1911) advanced hermeneutics as a systematic method capable of achieving the objectivity valued by the natural sciences model. Scheielermacher set himself the task of isolating and delineating the procedures necessary to overcome the misunderstanding that automatically occurs when interpreting a text. He

stated that text must be interpreted from two points of view: (1) grammatical, referring to the usage of common language; and (2) technical or psychological, relating to the author's style (Honderich, 1995; Reeder, 1988). For him, only reproduction of the original author's meaning brings about understanding. As Gadamer (1989) noted: "What is understood is now not only the exact words and their objective meaning, but also the individuality of the speaker or author" (p. 186) in order "*to understand a writer better than he understood himself*" (p. 192). Dilthey, influenced by Scheielermacher's psychological point of view necessary for interpretation, extended hermeneutics to the understanding of all human behavior and products (Honderich, 1995; Palmer, 1969). He formalized the epistemology of human sciences as a historical method stating, "A science belongs to the human studies only if its object becomes accessible to us through a procedure based on the systematic relation between life, expression, and understanding" (Palmer, 1969, p. 106). Thus, for him, the aim of reproduction was not the thoughts of the author, but the social-historical world in which he lived objectified through written expression. Such a reproduction allowed a historical understanding rather than an empirical explanation.

Having studied Dilthey's hermeneutics and Husserl's phenomenology, Heidegger (1889-1976) proposed a renewed exploration of the question "What is Being?" *Dasein* (German for existence, literally "being there") is his conception of the human being aware of the possibilities of existence in a

world within which he finds himself already immersed and from which he is inseparable. Understanding is no longer a method for legitimizing the human sciences, but rather a fundamental, future-oriented being-in-the-world operating within a whole (Palmer, 1969). All understanding is therefore temporal, intentional, and historical.

Philosophical Hermeneutics

Drawing from all these influences, Gadamer advocated an ontological approach (a process rather than a method) to understanding known as Philosophical Hermeneutics. Essential elements of this approach include the universality of the hermeneutic problem (or situation) and the centrality of language. The aim of Philosophical Hermeneutics is to "illuminate the human context" (Linge, 1976, p. xviii), the mode of being-in-the-world, in which understanding occurs.

We are already immersed in the world when we become aware of it. We make judgments about and assign meaning to reality before being aware of the continuity and influence of history. Gadamer (1976) calls these pre-judgments and pre-understandings our forestructure, our prejudices, refuting the commonly accepted negative connotation of the word prejudice:

> Prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth. In fact, the historicity of our existence entails that prejudices, in the literal sense of the word, constitute the initial

> directedness of our whole ability to experience. Prejudices are biases of our openness to the world. They are simply conditions whereby we experience something – whereby what we encounter says something to us (p. 9).

Recognizing that we are historically situated, becoming aware of the "preconceptual operativeness of tradition" (Gadamer, 1997, p. 26), heralds the development of a historically affected and effective consciousness. Such consciousness leads to the realization that our choices lie not in the uncontrollable past but in the imagined possibilities of the future. Our "present situation loses its status as a privileged position and becomes instead a fluid and relative moment in the life of effective history" (Linge, 1976, p. xix). We achieve what Gadamer terms a fusion of horizons, a transcendent understanding that becomes more than just a sum of two points of view. Recognizing that we are formed by what is past and what we project into the future, we are unable to remove ourselves from the world in order to objectively study it. In other words, our part in life cannot be viewed except in relationship to the whole of the world itself. Nor can the whole be viewed without reference to our horizon. We find ourselves on a journey around an unbreakable hermeneutic circle.

The hermeneutic process takes place when an experience of transcendent fusion of horizons is put into words for communicating with others. Language is both the voice of the past in the present and the ground

in which our prejudices are embedded (Linge, 1976). As such, "understanding is language bound" (Gadamer, 1976, p. 15). Language is the medium of understanding. Language is not a tool that we pick up to do a specific job and put down when we are through doing it. Rather it is the whole expression of our being-in-the-world, our reality. Language and understanding are one and the same; both open to expansion dependent on situational context.

Philosophical hermeneutics is the ontological framework for this study with the specific application to text interpretation. In this framework, the process of text interpretation involves reflective dialogue and fusion of horizons. The interpreter approaches the text with a genuine question, one that she has been thinking about, one that she realizes could have several answers. Since she has not taken a stance that only one of these possible answers is correct, the interpreter is not looking for proof or validation of a set point of view. Nor is she attempting to reconstruct the viewpoint of the author of the interpreted text. As the interpreter moves between parts (words, sentences, paragraphs) and the whole (text) she engages in a conversation with the text, a reciprocal dialogue founded on questions and answers.

As with any conversation surrounding a topic or question held in common, the ideas offered by one participant provoke ideas and questions in the other participant. Gadamer (1997) described the process of understanding when he defined dialectic as:

> . . . the art of having a conversation, and that includes having a conversation with oneself and fervently seeking an understanding of oneself. It is the art of thinking. But this means the art of seriously questioning what one really means when one thinks or says this or that. In doing so, one sets out on a journey, or better, is already on a journey . . . Thinking constantly points beyond itself (pp. 33-34).

The act of reading itself requires the interpreter to look for the meaning behind and beyond the actual words of the text (Gadamer, 1989). In this way, the text asks questions of the interpreter. At the same time, the interpreter reflects on her own questions and answers leading to further dialogue with the text.

A genuine dialogue is marked by its buoyant nature, being immersed in and carried along by the subject matter, that Gadamer (1989) likens to playing a game. When we are introduced to a game we expend conscious effort to learn the rules, master the moves, and understand the purposive goal. At this stage, playing the game feels awkward and stressful. We know from experience that "play fulfills its purpose only if the player loses himself in play" (Gadamer, 1989, p. 102). We begin to enjoy ourselves when we quit worrying about our performance and get caught up in the repetitive "to-and-fro movement that is not tied to any goal that would bring it to an end" (Gadamer, 1989, p.103). Indeed, despite successfully reaching the goal, we may be

sorry that the game is over.

The same state of transcending self-consciousness occurs in text interpretation. Think of the difference between studying for a multiple choice chemistry test and writing an essay articulating a personal interpretation of a poem. In the first instance, we know there will be only one acceptable answer to each question. We look to the text for those specific facts. We can pass the test by knowing those parts without ever understanding the whole. But in the assignment of interpreting the poem, we look for the meaning in relation to not only the individual words and thoughts of the author, but in the context of our past experience, present knowledge, and future hopes. If we limit our interpretation to prescribed rules for analyzing poetry, we are viewing the poem as an object rather than a mode of being-in-the-world. We might as well be studying for the chemistry examination.

To interpret the poem, to communicate its meaning to others, requires a genuine dialogue. Engaging in such a dialogue changes our mode of being-in-the-world by increasing our self-knowledge and self-understanding by fusing our horizon (perspective of reality) with that of the text. It is this fusion, this new and different perspective, that constitutes understanding. The result is not an understanding of how the text came to be or a reconstruction of the author's intent, but rather an understanding of how it applies to our current situation, what Gadamer (1989) called a "unique co-existence of past and

present" (p. 390).

The Philosophical Hermeneutic process implies that the interpreter begins by (1) describing the historical and cultural horizons of both the text and the interpreter; (2) explaining the perspectival differences between the original text and the interpretation; and (3) being conscious of why the research question was chosen and what impact the answer will have on present and future thought and practice (Thompson, 1990). The actual process of interpretation suggested by philosopher and nurse David Allen (1995) and made explicit by Alligood et al. (1998) includes: (1) production of meaning through reading; (2) interpretation of the part in relation to the whole; (3) conscious consideration of the text's historical context; and (4) the written record of the interpreter's understanding and the hermeneutic process through which new text is produced. The process begins with "develop(ing) a sense of the whole . . . accomplished by reading through it several times" (Draper, 1997, p. 86). The whole is then divided into parts (chapters, paragraphs, and sentences) and examined for explicit and implicit meanings.

Although the understanding of the text belongs to the interpreter and, therefore, is not subject to objective quantitative measures, it must exist within the realm of possibilities without claiming to be the sole and definitive interpretation. The interpreter's reasoning must be logical and consistent. Words must retain the same meaning from part to part and both the parts and

the whole must be congruent with the historical context in which it is produced. Validating the interpretation involves gaining intersubjective agreement and most importantly, describing its utility (Allen, 1995; Angen, 2000). Intersubjective validation takes place when previously published information and peer review support the interpretation. During the latter the reviewers are testifying to the truth of the interpretation by evaluating its comprehensiveness, comprehensibility, and persuasive power (Angen, 2000). According to Angen (2000), utility lies in the interpretation's ability to provide "practical answers to the so-what question" (p. 388) and its generative promise of stimulating new dialogue.

Defining High-Quality Nursing Care

In this study King's General Systems Framework, her Theory of Goal Attainment, and my forestructure exemplify the unique coexistence of past and present. King published the foundation of her model, which she prefers to label a "framework" (Fawcett, 1995), in 1964 and 1968 journal articles prior to the release of the 1971 Toward a Theory for Nursing: General Concepts of Human Behavior. Her later publication, A Theory for Nursing: Systems, Concepts, Process (1981) and recent journal articles constitute the examined texts. Revealing that her initial orientation to research was qualitative and her philosophy of nursing congruent with General System Theory, King (1990) wrote:

> My inquiry into the essence of professional nursing began with a few questions. What is nursing? Who is a nurse? What functions do nurses perform as professionals? Where do they perform their functions? What is a nursing act? What is the nursing process? Following a review of nursing literature and my experiences as a nurse and as a teacher of nursing students, I began to find information to help me answer some of these questions and to ask more questions (p. 74).

I chose King's framework for this study because it is used by a number of nurses in a variety of settings to guide their practice. In 1995 Fawcett and Whall observed that "evidence supporting the contention that use of the general systems framework . . . leads to improvement in individual's health status has been accruing for several years" (p. 329). Like most of the authors of the major conceptual models (with the exception of Rogers), King espouses a reciprocal interaction worldview. She is, however, unique in her view of nursing as primarily an interpersonal process (Hilton, 1997). Her identification of *perception* as a major concept is congruent with nursing research findings in the study of quality care. Moreover, models formulated to define high-quality care give evidence to the importance of goal attainment. The hermeneutic process fits with King's framework as "both achieve understanding of the whole in terms of the parts and parts in term of

the whole" (Alligood et al., 1998).

On a more personal level, King and I possess similar backgrounds. Both of us were born in the Midwestern United States; graduated from diploma nursing programs; and converted to the belief that the baccalaureate degree is the appropriate entry level to the profession. Like me, King lived in the Chicago area for a significant amount of time and moved to the Southeastern United States to escape unpleasant weather (King & Lewenson, 2000).

I was introduced to King's framework while attaining my Master's degree in Nursing Administration and was attracted by her recognition of the effect of bureaucracy (delineated in the social system concepts) on nursing practice. I have participated for several years in the University of Tennessee College of Nursing Empathy Research Team's interpretation of her framework. While presenting the team's research at the inaugural King International Nursing Group (KING) conference, I met and conversed with Dr. King. Although aspects of a shared background allow the possibility of our shared understanding (interpretation) of what nursing is, there exist significant experiential differences. To begin with there is at least 25 years difference in our ages. King immediately recognized the value of higher education and began attending college classes within a month of graduating from the diploma program. I worked for ten years before returning to school. The major

portion of King's career has been spent teaching, whereas until recently I have always worked in a hospital inpatient setting.

My forestructure (and prejudices) are comprised of my experiences as first a staff nurse and then a nursing administrator in the present health care environment, my search of the nursing literature for an explicit definition of high-quality care, and my own questions regarding the nature of nursing. The introduction and literature review sections of this study describe the historical and cultural horizons of both King and myself. It is my conscious belief that descriptions of high quality care derived from a nursing conceptual model rather than an industrially derived medical model will benefit both patients and the nursing profession. Although the interpretation of King's text is mine and, therefore, not subject to objective quantitative measures, it must exist within the realm of possibilities. That is, the interpretation must be defensible and supported by excerpts from the original text (Draper, 1997). To assure this, a King scholar, Dr. Martha Alligood, reviewed the interpretative product. Support for my interpretation also exists in concept analyses and research studies found in contemporary nursing literature.

I approached King's texts then with the question: *What are the characteristics of high-quality nursing care?* Within the framework of Fawcett's Structural Hierarchy of Contemporary Nursing Knowledge, the meaning and experience of high-quality nursing care lies in the metaparadigm

relational proposition that the discipline is concerned with the nursing actions or processes by which positive changes in the person's health status are effected. This proposition states the relationships among person, nursing, and health (Fawcett, 2000). The meaning of high-quality nursing care is understood through interpretation of the philosophical underpinnings and the actual content of the framework. Conducting a hermeneutic interpretation of King's framework of interacting systems (personal, interpersonal, and social) and her theory of goal attainment explicates the meaning of high-quality nursing care from a conceptual model of nursing.

The Process

Prior to undertaking this study, my interaction with King's (1981) text A Theory for Nursing had been limited to cursory readings aimed at obtaining general knowledge of the framework. This time I approached the text with a genuine question whose answer would require deeper understanding of the conceptual model. This distinct purpose required a reading process different from that which I had employed previously. Wanting to get a feel of the rhythm of the work as a whole rather than a staccato examination of its parts, I purposively put pen and paper out of reach during the initial readings. Reading the text from beginning to end in a single sitting on two separate occasions provided a familiarity with the framework's content. This familiarity deepened as I returned to the text again and again throughout the study.

I began a systematic analysis of the framework with a review of the philosophy of science guiding its conception, that is, General System Theory (GST). After rereading von Bertalanffy's (1968) General System Theory: Foundations, Development, Applications, I returned to King's (1981) work and looked for her use of GST concepts. Continuing to use Fawcett's (1997) Structural Hierarchy of Contemporary Nursing Knowledge as a blueprint, I proceeded to find metaparadigm concept definitions and evidence of the relationship propositions. This study yielded conclusions regarding the meaning of high-quality nursing care in King's framework. Not surprisingly, it also provoked more questions. Possible answers to these questions emerged from the processes of concept clarification and concept development. King (1981) supported the congruence of these processes with the purpose of this study when she wrote: "continuous development of concepts . . . (is) essential for delivering quality nursing care" (p. 3). The resulting concept analyses necessitated validation by a return to King's writings and evidence of support from existing nursing literature.

Morse (1995) identified six distinct outcomes of concept analyses including (1) development, (2) delineation, (3) comparison, (4) clarification, (5) correction, and (6) identification. Determination of the appropriate outcome occurs after an extensive literature review including "books and articles that discuss the nature of the concept, and articles that review the concept's

research and utilization in practice" (Morse, 1995, p. 36). Questions provoked by my initial conclusions identified the need for clarification or development of specific concepts (explicit or implicit) within the three interacting systems.

Concept clarification is the goal when "there is an enormous body of literature" but "the concept appears confusing and is murky with many implicit assumptions" (Morse, 1995, p. 37). The process involves a content analysis of the literature to "identify, describe, and compare and contrast the attributes" (Morse, 1995, p. 41) with consideration of the various authors' underlying assumptions. Clarification of nurse *empathy*, implicit in King's personal system, validated Alligood's (1992) determination of the existence of two types of empathy, rather than the commonly held position that only one type exists, however multidimensional.

The process of concept development becomes appropriate when "after reviewing the literature it is clear that the concept is still nebulous and has not been well explicated" (Morse, 1995, p. 36). In her writings, King frequently cited *mutuality* as a characteristic of interaction, a concept of the interpersonal system. There is, however, no clear description of the attributes (such as degree of participation and degree of responsibility for outcomes) of this important element. Furthermore, interpretation of the meaning of high-quality nursing care within the framework led me to question the relationship of mutuality with two social system concepts, *power* and *decision-making*.

Fusion of horizons occurs in the chapter delineating the application of the theory to nursing practice, education, and research of a theory of high-quality nursing care derived from King's framework. Demonstrating the utility of the theory in these three areas also testifies to its validity by providing "practical answers to the so-what question" (Angen, 2000, p. 388). Arrival at these implications necessitated another return to the nursing literature focusing on contemporary nursing care delivery systems, curricula, and research priorities.

In summary, the process of hermeneutic interpretation of King's framework to find the meaning of high-quality nursing care involved multiple readings of King's 1981 text both as a whole and in relation to specific parts, followed by corresponding reviews of the nursing literature.

CHAPTER FOUR

HIGH-QUALITY NURSING CARE AND KING'S INTERACTING SYSTEMS

This hermeneutic interpretation of King's (1981) A Theory for Nursing was conducted to uncover the meaning of high-quality nursing care within a model specific to nursing. It began with an overview of the framework examining the guiding philosophy of science, metaparadigm concept definition and use, and metaparadigm propositional statements. Conclusions drawn from this examination led to concept clarification and development within the three systems that resulted in an explicit theory of high-quality nursing care derived from King's Interacting Systems.

Overview of King's Framework

Philosophy of science

General System Theory (GST) proposes a method of investigating complex wholes in which phenomena are "not resolvable into local events . . . not understandable by investigation of their respective parts in isolation" (von Bertalanffy, 1968, p. 37). These wholes are systems defined as "sets of elements standing in interrelation" (von Bertalanffy, 1968, p. 38) and categorized as either open or closed depending on their interaction with the environment (feedback) and their purposive goals. Machines exemplify closed systems in that, lacking a mutual exchange of matter with the environment, the goal consists of maintaining the status quo, equilibrium. On the other

hand, living organisms, open systems, purposively increase their complexity by differentiation and transformation during an irreversible and continuous exchange of information and matter with the environment. For as von Bertalanffy (1968) stated "Life is not a comfortable settling down in pre-ordained grooves of being; at its best it is *élan vital*, inexorably driven towards a higher form of existence" (p. 192).

King (1999) identified GST as the philosophy of science that allowed her to describe the complex "organized wholes within which nurses are expected to function" (p. 292): the interacting personal, interpersonal, and social systems (Figure 4-1). These three systems compose the framework used by King to structure her characterization of nursing. Her summarization of the framework explained:

> Individuals comprise one type of system in the environment called personal systems. Individuals interact to form dyads, triads, and small and large groups, which comprise another type of system called interpersonal systems. Groups with special interests and needs form organizations, which make up communities and societies and are called social systems (King, 1981, p. 141).

King identified important concepts within each system, but as Fawcett (2000) noted: "The concepts associated with each system in no way represent parts or subsystems. Rather, they may be construed as global characteristics of the

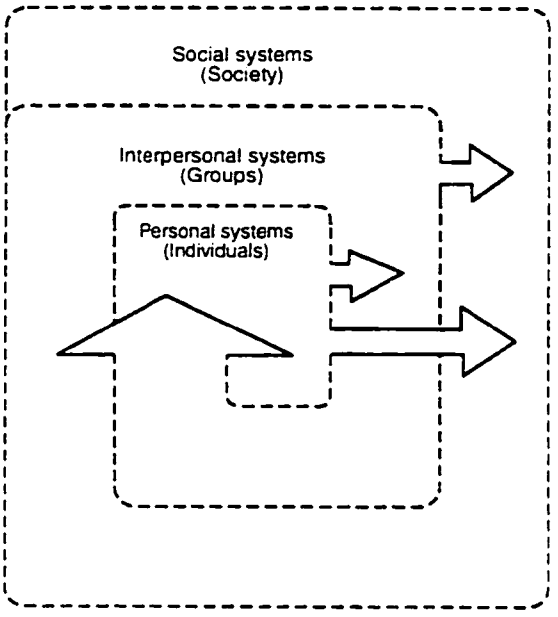


Figure 4-1. King's Interacting Systems.

Source: King, I. M. (1981). A theory for nursing (p. 11). Albany, New York: Delmar.

system" (p. 112). As with all open systems, the boundaries between the personal, interpersonal, and social systems are permeable allowing interaction. Therefore, although King placed specific concepts within specific systems for the purpose of definition and description, the concepts are not confined to those systems. The dynamic and continuous nature of the systems' interaction results in every concept influencing each system. Other characteristics of systems incorporated into King's framework include goals, functions, resources, and decision-making. According to King (1995a), goals relate to health; functions to actions and roles; resources to technology,

money, and the workforce; and decision-making to the influence of information on behavior and consequently, goal attainment.

Metaparadigm Concepts

King's definitions (Table 4-1) and discussions of the metaparadigm concepts reflect elements of GST. Her emphasis on how individuals create their world through perceptual experiences resulting in unique selves demonstrates equifinality, "a move toward a characteristic final state from different initial states and in different ways" (von Bertalanffy, 1968, p. 46). *Human beings*, represented by the three multidimensional systems (Fawcett, 2000), are rational and sentient, capable of thoughtful and emotional interaction with their environment. *Environment* extends beyond the immediate physical setting to include spatial-temporal reality, and the systems involved in social interaction. Not only objects surround man but also symbols of culture (such as language) reflecting values (von Bertalanffy, 1968). Behavioral adjustments aimed at goal attainment embody the person-environment interactive exchange of information. Evaluatory feedback from the environment prompts further action in a continuous cycle. Once information has been received and action taken it is impossible for an individual to return to a condition identical to a previous one. The purpose is not to achieve static equilibrium (status quo) but rather to adjust to increasing complexity.

Table 4-1. Definitions of metaparadigm concepts in King's framework

Metaparadigm Concept	Definition
PERSON	Human beings are open systems interacting with the environment who function in roles in a variety of groups Social beings who are rational and sentient
ENVIRONMENT (implicit)	Immediate physical setting Spatial-temporal reality Interacting systems
HEALTH	Dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of resources to achieve maximum potential for daily living
NURSING	Perceiving, thinking, relating, judging, and acting vis-à-vis the behavior of individuals who come to a nursing situation

Source: King, I. M. (1981). A theory for nursing. Albany, New York: Delmar.

This adjustment is health, a valuation of the human being's open system characteristics. *Health* is a functional cyclical adjustment to an ever-changing environment, while illness is "an imbalance in a person's biological structure or in his psychological make-up, or a conflict in a person's social relationship" (King, 1981, p. 5). *Nursing* is the process of "action, reaction, and interaction whereby nurse and client share information about their perceptions in the nursing situation" (King, 1981, p. 2) with the goal of maintaining or regaining health. The extent and accuracy of the shared information can be measured in terms of decisions made, actions taken, and goals attained.

Metaparadigm relational propositions

Nursing is concerned with the principles and laws that govern the life process, well-being and optimal functioning of human beings, sick or well (Fawcett, 1995, p. 7). King's (1981) description of human beings and the environment as open systems in continuous and dynamic interaction affirms this relationship. Nurses, then, "are expected to integrate knowledge from natural and behavioral sciences and the humanities and to apply knowledge in concrete situations" (King, 1981, p. 9). This application mandates nurses' acquisition of cognitive, affective, and psychomotor skills.

Nursing is concerned with the pattern of human behavior in interaction with the environment in both normal and critical situations (Fawcett, 1995,

p. 7). Understanding the relationships among person, environment, and nursing requires the realization that nursing occurs in a variety of settings whenever "the internal environment of human beings transforms energy to enable them to adjust to continuous external environmental changes" (King, 1981, p. 5) with the purpose of maintaining health. Nurse and patient collaborate in arranging the environment to prevent disruption of the patient's sense of identity, circadian rhythms, and perception of time. According to King (1981) this relationship necessitates that nurses possess knowledge of human behavior and a specific knowledge of behavior under stress. It further requires knowledge of cultural patterns of growth and development.

Nursing is concerned with the nursing actions or processes by which positive changes in the person's health status are effected (Fawcett, 1995, p. 7). This proposition delineates the relationships among person, health, and nursing. King (1981) defined nursing action as a sequence of behaviors including recognition of presenting conditions, initiation of activities related to that condition, and controlling events and activities to move toward goal attainment. Such actions constitute the function of nursing and are performed in an interpersonal field with the primary purpose of assisting the patient in coping with health problems or concerns. The quality of these interactions "may have a positive or negative influence on the promotion of health in any nursing situation" (King, 1981, p.88).

The nursing process (assessment, diagnosis, planning, implementation, and evaluation) systematically structures the nurse-patient interaction. It begins with "objective assessment of functional abilities and disabilities of individuals and groups" (King, 1981, p.8) through observation, physiological measurements, and data interpretation. The nurse initiates the development of an interpersonal relationship using verbal and nonverbal communication, the information component of the interaction-transaction process (illustrated in Figure 4-2). When the perceptions of the nurse are congruent with the reality of the patient, the interaction results in shared understanding of patient needs and expectations. When expectations of the nurse and patient are consistent with each other and result in mutual decision-making, transactions occur. King (1981) described the transaction

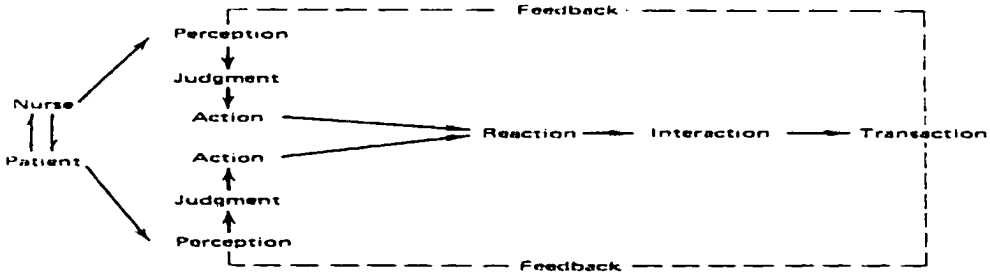


Figure 4-2 The Interaction-Transaction Process

Source: King, I. M. (1981). A theory for nursing (p. 145). Albany, New York: Delmar.

process as the valuation component of interaction stating: "When nurses and clients share their frame of reference about events in the present, they identify commonalities whereby they can mutually set goals. When transactions are made between nurses and clients, goals are attained" (p. 147). The quality of the nursing care provided can be judged by the effectiveness of nursing action in attaining the goals for health promotion, health maintenance, or recovery (King, 1981). Evaluation of the effectiveness of nursing actions includes "satisfactions in performing activities of daily living, success in performing activities in one's usual role, and achievement of immediate and long-range goals" (King, 1981, p.1).

Nursing is concerned with the wholeness or health of human beings in continuous interaction with the environment (Fawcett, 1995, p. 7). This relational proposition, linking all four metaparadigm concepts, is reflected in King's (1981) statement: "The focus of nursing is human beings interacting with their environment leading to a state of health for individuals" (p. 143). Nursing provides "an essential service to meet a social need" (King, 1981, p.8) that includes teaching, guiding, and counseling as well as planning, providing, and coordinating appropriate aspects of health care. Nursing participates in community health promotion, illness prevention, and treatment utilizing the findings of quantitative and qualitative research. Furthermore, through these activities, nursing "overtly and covertly exerts some influence on a culture's notion of health" (King, 1981, p. 7).

Conclusions

My examination of King's framework and analysis of the metaparadigm concepts and relational propositions resulted in the following interpretive conclusions.

(1) Nursing actions are performed in an interpersonal field and influenced by the developmental level of the personal system of each participant as well as the conceptual characteristics of the larger social system.

(2) Quality is an experiential judgment emerging from the nurse-patient interaction and reflects both the unique and shared values of the participants. As such, the process of providing high-quality nursing care mirrors King's interaction-transaction process.

(3) High-quality nursing care necessitates an accurate identification of patient problems and needs, appropriate actions, and realistic goals. Goal attainment provides measurable evidence of the quality of nursing care provided.

(4) High-quality nursing care focuses on the health and welfare of the patient. The patient's active participation in the activities of the nursing process facilitates the provision of high-quality care. Irrespective of the degree of patient participation, the nurse retains responsibility for the quality of care provided.

These conclusions provoked further questions. Accepting that it is the nurse's professional responsibility to initiate, promote, and ensure the development of the interpersonal relationship culminating in effective action,

what is the requisite developmental level of the nurse's personal system? What is the meaning of the concept *mutuality* in the nurse-patient activities of decision-making and goal setting? What elements of the interacting systems promote or prevent achieving mutuality?

A Theory of High-Quality Nursing Care

A hermeneutic interpretation of King's (1981) text resulted in the propositions stated below and formed a theory of high-quality nursing care derived from her framework (Figure 4-3). Subsequent literature reviews regarding individual concepts/constructs and their relationships support the theory.

Definitions

Self-awareness involves a conscious exploration of thoughts, feelings, and behaviors for the purpose of developing personal and interpersonal understanding.

Perceptual accuracy, demanding neurological awareness and deliberate analysis of selected sense data, is the ability to understand the patient's interpretation of the current situation.

Empathy is a basic universal trait that enables the nurse to accurately predict the attitudes, needs, and goals of the patient. It is a process of sensing, perceiving, understanding, and communicating understanding.

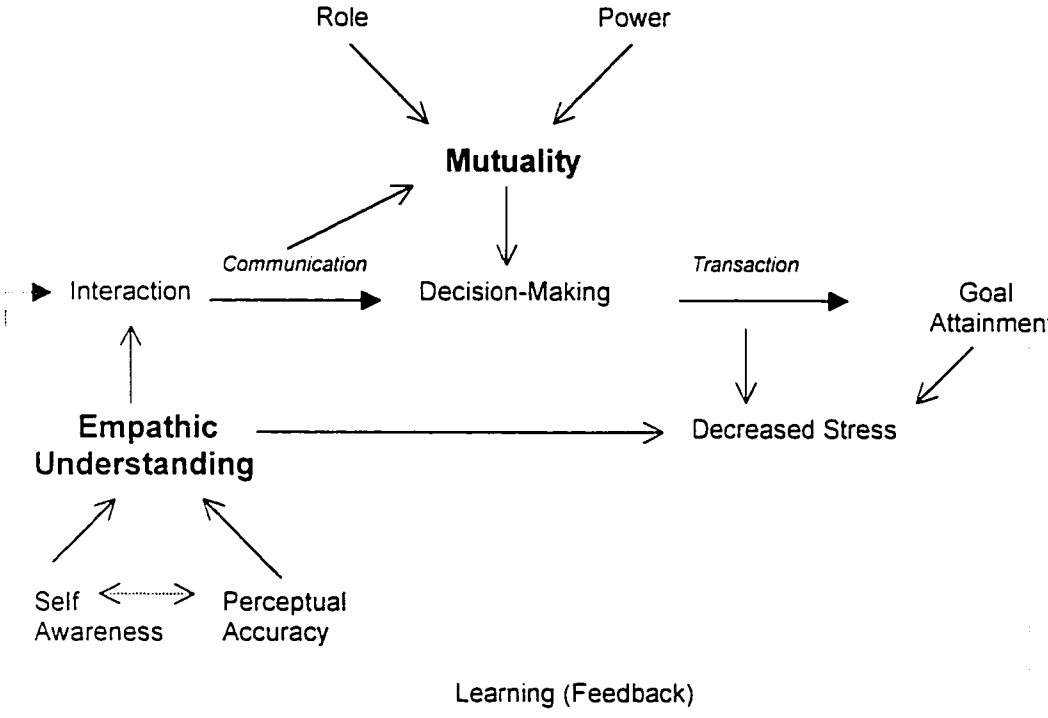


Figure 4-3 High-Quality Nursing Care In King's Interacting Systems

Interaction consists of the perceptions, actions and communication occurring between two or more persons.

Communication is the verbal and nonverbal exchange of information between nurse and patient aimed at establishing a common frame of reference from which to interpret the meaning of the current situation.

Transaction is the exchange of value between nurse and patient.

Role incorporates the functions of the nurse as defined by the profession, the employing institution, and the patient.

Power is both a control process and a capability to attain goals.

Mutuality is an interdependence of nurse and patient, a reciprocal interaction, promoting goal attainment.

Decision-making is the process of making choices between and among alternative courses of actions leading to goal attainment.

Stress is the perception that demands arising from interaction with the environment exceed personal resources.

Propositions

Self-awareness promotes perceptual accuracy (and vice versa).

Self-awareness and perceptual accuracy correspond with empathic understanding.

Empathic understanding increases the speed and effectiveness of nurse-patient communication.

Empathic understanding on the part of the nurse increases the perception of quality on the part of the patient.

Transaction transpires with alignment of nurse and patient perspectives.

A power differential favoring the nurse exists in every nurse-patient relationship.

Quality of nursing care increases as the disparity in the degree of power granted to and exerted by the participants of the interaction decreases.

Symmetry of nurse power and patient power determines mutuality.

Mutual decision-making increases the perception of the quality of care, the effectiveness of interventions, and overall satisfaction.

Empathic understanding, transaction, and goal attainment decrease the amount and intensity of stress experienced by both participants in the nurse-patient interaction.

Feedback facilitates communication and increases understanding.

Feedback allows learning to take place through an on-going discussion resulting in behavioral change.

Theory Overview

It is the nurse's professional responsibility to initiate, promote, and maintain development of a therapeutic relationship with the patient. Nursing actions, while performed in an interpersonal field, are influenced by the developmental level of the nurse's personal system. Prerequisites for the

provision of high-quality nursing care include self-awareness and perceptual accuracy on the part of the nurse. It is proposed that a direct positive relationship exists between self-awareness and perceptual accuracy. That is, an increase in one attribute results in an increase in the other attribute.

Perceptual accuracy is the ability to perceive and communicate an accurate understanding and acceptance of the individual's perspective of reality. This ability embodies empathy (Alligood & May, 2000; Ciaramicoli & Ketchum, 2000; Forsyth, 1980; Gagan, 1983; Hogan, 1969; Kalisch, 1973; Morse et al., 1992; Northouse, 1979; White, 1997; Zderad; 1969). Therefore, nurse empathy is proposed as a prerequisite for high-quality nursing care.

Empathic understanding guides communication during the nurse-patient interaction. The nurse demonstrates and communicates awareness of how past experiences, present needs, and future goals affect the patient's perception of health and nursing care needs as well as expectations of the outcomes of that care.

Dialogue between the nurse and the patient results in identification of patient goals and decision-making regarding the actions necessary to achieve them. These goals and actions (behavior) reflect the values of the patient as manifested through nursing interventions.

Mutuality in decision-making enhances these transactions leading to goal attainment. The role assumed by both the nurse and the patient reflects the degree of power assumed by or granted to the nurse and determines the

degree of mutuality in decision-making. The degree of mutuality decreases as the power assumed by or granted to the nurse increases. Irrespective of the degree of patient participation, the nurse retains responsibility for the quality of the care provided because of the professional role and the power granted by professional knowledge and skills.

Feedback regarding the effectiveness of nursing actions in meeting patient expectations and attaining goals initiates learning on the part of the nurse and the patient as demonstrated by behavioral changes.

Empathic understanding and goal attainment decrease the amount and intensity of stress experienced by both participants in the nurse-patient interaction.

High-quality nursing care requires empathic understanding on the part of the nurse. Mutuality in decision-making regarding goals and the actions necessary to achieve them enhances the value of the interaction. Goal attainment corresponds to effective nursing care and, therefore, is an empirical indicator of high-quality nursing care.

Personal System

Although nursing actions are performed in an interpersonal field, they are affected by the personal and social systems' concepts. The personal system of both the nurse and the patient contributes to their interpersonal relationship and thus, to the provision of effective nursing care. However, irrespective of the degree of patient participation, the nurse retains

responsibility for the quality of the care provided. Therefore, the following discussion focuses on the development of the nurse's personal system.

King defined six personal system concepts (Table 4-2): (1) perception, (2) self, (3) growth and development, (4) body image, (5) time, and (6) space. These concepts provide the structure for organization and interpretation of experiences as human beings interact with the environment. The concepts are interrelated in that "a concept of self emerges in the process of growth and development, which is influenced by time and space. A concept of self influences one's perceptions, and one's perceptions help develop a concept of self' (King, 1981, p. 142).

Self-awareness.

"Knowledge of self is a key to understanding human behavior" (King, 1981, p. 26) as it increases understanding of the individuality of values, needs, and goals. Thoughts, feelings, and behavior constitute self. A continuous and evolutionary process (Burnard, 1986; Cook, 1999), self-awareness is the conscious exploration of these interrelated components for the purpose of developing personal and interpersonal understanding as "attitudes toward self are often reflected in attitudes toward others" (King, 1981, p. 27). This conscious development of self-awareness entails the individual's ability to focus attention on and recognize internal thoughts,

Table 4-2. Personal System Concepts

Concept	Definition
Perception	A process of organizing, interpreting, and transforming information from sense data and memory. A process of human transaction with the environment
Self	The way I define *me* to myself and others Composite of thoughts and feelings which constitute a person's awareness of individual existence.
Growth and Development	Cellular, molecular, and behavioral changes in human beings as a function of genetic endowment, meaningful and satisfying experiences, and environment.
Body Image	A person's perception of his/her own body, others' reactions to appearance, and a result of others' reaction to self.
Space	Physical area called territory
Time	The duration between occurrence of one event and the occurrence of another event

Source: King, I. M. (1981). A theory for nursing. Albany, New York: Delmar.

feelings, and motives as well as the meaning of external events (Bohlander, 1995; Mansfield, 1980).

Being a dynamic open system (King, 1981), self develops through interaction with others. It implies the formation and recognition of ego boundaries, that is, a sense of where "I" end and the "Other" begins. Ciaramicoli and Ketchum (2000) explained the importance of this recognition: "If my boundaries get entangled with yours, then I become confused about what belongs to me and what is rightfully yours" (p. 63). It is, however, the flexibility of these boundaries that promotes an understanding of other peoples' experiences (Alligood, Evans, & Wilt, 1995; Ludemann, 1968). As Burnard (1986) observed: "The more we can discriminate ourselves from others, the more we can understand our similarities . . . If we are unaware and blind to ourselves, then we will remain blind to others" (p. 16).

To be self-aware is not the same as being self-conscious. The latter state suggests a painful awareness of the attention and judgmental perceptions of others (Burnard, 1986). As such, it breeds insecurity whereas self-awareness promotes self-esteem. The self-aware nurse is less likely to project personal thoughts, feelings, and needs onto the patient (Burnard, 1986; Seeger, 1977). Therefore, expectations regarding the patient's reaction to the situation are not preconceived and rigid. The self-aware nurse is open to and accepting of a variety of possible behaviors. Subsequently, nursing care tends toward individualization and consistency with the patient's

stated goals. "To nurse is to know oneself as fully as possible and to use one's personal presence in the context of privileged intimacy to come to know others who are in need of care" (American Academy of Colleges of Nursing, 1999, p. 61).

Perceptual accuracy.

However, nurse self-awareness is not a sufficient condition for the provision of effective nursing care. "If nurses are to help individuals they must have some understanding of how clients perceive self and current health status" (King, 1981, p. 28). Determination of patient needs and subsequent goal-setting and decision-making entails perceptual accuracy. King (1981) described perception as "each human being's representation of reality . . . an awareness of persons, objects, and events" (p. 20) that determines behavior. Perception, an active present-oriented process, is the imposition of meaning onto experience (Bunting, 1988; Gerrity, 1987). In a discourse on the art of nursing, Johnson (1996) described perception as "a way of knowing that involves gaining knowledge of a particular (versus a universal) through one's senses (including the external senses of sight, touch, taste, smell, hearing and the internal senses of imagination and emotional feeling)" (p. 309).

This description is congruent with King's (1981) statement: "Sensory experiences provide individuals with the raw data that helps them form particular and universal ideas as a way of knowing about their world" (p. 20). In King's framework, perception is characterized as being (1) universal;

(2) subjective, personal, and selective for each person; (3) action-oriented in the present; and (4) value-laden. Perceptual accuracy demands neurological awareness and deliberate analysis of selected sense data combined with the ability to imagine how the patient interprets current events. It requires that the nurse be open to the possibility that the patient's interpretation differs from the nurse's understanding.

King (1981) stated "an important element in nurse-patient interactions is accurate perception of each by the other" (p. 24). The accuracy of the nurse's perception is confirmed through communication with the patient. Congruence and accuracy of perceptions results in both the nurse and the patient feeling comfortable in the nursing situation as demonstrated by their behavior. Feeling comfortable in the situation allows the nurse to respond to the patient with warmth and concern, to give information freely, to answer questions honestly, and to spontaneously express feelings of reassurance (Lindell, 1979). Feeling comfortable in the situation allows the patient to confirm or refute the nurse's perceptions. Kalisch (1973) asserted: "The patient who is free to correct a nurse moves onto a higher level of self-understanding, but the patient who cannot refute a nurse's reflections tends to build up defenses and withdraw" (p. 1549).

Empathy.

Darwin first described the process of emotion communication as the biological basis for ethics aimed at creating and maintaining social order in

1872 (Buck & Ginsberg, 1997). It was not until 1887 that Lipps, a psychologist proposing a theory of aesthetics, first introduced the word *Einfuhlung* to describe the feeling of "losing one's self-awareness and fusing with an object" (Olsen, 1991, p. 63), such as a painting. Derived from the Greek *empatheia* (affection, passion) and a translation of the German *Einfuhlung* ("feeling into"), the word empathy was introduced into the English language around 1912. Contemporary usage denotes it as the ability to understand another person's feelings or difficulties (Encarta World English Dictionary, 2000).

Since its introduction, "more research attention has been devoted to the construct of empathy than to any other single variable purported to be of relevance to the psychotherapy process" (Ickes, Marangoni, & Garcia, 1997, p. 283). Ickes (1997) explained this attention as being due to the belief that empathy "may be the second greatest achievement of which the mind is capable, consciousness itself being the first" (p. 2). With its roots deep in the 1930s developmental psychology of Piaget (Eisenberg, Murphy, & Shepard, 1997) and related to the 1940s interpersonal perception research influenced by the phenomenologist-philosophers (Ickes, 1997), empathy was elevated to primary importance with the introduction of Carl Rogers' client-centered therapy (Levenson & Ruef, 1997). Viewing empathy as a process rather than a state, Rogers (1957) defined it as the ability "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (p. 99). Having defined a helping relationship as one wherein "at least one of the

parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other" (Rogers, 1961, p. 39), he noted that "a high degree of empathy in a relationship is possibly *the* most potent and certainly one of the most potent factors in bringing about learning and change" (Rogers, 1975, p. 3).

Rogerian psychologists view empathy as an expressive biological and developmental trait. Buck and Ginsberg (1997) described it as an "emergent property of a primordial biological capacity for communication that inheres in the genes" (p. 19) pointing to the posterior right hemisphere and amygdala as its physiologic home. Levenson and Ruef (1997) referred to empathy as autonomic nervous system synchrony while Aspy (1975) stated that it is a "universally crucial ingredient of healthy human development" (p. 13). More recently, Ciaramicoli and Ketchum (2000) designated it "the biological basis for tolerance" (p. 188) defined as the "willingness to put up with differences" (p. 189).

The importance of the concept to nursing first was recognized by nurse psychiatric-mental health specialists in response to the work and writings of Carl Rogers. Ludemann (1968) described empathy as the "ability to identify and share with another and then revert to one's own identity" (p. 280), which Zderad (1969) simplified to be a psychologic process of "experiencing oneness with another" (p. 656). Layton (1979) echoed Rogers when she wrote: "The foundation of good nursing practice is the ability to understand

and communicate with clients and their families" (p. 163). A review of subsequent nursing literature revealed that despite differences in the therapeutic relationships, the meaning of the concept for nursing remains consistent with its use in psychology.

Empathy is a basic universal human attribute, a developmental phenomenon appearing in early childhood, that allows a person to comprehend or share a frame of reference with another person (Alligood, et al., 1995; Gagan, 1983; Holden, 1990; Kalisch, 1973; Ludemann, 1968; Morse et al., 1992; Olsen, 1991; White, 1997; Zderad, 1969). It is the ability to use imagination to comprehend another's feelings and the meaning those feelings bring to the current situation (Baumgartner, 1970; Ehmann, 1971; Gagan, 1983; Kalisch, 1971; Mynatt, 1985). Empathy is a developmental affective sensing (Alligood & May, 2000) that enables the nurse to accurately predict the attitudes, needs, and goals of the patient (LaMonica, 1979; Northouse, 1979). Communication of the nurse's understanding constitutes an essential element of the interactive empathic process (Gagan, 1983; Hardin & Halaris, 1983; Kalisch, 1971; Layton, 1979; Layton, 1994; Mynatt, 1985; Northouse, 1979; Stetler, 1977; White, 1997; Wilt, Evans, Muenchen, & Guegold, 1995). Feedback from the patient provides evidence of the nurse's empathic accuracy as well as acknowledgement that the patient is aware of being understood.

Definitive characteristics differentiate empathy from related concepts. A spontaneous temporary interactive experience, empathy focuses on the "here and now" of the patient's feelings in the current situation for the purpose of understanding (Forsyth, 1980; Hardin & Halaris, 1983; Kalisch, 1973; Ludemann, 1968; Pike, 1990). The nurse's perception and understanding of what the situation means to the patient is "based on contemporary affective information . . . and not on inferences derived from prior experience with this person or on theories about how most individuals would feel" (Kunst-Wilson et al., 1981, p. 284). Empathy is altruistically motivated and nonjudgmental (Holden, 1990; Kalisch, 1973; Morse et al., 1992). Rogers (1961) referred to this attitude as unconditional acceptance, warm regard, and non-possessive caring.

Being a function of the nurse rather than the patient (Sutherland, 1995; Williams, 1979), empathic understanding need not be reciprocal although acknowledgement of the nurse's understanding may necessitate some degree of self-awareness on the part of the patient. Recognition and acknowledgement of the nurse's empathic understanding also depends on the patient's mental and physical condition as well as the ability to provide feedback (Olsen 1991; Walker, 1993). Empathic understanding and communication are action-oriented resulting in nursing care being based on the nurse's cognitive evaluation and emotional responsiveness with the

purpose of helping the patient.

Sympathy, the related concept most commonly confused with empathy, consists of a passive involuntary emotional response with no purpose other than consolation (Ciaramicoli & Ketcham, 2000; Morse & Mitchem, 1997). As such, it contains elements of condolence, agreement, or pity (Ehmann, 1971) and is related to compassion and commiseration. Sympathy occurs as recognition of the similarity between some past experience of the nurse and the patient's current condition. No attempt to understand the patient's perspective is necessary to arouse sympathy. An expression of pity, sorrow, and/or deep distress for the pain of another (Encarta World English Dictionary, 2000), sympathy entails an expression of personal grief rather than interpersonal understanding. Holden (1990) explained that the difference between empathy and sympathy lies in the "degree of recognition that the feelings are those of the patient not one's own" (p. 74). It is sympathy, not empathy that "connotes overinvolvement with the patient that ultimately leads to emotional exhaustion and burnout" (Holden, 1990, p. 77).

Other related concepts include rapport and intuition (Buck & Ginsberg, 1997). Rapport, from the French *raporter* ("to bring back"), refers to an emotional bond between two people who share each other's concerns (Encarta World English Dictionary, 2000). While it may occur in a helping

relationship, it is not the impetus for one of the participants to take action on behalf of the other. The same holds true for intuition, a *feeling* of knowing (Buck & Ginsberg, 1997), involving neither conscious perception nor need for confirmation.

Perhaps the most closely related concept found in contemporary nursing literature is that of "knowing the patient." Definitions of this conceptual construct resemble that of empathy to such a degree that they may be interchangeable. Indeed, Radwin (1996) identified empathy and communication as factors related to knowing the patient, while Jenny and Logan (1992) wrote that empathy facilitates the process. Jenny and Logan (1992) described knowing the patient as "knowledgeable awareness of the patient as a person" (p. 255). Tanner, Benner, Chesla, and Gordon (1993) elaborated on this idea by stating it "means an immediate grasp, an involved, rather than detached understanding of the patient's situation and the patient's responses" (p. 275).

Knowing the patient is viewed as the basis for therapeutic reasoning and decision-making (Radwin, 1996), individualized care (Jenny & Logan, 1992), and patient advocacy (Tanner et al., 1993). Luker, Austin, Caress, and Hallett (2000) concluded from their study findings that knowing the patient constituted "an essential antecedent for the provision of good quality care" (p. 777). Studying the literature pertaining to empathy and knowing the patient

led me to believe that they describe the same conceptual process. The two bodies of literature differed in that conceptual analyses of and studies conducted regarding knowing the patient (Jenny & Logan, 1992; Luker et al., 2000; Radwin, 1996; Tanner et al., 1993) focused on the consequences for the nurse while writings about empathy concentrated on outcomes experienced by the patient.

Renaming empathy as knowing the patient possibly resulted from disagreement and confusion about the utility and appropriateness of the concept of empathy for nursing as exemplified by the methodological problems encountered in research studies (Alligood, 1992; Morse et al., 1992; Reynolds, Scott, & Jessiman, 1999). Alligood (1992) proposed that the confusion about empathy resulted from "problems in understanding its nature" (p. 14). Similar problems have plagued psychology's research programs. Ickes et al. (1997) observed that conceptual disagreements revolve around the existence of more than one type (affective, cognitive, behavioral) versus merely all these dimensions within one type. This uncertain differentiation of empathy's nature produced difficulty for both disciplines in operationalizing the concept and in choosing theoretically appropriate measurement instruments (Alligood, 1992; Ickes et al., 1997; Reynolds, Scott, & Jessiman, 1999). Alligood (1992) proposed that these problems could be addressed through the recognition of the existence of two distinct types of empathy,

basic (trait) and trained (state). Subsequent literature from nursing and psychology continues to support her conclusion (Bennett, 1995; Ciaramicoli & Ketcham, 2000; Evans et al., 1998; Hodges & Wegner, 1997; Morse et al., 1992; Omdahl & O'Donnell, 1999; Reynolds et al., 1999; Smyth, 1996; Walker, 1993; Williams, 1990; Wilt et al., 1995).

Basic empathy is the developmental human trait emphasizing the affective sensing of the meaning of an experience for another. It is a process of sensing, perceiving, understanding, and communicating. As such, it constitutes the basis for therapeutic empathy. Although it cannot be taught, it can be "identified, reinforced, and refined" (Evans et al., 1998). Requiring self-awareness (Baillie, 1996; Baumgartner, 1970; Dagenais & Meleis, 1982; Ehmann, 1971; Forsyth, 1980; Gould, 1990; Kunst-Wilson et al., 1981; Olsen, 1991; Wilt et al., 1995; Zderad, 1979), flexible ego boundaries (Ludemann, 1968; Pike, 1990; Sutherland, 1995; Zderad, 1969), as well as concentrated and focused attention (Kalisch, 1973; Reynolds & Scott, 2000; Sutherland, 1995), basic empathy blends intrapersonal (developmental) affective and cognitive energy embodied in the holistic art and science of nursing (Alligood et al., 1995).

Trained empathy, on the other hand, involves the acquisition of psychomotor and communication (verbal and nonverbal) skills used in the interpersonal processes of a clinical situation. As Forsyth (1979) observed,

"Nurses can make empathic remarks without experiencing empathy" (p. 58). That is, behavioral communication techniques, such as active reflective listening, can be taught (Kalisch, 1971; Kunst-Wilson et al., 1981; LaMonica, 1978, 1979; LaMonica et al., 1987; Layton, 1979). The purpose of such simulated (or state) empathy emphasizes gathering further information about the patient to guide nurse decision-making. Genuine understanding is de-emphasized and trained empathy, if "falsely perceived as therapeutic empathy, may be detrimental to the nurse-patient relationship" (Evans et al., 1998, p. 460). Moreover, trained empathy levels do not appear to be sustained possibly due to the superficiality of narrow rote learned behaviors (Evans et al., 1998). For these reasons, Morse et al. (1992) advocated "a broader communication model with emotional empathy as the antecedent" (p. 279).

Morse and Mitcham (1997) stated "It is important to note that the emphasis which theory places on recognizing phenomena bears no relation to the actual existence of the phenomena" (p. 655). King (1981) never used the word empathy in discussing nurse-patient interaction. However, several of her statements validate the contention that the concept fits in the framework. To begin with, King (1981) defined nursing as "perceiving, thinking, relating, judging, and acting vis-à-vis the behavior of individuals who come to a nursing situation" (p. 2). The nurse undertakes these activities for the purpose

of understanding what the current situation means to the patient and what outcomes the patient expects from the interaction. Once the patient verifies this understanding, the nurse uses specialized knowledge and skills to assist in goal attainment. Nursing occurs in the present through these actions.

Furthermore, King's (1981) observations on the importance of self-awareness and perceptual accuracy underline the degree of the nurse's personal system development necessary for the provision of high-quality nursing care. Self-awareness "helps one to become a sensitive human being" (King, 1981, p. 28), while perceptual accuracy establishes the "first step toward mutual goal setting and toward exploring means to move toward those goals" (King, 1981, p. 24). Attainment of goals constitutes effective nursing care. Intrapersonal empathy enables the nurse's understanding of individual patients within a social and historical context by organizing perceptions, facilitating awareness, increasing sensitivity, and advancing learning (Alligood & May, 2000).

Genuine empathic understanding increases the speed and effectiveness of nurse-patient communication (Alligood et al., 1995; Larsson & Starrin, 1990; Niven & Robinson, 1994) with a subsequent impact on the quality of care given and perceived (Layton, 1979). The patient's perception of quality outcomes relates to their improved self-concept (Kalisch, 1973; Reynolds & Scott, 2000; Triplett, 1969; Wheeler, 1990; Williams, 1979) and

increased sense of well-being (Garvin & Kennedy, 1992) as the feeling of being understood relieves loneliness and alienation (American Academy of Colleges of Nursing, 1999; Carver & Hughes, 1990; Ehmann, 1971; Holden, 1990; Kalisch, 1973; Williams, 1979). Feeling more secure and safe in an unfamiliar environment and situation (Larsson & Starrin, 1990), the patient experiences less stress (Reynolds & Scott, 2000) and therefore, decreased anxiety, depression and anger (Alligood et al., 1995; LaMonica et al., 1987; Larsson & Starrin, 1990; Olson, 1995; Olson & Hanchett, 1997; Reynolds & Scott, 2000). The empathic nurse benefits from increased job satisfaction (Luker et al., 2000), less burnout (Astrom, Nilsson, Norberg, & Winbland, 1990; Omdahl & O'Donnell, 1999) and a resultant increased commitment to patients and the profession (Baumgartner, 1970; Davitz, Davitz, & Rubin 1980).

Summary of personal system.

The developmental levels of the personal system of each participant influence nursing actions, performed in an interpersonal field. Irrespective of the degree of patient participation, the nurse retains responsibility for the quality of care provided. Therefore, the developmental level of the nurse's personal system gains primary importance in the provision of high-quality care. King (1981) cited the necessity for nurse self-awareness and perceptual accuracy when interacting with the patient. Self-awareness fosters perceptual

accuracy and, in combination, the two facilitate the nurse's understanding of the meaning of the experience for the patient. This empathic understanding, the basis for a therapeutic relationship, requires interaction made possible through communication with the patient for verification and advancement of the nurse's understanding. Furthermore, once established, empathic understanding increases the speed and effectiveness of communication in the nurse-patient interaction.

Interpersonal System

"Simple human interaction *is* a primary nursing function" (Holden, 1990, p. 71) and the defining characteristic of the interpersonal system. In addition to interaction, important concepts of King's (1981) interpersonal system include communication, transaction, role, and stress (Table 4-3). Communication, an essential element of and vehicle for expressing empathic understanding, comprises the informational component of interaction while transaction is the valuational component. While all the interpersonal system concepts identified by King play a part in the provision of high-quality nursing care, this study emphasizes interaction, communication, and transaction.

Interaction.

King (1981) defined interaction as "a process of perception and communication between person and environment and person and person, represented by verbal and nonverbal behaviors" (p. 145). Each individual's

Table 4-3. Interpersonal System Concepts

Concept	Definition
Interaction	Observable process of verbal and nonverbal goal directed behaviors between two or more individuals Activities of two or more persons in mutual presence
Communication	Process whereby information is given from one person to another An interchange of thoughts and opinions among individuals
Transaction	A process of interaction in which human beings communicate with the environment to achieve goals that are valued Goal-directed human behaviors
Role	A set of behaviors expected when occupying a position in a social system A relationship with one or more individuals interacting in specific situations for a purpose
Stress	A dynamic state whereby a human being interacts with the environment to maintain balance for growth, development, and performance, which involves and exchange of energy

Source: King, I. M. (1981). A theory for nursing. Albany, New York: Delmar.

knowledge, needs, goals, experiences, and perception influence their behavior and thus, the interpersonal interaction (King, 1981). According to King (1981), individual behavior corresponds with mental and/or physical goal-directed actions pertinent to the present situation. Human interactions are purposive. They aim at establishing, to varying depths and durations, a relationship, defined as the involvement of two people with each other as regards how they feel toward each other and communicate or cooperate (Encarta World English Dictionary, 2000).

Communication.

Maintenance of an interpersonal relationship depends on the type and amount of communication (Johnson, 1980). Communication can be either intrapersonal or interpersonal. This study's previous discussion of the nurse's self-awareness and perceptual accuracy, formed by both genetic and experiential environments, provided examples of intrapersonal communication. The importance of these personal system attributes lies in their contribution to the nurse-patient interaction for "interpersonal processes reflect intrapersonal dynamics; what is going on within an individual is manifested in the behavior between individuals" (LaMonica, 1978; p. 5). Communication, then, constitutes the process that "expands the world from awareness of self" (King, 1981, p. 79) through incorporation of others.

Complexity and variability of communication increases as the number

of people involved in the interaction increases because each person brings perception and meaning to the situation. Communication establishes a common frame of reference from which to interpret the meaning of the current experience. Feedback allows learning to take place through on-going discussion of this meaning resulting in behavioral changes. Communication is personal, situational, and irreversible as "an individual is never the same person at any moment in time since there is continuous change internal and external to the person" (King, 1981, p. 73). Communication makes up the information component of all interactions; the processing of information results in behavior; and all behavior is communication (King, 1981).

Empathic understanding, requiring and facilitating communication, manifests itself through verbal and nonverbal behaviors. Verbal behavior includes both vocal (speech) and non-vocal (written) components. Nonverbal manifestations include touch, distance, posture, facial expressions, physical appearance, and time spent with the patient (King, 1981). The degree of congruence, the match between verbal and nonverbal behaviors, determines the clarity of the message while promoting trust in the relationship (Lindell, 1979). With the focus on the feelings the interaction provokes more than the context of what is said (Forsyth, 1980), trust cannot exist when either participant doubts the authenticity of the other's behavior.

Establishing a genuine dialogue in trusting relationships presupposes

that nurses contribute more than factual questioning or reflective restatements. Entering the conversation without preset opinions as to the meaning of the situation to the patient, the nurse allows each patient to express themselves in their own language at their own pace, thereby eliciting individual perspectives, expectations, and goals. Creating an environment that acknowledges and accepts the uniqueness of the individual, the nurse maintains a sense of human connectedness. If necessary, the nurse asks for clarification using open-ended questions. The nurse provides information freely and honestly, helping the patient understand the bio-scientific meaning of the situation while the patient helps the nurse understand the personal meaning (Brown, 1999). This dialogue constitutes the essence of collaboration (Van Ess Coeling & Cukr, 2000).

The language of the empathic nurse displays an attitude of receptiveness, warmth, and concern (Brown, 1999; Caris-Verhalken, Kerkstra, van der Heijden, & Bensing, 1998; Garvin & Kennedy, 1992; Katims, 1995; Lindell, 1979; Zderad, 1969) through a "calm, quiet demeanor that is confident yet ready to listen and accept unconditionally the patient's viewpoint" (Tyner, 1985). Giving full attention to the patient, the nurse acknowledges individuality, makes explicit statements of concern, reassures by focusing on abilities and resources, and validates the worth of feelings (Kralik, Koch, & Wotton, 1997; Stetler, 1977). King (1981) stated: "Nurses and

patients in interactions respond to the humanness of each other" (p. 86). The empathic nurse acknowledges this shared humanness through appropriate self-disclosure (Baille, 1996; Brown, 1999; Carver & Hughes, 1990; Forsyth, 1980; Johnson, 1980; Larsson & Starrin, 1990; Pike, 1990; Tyner, 1985) thus decreasing the patient's feelings of being alone in a strange and hostile environment where strangers control all aspects of life.

Appropriate self-disclosure on the part of the nurse consists of sharing personal experiences pertinent to the patient's present situation. Empathic self-disclosure is discriminative, nonjudgmental, and nondirective. That is, it communicates the recognition that, although shared to some degree, each individual's experiences are nevertheless separate and unique. In essence, the nurse relates, "This is what it is like for me" and asks "Is this what it is like for you?" Feedback from the patient then increases the nurse's understanding of and ability to communicate with the patient. The intent of self-disclosure lies in the establishment of a "reciprocal relationship between nurse and patient in which information sharing, negotiation and decision-making as regards nursing goals can take place" (Caris-Verhallen et al., 1998, p. 95). Sharing experiences, opinions, and feelings encourages further disclosures from the patient (Niven & Robinson, 1994) and promotes mutual goal-setting (Garvin & Kennedy, 1992). Self-disclosure becomes inappropriate when it shifts the focus of the relationship from meeting the

needs of the patient to meeting the needs of the nurse.

But it takes more than words to make a patient feel comfortable and safe in the relationship. Furthermore, nonverbal behavior contains "more accurate information than verbal pronouncements" (King, 1981, p. 62) with the most accurate transmitters of information being facial expression, body language, and tone of voice (Niven & Robinson, 1994). Through nonverbal behaviors, "nurses are perceived by patients as caring; as too busy to stop to discuss what is happening; as cool and efficient; as disheveled and flighty; as warm, kind, and helping" (King, 1981, p. 75). The empathic nurse spends time with the patient – time beyond that dedicated to physical care activities. The nurse's physical position in relation to the patient conveys the message of wanting to initiate (or terminate) the interaction (King, 1981). Entering the room (rather than standing poised for flight in the doorway), the empathic nurse approaches the patient and, if necessary and possible, sits so that their faces are at the same level. Making eye contact, the nurse leans toward the patient as they converse. Gestures and touch are spontaneous and comforting (Baillie, 1996; Lindell, 1979; Pike, 1990; Tyner, 1985).

Above all, the empathic nurse listens with awareness and sensitivity (Dagenais & Walker, 1992; Walker, 1993) without interrupting or attempting to control the conversation (Stetler, 1977). For as King (1981) observed: "It is important to listen and to be silent . . . Patients want someone to listen"

(p. 77). However, as Niven and Robinson (1994) stressed:

> Listening should not be seen as a passive process. It is not time to sit back and have a break from speaking, nor is it an interlude between talking. Active listening involves communicating to the patient that you are interested in what they have to say (p. 30).

Active listening incorporates "curbing preconceptions, soliciting the patient's perspective, and validating conclusions" (Thorne & Robinson, 1988, p. 788). Attentive presence conveys reassurance and comfort as the nurse participates in identifying the patient's goals and the actions necessary to attain them. Relaxed, composed, and confident (Lindell, 1979; Pike, 1990, Tyner, 1985), the nurse's facial expression conveys acceptance and encouragement, reinforcing the patient's feeling of participating in the provision of quality care.

Transaction.

Patient participation in the provision of high-quality nursing care resides predominantly in the planning, implementation, and evaluation phases of the nursing process. It is examined in the discussion of the effect of role and power on mutuality in decision-making and goal attainment. Participation requires communication, the process by which information is exchanged, and leads to transaction, the "process of interaction in which human beings communicate with the environment to achieve goals that are valued" (King, 1981, p. 82).

Transaction, a "transfer of value between two or more persons" (King, 1981, p. 82), requires recognition that the values of each individual arise from their perceptions of the world as colored by the details of the current situation. Transaction transpires with the alignment of nurse and patient perspectives. Through communication the nurse and patient establish, to varying degrees, a "frame of reference . . . consisting of facts, beliefs, expectancies, and preferences" (King, 1981, p. 82). King (1981) explained the importance of recognizing different perspectives:

> In the course of human experiences, one might search for each person's frame of reference rather than absolute answers to problems. Instead of trying to impose one's values on consumers of health care, one must find a common framework to help individuals cope with life's trials and tribulations (p. 82).

Influential interactions, transactions affect the growth and development and subsequent behaviors of both participants (Hanna, 1993). King (1981) noted that transaction is a reciprocally contingent interaction in that "active participation in movement toward the achieving of a goal brings about change in the individual" (p. 60).

Transaction begins with an exchange of information. Together the nurse and patient identify acceptable, realistic, and worthwhile goals. The

nurse brings professional knowledge and skills to the situation and, with knowledge gained from the patient regarding resources, provides information about actions necessary to achieve the goals. The patient voices personal preferences (acceptance or rejection) by choosing from among the offered alternative actions. Transaction occurs when a goal valued by both participants has been identified and attained. If the nurse and patient do not agree on the worth of a goal, transaction cannot occur even when perceptual accuracy and clear communication exists within the relationship (Austin & Champion, 1983). Indeed, unresolved conflicting perspectives generate severe communication problems and consequently, a decrease in the quality of care (Niven & Robinson, 1994). Transaction is a process of clarifying values and expectations leading to identification of goal-directed actions through negotiation and bargaining (King, 1981; Thorne & Robinson, 1988). It requires mutual decision-making that is influenced by role and power.

Social System

King (1981) defined a social system (including family, religious, educational, and work groups) as "an organized boundary system of social roles, behaviors and practices developed to maintain values and the mechanisms to regulate the practice and rules" (p. 115). For nurses, the social system involves the institution and/or setting in which they deliver care. King (1981) identified and defined five social system concepts (Table 4-4):

Table 4-4. Social System Concepts

Concept	Definition
Organization	Composed of human beings with prescribed roles and positions who use resources to accomplish personal and organizational goals.
Power	Process whereby one or more persons influence other persons in a situation. Ability to control events and behaviors. Capability or capacity to achieve goals.
Authority	Power to make decisions that guide the actions of self and others. Function of concrete situations in which one person commands and one obeys and functions change as situations change.
Status	Position of an individual in a group or a group in relation to other groups.
Decision-Making	Dynamic and systematic process by which goal-directed choice of perceived alternatives is made and acted upon by individuals or groups to answer a question and attain a goal.

Source: King, I. M. (1981). A theory for nursing. Albany, New York: Delmar.

(1) organization; (2) power; (3) authority; (4) status; and (5) decision-making. Although these concepts, as defined in the context of the social system, affect the provision of high-quality nursing care, this study examines their relevance to the interpersonal system's nurse-patient relationship. A description of the interpersonal system concept role introduces the concept of power applied to the nurse-patient relationship. These two concepts affect mutuality, a quality of decision-making endorsed, but not fully described, by King.

Role.

"Role of a nurse can be defined as an interaction between one or more individuals who come to a nursing situation in which nurses perform functions of professional nursing based on knowledge, skills, and values identified as nursing" (King, 1981, p. 93). The role is (1) influenced by the perceptions of the involved individuals; (2) a learned function with a set of rules and expected behaviors; (3) dynamic and changing depending on the specific situation; and (4) defined by the nursing profession, health care institutions (employers) and recipients of care (King, 1981). Some examples of the roles assumed by hospital staff nurses include (1) direct care provider; (2) coordinator or care manager; (3) health care educator; and (4) patient advocate. In King's framework, the role functions of the nurse are identified in the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

The role of the nurse is defined and described by professional organizations' standards as well as policies and procedures of health care institutions. Varying perspectives of the individual nurse, other health care providers, and the individual patient determine the roles assumed and granted to the participants of the health care interaction and the decision-making process. This role expresses power, a function of both interaction and decision-making (King, 1981).

Power.

Power can be viewed as either a control process or a goal attainment capability (King, 1981). "Power over" characterizes the former, while "power to" illustrates the latter. "Power over," the ability to control the behavior of others, denotes a struggle for dominance involving varying degrees of force (Hawks, 1991; Kohler, 1988). Manifested in interpersonal and social interactions, "power over" implies a dependency relationship in which one person allows the other to command events and behaviors (Hawks, 1991; Hewison, 1995; King, 1981; Kohler, 1988). In a concept analysis guided by King's framework, Hawks (1991) defined "power to" as "the actual or potential ability to achieve objectives through an interpersonal process in which the goals and means to achieve the goals are mutually established and worked toward" (p. 754). Associated with effectiveness, "power to" reflects role and competence in decision-making (Hawks, 1991).

The power given to nurses by patients arises from multiple assumptions and expectations. The patient recognizes the nurse's expert power reflecting the specialized knowledge and skills attained from education and experience. As Lupton (1995) explained:

> The expectation of both health care professionals and patients are generally that the professional will "know more" than the patient: it is for this reason that the professional/patient relationship exists (p. 162).

Furthermore, the fact that a state regulatory agency granted a license to practice and the health care institution employs the nurse indicates legitimate power in the patient's view. If the relationship has advanced to the point where the patient admires and respects the nurse as an individual, thus being influenced by the nurse's opinion and judgment, referent power exists. At this point, attaining personal health care goals may become secondary to the importance of gaining the nurse's acknowledgement and praise (reward power). An unhealthy dependency exists when the patient acquiesces to the nurse's dictatorial orders because of fear of punishment or reprisal (coercive power)

For these reasons, a power differential favoring the nurse exists in every provider-patient relationship (Briant & Freshwater, 1998; Henson, 1997; Hewison, 1995; Lupton, 1995). The nurse's use of this inherent power

determines the quality of care provided. Quality of nursing care increases as the disparity in the degree of power granted to and exerted by the participants of the interaction decreases. Although never perfectly balanced, the symmetry of nurse power and patient power in the therapeutic relationship establishes the degree of mutuality in decision-making.

Mutuality.

King (1981) described mutual decision-making as a reciprocally contingent interaction involving the active participation of both nurse and patient that fostered collaboration. She addressed the concept of mutuality in her discussion of the characteristics of interactions:

> Interactions are reciprocal. When one initiates an interaction with another, an action takes place, each person reacts to the other, and a reciprocal spiral develops in which the individuals continue to interact or withdraw from the situation. Each has something to give the other that the other wants or needs, which may be facilitated by active participation of both individuals in the situation. There is a mutuality, an interdependence in the situation in which both achieve goals (King, 1981, p. 84).

Curley (1997) echoed King when she described mutuality as "responsive interdependence, intersubjectivity, shared commonality, and equity within the relationship" (p. 210).

Attributes of mutuality in the nurse-patient relationship include (1) an exchange of information between nurse and patient resulting in (2) clarification and validation of the meaning of the experience to both patient and nurse leading to (3) congruent expectations regarding outcomes, thus promoting (4) the patient's active participation in selected mental and/or physical activities of nursing care (Cahill, 1996; Curley, 1997; Henson, 1997; Leddy, 1998; Roberts & Krouse, 1990; Thorne & Robinson, 1988). The focus of the interaction always remains the patient, not the convenience or needs of the nurse or the organization (King, 1981; Moughton, 1982).

Antecedents to establishing mutuality include: (1) a need that precipitates the relationship (Henson, 1997); (2) a dialogical exchange of information (Buchmann, 1997; Curley, 1997; Hanucharurnkui & Vinya-nguag, 1991; Henson, 1997); (3) nurse empathy defined as the ability to understand the patient's perspective (Curley, 1997; Henson, 1997; Olsen, 1997; Thorne & Robinson, 1988); (4) interpersonal trust (Henson, 1997; Kohler, 1988); (5) recognition of the positive benefits of collaboration (Cahill, 1996; Ellis-Stoll & Popkess-Vawter, 1998); and (6) respect for and acknowledgement of the decision-making competence of both participants (Cahill, 1996; Davies, Laker, & Ellis, 1997; Kenny, 1990; Leddy, 1998).

Marck (1990) proposed that the nurse who fosters mutuality holds specific philosophic premises: (1) existence has multiple meanings;

(2) personal meaning can be shared; (3) multiple, unpredictable outcomes are amenable to change; (4) interaction results in mutual learning; and (5) knowledge can be attained through personal, intuitive, rational, and empirical means. The patient must want to be involved and the nurse must be willing to relinquish some degree of control while maintaining commitment to the prescribed treatment regimen (Cahill, 1996; Curley, 1997; Morse, 1991). On the social system level, the organization must recognize the value of a care delivery system that promotes individualized care (Davies et al., 1997).

Mutuality results in positive consequences for both the nurse and patient. The patient experiences an increased sense of control (power and autonomy) regarding personal health care needs (Buchmann, 1997; Cahill, 1996; Curley, 1997; Henson, 1997; Kenny, 1990; Kohler, 1988; Marck, 1990). This enhances self-esteem and self-confidence (Buchmann, 1997; Henson, 1997; Kohler, 1988), increases the ability to cope with the health problem (Marck, 1990), and fosters independence (Buchmann, 1997; Cahill, 1996; Henson, 1997; Kohler, 1988; Moughton, 1985; Tryon & Leonard, 1964). The patient is more likely to follow the treatment plan (Buchmann, 1997; Ellis-Stoll & Popkess-Vawter, 1998; Kohler, 1988) for as King (1981) stated: "When individuals participate in the decisions that affect their lives, there is less resistance to implementing those decisions, and learning takes place" (p. 134). Nursing interventions are more effective (Tryon & Leonard, 1964)

resulting in more positive outcomes (Curley, 1997; Henson, 1997; Marck, 1990; Moughton, 1985) including a decreased length of hospital stay (Hanucharunkui & Vinya-nguag, 1991; Moughton, 1985) as well as better home care management and an enriched quality of life (Cahill, 1996). Overall, satisfaction with both the nurse and the care provided increases (Cahill, 1996; Hanucharunkui & Vinya-nguag, 1991; Henson, 1997; Kohler, 1988; Marck, 1990). Positive outcomes of mutuality in the relationship for the nurse include increased competence, creativity, and learning (Ellis-Stoll & Popkess-Vawter, 1998; Henson, 1997; Marck, 1990; Minicucci, 1998). As role strain (Curley, 1997; Minicucci, 1998) and work stress (Henson, 1997) decrease, job satisfaction increases (Henson, 1997; Tryon & Leonard, 1964). Empirical indicators of mutuality in the nurse-patient relationship emerge in the decision-making process.

Decision-making.

Decision-making is the process of choosing among alternative actions or reaching conclusions (Encarta World English Dictionary, 2000). According to King (1981), it is making judgments "that affect a course of action in specific situations" (p. 130). Variables affecting decision-making include "knowledge, experiences, goals, values, and perceptions of the situation" (King, 1981, p. 134). King (1981) advised nurses to "be aware of the patient's need for help in making decisions and need to share in those decisions" (p. 134).

Tryon and Leonard (1964) advised nurses to remember "acknowledgement of the need for nursing help is not an admission of inability to make decisions" (p. 79). Cahill (1996) regarded desire and motivation as the most crucial variables in the patient's active participation, compounded by the severity and type of illness, possession and access to information, and the organizational structure. In the decision-making process, information is power. Manipulation of information, as in providing only selective pieces or withholding it, results in an unhealthy power disparity between participants (Leddy, 1998; Prescott, 1985). Leddy (1998) stated the success of participatory decision-making relies on the persons involved not becoming "prematurely concerned with implementing the decision" (p. 412).

This means allowing sufficient time for negotiation, identified by several authors as the key process in decision-making (Gibson, 1991; Leddy, 1998; Morse, 1991; Roberts & Krouse, 1990; Roberts, Krouse, & Michard, 1995). Using empathic patterns of communication, the nurse initiates negotiation by interpreting the assessment of the patient's needs, summarizing a proposed plan of care, and encouraging the patient to question and comment on those activities for the purpose of reaching a decision agreeable to both nurse and patient (Roberts & Krouse, 1990). Expectations, as well as strengths and resources, are examined. Roberts and Krouse (1990) warned:

> This process may seem simplistic, but it does not come easily to either the nurse or the client . . . health care professionals are

> educated to think of themselves as in control and as 'the expert.' Clients have been socialized to think of themselves either as the passive recipients of professional advice or as the unwilling targets of professional dominance. Neither come to the encounter well prepared for an equal interaction, which needs practice and reinforcement (p. 33).

If consensus about a plan cannot be reached, goals need to be re-examined considering the patient's (1) desire and willingness to participate and (2) strengths, abilities, and resources. The nurse needs to ensure that the patient, not the tasks involved in providing care, remains the focus (Davies et al., 1997; Hewison, 1995; Kenny, 1990; Lupton, 1995; May, 1990; Miller, 1985; Moughton, 1982; Tryon & Leonard, 1964). The nurse demonstrates trust in the patient's ability to make decisions as evidenced by resulting patterns of communication (Davies et al., 1997; Gibson, 1991; Thorne & Robinson, 1988).

The nurse's verbal interactions with the patient contain a conversational give and take, with an exchange of ideas, and a display of respect for those ideas demonstrated in the use of words of agreement and satisfaction (Brown, 1999; Henson, 1997). Asking open-ended questions, the nurse encourages questions in return, and provides explanations while offering choices (Davies et al., 1997; King, 1981; Tryon & Leonard, 1964).

Rather than issuing commands and directions, the empathic nurse makes recommendations (Brown, 1999; Thorne & Robinson, 1988;Tryon & Leonard, 1964). Remembering who is the focus of the interaction, the nurse talks less than the patient does. Eliminating all controlling language from the interaction with the patient, the nurse does not use first names, terms of endearment, or the pluralized "we." (Davies et al., 1997). Furthermore, the empathic nurse never engages in "talking over" the patient, for as Hewison (1995) explained: "The discussion of people in their presence, often with only minimal efforts to involve them, clearly demonstrates who is in control and whose decisions matter" (p. 79). Above all, the nurse does not label any patient "non-compliant" or "difficult" (Moughton, 1982).

Nurses who want patients to be involved in decision-making spend more time with them (Davies et al., 1997; May, 1990). Their movements, gestures, looks, touch, and use of space convey a sense of understanding (Henson, 1997). That understanding includes asking about the patient's personal preferences and adapting hospital routines (such as meal times, bathing, visiting policies) to meet them (Davies et al., 1997; Hewison, 1995; Kenny, 1990; King, 1981).

Decision-making constitutes a function of power as it connotes the ability to gain or retain control of events and behaviors of others. As previously noted, the perception of the quality of care, the effectiveness of

interventions, and overall satisfaction improves with the patient's involvement in making decisions regarding their lives.

CHAPTER FIVE

APPLICATION OF A THEORY OF HIGH-QUALITY NURSING CARE

A theory of the meaning of high-quality nursing care derived from King's Interacting Systems begins with the assumption that it is the professional responsibility of the registered nurse (RN) to initiate, promote, and maintain development of a therapeutic relationship with the patient. The developmental level of the nurse's personal system significantly influences nursing actions performed in an interpersonal field. The provision of high-quality nursing care requires empathic understanding on the part of the RN to facilitate effective communication. Mutuality in decision-making regarding goals and the actions necessary to achieve them enhances transaction, the value of the interaction. Goal attainment corresponds to effective nursing care and, therefore, is an empirical indicator of high-quality nursing care. This chapter explores the meaning and application of this theory to nursing education, nursing practice, and nursing research.

Nursing Education

Koerner (1996) identified four sets of skills needed in the provision of high-quality nursing care: (1) instrumental (technical); (2) interpersonal (perception and communication); (3) imaginal (creative and interpretive); and (4) systems (seeing the whole in the single part). Nursing education focuses on the acquisition of these skills. King (1986) defined learning as "a process

of sensory perception, conceptualization, and critical thinking involving multiple experiences in which changes in concepts, skills, symbols, habits, and values can be evaluated in observable behaviors and inferred from behavioral manifestations" (p. 24). Learning occurs in affective (feeling), cognitive (thinking), and psychomotor (doing) domains (Krathwohl, Bloom, & Masia, 1964 cited in King, 1986). High-quality nursing care requires competence in all three domains. Unfortunately, cognitive and psychomotor competencies dominate nursing education as evidenced by an emphasis on pathophysiology and technical skills.

Explaining this tendency, Moyle, Barnard and Turner (1995) offered a philosophical view: "As technology advances, the importance of the patient as a human being is often relegated to the background where humans are treated as objects rather than subjects" (p. 961). Woods (1993) saw the problem less abstractly:

> Cognitive and psychomotor competencies are taught without question in most preparatory courses in nursing and have well-established pedagogy and taxonomies. Affective competencies, however, are more elusive and tend to be avoided as much as possible by most nursing faculty, principally because of misunderstanding of the content that needs to be taught (p. 66).

Compounding the problem is the erroneous belief that affective behaviors are

a by-product of cognitive processes (Menix, 1996).

This misunderstanding is most evident in training programs that operationalize empathy as a cognitive skill rather than an affective trait enhanced by cognition (Alligood, 1992). Learned rote verbal responses and cues do not require, and are no substitute for, a nurse's self-awareness and perceptual accuracy. Since such training concentrates on the cognitive domain without incorporating affective competencies, behavioral changes are not sustainable over time. Preparing nurses for the provision of high-quality care necessitates development of their personal system, primarily the cultivation of self-awareness and perceptual accuracy in interpreting the meaning of events for others (Brooks, 1995; Menix, 1996; Moyle et al., 1995; Rinne, 1987; Seeger, 1977; Smyth, 1996; Wheeler & Barrett, 1994). Such development both enhances empathic capacity forming a foundation for caring and stimulates critical thinking ability (Kovner &Schore, 1998; Rinne, 1987; Smyth, 1996; Zimmerman & Phillips, 2000).

A taxonomy of affective learning objectives, developed by Krathwohl et al. (1964) and endorsed by King (1986), places resultant observable behaviors on a continuum of increasing complexity. The five hierarchical categories, described as low- to high-level behaviors, include (1) receiving, (2) responding, (3) valuing, (4) organization, and (5) characterization by value or value complex. Receiving and responding (low-level behaviors) involve

"getting, holding, and directing students' attention" (Menix, 1996, p. 202) to engage their participation in a process of sensitization to diversity (Schoenly, 1994). Valuing and organization (mid-level behaviors) result from personal values clarification and a subsequent identification of a philosophy of life and nursing (Menix, 1996). The final and highest level of learning in the affective domain, characterization by value or value complex, manifests itself in consistent and committed behavior in the clinical setting (Schoenly, 1994) demonstrating internalization of values.

These categories have been linked to teaching strategies including lecture and discussion sessions, clinical logs, process recordings, case studies, role play, and values clarification exercises (Burnard, 1986; Kalisch, 1971; Schoenly, 1994; Seeger, 1977; Wheeler & Barrett, 1994). Zimmerman and Phillips (2000) described the introduction of reflective practice using journals and conceptual drawings. Other nurse educators advocate the use of popular literature (Moyle et al., 1995; Rawnsley, 1980), art (Smyth, 1996), and contemporary movies (Wilt et al., 1995) to sensitize nurses to the diversity of human experiences. Demonstrating and instilling a sense of the importance of affective competencies requires that these learning opportunities be introduced early in the program and be consciously incorporated into every clinical course (Layton, 1979; Zimmerman & Phillips, 2000).

Personal system development begins with an exploration of the

students' attitudes, values, and beliefs best accomplished through small discussion groups. Since this entails the risks inherent in self-disclosure, the faculty must establish a conducive environment by modeling open and accepting behaviors. Faculty members function as role models, demonstrating affective competencies in their relationships with both students and patients. King (1986) described this role as ensuring "a climate that is free from threat without being free from challenge" (p. 22).

Discussion of the experiences and feelings of individual students enables the introduction and nurturance of empathic understanding. As the student progresses through the program, gaining insight into the meaning of events for others, the faculty deliberately shifts the focus from the student to the patient (Brooks, 1995; Seeger, 1977; Woods, 1993). "Faculty see their discipline through a student's eye, choosing content and learning experiences that support the student's growth toward identified outcomes" (Gaines, 2001, p. 145). Clinical post-conferences center on interpersonal aspects of nursing care, identifying both the students' interpretation of the meaning of the situation to patients and the students' emotional response (Schoenly, 1994; Seeger, 1977; Wheeler & Barrett, 1994; Woods, 1993). Reynolds, Scott and Jessiman (1999) advised nurse educators that students value "seeing and doing it in the here and now" (p. 1180) more than classroom role-play. Recognizing that the students value this mode of learning facilitates their

acquisition of affective competencies. This process mirrors King's (1981) transaction model resulting in goal attainment, equated with effective and high-quality nursing education.

Conclusions and Recommendations

High-quality nursing care requires competence in affective, cognitive, and psychomotor skills. The degree of individual competence in these areas differs depending on education and experience. As King (1971) stated, "educational preparation is a variable in patient care" (p. 34). Newman and Davidhizar (1990), replicating an earlier study, concluded that graduates of the baccalaureate (BSN) and associate (ADN) degree nursing programs differ significantly in their approaches to patient care. In their findings, BSN graduates were more proficient in assessment, diagnosis, decision making, and evaluation than ADN graduates, who were concerned most with technical aspects of patient care. These findings, congruent with the expected educational cognitive and psychomotor outcomes of the two programs, do not directly address the resultant levels of affective competence.

Affective skills are necessary for the provision of high-quality nursing care for "although nursing involves assessment, diagnosis, and technological skill, it also attends to human vulnerability and helps people cope" (American Association of Colleges of Nursing, 1999, p. 59). Development of the nurse's personal system, significantly influencing actions in the interpersonal field,

enhances empathic capacity. Baccalaureate degree programs, incorporating studies in the humanities and behavioral sciences, facilitate personal system development and empathic understanding (Ehmann, 1971; Kunst-Wilson, et al., 1981; LaMonica, 1979; May & Alligood, 2000; Moyle et al., 1995; Rawnsley, 1980; Rogers, 1986; Smyth, 1996; Wilt et al., 1995). Therefore, a BSN degree is the minimum educational requirement requisite for the delivery of high-quality nursing care. Affective learning objectives and teaching strategies need to be identified and goal attainment evaluated in each nursing course.

Nursing Practice

From a 1998 study involving structured interviews of 27 nurse leaders responsible for the provision of nursing care in nine medical centers, R. P. Williams (1998) derived the following definition:

> Quality nursing focuses on the patient as a unique individual with specific needs. It is care provided by nurses with clinical competence and expertise. This care must meet patients' needs at or above accepted standards. Quality nursing equips patients with knowledge and ultimately makes a difference in their lives (p. 263).

Patistea and Siamantra (1999) reiterated the importance of focusing on the individual patient: "Knowledge of how patients perceive their own caring needs is important for nurses to improve the quality of care they provide"

(p. 302). This perceptual accuracy constitutes an essential element of empathic understanding vital for effective nurse-patient interaction and communication. Yet Reynolds and Scott (2000) concluded from a review of the discipline's literature that nurses (1) possess low levels of empathy and (2) value technology more than relationships resulting in (3) a general perception "that an interpersonal deficit exists in nursing practice" (p. 230). A review of contemporary nursing literature supports this conclusion to some degree.

In the Health Care Relationships Project, a grounded theory study of the evolution of relationships between nurses and chronically ill patients, Thorne and Robinson (1988) stated it "quickly became evident . . . health care professionals did not generally understand or even care about the patient's perspective of his own best interest" (p. 783). May (1990) found that while nurses said they valued holistic relationships, they depersonalized patients "tend(ing) to deal with types of people, types of behavior, and types of disease" (p. 308). Curley (1997) noted that when dealing with families, pediatric nurses "tend to intervene in a similar manner with all families whose needs are perceived to be essentially the same" (p.212). Kralik, Koch and Wotton (1997) noted that computerized care planning has moved the RN further from the bedside making "the uniqueness of the patient as an individual . . . less visible and vocal in the process of nursing care" (p. 400).

Major barriers to nurse empathy and communication pertinent within the interacting systems include: (1) lack of knowledge of therapeutic potential (Reynolds et al., 2000); (2) lack of interpersonal skills (Baillie, 1996; Johnson, 1980; Staniszewska & Ahmed, 1998); (3) lack of support from colleagues and the organization (Mynatt, 1985; Reynolds et al., 2000); and (4) lack of time (Baillie, 1996; Gould, 1990; Johnson, 1980; Morse et al. 1992; Staniszewska & Ahmed, 1998). Thus, we see that the problem arises not only from the undeveloped personal system of the nurse, but also from multiple aspects of the interpersonal and social systems, especially role and stress.

The increasing complexity of and accelerating change within the health care system over the past 50 years complicates patient care management. Nursing's workload is marked by role complexity and role overlap (Jacox, 1997; Murphy, Roch, Pepicello, & Murphy, 1997; Sines, 1994). While the discipline relinquished some care activities (for example, respiratory therapy), nursing accepted more responsibility for complicated decision-making, supervision of unlicensed personnel, and complex technical skills. Findings of a study involving 170,000 health care workers (including 47,692 RNs) in 138 acute care institutions revealed the bedside nurse performs an average of 74 different activities in the course of providing care, more than any other type of hospital worker (Murphy et al., 1997). By the late 1990s, nursing had become a "sum of tasks or chores that needed to be completed and the quicker the

better" (Kralik et al., 1997, p. 405). It is the sheer amount of work needing to be done, not advancing technology, which overwhelms the hospital staff nurse.

Although RNs continue to constitute about two-thirds of the labor force in hospitals, they spend less time than ever on direct patient care, despite the introduction of unlicensed assistive personnel (Beyers, 1987; Kobs, 1997; Kovner & Gergen, 1998). Nurses spend approximately 40-50% of work time performing non-nursing activities (Boston, 1990; Krapohl & Larson, 1996; McClary, 1997; Murphy et al., 1997). That results in approximately 31% of the nurse's time being spent with the patient, or a mere 25-30 minutes per shift per patient (Gardner, 1991). Furthermore, 65% of the nurse's time is spent on activities delegated or influenced by other health care providers with over 70% of that time spent in activities duplicated by other workers (Murphy et al., 1997). Sociologist Chambliss (1996) in his ethnographic study Beyond caring: Hospitals, nurses, and the social organization of ethics, noted:

> Much of their work is determined by others. Embedded in the organization, the nurse typically works on a tight schedule, with a long list of mandated tasks to be done in a limited time, with fairly severe consequences if she fails to complete her work. The tasks, too, must be done according to various defined standards,

which are often legally sanctioned (p. 81).

This emphasis on timely task completion reduces the patient to the status of an object that must be managed and thus, obstructs empathic understanding (Boschma, 1994; Briant & Freshwater, 1998; Carver & Hughes, 1990; Chambliss, 1996; Hodges & Wegner, 1997; Kenny, 1990; Kralik et al., 1998; May, 1990). As Hodges and Wegner (1997) warned: "All the available cues in the world will not help us if we do not have space to think about them" (p. 324).

Work overload and insufficient time spent with individual patients constitute the top two causes of job-related stress for hospital nurses (Astrom et al., 1990; Callaghan, Tak-Ying, & Wyatt, 2000; Foxall, Zimmerman, Standley, & Bene, 1990; Harris, 1989; Healy & McKay, 2000; Janssen, deJonge, & Bakker, 1999; Malach-Pines, 2000). In a survey conducted by the American Nurses Association (ANA) in 2001 involving 7,299 respondents, 75% of nurses expressed the belief that the quality of nursing care provided in the hospitals where they work declined over the past two years due to inadequate staffing and decreased time spent with patients. Concentrating on tasks then becomes an attempt to control the workload and decrease stress (Chambliss, 1996; Malach-Pines, 2000; May, 1990; Sines, 1994). Stress relates directly to increased nurse-patient ratios due to reduced and/or inadequate staffing compounded by decreased lengths of stay and rapid

patient turnover. Baker (1997) observed: "Hospital nurses have become famous for living with chaos. Their lives are continually consumed with change and newness: new patients, new families, new staff members, new doctors, new diseases, and new technology" (p. 20).

When the late 1980s nursing shortage and rising salaries prompted the dilution of all-professional staffs, nurse administrators chose to hire unlicensed personnel. A 1990 American Hospital Association (AHA) survey reported that 97% of hospitals were using some type of unlicensed assistive personnel (UAP), known by at least 65 different titles (Krapohl & Larson, 1996; Hall, 1998). The primary purpose of these workers is to assume non-nursing and basic clinical duties in order to maximize the availability of the RN at the bedside thus improving RN morale by easing the workload and decreasing stress. No empirical proof exists supporting either assumption.

Educated to assume full responsibility for meeting their patient's needs and unskilled in delegation and supervision, many RNs perceive that their workload actually increased with the addition of UAP. This perception is verified by nursing administration researchers who claim that the number of patients assigned to individual RNs has increased (Boston, 1990; Krapohl & Larson, 1996; Larson, 1998; Hall, 1998; McManus & Pearson, 1993; Melberg, 1997). In addition, Krapohl and Larson (1996) reported that while RNs spent 14% of their work time for personal use, UAP spent 28% for personal

activities, meaning they spent less time assisting the RN who retained responsibility for task completion. Melberg (1997) conducted a study in five teaching hospitals in which the hospital with the lowest percentage of RNs reported the highest nursing salary per patient day. Decreasing the percentage of RNs may increase the actual number of employees resulting in little or no cost savings.

Using UAP to substitute for, rather than complement, RNs increases complexity of providing patient care by decreasing the flexibility and versatility of the entire staff. It is patient care needs that should drive the decisions regarding staff mix, not hospital revenue. Ironically, decreasing the RN staff may also increase adverse events and, therefore, costs. For example, after conducting a study in 506 hospitals in ten states across the country, Kovner and Gergen (1998) concluded an additional 30 minutes a day of direct nursing care by a RN may reduce post-operative infections by 4.5%.

Furthermore, the use of UAP as a substitute for RNs in performing clinical duties violates the institution's social contract with the community. As Melberg (1997) explained:

> Institutions with solid commitment to the integrity of patient care restructure their organizational pyramid not nursing. Patients are admitted to hospitals because they need a registered nurse to help them regain function and survive. Nursing care means just that –

> direct care by a nurse. When any care giver other than a RN provides direct care, the facility has failed to deliver the promised product (p. 47).

Conclusions and Recommendations

Determination of adequate RN staffing levels, critical to the delivery of high-quality nursing care, reflects individual and aggregate patient needs as well as the clinical competencies required to meet those needs (ANA, 1999). The way to manage complexity in the acute care setting is not by adding layers of personnel, especially personnel who are incapable of managing the complexity already present and who actually increase the stress in the environment. Once again, the problem lies in the discipline's continuing inability to recognize and clearly articulate their role in health care. As Beyers (1987) noted: "Nursing has, over the years, never resolved its identify crisis" (p. 76). Newman (1990) put it most succinctly:

> The time is long overdue for the profession to move from having nurses with various levels of education doing the same thing, or nurses with one level of preparation doing everything, to practitioners with different levels of preparation doing different, interrelated things (p. 167).

Nursing's contribution to controlling costs while providing high-quality care will be increasing productivity through efficient organization of the work and

utilization of resources (Gardner, 1991; Manthey, 1994; Smith, 1987). Effective organization will not occur through a reordering of a reductionistic list of tasks, but rather through clarification of the role of the professional nurse.

Managing the workload demands clarification of roles within the nursing process, the art and science of nursing as it is practiced at the bedside. Any staffing pattern that recognizes and uses the differing talents, education, and experience of a RN constitutes a form of differentiated practice. As Wake (1990) defined it, differentiation is "any mechanism that counteracts the idea that 'a nurse is a nurse'" (p. 49). Clinical ladders, compensatory programs created to reward RNs for remaining in patient care areas, are not forms of differentiated practice as they "merely compartmentalize levels of performance within the traditional staff nurse role" (Tonges, 1993, p. 18) without allowing RNs to realize their practice potential. Clinical ladders are not used to guide patient assignment nor is career advancement related to patient outcomes.

Differentiated practice is not to be confused with the entry into practice argument, referring to the minimal level of education required to sit for licensing examinations. The age old argument that since there is only one version of the examination there can be only one level of nurse is neither logical nor valid – nor is it the purpose of the examination to place all RNs on

one level. In an "era of chaos" in which complex organizations profess to value the knowledge worker, roles must be determined by education (Koerner, 1993). Differentiation of the RN role must be based on education.

Viewing differentiated roles through the nursing process lens, the BSN devotes the majority of time and energy to planning and evaluating, while the ADN specializes in intervention. The BSN is dedicated to the overall management and coordination of the patient's entire hospital stay by assuming a leadership role in multidisciplinary activity associated with each patient. This nurse meets daily with each patient to assess, plan, intervene, and evaluate progress toward mutual goals. Discharge planning is a major focus of these activities. During all this, the BSN acts as an on-site patient advocate and case manager to ensure the maintenance of the patient's individuality.

Morse (1991) noted work patterns (shift rotations and days off when working twelve hour shifts) as well as daily changes in patient assignment force patients to continually establish new relationships. "From the patient's perspective, the clinical relationship means that nurses are invisible and interchangeable, rather like an excellent waiter, unnoticed and in the background, as long as one's needs are met" (Morse, 1991, p. 467). The BSN having a caseload rather than a shift assignment assures consistency of care and the opportunity to develop a therapeutic relationship.

The ADN, providing care to an assigned group of patients over the time span of a shift, concentrates on clinical physical assessment, administration of medications, initiation and maintenance of intravenous fluids, monitoring, and documentation. Each nurse, whether ADN or BSN, remains involved in all steps of the nursing process, but to varying degrees and within differing time frames. It is a basis for a division of labor, not duplication of effort. Again, it is Newman (1994) who summarized:

> Differentiation of practice is both an economy measure and a quality measure. It has not been reasonable to have practitioners with different levels of preparation doing the same thing, or to require all practitioners to have the same level of preparation. The first approach underutilizes some nurses and overextends others and does not promote collaborative partnership in practice. The latter does not take into consideration the type of education needed for the various responsibilities of nurses in health care (p. 126).

Regardless of their educational background, both ADN and BSN graduates are expected to fill the standard staff nurse position when employed by an acute care institution. Despite purpose statements and identification of competencies of associate and baccalaureate nursing education programs, many nurses are educated for an undifferentiated role. This adds to their stress when they enter practice due to the underutilization

and over-extension mentioned by Newman (1994). Stress has a negative impact on both their provision of care and their intent to continue practicing in the discipline.

Nursing Research

In response to two studies focusing on the roles of RNs in delivering high-quality care conducted by the Economic Policy Institute, the ANA (1999) Board of Directors approved a set of staffing principles based on patient needs and RN competencies. Recommending research addressing the relationship between staffing and patient outcomes, ANA (2001) proposed a national state legislative agenda including a mandated collection of workforce and nursing-sensitive quality data. The desired outcomes identified by ANA (1999) are synonymous with the attainment of goals identified in this study as empirical indicators of quality: (1) improved health status; (2) appropriate self-care functioning; (3) health-promoting behaviors; (4) perception of being well cared for; and (5) symptom management. Furthermore, length of stay reflects economic indicators of the quality of care (ANA, 1999). Included in the legislative agenda is a mandate to incorporate nursing research and workforce data into public reports of hospital quality indicators (ANA, 2001).

Discussing the need for research regarding nursing care quality, Campbell-Heider et al. (1998) noted: "Unfortunately, information about interpersonal processes is more difficult to extract and measure than

technical skills. Consequently, there is a dearth of data documenting the essential nature of nursing" (p. 27). Even though it is not directly testable, the grand theory of high-quality nursing care derived from King's framework provides a basis for documenting that essential nature through further exploration of empathy and mutuality, generation of middle-range theories regarding their relationship to quality, and empirical testing. Fawcett (1992) stated:

> Concepts are empirically observable if they are connected to empirical indicators by operational definitions. Propositions are measurable when empirical indicators are substituted for concept names in the propositions and when statistical procedures can provide evidence regarding the assertions made (p. 41).

What is essential is that operational definitions and measurement instruments be congruent with the theory and the conceptual model. For example, in this theory, empathy is defined as an affective trait. Therefore, using an instrument that measures empathy as a learned state would be inappropriate and invalidate the study.

Empathy

Since it is an inherent developmental trait, empathy cannot be taught. However, it can be nurtured through learning strategies influencing the affective domain (Wilt et al.,1995). Learning objectives can be developed and progress toward attaining them evaluated. Longitudinal studies are needed to

assess the influence of higher education on the development of empathic understanding. Propositions specific to the personal system needing testing include: (1) self-awareness promotes perceptual accuracy corresponding with empathic understanding (and vice versa) and (2) fostering development of competency in the affective domain increases empathic understanding.

The theory proposes that goal attainment corresponds to effective nursing care and, therefore, is an empirical indicator of high-quality nursing care. The relationship between the nurse's empathic understanding capacity and the patient's goal attainment provides an outcomes study that examines the interpersonal nature of nursing. Propositions specific to the interpersonal system needing testing include: (1) empathic understanding increases the speed and effectiveness of nurse-patient communication and (2) empathic understanding on the part of the nurse increases the perception of quality on the part of the patient.

The relationship among the interpersonal and social system concepts role, stress, and organization and empathic understanding needs to be explored in light of contemporary hospital practice. How does nurse empathy affect interaction and communication with other health care disciplines? Does empathic interaction have an affect on the quality of care nurses provide to patients? To what extent do rising acuity levels and shortened lengths of stay affect the nurse's ability to develop a relationship with patients? If it is not

possible to provide high-quality nursing care as defined by this model in today's hospital, what are the defining attributes of hospital nursing practice?

Mutuality

Curley (1997) concluded that qualitative methodology would explicate mutuality best:

> Testing mutuality requires matching the patient's and nurse's report of the degree of shared connectedness and mutual benefit within the dyad. One cannot test outside the paired relationship because mutuality can only be achieved within a relationship. Data points may include reports of shared understanding, empowerment, satisfaction, benefit, congruent outcomes, and the absence of role strain (p. 212).

Propositions from this study's theory needing testing include: (1) quality of nursing care increases as the disparity in the degree of power granted to and exerted by the participants of the interaction decreases and (2) mutual decision-making increases the perception of the quality of care, the effectiveness of interventions, and overall satisfaction. Studies exploring patients' desire and willingness to be involved in making decisions regarding care across settings (hospitals, skilled nursing units, nursing homes, ambulatory clinics, etc) as well as the relationship between mutuality and cost of care are needed.

Conclusion

By conceptualizing high-quality nursing care within King's Interacting Systems Framework, nursing knowledge is differentiated from that of medicine, resulting in conceptual and theoretical clarity. Nursing is concerned with actions and processes by which positive changes in a person's health status are effected (Fawcett, 1995). The experience of high-quality nursing care arises from interpersonal interaction and transaction aimed at achieving mutually determined health status goals. These interpersonal processes are influenced heavily by nurses' personal system developmental levels and social system determination of role and power. This clarification of high-quality nursing care is proposed to facilitate collaboration with other health care disciplines for the benefit of the individual patient by providing an understanding of the domain and scope of nursing necessary for professional autonomy.

LITERATURE CONSULTED

References

Abdellah, F. G. (1969). The nature of nursing science. Nursing Research, 18, 390-393.

Abramowwitz, S., Cote, A. A. & Berry, E. (1987). Analyzing patient satisfaction: A multianalytic approach. Quality Review Bulletin, 13(4), 122-130.

Aguayo, R. (1990). Dr. Deming: The American who taught the Japanese about quality. New York: Simon & Schuster.

Al-Kandari, F. & Ogndeyin, W. (1998). Patients' and nurses' perceptions of the quality of nursing care in Kuwait. Journal of Advanced Nursing, 27, 914-921.

Allen, D. G. (1995). Hermeneutics: Philosophical traditions and nursing practice research. Nursing Science Quarterly, 8(4), 174-182.

Alligood, M. R. (1992). Empathy: The importance of recognizing two types. Journal of Psychosocial Nursing, 30(3), 14-17.

Alligood, M. R. (1997). The nature of knowledge needed for nursing practice. In M. R. Alligood & A. Marriner-Tomey (Eds.), Nursing theory: Utilization and application (pp. 3-13). St. Louis: C. V. Mosby.

Alligood, M. R. & Choi, E. C. (1998). Evolution of nursing theory development. In A. Marriner-Tomey & M. R. Alligood (Eds.), Nursing theorists and their work (4th ed.), (pp. 55-66). St. Louis: C. V. Mosby.

Alligood, M. R., Evans, G. W., & Wilt, D. L. (1995). King's interacting systems and empathy. In M. A. Frey & C. L. Sieloff (Eds.), Advancing King's systems framework and theory of nursing (pp. 66-78). Thousand Oaks, CA: Sage.

Alligood, M. R., Evans, G. W., Wilt, D. L., Seavor, C., May, B., & Witucki, J. (February, 1998). A conceptualization of nursing empathy using hermeneutics. Paper presented at the Southern Nursing Research Conference, Fort Worth, TX.

Alligood, M. R. & May, B. A. (2000). A nursing theory of personal system empathy: Interpreting a conceptualization of empathy in King's interacting systems. Nursing Science Quarterly, 13(3), 243-247.

American Association of Colleges of Nursing. (1999).A vision of baccalaureate and graduate nursing education: The next decade. Journal of Professional Nursing, 15(1),59-65.

American Nurses Association (1999). Principles for nurse staffing. Available: www.ana.org/readroom/stffprnc.htm.

American Nurses Association (2001). Nurses concerned over working conditions, decline in quality of care, ANA survey reveals. Available: www.ana.org/pressrel/2001/pr0206.htm.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. Qualitative Health Research, 10(3), 378-395.

Aspy, D. N. (1975). Empathy: Let's get the hell on with it. The Counseling Psychologist, 5(2), 10-14.

Astrom, S., Nilsson, M., Norberg, A., & Winbland, B. (1990). Empathy, experience of burnout and attitudes towards demented patients among nursing staff in geriatric care. Journal of Advanced Nursing, 15, 1236-1244.

Atree, M. (1993). An analysis of the concept of 'quality' as it relates to contemporary nursing care. International Journal of Nursing Studies, 30(4), 355-369.

Atree, M. (1996). Towards a conceptual model of "Quality Care." International Journal of Nursing Studies, 33(1), 13-28.

Austin, J. K. & Champion, V. L. (1983). King's theory for nursing: Explication and evaluation. In P. L. Chinn (Ed.), Advances in nursing theory development (pp. 49-61). Rockville, MD: Aspen.

Baillie, L. (1996). A phenomenological study of the nature of nursing. Journal of Advanced Nursing, 24, 1300-1308.

Baker, D. (1997). Tennessee studies of BSN hospital nurses and their enduring interpersonal values. Tennessee Nurse, 60(4), 19-20.

Baumgartner, M. (1970). Empathy. In C. E. Carlson (Ed.), Behavioral concepts and nursing interventions (pp. 29-35). Philadelphia: J. B. Lippincott.

Beaudin, C. L. & Pelletier, L. R. (1996). Consumer-based research: Using focus groups as a method of evaluating quality of care. Journal of Nursing Care Quality, 10(3), 28-33.

Beck, C. T. (1982). The conceptualization of power. Advances in Nursing Science, 4(2), 1-17.

Bennett, J. A. (1995). 'Methodological notes on empathy:" Further considerations. Advances in Nursing Science,18(1), 36-50.

Berman, S. (1995). Ending the QA/CQI confusion: An interview with Bonnie Fossett. The Joint Commission Journal on Quality Improvement, 21(3), 144-147.

Bertalanffy, L. von.(1968). General system theory: Foundations, development, applications. (Revised edition). New York: George Braziller.

Beyers, M. (1987). Future of nursing care delivery. Nursing Administration Quarterly, 11(2), 71-80.

Blouin, A. S. & Brent, N. J. (1998). Creating value for patients: A legal perspective. Journal of Nursing Administration, 28(6), 7–9.

Bohlander, J. R. (1995). Differentiation of self: An examination of the concept. Issues in Mental Health Nursing, 16, 165-184.

Boschma, G. (1994). The meaning of holism in nursing: Historical shifts in holistic nursing ideas. Public Health Nursing, 11(3), 324-330.

Boston, C. M. (1990). Nurse assistive programs. Journal of Nursing Administration, 20(1), 5-6.

Briant, S. & Freshwater, D. (1998). Exploring mutuality within the nurse-patient relationship. British Journal of Nursing, 7(4), 204, 206, 208-211.

Brodie, J. N. (1984). A response to Dr. J. Fawcett's paper: The metaparadigm of nursing: Present status and future refinements. Image: Journal of Nursing Scholarship, 16(3), 87-89.

Brooks, E. M. (1995). Exploring the perception and judgment of senior baccalaureate nurses in clinical decision making from a nursing theoretical perspective. Unpublished doctoral dissertation, University of Tennessee, Knoxville.

Brown, S. J. (1999). Patient-centered communication. Annual Review of Nursing Research, 17, 85-104.

Bruns, G. L. (1992). Hermeneutics ancient and modern. New Haven: Yale University.

Brunt, J. H. (1985). An exploration of the relationship between nurses' empathy and technology. Nursing Administration Quarterly, 9(4), 69-78.

Buchmann, W. F. (1997). Adherence: A matter of self-efficacy and power. Journal of Advanced Nursing, 26, 132-137.

Buck, R. & Ginsberg, B. (1997). Communicative genes and the evolution of empathy. In W. Ickes (Ed.), Empathic accuracy (pp. 17-43) New York: Guilford Press.

Bunting, S. M. (1988). The concept of perception in selected nursing theories. Nursing Science Quarterly, 1(4), 168-174.

Burnard, P. (1986). Self-awareness for nurses: An experiential guide. Rockville, MD: Aspen.

Cahill, J. (1996). Patient participation: A concept analysis. Journal of Advanced Nursing, 24, 561-571.

Callaghan, P., Tak-Ying, S. A., & Wyatt, P. A. (2000). Factors related to stress and coping among Chinese nurses in Hong Kong. Journal of Advanced Nursing, 31,1518-1527.

Cameron, F. J. (1963). Quality nursing. International Nursing Review, 10(1), 21-27.

Campbell-Heider, N., Krainovich-Miller, B., King, K. B., Sedhom, L., & Malinski, V. (1998). Empowering staff nurses to participate in the American Nurses Association's call for quality indicators research. Journal of the New York State Nurses Association, 29(3/4), 21-27.

Caris-Verhallen, W. M. C. M., Kerkstra, A., van der Heijden, P. G. M., & Bensing, J. M. (1998). Nurse-elderly patient communication in home care and institutional care: An explorative study. International Journal of Nursing Studies, 35, 95-108.

Carper, B. A. (1992). Philosophical inquiry in nursing: An application. In J. F. Kikuchi & H. Simmons (Eds.), Philosophic inquiry in nursing (pp. 71-80). Newbury Park: Sage Publications.

Carver, E. J. & Hughes, J. R. (1990). The significance of empathy. In R. C. MacKay, J. R. Hughes, & E. J. Carver (Eds.), Empathy in the helping relationship (pp. 13-27). New York: Springer.

Chambliss, D. F. (1996). Beyond caring: Hospitals, nurses, and the social organization of ethics. Chicago: The University of Chicago Press.

Chance, K. S. (1980). The quest for quality: An exploration of attempts to define and measure quality nursing care. Image: Journal of Nursing Scholarship, 28(2), 41-45.

Chance, K. S. (1982). Nursing models: A requisite for professional accountability. Advances in Nursing Science, 4(2), 57-65.

Chinn, P. L. (1983). Nursing theory development: Where we have been and where we are going. In N. L. Chaska (Ed.), The nursing profession: A time to speak (pp. 394-405). New York: McGraw-Hill.

Chinn, P. L. & Kramer, M. K. (1998). Theory and nursing: Integrated knowledge development. St. Louis: C. V. Mosby.

Ciaramicoli, A. P. & Ketchum, K. (2000). The power of empathy. New York: Dutton.

Clark, C. A., Pokorny, M. E. & Brown, S. T. (1996). Consumer satisfaction with nursing care in a rural community hospital emergency department. Journal of Nursing Care Quality, 10(2), 49-57.

Clark, C. C., Cross, J. R., Deane, D. M. & Lowry, L. W. (1991). Spirituality: Integral to quality care. Holistic Nursing Practice, 5(3), 67-76.

Conway, M. E. (1985). Toward greater specificity in defining nursing's metaparadigm. Advances in Nursing Science, 7(4), 73-81.

Cook, S. H. (1999). The self in self-awareness. Journal of Advanced Nursing, 29, 1292-1299.

Coulon, L., Mok, M., Krause, K. L. & Anderson, M. (1996). The pursuit of excellence in nursing care: What does it mean? Journal of Advanced Nursing, 24, 817–826.

Crosby, P. B. (1980). Quality is free. New York: Penguin.

Curley, M. A. Q. (1997). Mutuality – An expression of nursing presence. Journal of Pediatric Nursing, 12(4), 208-213.

Dagenais, F. & Meleis, A. I. (1982). Professionalism, work ethnic, and empathy in nursing: The nurse self-description form. Western Journal of Nursing Research, 4(4), 407-422.

Davitz, L. L., Davitz, J. B., & Rubin, C. F. (1980). Nurses' responses to patients' suffering. New York: Springer.

Deets. C. A. (1990). Nursing's metaparadigm and a search for its methodology. In N. L. Chaska (Ed.), The nursing profession: Turning points (pp. 149-154). St. Louis: C. V. Mosby.

Doering, E. R. (1983). Factors influencing inpatient satisfaction with care. Quality Review Bulletin, 9(10), 291-299.

Donabedian, A. (1980). The definition of quality and approaches to its assessment. Ann Arbor, Michigan: Health Administration Press.

Donaldson, S. K. & Crowley, D. M. (1978). The discipline of nursing. Nursing Outlook, 26, 113-120.

Draper, P. (1997). Nursing perspectives on quality of life. London: Routledge.

Duffield, C., Donoghue, J. & Pelletier, D. (1996). Do clinical nurse specialists and nursing unit managers believe that the provision of quality care is important? Journal of Advanced Nursing, 24, 334-340.

Edgerton, S. G. (1988). Philosophical analysis. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 169-182). New York: National League for Nursing.

Edwards, S. D. (1999). The idea of nursing science. Journal of Advanced Nursing, 29, 563-569.

Ehmann, V. E. (1971). Empathy: Its origins, characteristics, and process. Perspectives in Psychiatric Care, 9(2), 72-80.

Eisenberg, N., Murphy, B. C., & Shepard, S. (1997). The development of empathic accuracy. In W. Ickes (Ed.), Empathic accuracy (pp. 73-116) New York: Guilford Press.

Ellis, R. (1982). Conceptual issues in nursing. Nursing Outlook, 32, 406-410.

Ellis-Stoll, C. C. & Popkess-Vawter, S. (1998). A concept analysis on the process of empowerment. Advances in Nursing Science, 21(2), 62-68.

Encarta world English dictionary. (1999). New York: St. Martin's Press.

Eriksen, L. (1988). Measuring patient satisfaction with nursing care: A magnitude estimation approach. In C. F. Waltz & O. L. Strickland (Eds.), Measurement of nursing outcomes: Vol. 1. Measuring client outcomes (pp. 523-537). New York: Springer.

Evans, G. W., Wilt, D. L., Alligood, M. R., & O'Neil, M. (1998). Empathy: A study of two types. Issues in Mental Health Nursing, 19, 453-461.

Fawcett, J. (1983). Hallmarks of success in nursing theory development. In P. Chinn (Ed.), Advances in nursing theory development (pp. 3-17). Rockeville, MD.: Aspen.

Fawcett, J. (1984). The metaparadigm of nursing: Present status and future refinements. Image: Journal of Nursing Scholarship, 6(3), 84-89.

Fawcett, J. (1989). Analysis and evaluation of conceptual models of nursing. Philadelphia: F. A. Davis.

Fawcett, J. (1992). Contemporary conceptualizations of nursing: Philosophy or science? In J. F. Kikuchi & H. Simmons (Eds.), Philosophic inquiry in nursing (pp. 64-70). Newbury Park: Sage.

Fawcett, J. (1993a). Analysis and evaluation of nursing theories. Philadelphia: F. A. Davis.

Fawcett, J. (1993b). From a plethora of paradigms to parsimony in worldviews. Nursing Science Quarterly, 6(2), 56-58.

Fawcett, J. (1995). Analysis and evaluation of conceptual models in nursing (3rd ed.). Philadelphia: F. A. Davis.

Fawcett, J. (1997a). Conceptual models of nursing, nursing theories, and nursing practice: Focus on the future. In M. R. Alligood & A. Marriner-Tomey (Eds.), Nursing theory: Utilization and application (pp. 211-221). St. Louis: Mosby.

Fawcett, J. (1997b). The structural hierarchy of nursing knowledge: Components and their definitions. In I. M. King & J. Fawcett (Eds.), The language of nursing theory and metatheory (pp. 11-17). Indianapolis, IN: Center Nursing Press.

Fawcett, J. (2000). Analysis and evaluation of contemporary nursing knowledge: Nursing models and theories. Philadelphia: F. A. Davis.

Fawcett, J. & Whall, A. L. (1995). State of the science and future directions. In M. A. Frey & C. L. Sieloff (Eds.), Advancing King's systems framework and theory of nursing (pp. 327-334). Thousand Oaks, CA: Sage Publications.

Fiesel, K. (1963). What quality nursing means today. International Nursing Review, 10(6), 37-45.

Flaskerud, J. H. & Halloran, E. J. (1980). Areas of agreement in nursing theory development. Advances in Nursing Science, 3(1), 1-7.

Forsyth, G. L. (1979). Exploration of empathy in nurse-client interaction. Advances in Nursing Science, 1(2), 53-60.

Forsyth, G. L. (1980). Analysis of the concept of empathy: Illustration of one approach. Advances in Nursing Science, 2(2), 33-42.

Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. Journal of Advanced Nursing, 20, 1085-1093.

Foxall, M. J., Zimmerman, L., Standley, R., & Bene, B. (1990). A comparison of frequency and sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses. Journal of Advanced Nursing, 15, 577-584.

Friedman, E. (1988). Quality as a social issue: A journalist's perspective. In E. F. X. Hughes (Ed.), Perspectives on quality in American health care (pp. 247-269). Washington, D. C.: McGraw-Hill.

Frost, M. H. (1992). Quality: A concept of importance to nursing. Journal of Nursing Care Quality, 7(1), 64-69.

Fry, S. T. (1992). Neglect of philosophic inquiry in nursing: Cause and effect. In J. F. Kikuchi & H. Simmons (Eds.), Philosophic inquiry in nursing (pp. 85-96). Newbury Park: Sage.

Gadamer, H-G. (1976). Philosophical hermeneutics. (D. Linge, Trans.) Berkeley, CA: University of California.

Gadamer, H-G. (1989). Truth and method (2nd. ed.). New York: Continuum.

Gadamer, H-G. (1997). Reflections on my philosophical journey. (R. E. Palmer, trans.). In L. E. Hahn (Ed.), The philosophy of Hans-Georg Gadamer (pp. 3-63). Chicago: Open Court.

Gagan, J. M. (1983). Methodological notes on empathy. Advances in Nursing Science, 5(2), 65-71.

Gaines, B. C. (2001). From revolution to transformation: Curriculum development in a new millennium. In N. L. Chaska (Ed.), The nursing profession: Tomorrow and beyond (pp. 141-150). Thousand Oaks: Sage.

Gardner, D. L. (1991). Issues related to the use of nurse extenders. Journal of Nursing Administration, 21(10), 40-45.

Garvin, B. J. & Kennedy, C. W. (1992). Interpersonal communication between nurses and patients. Annual Review of Nursing Research, 8, 213-234.

Gaut, D. A. (1985). Philosophical analysis as research method. In M. M. Leininger (Ed.), Qualitative research methods in nursing (pp. 73-80). New York: Grune and Stratton.

Gerrity, P. L. (1987). Perception in nursing: The value of intuition. Holistic Nursing Practice, 1(3), 63-71.

Gibson, C. H. (1991). A concept analysis of empowerment. Journal of Advanced Nursing, 16, 354-361.

Giger, J. & Davidhizar, R. E. (1990). Conceptual and theoretical approaches to patient care: Associate versus baccalaureate degree prepared nurses. Journal of Advanced Nursing, 15, 1009-1015.

Glen, S. (1998a). Emotional and motivational tendencies: The key to quality nursing care? Nursing Ethics, 5(1), 36-42.

Glen, S. (1998b). The key to quality nursing care: Towards a model of personal and professional development. Nursing Ethics, 5(2), 95-102.

Goonan, K. J. & Jordan, H. S. (1992). Is QA antiquated, or was it at the right place at the wrong time? Quality Review Bulletin, 18(11), 372-379.

Gortner, S. R. (1983). The history and philosophy of nursing science and research. Advances in Nursing Science, 6(1), 1-8.

Gould, D. (1990). Empathy: A review of the literature with suggestions for an alternative research strategy. Journal of Advanced Nursing, 15, 1167-1174.

Greeneich, D. (1993). The link between new and return business and quality of care: Patient satisfaction. Advances in Nursing Science, 16(1), 62-72.

Grillo-Peck, A. M. & Risner, P. B. (1995). The effect of a partnership model on quality and length of stay. Nursing Economics, 13(6), 367-374.

Grondin, J. (1994). Introduction to philosophical hermeneutics. New Haven: Yale University.

Hall, L. M. (1998). Policy implications when changing staff mix. Nursing Economics, 16(6), 291-297, 312.

Hanna, K. M. (1993). Effect of nurse-client transaction on female adolescents' oral contraceptive adherence. Image: Journal of Nursing Scholarship, 25(4), 285-290.

Hanucharurnkui, S. & Vinya-nguag, P. (1991). Effects of promoting patients' participation in self-care on postoperative recovery and satisfaction with care. Nursing Science Quarterly, 4(1), 14-20.

Hardin, S. B. & Halaris, A. L. (1983). Nonverbal communication of patients and high and low empathy nurses. Journal of Psychiatric Nursing and Mental Health Services, 21(1), 14-20.

Harris, R. B. (1989). Reviewing nursing stress according to a proposed coping-adaptation framework. Advances in Nursing Science, 11(2), 12-28.

Hart, M. (1996). Incorporating outpatient perceptions into definitions of quality. Journal of Advanced Nursing, 24, 1234-1240.

Hawks, J. H. (1991). Power: A concept analysis. Journal of Advanced Nursing, 16, 754-762.

Healy, C. M. & McKay, M. F. (2000). Nursing stress: The effects of coping strategies and job satisfaction in a sample of Australian nurses. Journal of Advanced Nursing, 31, 681-688.

Henson, R. H. (1997). Analysis of the concept of mutuality. Image: Journal of Nursing Scholarship, 29(1), 77-81.

Hewison, A. (1995). Nurses' power in interactions with patients. Journal of Advanced Nursing, 21, 75-82.

Higgins, M., McCaughan, D., Griffiths, M. & Carr-Hill, R. (1992). Assessing the outcomes of nursing care. Journal of Advanced Nursing, 17, 561-568.

Hilton, P. A. (1997). Theoretical perspectives of nursing: A review of the literature. Journal of Advanced Nursing, 26, 1211-

Hodges, S. D. & Wegner, D. M. (1997). Automatic and controlled empathy. In W. Ickes (Ed.), Empathic accuracy (pp. 311-339) New York: Guilford Press.

Hogan, R. (1969). Development of an empathy scale. Journal of Consulting and Clinical Psychology, 33(3), 307-316.

Hogston, R. (1995a). Evaluating quality nursing care through peer review and reflection: The findings of a qualitative study. International Journal of Nursing Studies, 32(2), 162-172.

Hogston, R. (1995b). Quality nursing care: A qualitative inquiry. Journal of Advanced Nursing, 21, 115-124.

Holden, R. J. (1990). Empathy: The art of emotional knowing in holistic nursing care. Holistic Nursing Practice, 5(1), 70-79.

Honderich, T. (Ed.) (1995). The Oxford companion to philosophy. New York: Oxford University.

Ickes, W. (1997). Introduction. In W. Ickes (Ed.), Empathic accuracy (pp. 1-16) New York: Guilford Press.

Ickes, W., Maragoni, C., & Garcia, S. (1997). Studying empathic accuracy in a clinically relevant context. In W. Ickes (Ed.), Empathic accuracy (pp. 282-310) New York: Guilford Press.

Irvine, D., Sidani, S. & Hall, L. M. (1998a). Linking outcomes to nurses' roles in health care. Nursing Economics, 16(2), 58-64,87.

Irvine, D., Sidani, S. & Hall, L. M. (1998b). Finding value in nursing care: A framework for quality improvement and clinical evaluation. Nursing Economics, 16(3), 110-116.

Jacobson, S. F. (1983). The contexts of nurses' stress. In S. F. Jacobson & H. M. McGrath (Eds.), Nurses under stress (pp. 49-60). New York: John Wiley & Sons.

Jacox, A. (1997, December). Determinants of who does what in health care. Online Journal of Issues in Nursing.
Available: http://www.nursingworld.org/ojin/tpc5_1.htm.

Janssen, P. P. M., deJonge, J., & Bakker, A. B. (1999). Specific determinants of intrinsic work motivation, burnout and turnover intentions: A study among nurses. Journal of Advanced Nursing, 29, 1360-1369.

Jenny, J. & Logan, J. (1992). Knowing the patient: One aspect of clinical knowledge. Image: Journal of Nursing Scholarship, 24(4), 254-258.

Johnson, J. L. (1996). The perceptual aspect of nursing art: Sources of accord and discord. Scholarly Inquiry for Nursing Practice: An International Journal, 10(4), 307-322.

Johnson, M. N. (1980). Self-disclosure and anxiety in nurses and patients. Issues in Mental Health Nursing, 2, 42-56.

Joiner, G. A. (1996). Caring in action: The key to nursing service excellence. Journal of Nursing Care Quality, 11(1), 38-43.

Jones, K. R. (1991). Maintaining quality in a changing environment. Nursing Economics, 9(3), 159-164.

Jun, M., Peterson, R. T. & Zsidisin, G. A. (1998). The identification and measurement of quality dimensions in health care: Focus group interview results. Health Care Management Review, 23(4), 81-96.

Kalisch, B. J. (1971). An experiment in the development of empathy in nursing students. Nursing Research, 20(3), 202-211.

Kalisch, B. J. (1973). What is empathy? American Journal of Nursing, 73(9), 1548-1552.

Kalisch, P. A. & Kalisch, B. J. (1995). The advance of American nursing (3rd ed.). Philadelphia: J. B. Lippincott.

Kasch, C. R. (1985). Toward a theory of nursing action: Skills and competency in nurse-patient interaction. Nursing Research, 35(4), 226-230.

Katims, I. (1995). The contrary ideals of individualism and nursing value of care. Scholarly Inquiry for Nursing Practice: An International Journal, 9(3), 231-240.

Kegley, J. A. K. (1995). Science as tradition and tradition shattering: Thomas Kuhn's philosophy of science. In A. Omery, C. E. Kasper, & G.G. Page (Eds.), In search of nursing science (pp. 43-57). Thousand Oaks, CA: Sage Publications.

Kenney, T. (1990). Erosion of individuality in care of elderly people in hospital – an alternative approach. Journal of Advanced Nursing, 15, 571-576.

Kidd, P. & Morrison, E. F. (1988). The progression of knowledge in nursing: A search for meaning Image: Journal of Nursing Scholarship, 20(4), 222-224.

Kikuchi, J. F. (1992). Nursing questions that science cannot answer. In J. F. Kikuchi & H. Simmons (Eds.), Philosophic inquiry in nursing (pp. 26-37). Newbury Park: Sage.

King, I. M. (1971). Toward a theory for nursing: General concepts of human behavior. New York: John Wiley & Sons.

King, I. M. (1981). A theory for nursing: Systems, concepts, process. Albany, New York: Delmar Publishers.

King, I. M. (1986). Curriculum and instruction in nursing: Concepts and process. Norwalk, CT: Appleton-Century-Crofts.

King, I. M. (1990). King's conceptual framework and theory of goal attainment. In M. E. Parker (Ed.), Nursing theories in practice (pp. 73-84). New York: National League for Nursing.

King, I. M. (1995). A system framework for nursing. In M. A. Frey & C. L. Sieloff (Eds.), Advancing King's systems framework and theory of nursing (pp. 14-22). Thousand Oaks, CA: Sage.

King, I. M. (1999). A theory of goal attainment: Philosophical and ethical implications. Nursing Science Quarterly, 12(4), 292-296.

King, I. M. & Lewenson, S. B. (2000) Interview with Imogene King. Nursing Leadership Forum, 4(3), 91-95.

Kitson, A. (1986). The methods of measuring quality. Nursing Times, 82, 32-34.

Kobs, A. (1997). The adequacy of nurse staffing. Nursing Management, 28(11), 16, 20.

Koerner, J. G. (1993). Work redesign: A journey not a destination. In K. J. McDonagh (Ed.), Patient-centered hospital care: Reform from within (pp. 193-210). Ann Arbor, MI: American College of Healthcare Executives.

Koerner, J. G. (1996). Congruency between nurses' values and job requirements: A call for integrity. Holistic Nursing Practice, 10(2), 69-77.

Kohler, P. (1988). Model of shared control. Journal of Gerontological Nursing, 14(7), 21-25.

Komarek, A. G. (1996). Professional shopping of hospital services: An analysis of sub rosa investigative methods in determination of quality. Journal of Nursing Care Quality, 11(1), 44-55.

Kovner, C. & Gergen, P. J. (1998). Nurse staffing levels and adverse events following surgery in U. S. hospitals. Image: Journal of Nursing Scholarship, 30(4), 315-321.

Kovner, C. T. & Schore, J. (1998). Differentiated levels of nursing work force demands. Journal of Professional Nursing, 14(4), 242-253.

Kralik, D., Koch, T., & Wotton, K. (1997). Engagement and detachment: Understanding the patients' experiences with nursing. Journal of Advanced Nursing, 26, 399-407.

Krapohl, G. L. & Larson, E. (1996). The impact of unlicensed assistive personnel on nursing care delivery. Nursing Economics, 14(2), 99-110, 122.

Kuhn, T. S. (1970). The structure of scientific revolutions (2nd Ed.) Chicago: University of Chicago.

Kuhn, T. S. (1977). The essential tension. Chicago: University of Chicago.

Kunst-Wilson, W., Carpenter, L., Poser, A., Venohr, I., & Kushner, K. (1981). Empathic perceptions of nursing students: Self-reported and actual ability. Research in Nursing and Health, 4, 283-293.

Kuokkanen, L. & Leino-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. Journal of Advanced Nursing, 31, 235-241.

LaMonica, E. L. (1978). Empathy: Educating nurses in professional practice. Journal of Nursing Education, 17(2), 3-11.

LaMonica, E. L. (1979). Empathy in nursing practice. Issues in Mental Health Nursing, 2, 1-13.

LaMonica, E. L., Wolf, R. M., Madea, A. R., & Oberst, M. T. (1987). Empathy and nursing care outcomes. Scholarly Inquiry for Nursing Practice: An International Journal, 1(3), 197-213.

Lang, N. M. & Clinton, J. F. (1984). Assessment of quality of nursing care. In H. H. Werley & J. J. Fitzpatrick (Eds.), Annual review of nursing research: Vol. 2 (pp. 135-163). New York: Springer.

Larrabee, J. H., Engle, V. F. & Tolley, E. A. (1995). Predictors of patient–perceived quality. Scandinavian Journal of Caring Science, 9, 153–164.

Larrabee, J. H. (1996). Emerging model of quality. Image: Journal of Nursing Scholarship, 28(4), 353-358.

Larson, L. C. (1998). Delegation skills and nurse job satisfaction. Nursing Economics, 16(1), 18-26.

Larsson, B. W. & Larsson, G. (1999). Patients' views on quality of care: Do they merely reflect their sense of congruence? Journal of Advanced Nursing, 30, 33-39.

Larsson, G. & Starrin, B. (1990). Patient-nurse interactions: Relationships between person characteristics, empathy, content of communication, and patients' emotional reactions. Scandinavian Journal of Caring Science, 4(3), 129-135.

Layton, J. M. (1979). The use of modeling to teach empathy to nursing students. Research in Nursing and Health, 2, 163-176.

Layton, J. M. (1994). Empathy: Theory, research, and nursing applications. In L. R. Allen (Ed.), Review of research in nursing education (pp. 91-106). New York: National League for Nursing.

Leddy, S. K. (1998). Conceptual bases of professional nursing (4th ed.). New York: Lippincott.

Leino-Kilpi, H. & Vuorenheimo, J. (1993). Perioperative nursing care quality: Patients' opinions. AORN Journal, 57(5), 1061-1071.

Leinonen, T., Leino-Kilpi, H. & Katajisto, J. (1996). The quality of intraoperative nursing care: The patient's perspective. Journal of Advanced Nursing, 24, 843-852.

Leveck, M. L. & Jones, C. B. (1996). The nursing practice, environment, staff retention, and quality of care. Research in Nursing & Health, 19, 331-343.

Levenson, R. W. & Ruef, A. M. (1997). Physiological aspects of emotional knowledge and rapport. In W. Ickes (Ed.), Empathic accuracy (pp. 44-72) New York: Guilford Press.

Lindell, A. R. (1979). Congruence – A necessary behavior in the nurse-patient relationship. Issues in Mental Health Nursing, 2, 28-40.

Linge, D. E. (1976). Editor's introduction. In H-G. Gadamer (D. E. Linge, trans), Philosophical hermeneutics (pp. xi-lviii). Berkeley, CA: University of California.

Ludemann, R. S. (1968). Empathy: A component of therapeutic nursing. Nursing Forum, 7(3), 276-287.

Ludwig-Beymer, P., Ryan, C. J., Johnson, N. J., Hennessy, K. A., Gattuso, M. C., Epsom, R. & Czurylo, K. T. (1993). Using patient perceptions to improve quality care. Journal of Nursing Care Quality, 7(2), 42-51.

Luker, K. A., Austin, L., Caress, A., & Hallett, C. E. (2000). The importance of 'knowing the patient": Community nurses' construction of quality in providing palliative care. Journal of Advanced Nursing, 31, 775-782.

Lupton, D. (1995). Perspectives on power, communication and the medical encounter: Implications for nursing theory and practice. Nursing Inquiry, 2, 157-163.

Lynn, M. R. & McMillen, B. J. (1999). Do nurses know what patients think is important in nursing care? Journal of Nursing Care Quality, 13(5), 65-74.

Lynn, M. R. & Moore, K. (1997). Relationship between traditional quality indicators and perceptions of care. Seminars for Nurse Managers, 5(4), 187-193.

Mahon, P. Y. (1996). An analysis of the concept 'patient satisfaction' as it relates to contemporary nursing care. Journal of Advanced Nursing, 24, 1241–1248.

Malach-Pines, A. (2000). Nurses' burnout: An existential psychodynamic perspective. Journal of Psychosocial Nursing, 38(2), 23-31.

Malosh, B. (1982). The physician's hand: Work culture and conflict in American nursing. Philadelphia: Temple University.

Mansfield, E. (1980). A conceptual framework for psychiatric-mental health nursing. Journal of Psychiatric Nursing and Mental Health Services, 18(6), 34-41.

Manthey, M. (1994). Issues in patient care delivery. Journal of Nursing Administration, 24(12), 14-16.

Marck, P. (1990). Therapeutic reciprocity: A caring phenomenon. Advances in Nursing Science, 13(1), 49-59.

May, B. A. & Alligood, M.R . (2000). Basic empathy in older adults: Conceptualization, measurement, and application. Issues in Mental Health Nursing, 21, 375-386.

May, C. (1990). Research on nurse-patient relationships: Problems of theory, problems of practice. Journal of Advanced Nursing, 15, 307-315.

May, C. (1995). Patient autonomy and the politics of professional relationships. Journal of Advanced Nursing, 21, 83-87.

McClary, K. (1997). Nursing in today's hospital environment. Indiana State Nurses Association Bulletin, 23(3), 1-2.

McManus, S. M. & Pearson, J. V. (1993). Nursing at a crossroads: Managing without facts. Health Care Management Review, 18(1), 79-90.

Meisenheimer, C. (1991). The consumer: Silent or intimate player in the quality revolution. Holistic Nursing Practice, 5(3), 39-50.

Meister, C. & Boyle, C. (1996). Perceptions of quality in long-term care: A satisfaction survey. Journal of Nursing Care Quality, 10(4), 40-47.

Melberg, S. E. (1997). Effects of changing skill mix. Nursing Management, 28(11), 47-48.

Meleis, A. I. (1983). The evolving nursing scholarliness. In P. L. Chinn (Ed.), Advances in nursing theory development (pp. 19-34). Rockville, MD: Aspen.

Meleis, A. I. (1986). Theory development and domain concepts. In P. Moccia (Ed.), New approaches to theory development (pp. 3-21). New York: National League for Nursing.

Menix, K. D. (1996). Domains of learning: Interdependent components of achievable learning outcomes. Journal of Continuing Education in Nursing, 27(5), 200-208.

Menke, E. M. (1990). Rhetoric and reality in the development of nursing knowledge. In N. L. Chaska (Ed.), The nursing profession: Turning points (pp. 205-213). St. Louis: C. V. Mosby.

Miller, A. (1985). Nurse/patient dependency – Is it iatrogenic? Journal of Advanced Nursing, 10, 63-69.

Ming Ho Lau, V. & Mackenzie, A. (1996). Attributes of nurses that determine quality of care for mentally handicapped people in an institution. Journal of Advanced Nursing, 24, 1109-1115.

Minnick, A. F., Roberts, M. J., Young, W. B., Kleinpell, R. M. & Mercantanio, R. J. (1997). What influences patients' reports of three aspects of hospital services? Medical Care, 35(4), 399-409.

Minicucci, D. S. (1998). A review and synthesis of the literature: The use of presence in the nursing of families. Journal of the New York State Nurses Association, 29(3/4), 9-15.

Mitchell, P. H., Ferketich, S, Jennings, B. M. & American Academy of Nursing Expert Panel on Quality Health Care. (1998). Quality health outcomes model. Image: Journal of Nursing Scholarship, 30(1), 43-46.

Morse, J. M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, 455-468.

Morse, J. M. (1995). Exploring the theoretical basis of nursing using advanced techniques of concept analysis. Advances in Nursing Science, 17(3), 31-46.

Morse, J. M., Anderson, G., Bottorff, J. L., Yonge, O., O'Brien, B., Solberg, S. M., & McIlveen, K. H. (1992). Exploring empathy: A conceptual fit for nursing practice? Image: Journal of Nursing Scholarship, 24(4), 273-279.

Morse, J. M. & Mitcham, C. (1997). Compathy: The contagion of physical distress. Journal of Advanced Nursing, 26, 649-657.

Morse, J. M., Solberg, S. M., Neander, W. L., Bottorff, J. L. & Johnson, J. L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.

Motyka, M., Motyka, H., & Wsolek, R. (1997). Elements of psychological support in nursing care. Journal of Advanced Nursing, 26, 909-912.

Moughton, M. (1982). The patient: A partner in the health care process. Nursing Clinics of North America, 17(3), 467-479.

Moyle, W., Barnard, A., & Turner, C. (1995). The humanities and nursing: Using popular literature as a means of understanding human experience. Journal of Advanced Nursing, 21, 960-964.

Murphy, E. C., Ruch, S., Pepicello, J., & Murphy, M. (1997). Managing an increasingly complex system. Nursing Management, 28(10), 33-38.

Myers, S. M. (1998). Patient-focused care: What managers should know. Nursing Economics, 16(4), 180-188.

Mynatt, S. (1985). Empathy in faculty and students in different types of nursing preparation programs. Western Journal of Nursing Research, 7(3), 333-348.

Nash, M. G., Blackwood, D., Boone, E. B., Klar, R., Lewis, E., MacInnis, K., McKay, J., Okress, J., Richer, S. & Tannas, C. (1994). Managing expectations between patient and nurse. Journal of Nursing Administration, 24(11), 49-55.

Newman, J. & Davidhizar, R. E. (1990). Conceptual and theoretical approaches to patient care: Associate versus baccalaureate degree prepared nurses. Journal of Advanced Nursing, 15, 1009-1015.

Newman, M. A. (1990). Toward an integrative model of professional nursing. Journal of Professional Nursing, 6(3), 167-173.

Newman, M. A. (1994). Health as expanding consciousness (2nd ed.). New York: National League for Nursing.

Newman, M. A., Sime, A. M. & Corcoran-Perry, S. A. (1991). The focus of the discipline of nursing. Advances in Nursing Science, 14(1), 1-6.

Nielsen, P. A. (1992). Quality of care: Discovering a modified practice theory. Journal of Nursing Care Quality, 6(2), 63-76.

Nightingale, F. (1859/1992). Notes on nursing: What it is and what it is not (Commemorative edition). Philadelphia: J. B. Lippincott.

Niven, N. & Robinson, J. (1994). The psychology of nursing care. London: Macmillan.

Norris, C. M. (1964). Toward a science of nursing - A method for developing unique content in nursing. Nursing Forum, 3(3), 10-45.

Northouse, P. G. (1979). Interpersonal trust and empathy in nurse-nurse relationships. Nursing Research, 28(6), 365-368.

Oermann, M. H. (1999). Consumers' descriptions of quality health care. Journal of Advanced Nursing, 14, 47-55.

Oermann, M. H. & Templin, T. (2000). Important attributes of quality health care: Consumer perspectives. Journal of Nursing Scholarship, 32(2), 167-172.

Olsen, D. P. (1991). Empathy as an ethical and philosophical basis for nursing. Advances in Nursing Science, 14(1), 62-75.

Olsen, D. P. (1997). When the patient causes the problem: The effect of patient responsibility on the nurse-patient relationship. Journal of Advanced Nursing, 26, 515-522.

Olson, J. K. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy, and patient distress. Image: Journal of Nursing Scholarship, 27(4), 317-322.

Olson, J. K. & Hanchett, E. (1997). Nurse-expressed empathy, patient outcomes, and development of a middle-range theory. Image: Journal of Nursing Scholarship, 29(1), 71-76.

Omdahl, B. L. & O'Donnell, C. (1999). Emotional contagion, empathic concern and communicative responsiveness as variables affecting nurses' stress and occupational commitment. Journal of Advanced Nursing, 29, 1351-1359.

Palmer, R. E. (1969). Hermeneutics. Evanston, IL: Northwestern University.

Patistea, E. & Siamanta, H. (1999). A literature review of patients' compared with nurses' perceptions of caring: Implications for practice and research. Journal of Professional Nursing, 15(5), 302-312.

Pearson, A., Durant, I. & Punton, S. (1989). Determining quality in a unit where nursing is the primary intervention. Journal of Advanced Nursing, 14, 269-273.

Peters, D. A. (1995). Outcomes: The mainstay of a framework for quality care. Journal of Nursing Care Quality, 10(1), 61-69.

Phillips. J. R. (1977). Nursing systems and nursing models. Image: Journal of Nursing Scholarship, 9(1), 4-7.

Pierce, S. F. (1997). Nurse–sensitive health care outcomes in acute care settings: An integrative analysis of the literature. Journal of Nursing Care Quality, 11(4), 60–72.

Pike, A. W. (1990). On the nature and place of empathy in clinical nursing practice. Journal of Professional Nursing, 6(4), 235-240.

Powers, B. A. & Knapp, T. R. (1990). A dictionary of nursing theory and research. Newbury Park: Sage.

Prescott, P. A. (1985). Power and powerlessness in hospital nursing departments. Journal of Professional Nursing, 1(6), 348-355.

Price, N. J. (1993). Parents' perceptions of the meaning of quality nursing care. Advances in Nursing Science, 16(1), 33-41.

Quinton, A. (1995). Philosophy. In T. Honderich (Ed.), The Oxford companion to philosophy (pp. 666-670). Oxford: Oxford University.

Radwin, L. E. (1996). 'Knowing the patient': A review of research on an emerging concept. Journal of Advanced Nursing, 23, 1142-1146.

Ramos, M. C. (1992). The nurse-patient relationship: Themes and variations. Journal of Advanced Nursing, 17, 496-506.

Rantz, M. J. (1995). Nursing quality measurement: A review of nursing studies. Washington, D. C.: American Nurses Association.

Rawnsley, M. M. (1980). Toward a conceptual base for affective nursing. Nursing Outlook,28, 244-247.

Rawnsley, M. M. (1987). Response to "Empathy and nursing care outcomes." Scholarly Inquiry for Nursing Practice: An International Journal, 1(3), 215-219.

Rawnsley, M. M. (1998). Ontology, epistemology, and methodology: A clarification. Nursing Science Quarterly, 11(1), 2-4.

Redfern, S. J. & Norman, I. J. (1990). Measuring the quality of care: A consideration of different approaches. Journal of Advanced Nursing, 15, 1260-1271.

Reed, J. & Ground, I. (1997). Philosophy for nursing. London: Arnold.

Reed, L., Blegen, M. A. & Goode, C. S. (1998). Adverse patient occurrences as a measure of nursing care quality. Journal of Nursing Administration, 28(5), 62-69.

Reeder, F. (1988). Hermeneutics. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 193-238). New York: National League for Nursing.

Reynolds, W. J. & Scott, B. (2000). Do nurses and other professional helpers normally display much empathy? Journal of Advanced Nursing, 31, 226-234.

Reynolds, W. J., Scott, B., & Jesseman, W. C. (1999). Empathy has not been measured in clients' terms or effectively taught: A review of the literature. Journal of Advanced Nursing, 30, 1177-1185.

Reynolds, W., Scott, P. A., & Austin, W. (2000). Nursing, empathy and perception of the moral. Journal of Advanced Nursing, 32, 235-242.

Riemen, D. J. (1986). Noncaring and caring in the clinical setting: Patients' descriptions. Topics in Clinical Nursing, 8(2), 30-36.

Rinne, C. (1987). The affective domain – Equal opportunity in nursing education? Journal of Continuing Education in Nursing, 18(2), 40-43.

Roberts, J. S. & Walczak, R. M. (1984). Toward effective quality assurance: The evolution and current status of the JCAH QA standard. Quality Review Bulletin, 10(1), 11-15.

Roberts, S. J. & Krouse, H. J. (1990). Negotiation as a strategy to empower self-care. Holistic Nursing Practice, 4(2), 30-36.

Roberts, S. J., Krouse, H. J., & Michaud, P. (1995). Negotiated and nonnegotiated nurse-patient interactions. Clinical Nursing Research, 4(1), 67-77.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21(2), 95-103.

Rogers, C. R. (1961). On becoming a person. Boston: Houghton Mifflin.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. The Counseling Psychologist, 5(2), 2-10.

Rogers, I. A. (1986). The effects of undergraduate nursing education on empathy. Western Journal of Nursing Research, 8(3), 329-342.

Rogers, M. E. (1970). An introduction to the theoretical basis of nursing. Philadelphia: F. A. Davis.

Rudolph, B. A. & Hill, C. A. (1994). The component of hospital quality. In E. F. X. Hughes (Ed.), Perspectives on quality in American health care (pp. 3-33). Washington, D. C.: McGraw-Hill.

Rutty, J. E. (1998). The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. Journal of Advanced Nursing, 28, 243-250.

Sarter, B. (1988). The stream of becoming: A study of Martha Rogers's theory. New York: National League for Nursing.

Schoenly, L. (1994). Teaching in the affective domain. Journal of Continuing Education in Nursing, 25(5), 209-212.

Seeger, P. A. (1977). Self-awareness and nursing. Journal of Psychiatric Nursing and Mental Health Services, 15(8), 24-26.

Silva, M. C. & Rothbart, D. (1984). An analysis of changing trends in philosophies of science on nursing theory development and testing. Advances in Nursing Science, 6(2), 1-13.

Simpson, L., Osborne, J., & Eisenberg, J. M. (1999). Planning and accountability at AHCPR: Applying the quality message at home. Health Services Research, 34(2), 461-483.

Sines, D. (1994). The arrogance of power: A reflection on contemporary mental health nursing practice. Journal of Advanced Nursing, 20, 894-903.

Smith, G. R. (1987). The new health care economy: Opportunity for nurse entrepreneurs. Nursing Outlook, 35(4), 182-184.

Smyth, T. (1996). Reinstating the person in the professional: Reflections on empathy and aesthetic experience. Journal of Advanced Nursing, 24, 932-937.

Sowell, R. L. & Lowenstein, A. (1994). King's theory as a framework for quality: Linking theory to practice. NursingConnections, 7(2), 19–31.

Sparling, S. L. & Jones, S. L. (1977). Setting: A contextual variable associated with empathy. Journal of Psychiatric Nursing and Mental Health Services, 15(4), 9-12.

Staniszewska, S. & Ahmed, L. (1998). Patient expectations and satisfaction with health care. Nursing Standard, 12(18), 34-38.

Stetler, C. B. (1977). Relationship of perceived empathy to nurses' communication. Nursing Research, 26(6), 432-438.

Strzalka, A. & Havens, D. S. (1996). Nursing care quality: Comparison of unit-hired, hospital float pool, and agency nurses. Journal of Nursing Care Quality, 10(4), 59-65.

Suppe, F. & Jacox, A. K. (1985). Philosophy of science and the development of nursing theory. Annual Review of Nursing Research, 3, 241-267.

Sutherland, J. A. (1995). Historical concept analysis of empathy. Issues in Mental Health Nursing, 16, 555-566.

Tanner, C. A., Benner, P., Chesla, C., & Gordon, D. R. (1993). The phenomenology of knowing the patient. Image: Journal of Nursing Scholarship, 25(4), 273-280.

Thorne, S. E. & Robinson, C. A. (1988). Reciprocal trust in health care relationships. Journal of Advanced Nursing, 13, 782-789.

Tonges, M. C. (1993). Work redesign: Theory, approaches, and lessons. In K. J. McDonagh (Ed.), Patient-centered hospital care: Reform from within (pp. 9-20). Ann Arbor, MI: American College of Healthcare Executives.

Triplett, J. L. (1969). Empathy is . . . Nursing Clinics of North America, 4(4), 673-681.

Tryon, P. A. & Leonard, R. C. (1964). The effect of the patient's participation on the outcome of a nursing procedure. Nursing Forum, 3(2), 79-89.

Van Ess Coeling, H. & Cukr, P. L. (2000). Communication styles that promote perceptions of collaboration, quality, and nurse satisfaction. Journal of Nursing Care Quality, 14(2), 63-74.

Varholak, D. & Korwan, R. (1995). The patient's perception of quality: Implications for nurse managers in long-term care. Seminars for Nurse Managers, 3(3), 152-156.

Ventura, M. R., Fox, R. N., Corley, M. C. & Mercurio, S. M. (1982). A patient satisfaction measure as a criterion to evaluate primary nursing. Nursing Research, 31, 226-230.

Volicer, B. J. (1974). Patients' perceptions of stressful events associated with hospitalization. Nursing Research, 23(3), 235-238.

Wainwright, S. P. (1997). A new paradigm for nursing: The potential of realism. Journal of Advanced Nursing, 26, 1262-1271.

Wake, M . M. (1990). Nursing care delivery systems: Status and vision. Journal of Nursing Administration, 20(5), 47-51.

Walker, J. D. (1993). Enhancing physical comfort. In M. Gerteis, S. Edgeman-Levitan, J. Daley, & T. L. Delbanco (Eds.), Through the patient's eyes (pp. 119-153). San Francisco: Jossey-Bass.

Walker, L. O. (1971). Toward a clearer understanding of the concept of nursing theory. Nursing Research, 20, 428-495.

Waterworth, S. & Luker, K. A. (1990). Reluctant collaborators: Do patients want to be involved in decisions regarding care? Journal of Advanced Nursing, 15, 971-976.

Watt-Watson, J., Garfinkel, P., Gallop, R., Stevens, B., & Streiner, D. (2000). The impact of nurses' empathic responses on patients' pain management in acute care. Nursing Research, 49(4), 191-200.

Watson, J. (1995). Postmodernism and knowledge development in nursing. Nursing Science Quarterly, 8(2), 60-64.

Weiss, S. J. (1995). Contemporary empiricism. In A. Omery, C. E. Kasper & G. C. Page (Eds.), In search of nursing science (pp. 13-26). Thousand Oaks, CA: Sage Publications.

Westfall, U. E. (1984). Nursing diagnosis: Its use in quality assurance. Topics in Clinical Nursing, 6, 78-88.

Wheeler, K. (1990). Perception of empathy inventory. In O. L. Strickland & C. F. Walker (Eds.), Measurement of nursing outcomes: Volume 4 (pp. 181-197). New York: Springer.

Wheeler, K. & Barrett, E. A. M. (1994). Review and synthesis of selected nursing studies on teaching empathy and implications for nursing research and education. Nursing Outlook, 42(5), 230-236.

White, S. J. (1997). Empathy: A literature review and concept analysis. Journal of Clinical Nursing, 6, 253-257.

Williams, A. M. (1998). The delivery of quality nursing care: A grounded theory study of the nurse's perspective. Journal of Advanced Nursing, 27, 808-816.

Williams, C. A. (1990). Biophysical elements of empathy: A multidimensional model. Issues in Mental Health Nursing, 11, 155-174.

Williams, C. L. (1979). Empathic communication and its effect on client outcome. Issues in Mental Health Nursing, 2, 16-26.

Williams, R. P. (1998). Nurse leaders' perceptions of quality nursing: An analysis from academe. Nursing Outlook, 46(6), 262-267.

Williams, S. A. (1997). Caring in patient-focused care: The relationship of patients' perceptions of holistic nursing caring to their levels of anxiety. Holistic Nursing Practice, 11(3), 61-68.

Wilt, D. L., Evans, G. W., Muenchen, R., & Guegold, G. (1995). Teaching with entertainment films. Journal of Psychosocial Nursing, 33(6), 5-14.

Woods, J. H. (1993). Affective learning: One door to critical thinking. Holistic Nursing Practice, 7(3), 64-70.

Young, W. B., Minnick, A. F. & Marcantanio, R. (1996). How wide is the gap in defining quality care? Journal of Nursing Administration, 26(5), 15-20.

Zderad, L. T. (1969). Empathic nursing: Realization of a human capacity. Nursing Clinics of North America, 4(4), 655-662.

Zimmerman, B. J. & Phillips, C. Y. (2000). Affective learning: Stimulus to critical thinking and caring practice. Journal of Nursing Education, 39(9), 422-425.

Bibliography

Allen, M. N. & Jensen, L. (1990). Hermeneutical inquiry: Meaning and scope. Western Journal of Nursing Research, 12(2), 241-253.

Baker, C. M., Lamm, G. M., Winter, A. R., Robbleloth, V. B., Ransom, C. A., Conly, F., Carpenter, K. C., & McCoy, L. E. (1997). Differentiated nursing practice: Assessing the state-of-the-science. Nursing Economics, 15(5), 253-262, 264.

Bennett, J. A. (1995). "Methodological notes on empathy": Further considerations. Advances in Nursing Science, 18(1), 36-50.

Caper, P. (1988). Defining quality in medical care. Health Affairs, 7(1), 49-61.

Carter, K. F. & Dufour, L. T. (1994). King's theory: A critique of the critiques. Nursing Science Quarterly, 7(3), 128-133.

Crowe, M. (2000). The nurse-patient relationship: A consideration of its discursive context. Journal of Advanced Nursing, 31, 962-967.

Diers, D. (1990). Response to "On the nature and place of empathy in clinical nursing practice". Journal of Professional Nursing, 6(4), 240-241.

Ellis, R. (1983). Philosophic inquiry. In H. H. Werley & J. J. Fitzpatrick (Eds.), Annual review of nursing research: Vol. I (pp. 211-228). New York: Springer.

Fawcett, J. (1990). Conceptual models and rules for nursing practice. In N. L. Chaska (Ed.), The nursing profession: Turning points (pp. 255-262). St. Louis: C. V. Mosby.

Fawcett, J. (1991). Approaches to knowledge development in nursing. Canadian Journal of Nursing Research, 23(4), 23-34.

Fawcett, J. (1992). Conceptual models and nursing practice: The reciprocal relationship. Journal of Advanced Nursing, 17, 224-228.

Fawcett, J. & Downs, F. S. (1992) The relationship of theory and research (2nd. Ed.) Philadelphia: F. A. Davis.

Fawcett, J. (1996). On the requirements for a metaparadigm: An invitation to dialogue. Nursing Science Quarterly, 9(3), 94-97.

Fawcett, J. (1999). The state of nursing science: Hallmarks of the 20th and 21st centuries. Nursing Science Quarterly, 12(4), 311-315.

Fitzpatrick, J. J. (1997). Nursing theory and metatheory. In I. M. King & J. Fawcett (Eds.), The language of nursing theory and metatheory (pp. 37-39). Indianapolis, IN.: Sigma Theta Tau.

Gadamer, H-G. (1996). The enigma of health: The art of healing in a scientific age. (J. Gaiger & N. Walker, Trans.) Stanford, CA: Stanford University Press.

Hegyvary, S. T. (1976). Correlates of the quality of nursing care. Journal of Nursing Administration, 6(11), 22-27.

Hogan, R. (1975). Empathy: A conceptual and psychometric analysis. The Counseling Psychologist, 5(2), 14-18.

Johnson, D. E. (1974). Development of theory: A requisite for nursing as a primary health profession. Nursing Research, 23(5), 372-377.

Jones, J. & Houston, S. (1994). Contemporary healthcare delivery: Trends and economics. In J. Zerwekh & J. C. Claborn (Eds.), Nursing today: Transition and trends (pp. 218-235). Philadelphia: W. B. Saunders.

Kenney, J. W. (Ed.) (1996). Philosophical and theoretical perspectives for advance nursing practice. Boston: Jones and Bartlett.

Kim, H. S. (1997). Terminology in structuring and developing nursing knowledge. In I. M. King & J. Fawcett (Eds.), The language of nursing theory and metatheory (pp. 27-36). Indianapolis, IN.: Sigma Theta Tau.

King, I. M. (1991). Nursing theory 25 years later. Nursing Science Quarterly, 4(3), 94-95.

King, I. M. (1994). Quality of life and goal attainment. Nursing Science Quarterly, 7(1), 29-32.

King, I. M. (1995). The theory of goal attainment. In M. A. Frey & C. L. Sieloff (Eds.), Advancing King's systems framework and theory of nursing (pp. 23-32). Thousand Oaks, CA: Sage.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour, and representation. Journal of Advanced Nursing, 24, 174-184.

Meleis, A. I. (1997). Theoretical nursing: Definitions and interpretations. In I. M. King & J. Fawcett (Eds.), The language of nursing theory and metatheory (pp. 41-49). Indianapolis, IN.: Sigma Theta Tau.

Nicoll, L. H. (Ed.) (1992). Perspectives on nursing theory (2nd ed.). New York: J. B. Lippincott.

Omery, A., Kasper, C. E., & Page, G. G. (Eds.) (1995). In search of nursing science. Thousand Oaks, CA: Sage Publications.

Palmer, R. H., Donabedian, A. & Povar, G. J. (1991). Striving for quality in health care. Ann Arbor, MI: Health Administration Press.

Pavalko, R. (1971). Sociology of occupations and professions. Itasca, N. Y.: Peacock Publishers.

Phillips, J. R. (1992). The aim of philosophical inquiry in nursing: Unity of diversity of thought. In J. F. Kikuchi & H. Simmons (Eds.), Philosophic inquiry in nursing (pp. 45-50). Newbury Park: Sage.

Polifroni, E. C. & Welch, M. (Eds.) (1999). Perspectives on philosophy of science in nursing: An historical and contemporary anthology. Philadelphia: Lippincott.

Primm, P. L. (1987). Differentiated practice for ADN- and BSN-prepared nurses. Journal of Professional Nursing, 3(4), 218-225.

Roberts, J. S. (1988). Quality healthcare: Its definition and evaluation. In E. F. X. Hughes (Ed.), Perspectives on quality in American health care (pp. 3-33). Washington, D. C.: McGraw-Hill.

Thompson, J. L. (1990). Hermeneutic inquiry. In L. E. Moody (Ed.), Advancing nursing science through research: Vol. 2 (pp. 223-280). Newbury Park: Sage.

Thorne, S., Canam, C., Dahinten, S., Hall, W., Henderson, A., & Reimer Kirkham, S. (1998). Nursing's metaparadigm concepts: Disimpacting the debates. Journal of Advanced Nursing, 27, 1257-1268.

Yegdich, T. (1999). On the phenomenology of empathy in nursing: Empathy or sympathy? Journal of Advanced Nursing, 30, 83-93.

VITA

Mary Ellen Gunther was born in Chicago, Illinois on September 19, [redacted] She graduated St. Mary of Nazareth Nursing School in [redacted]. She accepted a staff nurse position at Cook County Hospital where she worked until relocating to Madison, Wisconsin. While in Madison, she worked at the University of Wisconsin Hospital. In [redacted] she moved to Knoxville, Tennessee and accepted a staff nurse position at the University of Tennessee Medical Center. Entering the University of Tennessee College of Nursing, she received a Bachelor of Science in Nursing in [redacted] and a Master of Science in Nursing in [redacted]. During that time, she advanced to Head Nurse and eventually, Clinical Director of Pediatrics at the Medical Center. In 1995, while holding the position of Director of Nursing Finance at the Medical Center, she entered the doctoral program at the College of Nursing. In 1998, she resigned her position at the Medical Center to pursue her studies full-time. She accepted a part-time position teaching in the undergraduate nursing program at the University of Tennessee in 2000. The doctoral degree was received May, 2001.