Middle Range Theory for Nursing

Second Edition

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Patricia R. Liehr (left) and Mary Jane Smith (right).

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and

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Foreword

This second edition of *Middle Range Theories for Nursing* extends the disciplinary boundaries of nursing and at the same time, deepens our understandings of core nursing content relevant to research and professional nursing practice. The importance of this contribution cannot be overestimated.

At the time of the publication of the first edition of the book, Smith and Liehr were pioneers in addressing middle range theories. Importantly, in that first edition the editors brought together eight middle range theories for nursing that had never been presented collectively. Since that time, doctoral education in nursing has vastly expanded, and the demand for knowledge of middle range theories has increased. While it is always important to introduce a movement, it is even more important to sustain a movement, especially for a developing discipline such as nursing.

In this new edition, there are 12 middle range nursing theories presented, evidence that the discipline has moved forward in the development of theoretical knowledge. Of the four new theories added, one, the theory of symptom management, serves as an umbrella for a considerable program of research in nursing. As such it has undergone much testing and provides strong support for application to professional nursing practice. The other new chapters, focused on theories of cultural marginality, caregiving dynamics, and moral reasoning are in the early stages of their development. It is important to include these new ideas so that, through systematic evaluation, nurse scholars can assist the authors in the theory refinement.

There also are new chapters that add considerable depth to the book. These chapters provide substantive content that will be useful to both faculty and students. They place middle range theory development within the context of disciplinary knowledge, a contribution that is needed for nurse scholars at all levels, including those in academic and clinical environments. One of the most important contributions that Smith and Liehr have made is to refocus attention on the theory lens of nursing knowledge

development, particularly significant at a time when the focus has drifted to empirical and practical knowledge.

As with the first edition, there are key dimensions of the work that make it especially useful to new students of nursing theory, at the graduate and undergraduate levels. First, the structured format that is used across all theory chapters makes for a consistent level of explanation and analysis, and is especially useful for those trying to understand the similarities and differences in the theories. With this structure it is not difficult to assess knowledge development content components, or to evaluate the internal and external validity of the theories. Second, the ladder of abstraction diagrams that are presented for each of the theories provides a useful tool for those learning about middle range theories and how they are embedded in both philosophical and empirical referents. These figures also will serve as a springboard for future theorists, those who are using the middle range theories provided here to crystallize their own thinking about phenomena of interest within the discipline of nursing. And, importantly, each of the chapters is grounded in theory use in research and professional practice.

As with the first edition, this book is a welcome addition to nursing science literature. The content focus of the nursing discipline can be considered more critical for expansion, as nurse scholars search for their unique contribution to the understandings of health and wellness among individuals, families, and communities. This contribution extends our understandings and presents new opportunities for expanding the science of nursing through research and theory.

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Preface

The interest in middle range theory continues to grow as demonstrated by the increased number of published theories as well as the desire among nursing faculty and researchers to have theories at the mid-range level to guide practice and research. The book is based on the premise that students come to know and understand a theory as the meaning of concepts are made clear and as they experience the way a theory informs practice and research in the everyday world of nursing. Over the past years, we have heard from students and faculty telling us that the book is user-friendly and truly reflects what they need as a reference to move middle range theory to the forefront of research and practice.

Middle range theory can be defined as a set of related ideas that are focused on a limited dimension of the reality of nursing. These theories are composed of concepts and suggested relationships among the concepts that can be depicted in a model. Middle range theories are developed and grow at the intersection of practice and research to provide guidance for everyday practice and scholarly research rooted in the discipline of nursing. We use the ladder of abstraction to articulate the logic of middle range theory as related to a philosophical perspective and practice/research approaches congruent with theory conceptualization.

The middle range theories chosen for presentation in this book cover a broad spectrum—from theories that were proposed decades ago and have been used extensively to theories that are newly developed and just coming into use. Some of the theories were originated by the primary nurse–author who wrote the chapter, and some were originally created by persons outside of nursing. After much thought and discussion with colleagues and students, we have come to the conclusion that theories for nursing are those that apply to the unique perspective of the discipline, regardless of origin, as long as they are used by nurse scholars to guide practice or research and are consistent with one of the paradigms presented by Newman and colleagues (Newman, Sime, & Corcoran-Perry, 1991). These paradigms, which are recognized philosophical perspectives unique to the discipline, present an ontological grounding for the middle

range theories in this book. By connecting each theory with a paradig-matic perspective, we offer a view of the middle range theory's place within the larger scope of nursing science. This view was included to create a context for considering theories other than those developed by nurses that have been used to guide nursing practice and research.

We have added two new chapters on understanding and using mid-dle range theory. Marlaine Smith's "Disciplinary Perspectives Linked to Middle Range Theories" elaborates on the structure of the discipline of nursing as a context for the development and use of middle range theo-ries. This context is an important historical dimension for theory devel-opment today. It creates the foundation for what is shared in the chapters that follow. The second new chapter is titled "Building Structures for Research." This chapter presents a systematic approach to guide students in conceptualizing their ideas for research. The approach can also be used by faculty who teach courses in which students are working to establish their ideas for thesis and dissertation research. Included in this chapter are two exemplars written by students demonstrating use of the process. We decided to include this chapter as we simultaneously added to this edition of the book the theories of three new authors who had been our students. These students, like many others with whom we have engaged, contributed to our understanding of how to build structures for research. While this structure-building effort shares some of the processes of con-cept development, it is distinguished by its consistent foundation in nurs-ing practice stories and its culmination in a newly created model to be used in research.

Four new middle range theories have been added to this second edi-tion, bringing the total of theories in this book to 12. The new theories include: Symptom Management, Cultural Marginality, Caregiving Dy-namics, and Moral Reckoning. The theory of Symptom Management has been in the forefront of practice and research by Humphreys and colleagues for over a decade. Inclusion of this established theory brings an added dimension to this second edition by representing the work of a team of researchers focused on symptoms. The three chapters describ-ing new theories address major societal priorities that impact health in today's world. Immigration and the growing diversity of the nation call for related theory to inform understanding of health issues that arise for ethnically diverse populations. Choi's theory of cultural marginality de-scribes one of these issues, being on the edge of two distinct cultures while trying to transition. The second societal priority is the growing population of frail elderly and persons with chronic illness who need help from caregivers in managing everyday living. Williams' theory of care-giving dynamics offers a perspective for guiding research and practice focused on the energy necessary to persist with caregiving over time. The

third societal priority is the moral–ethical impact engendered by escalating use of technology and the complex nature of technologically driven health care delivery systems. Nathaniel's chapter on moral reckoning offers guidance in coming to terms with moral–ethical situational binds that arise in complex circumstances.

Those theories published in the first edition and included in this second edition are: Uncertainty, Meaning, Self-Transcendence, Community Empowerment, Unpleasant Symptoms, Self-Efficacy, Story, and Family Stress and Adaptation. Each chapter addressing a middle range theory follows a standard format. This includes purpose of the theory and how it was developed, concepts of the theory, relationships among the concepts and a model, use of the theory in nursing research, use of the theory in nursing practice, and conclusion. We believe this standard format facilitates a complete understanding of the theory and enables a comparison of the theories presented in the book.

Each theory is depicted on a ladder of abstraction that offers a clear and formal way of presenting the theories. The ladders were created by the editors and represent the editors' view of the philosophical grounding of the theory rather than the chapter authors' view. We have found that a ladder of abstraction can provide a starting place to guide students' thinking when they are trying to make sense of a theory. In addition, moving ideas up and down the ladder of abstraction generates scholarly dialogue. This process of moving up and down the ladder of abstraction is critical to building structures for research described in Chapter 3. The more dialogue on theory dimensions, the more likely it will be that theory will be understood, valued, and used as a guide for nursing practice and research.

The reader will notice when reading this book and comparing the theory descriptions from one edition of the book to the next that some theories have had ongoing development and use while others have received less attention and use during the last 5 years. The vibrancy of the theory is dependent on its use by scholars who critique and apply it, testing its relevancy to real-world practice and research. Proliferation of middle range theory without ongoing critique, application, and development is a concern that requires ongoing attention.

It is interesting that there are beginning clusters of middle range theories around important ideas for the discipline, such as symptoms. It would be useful to evaluate theory clusters, noting the common ground of guidance emerging from the body of scholarly work documented in the theory-cluster. An advantage of this effort would be that the thinking of unique nurse scholars would come together. One might expect that essential dimensions of the discipline could be made explicit by distilling and synthesizing messages from a theory-cluster. Although the analysis

of theory clusters is not undertaken in this book, the information about middle range theory provided here creates a foundation for considering theory-cluster analysis.

In conclusion, this second edition represents a broader range of middle range theories including those that address societal priorities impacting health. The added chapters on disciplinary perspectives linked to middle range theory and on building structures for research contribute essential foundations related to the historical underpinning for middle range theory and the development and direction for future scholarly endeavors. As with the previous edition, we have edited and written with the intention of clarifying the contribution of middle range theory. We believe this clarification serves established as well as beginning nurse scholars seeking a theoretical foundation for practice and research.

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REFERENCE

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Disciplinary Perspectives Linked to Middle Range Theory

Marlaine C. Smith

Each discipline has a unique focus for knowledge development that directs its inquiry and distinguishes it from other fields of study. The knowledge that constitutes the discipline has some organization. Understanding this organization or the structure of the discipline is important for those engaged in learning the theories of the discipline and for those developing knowledge expanding the discipline. Perhaps this need is more acute in nursing because the evolution of the professional practice based on tradition and knowledge from other fields preceded emergence of substantive knowledge of the discipline. Nursing knowledge is the inclusive total of the philosophies, theories, research, and practice wisdom of the discipline. As a professional discipline this knowledge is important for guiding practice. Theory-guided, evidence-based practice is the hallmark of any professional discipline. The purpose of this chapter is to elaborate the structure of the discipline of nursing as a context for understanding and developing middle range theories.

The disciplinary focus of nursing has been debated for decades, but now there seems to be some general agreement. In 1978, Donaldson and Crowley stated that a discipline offers "a unique perspective, a distinct way of viewing . . . phenomena, which ultimately defines the limits and nature of its inquiry" (p. 113). They specified three recurrent themes that delimit the discipline of nursing:

1. Concern with principles and laws that govern the life processes, well-being, and optimum functioning of human beings, sick or well;
2. Concern with the patterning of human behavior in interaction with the environment in critical life situations; and
3. Concern with the processes by which positive changes in health status are affected (p. 113).

Nursing is a professional discipline (Donaldson & Crowley, 1978). Professional disciplines such as nursing, psychology, and education are different from academic disciplines such as biology, anthropology, and economics, in that they have a professional practice associated with them. According to the authors, professional disciplines include the same knowledge, descriptive theories, and basic and applied research common to academic disciplines. In addition, prescriptive theories and clinical research are included. So the differences between academic and professional disciplines are the additional knowledge required for professional disciplines. This is important, because many refer to nursing as a practice discipline. This seems to imply that the knowledge is about the practice alone and not about the substantive phenomena of concern to the discipline.

Failure to recognize the existence of the discipline as a body of knowledge that is separate from the activities of practitioners has contributed to the fact that nursing has been viewed as a vocation rather than a profession. In turn, this has led to confusion about whether a discipline of nursing exists. (Conway, 1985, p. 73)

While we have made significant progress in building the knowledge base of nursing, this confusion about nursing lingers with other professions and in the public sphere.

Fawcett's (1984) explication of the nursing metaparadigm was another model for delineating the focus of nursing. According to Fawcett, the discipline of nursing is the study of the interrelationships among human beings, environment, health, and nursing. While the metaparadigm is widely accepted, the inclusion of nursing as a major concept of the nursing discipline seems tautological (Conway, 1985). Others have defined nursing as the study of the life process of unitary human beings (Rogers, 1970), caring (Boykin & Schoenhofer, 2001; Leininger, 1978; Watson, 1985), human–universe–health interrelationships (Parse, 1981), and "the health or wholeness of human beings as they interact with their environment" (Donaldson & Crowley, 1978, p. 113). Newman, Sime, and Corcoran-Perry (1991) created a parsimonious definition of the focus of nursing that synthesizes the unitary nature of human beings with caring: "Nursing is the study of caring in the human health experience" (p. 3).

My own definition uses similar concepts but shifts the direct object in the sentence: "Nursing is the study of human health and healing through caring" (Smith, 1994, p. 50). This definition can be stated even more parsimoniously: Nursing is the study of healing through caring. Healing comes from the same etymological origin as "health," haelen, meaning whole (Quinn, 1990, p. 553). Healing captures the dynamic meaning that health often lacks; healing implies a process of changing and evolving. Caring is the path to healing. In its deepest meaning it encompasses one's connectedness to all that is, a person-environment relatedness. Nursing knowledge focuses on the wholeness of human life and experience and the processes that support relationship, integration, and transformation. This is the focus of knowledge development in the discipline of nursing.

Defining nursing as a professional discipline does not negate or demean the practice of nursing. Knowledge generated from and applied in practice is contained within this description. The focus of practice comes from the definition of the discipline. Nursing has been defined as both science and art, with science encompassing the theories and research related to the phenomena of concern (disciplinary focus) and art as the creative application of that knowledge. Newman (1990) and others, perhaps influenced by critical/postmodern scholars, have used the term praxis to connote the unity of theory–research–practice lived in the patient–nurse encounter. Praxis breaks down the boundaries between theory and practice, researcher and practitioner, art and science. Praxis recognizes that the practitioner's values, philosophy, and theoretical perspective are embodied in the practice. Chinn refers to it as "doing what we know and knowing what we do" (Wheeler & Chinn, 1991, xii). Praxis reflects the embodied knowing that comes from the integration of values and actions and blurs the distinctions between roles of practitioner, researcher, and theoretician.

Middle range theories are part of the structure of the discipline. They address the substantive knowledge of the discipline by explicating and expanding on specific phenomena that are related to the caring-healing process. For example, the theory of self-transcendence explains how aging or vulnerability propels humans beyond self-boundaries to focus intrapersonally on life's meaning, interpersonally on connections with others and the environment, temporally to integrate past, present, and future, and transpersonally to connect with dimensions beyond the physical reality. Self-transcendence is related to well-being or healing, one of the identified foci of the discipline of nursing. This theory has been examined in research and used to guide nursing practice. With the expansion of middle range theories the skeletal outline of the discipline of nursing is enriched.

Several nursing scholars have organized the knowledge of the discipline into paradigms (Fawcett, 1995; Newman et al., 1991; Parse, 1987). The concept of *paradigm* originated in Kuhn's (1970) treatise on the development of knowledge within scientific fields. He asserted that the sciences evolve rather predictably from a preparadigm state to one in which there are competing paradigms around which the activity of science, normal science, is conducted. The activity of science to which he is referring is the inquiry examining the emerging questions and hypotheses surfacing from scientific theories and new findings. Paradigms are schools of shared assumptions, values and views about the phenomena addressed in particular sciences. It is common for mature disciplines to house multiple paradigms. If one paradigm becomes dominant and discoveries within it challenge the logic of other paradigms a scientific revolution may occur.

Parse (1987) modeled nursing with two paradigms: the totality and simultaneity. For her, the theories in the totality paradigm assert the view that humans are bio-psycho-social-spiritual beings responding or adapting to the environment, and health is a fluctuating point on a continuum. The simultaneity paradigm portends a unitary perspective. Unitary refers to the distinctive conceptualization of Rogers (1970, 1992) that humans are essentially whole and cannot be known by conceptually reducing them to parts. Also, the term unitary refers to the lack of separation between human and environment. Health is subjectively defined by the person (group or community) and reflects the process of evolving toward greater complexity and human becoming. Parse locates only two nursing conceptual systems/theories: the Science of Unitary Human Beings (Rogers, 1970, 1992) and the Theory of Human Becoming (Parse, 1981, 1987) in the simultaneity paradigm. For Parse, all nursing knowledge is related to the extant grand theories or conceptual models in the discipline. While she agrees that theories expand through research and conceptual development, she disagrees with the inclusion of middle range theories within the disciplinary structure if they are not grounded in the more abstract theoretical structure of an existing grand theory or conceptual model explicitly created by a nurse scholar.

Newman and colleagues (1991) identified three paradigms. These paradigms are conceptualized as evolving; the more complex paradigms encompass but extend the knowledge in a previous paradigm. The three paradigms are: particulate–deterministic, interactive–integrative, and unitary–transformative. From the perspective of the theories within the particulate–deterministic paradigm, human health and caring are understood through their component parts or activities; there is an underlying order and predictable antecedents and consequences, and knowledge development progresses to uncover these causal relationships. Reduction and causal inferences are characteristics of this paradigm. The

interactive–integrative paradigm acknowledges contextual, subjective, and multidimensional relationships among the phenomena central to the discipline. The interrelationships among parts and the probabilistic nature of change are assumptions that guide the way phenomena are conceptualized and studied. The third paradigm is the unitary–transformative. Here, the person–environment unity is a patterned, self-organizing field within larger patterned self-organizing fields. Change is characterized by fluctuating rhythms of organization, disorganization, toward more complex organization. Subjective experience is primary and reflects the whole pattern (Newman et al., 1991, p. 4).

Fawcett (1995, 2000) joined the paradigm dialogue with her version of three paradigms. She named them: reaction, reciprocal interaction, and simultaneous action. This model was synthesized from the analysis of views of mechanism versus organism, persistence versus change, and the Parse and Newman and colleagues' nursing paradigm structure. In the reaction worldview, humans are the sum of the biological, psychological, sociological, and spiritual parts of their nature. Reactions are causal and stability is valued; change is a mechanism for survival. In the reciprocal interaction worldview, the parts are seen within the context of the whole, human–environment relationships are reciprocal; and change is probabilistic based on a number of factors. In the simultaneous action worldview, human beings are characterized by pattern and are in a mutual rhythmic open process with the environment. Change is continuous, unpredictable, and toward greater complexity and organization (Fawcett, 2000, p. 11–12).

Each middle range theory has its foundations in one paradigmatic perspective. The philosophies guiding the abstract views of human beings, human–environment interaction, and health and caring are reflected in each of the paradigms. This influences the meaning of the middle range theory, and for this reason it is important that the theory has a philosophical link to the paradigm clearly identified.

Figure 1.1 illustrates the structure of the discipline of nursing. This is adapted from an earlier version (Smith, 1994). The figure depicts the structure as clusters of inquiry and praxis surrounding a philosophic paradigmatic nexus. The levels of theory within the discipline based on the breadth and depth of focus and level of abstraction are represented. Theory comes from the Greek word, theoria, meaning "to see." A theory provides a particular way of seeing phenomena of concern to the discipline. Theories are patterns of ideas that provide a way of viewing a phenomenon in an organized way. Walker and Avant (1995) describe these levels of theory as metatheory, grand theory, middle range theory, and practice theory.

The figure depicts five levels of abstraction. The top oval includes the nursing metaparadigm and focus of the discipline of nursing. This

is the knowledge beyond or at a more abstract level than theory per se. Grand theories are at the next level of the figure and include the abstract conceptual systems and theories that focus on the central phenomena of the discipline such as persons as adaptive systems, self-care deficits, unitary human beings, or human becoming. These grand theories are frameworks consisting of concepts and relational statements that explicate abstract phenomena. In the figure the grand theories cluster under the paradigms. Middle range theories are more circumscribed, elaborating more concrete concepts and relationships such as uncertainty, self-efficacy, meaning, and the others in this text. The number of middle range theories is growing. Middle range theory can be specifically derived from a grand theory or can be related directly to a paradigm. At the bottom level of the figure are the research and practice traditions related to the grand and middle range theories. Walker and Avant (1995) refer to this most specific level of theory as practice theory. Practice theories specify guidelines for nursing practice; in fact, the authors state that the word "theory" may be dropped to think of this level as "nursing practices" (p. 12) or what can be considered practice traditions. Both grand theories and middle range theories have practice traditions associated with them.
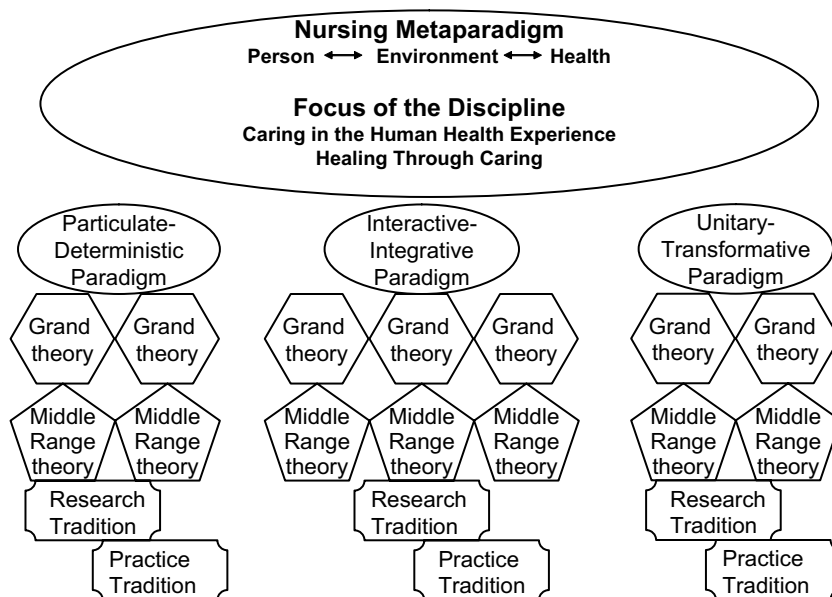

FIGURE 1.1   Structure of the discipline of nursing.

A practice tradition contains the activities, protocols, guidance, and practice wisdom that emerge from these theories. Models such as the LIGHT model (Andersen & Smereck, 1989) or the attendant nurse caring model (Watson & Foster, 2003) are examples. Smith and Liehr (2003) refer to these as micro-range theories, those that closely reflect practice events or are more readily operational and accessible to application in the nursing practice environment. Research traditions are the associated methods, procedures, and empirical indicators that guide inquiry related to the theory.

Some differentiate between grand theories and conceptual models. Fawcett (2000) differentiates them by how they address the metaparadigm concepts as she has defined them. Those that address the metaparadigm of human beings, environment, health, and nursing are labeled conceptual models, while those that do not are considered grand theories. Using her criteria, human caring theory (Watson, 1985) and Health as Expanding Consciousness (Newman, 1986) are considered grand theories. Walker and Avant (1995) include conceptual models under the classification of grand theories, and it seems more logical to define conceptual models by scope and level of abstraction instead of their explicit metaparadigm focus. In this chapter, the grand theories will be referred to as theories rather than conceptual frameworks.

The grand theories developed as nursing's distinctive focus became more clearly specified in the 1970s and 1980s. Prior to this time nursing scholars contributed to theoretical thinking without formalizing their ideas into theories. Nightingale's (1860/1969) assertions in *Notes on Nursing* about caring for those who are ill through attention to the environment are often labeled theoretical. Several grand theories share the same paradigmatic perspective. For example, the theories of Person as Adaptive System (Roy, 1989), Behavioral Systems (Johnson, 1980), and the Neuman (1989) System theory would share common views of the phenomena central to nursing that might locate them within the interactive–integrative paradigm. Others, such as the Science of Unitary Human Beings (Rogers, 1970), Health as Expanding Consciousness (Newman, 1986), and Human Becoming (Parse, 1998), cluster in the unitary–transformative paradigm.

There may be an explicit relationship between some grand theories and middle range theories. For example, Reed's (1991) middle range theory of self-transcendence and Barrett's (1988) theory of power are directly linked to Rogers's Science of Unitary Human Beings. Other middle range theories may not have such direct links to grand theories. In these instances, the philosophical assumptions underpinning the middle range theory may be located at the level of the paradigm rather than of the grand theory. Nevertheless, this linkage is important to establish the theory's validity as

a nursing theory. Theoretical work is located in the discipline of nursing when it addresses the focus of the discipline and shares the philosophical assumptions of the nursing paradigms or one of the grand theories.

Some grand theories in nursing have developed research and/or practice traditions. Laudan (1977) asserts that sciences develop research traditions or schools of thought such as "Darwinism" or "quantum theory"; but in addition, Lauden's view includes the "legitimate methods of inquiry" open to the researcher from a given theoretical system (p. 79). Research traditions include the appropriate designs, methods, and instruments for data generation and analysis and emerging research questions and issues that are at the frontiers of knowledge development. They reflect the logical and consistent linkages between ontology, epistemology, and methodology. Ontology refers to the philosophical foundations of a given theory and is the essence or foundational meaning of the theory. Epistemology is about how one comes to know the theory and incorporates ways of understanding and studying the theory. Methodology is a systematic approach for knowledge generation and includes the processes of gathering, analyzing, synthesizing, and interpreting information. There is a correspondence between ontology (meaning), epistemology (coming to know), and methodology (approach to study) in order to give breadth and depth to the theory.

Examples of the connection between ontology, epistemology, and methodology are evident in several grand theories. For instance, the research-as-praxis method was developed by Newman (1990) for the study of phenomena from the Health as Expanding Consciousness (HEC) perspective, and a research method was developed from the theory of Human Becoming (Parse, 1998). Tools have been developed to measure theoretical constructs such as self-care agency (Denyes, 1982) or functional status within an adaptive systems perspective (Tulman et al., 1991), and debates on the appropriate epistemology and methodology in a unitary ontology (Cowling, 2007; Smith & Reeder, 1998) characterize the research traditions of some extant theories. These examples reflect the necessary relationship between theory, knowledge development, and research methods.

The practice traditions are the principles and processes that guide the use of a theory in practice. The practice tradition might include a classification or labeling system for nursing diagnoses or it might explicitly eschew this type of labeling. It might include the processes of living the theory in practice such as Barrett's (1988) deliberative mutual patterning or the developing practice traditions around Watson's theory such as ritualizing hand washing and creating quiet time on nursing units (Watson & Foster, 2003). The practice traditions are the ways that nurses live the theory and make it explicit and visible in their practice.

Middle range theories have direct linkages to research and practice. They may be developed inductively through qualitative research and practice observations or deductively through logical analysis and synthesis. They may evolve through retroductive processes of rhythmic induction–deduction. As scholarly work extends middle range theories we can expect research and practice traditions to continue developing. For example, scholars advancing uncertainty theory will continue to test hypotheses derived from the theory with different populations. Nurses in practice can take middle range theories and develop practice guidelines based on them. For example, oncology nurses whose worldviews are situated in the interactive–integrative paradigm may develop protocols to care for patients receiving chemotherapy using the theory of unpleasant symptoms. The use of this protocol in practice will feed back to the middle range theory, extending the evidence for practice and contributing to ongoing theory development. The use of middle range theories to structure research and practice builds the substance, organization, and integration of the discipline.

The growth of the discipline of nursing is dependent on the systematic and continuing application of nursing knowledge in practice and development of new knowledge. Few grand theories have been added to the discipline since the 1980s. Some suggest that there is no longer a need to differentiate knowledge and establish disciplinary boundaries because interdisciplinary teams will conduct research around common problems, eliminating the urge to establish disciplinary boundaries. Even the National Institutes of Health Roadmap rewards interdisciplinary research enterprises. This emphasis can enrich perspectives through interdisciplinary collaboration, but it is critical to approach interdisciplinary collaboration with a clear view of nursing knowledge to enable meaningful weaving of disciplinary perspectives.

Nursing remains on the margin of the professional disciplines and is in danger of being consumed or ignored if sufficient attention is not given to the uniqueness of nursing's field of inquiry and practice. There are hopeful indicators that nursing knowledge is growing. The blossoming of middle range theories signifies a growth of knowledge development in nursing. Middle range theories offer valuable organizing frameworks to phenomena being researched by interdisciplinary teams. These theories are useful to nurses and persons from other disciplines in framing phenomena of shared concern. Hospitals seeking magnet status are now required to articulate some nursing theoretic perspective that guides nursing practice in the facility. The quality of the practice environment is important for the quality of care and the retention of nurses. Theory-guided practice elevates the work of nurses leading to fulfillment and satisfaction and providing a satisfying professional model of practice.

The new role of the doctor of nursing practice has the potential to enrich the current level of advanced practice by moving it toward true nursing practice guided by nursing theory. The movement toward translational research and enhanced absorption of research findings into the front lines of care will demand practice models that bring coherence and sense to research findings. Isolated, rapid cycling of findings can result in confusion and chaos if not sensibly synthesized into a model of care that is guided not only by evidence but also by a guiding compass of values and a framework that synthesizes research into a meaningful whole. This is the role of theory. With this continuing shift to theory-guided practice and research, productive scientist–practitioner partnerships will emerge committed to the application of knowledge to change care and improve quality of life for patients, families, and communities.

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