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Theoretical development in the context of nursing—The hidden epistemology of nursing theory

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Abstract

This article is about nursing theories, the development of nursing knowledge and the underlying, hidden epistemology. The current technical–economical rationality in society and health care calls for a specific kind of knowledge based on a traditional Western, Socratic view of science. This has an immense influence on the development of nursing knowledge. The purpose of the article was therefore to discuss the hidden epistemology of nursing knowledge and theories seen in a broad historical context and point to an alternative epistemology for a future context. It is a question about which nursing theories and what nursing knowledge should be developed in order to benefit patients and relatives of the future. We suggest that future knowledge development in nursing be developed in an interchange between theory and practice and guided by philosophy like a kind of pendulum where all three elements are treated as equals. We suggest a framework for the development of nursing knowledge based on a caring-ethical practice, a theory on life phenomena in suffering and relationship-based nursing, and thereby, we may be able to help patients to be cured, to recover, to be alleviated or comforted when suffering.

KEYWORDS

epistemology, evidence-based practice, life phenomena, nursing practice, nursing theory, Socratic

1 | INTRODUCTION

Nursing theory is for many reasons a contested issue. The critique comes from both within the discipline and from outside the discipline, and from society. Nursing theories have over the years served many purposes. The development has been influenced by society and by many different ontological and epistemological interests. For decades, nurse scholars have been strong in developing theory and at the same time scholars and practitioners have discussed the development of theories and concepts for practice (Hall, 1997), and not least the use and usefulness of nursing theories in practice.

The use and usefulness of nursing theory seems always to have been problematic. The historical critique of nursing theory is also the present critique. The critique is based on many differences: there still exists disagreement about the focus of nursing—is it the active, self-providing patient, that society needs in order to keep healthcare costs down, or is it the not-so-active patient who need society's/nurses' help to live with his or her illness. There is also disagreement about the philosophical foundation of the discipline: should nurses focus on self-care or caring, which is related to the focus of the discipline, and about the epistemology of nursing: should knowledge be derived from rationality or relations, which altogether constitute the problems we have with the development of theory and the use of theory. Add to that a global pressure to de-professionalize nursing and other professions in order to serve the New Public Management of health care. In that discourse, theory is of no use for nursing (Thorne

& Sawatzky, 2014). As a consequence, nursing theories are being faded out of nursing education and thereby nursing practice, which has now reverted back to being more task oriented and governed on the one hand, by bureaucrats hired by the government to increase effectiveness, and on the other, the marketization of society. Sadly, it seems that nurses have been "drawn into this preoccupation with productivity (cost)-effectiveness and efficiency, and more specifically, to accept and work hard for what has come to count as productivity in healthcare settings" (Rudge, 2013). This development has left nurses' practices as increasingly instrumental and rationalized (Ceci, Pols, & Purkis, 2017).

> *The discipline of nursing is on a slippery slope with regard to the ever increasing lack of nursing theory in its work. The misguided attempt to eliminate the use of nursing theory as the underpinning of practice is (…) ultimately affecting patient care. A clarion call to the discipline regarding the need for theory in research and practice is required. Nursing will soon become just another set of tasks rather than the profession needed by patients and their families.*

> *The discipline has allowed others to set the rules, make the decisions, and change nursing not for the benefit of the patient but for the convenience of healthcare organizations*
> *(Karnick, 2014, p. 117).*

This development has led us to question what kind of epistemological interests is guiding theory development in nursing.

If nursing theorizing should have relevance in clinical practice in this era, we would like to argue for an explicit epistemology of nursing grounded in explicit philosophical traditions instead of the hidden epistemology that has shaped the development of theory so far.

2 | EPISTEMOLOGICAL ISSUES IN NURSING

Nursing is situated in a field between a practice discipline and an academic discipline. Several perspectives are therefore inherent in the discussion about the theoretical foundation of nursing/nursing theories: generally, it is about what nurses should be able to do and what that requires from nursing education. Basically, it is about what constitutes the core of nursing—nursing ontology. This means that several positions/paradigms are at play. It is a constant interplay between if nurses have too much theory or too little, why do we/do we need philosophy, too few practical competencies, "too posh to wash" or too few theoretical competencies (Rolfe, 2014). The essence of the dispute is nursing ontologies and epistemologies—in the plural.

Nursing has a social mandate and exists on the basis of this mandate:

> *… the discipline is defined by social relevance and value orientations rather than by empirical truths. Thus the discipline must be continually re-evaluated in terms of societal needs and scientific discoveries*
> *(Donaldson & Crowley, 1978, p. 118).*

Thus, the discipline must continually be re-evaluated by society and by the profession, which means that nursing ontology and epistemology is developed/changed parallel to the development of society.

Nursing is characterized as a profession. Although contested and challenged (Schön, 1987), a profession is defined by a set of common markers/characteristics: autonomy, monopoly, specializing, abstraction, education, professional ethics and judgement (Staugaard, 2017). Most of these markers have distinctive theories and practices as prerequisites. Thus, nursing needs its own core theories as part of nursing's own body of knowledge because of the social mandate (the patients we are responsible for helping) and being an autonomous profession (the knowledge base we ground our practice in). Both have scientific development as prerequisites.

Jensen (1995) argues that if a science "is to be more than an arbitrary chosen label, a time bound classification; the use of it must be followed by theoretical considerations" (Jensen, 1995, p. 45). This is also true for nursing.

Any form of scientific practice is expressed in and regulated by concepts (Jensen & Andersen, 2005). Concept development is therefore an important part of knowledge development within a discipline (Eriksson, 2010). A scientific discipline constantly seeks to clarify specific issues, concepts and theories utilized in the discipline and which subject matter to be researched (Jensen, 1995). Concepts are developed through research, and development of core concepts is the first phase of knowledge development. By clarifying and specifying central concepts, the disciplines ontology and epistemology are clarified at the same time.

3 | WHAT IS THEORY?

It is interesting to look at how knowledge has been understood in nursing and just as important what has shaped and influenced how knowledge has been understood and interpreted during times. The goal of scientific activity is to generate knowledge. Then, it is obvious that you need to have an argument as to what constitutes valid knowledge (Delmar, 2006c, 2017; Hoeck, 2011).

When discussing knowledge, science and theory, it is important to understand the Western culture's deep roots in the classical Greek philosophers Plato, Socrates and Aristotle (app. 400 BC). A description of the concept theory and derived understandings of knowledge is therefore valuable (Delmar, 2017).

Socrates is the source of the characteristics of the concept of theory (Benner, Tanner, & Chesla, 2009). His intention was to try and understand what characterize the at that time new scientific disciplines like physics, astronomy and geometry. Earlier on, disciplines did exist, however not as scientific field, and they were based on

experiences and activities in practice. The understanding of the new sciences was that they had to be based on theory, which, according to Socrates, had three essential characteristics: explicit, universal and abstract. Since then, Descartes and Kant completed Socrates' mission by adding one characteristic each, discreet and systematic. The sixth characteristic has been added by modern science. The so-called ideal theory, which characterizes a scientific discipline, is therefore characterized by being (1) explicit: the theory is laid out so complete that it may be understood by any rational human being. Intuition and interpretation does not belong here. (2) Universal: the theory is true at all times and in all places. (3) Abstract: the theory does not contain specific examples. (4) Discrete: the theory must contain context-free elements. (5) Systematic: decontextualized elements are being related to each other by rules and laws. And (6) predictable and complete: all variations in the elements must be specified in order to predict (Delmar, 2017).

The conventional meaning of science is the epistemic meaning, which means "well founded" and "what must be regarded as correct" (Flyvbjerg, 2001, pp. 25, 172). This refers to science that has achieved "paradigmatic and normal-scientific level in the Kuhnian sense" (Flyvbjerg, 2001, p. 173), which means it can explain and predict in terms of context-free knowledge both in the natural and in human sciences. This understanding is the ideal in the natural sciences. The results are founded on a relative, cumulative knowledge production, whose elements are explanation and prediction.

Ideal theories in the conventional meaning do not refer to common interpretations, metaphors or exemplars as they are context-free. Flyvbjerg, who is a professor in Oxford and known as having developed the criteria for the concrete science, raises the classic question of whether the conventional model of science is a suitable ideal for the study of human activity. In other words, is the science of human beings and society different from natural science? Flyvbjerg (2001) points out that the study of human beings and social phenomena has never been, and never can be, scientific in the conventional meaning of science, in an epistemic sense, and therefore, it is not meaningful to talk about "theory" in the study of human activity and social phenomena. Hence, the social sciences should not model themselves on the natural sciences, or measure their achievements accordingly (Flyvbjerg, 2001). This means that the result of other forms of science can never be theory, understood as theory in the conventional meaning of science. Thus, by definition, it cannot explain or predict incidents in the world of the human being, using context-free characteristics.

4 | THE EPISTEMOLOGY OF NURSING THEORY—THE SOCRATIC IDEAL

During the last three decades, the traditional, Western, Socratic understanding of theory characterized by being abstract and context-free has influenced the development of nursing knowledge by the adoption of empirical methods and research, which has facilitated nursing science as an empirical science (Hall, 1997; Kim, 2010). This way of conceptualizing theory influenced the development in American social science in the classification of theories in grand theories and middle-range theories (Merton, 1968; Mills, 1959). The term "grand theory" was coined by sociologist C.W. Mills as a form of highly abstract theorizing where the formal organizing of concepts took priority of the social world. Grand theories were seen as more or less separate from concrete concerns of everyday life and its variety in time and space. A grand theory serves as an overall explanation of phenomena in a particular discipline. It is an approach to theory construction where the theory can be verified by data or empirical testing. A grand theory consists of a set of concepts and the relationships among them (Ayres, 2012). They serve as an overall explanation of a discipline. The concepts addressed in grand theories are highly abstract and therefore untestable. Grand theories are very broad, tend to simplify complex issues, are static and unresponsive to changing conditions (Ayres, 2012).

Middle-range theory was developed by sociologist R. K. Merton and is another approach to theory construction. Middle-range theories start with an empirical phenomenon and from that creating general statements that can be verified by data, in other words a kind of "truth testing" based on the belief that "if a 'theory' is valid it 'explains'." Middle-range theories are hypotheses that can be tested via empirical research. It consists of a limited set of assumptions. They have a limited set of data to research and interpret. It serves as the filling in of "blancs" in "is this working" and gives validity to the concepts. Middle-range theories were supposed to look at measurable aspects of social reality. Ultimately, the body of middle-range theories would become a system of universal laws. This way of looking at theorizing stems from the Socratic way of understanding theory where the goal is to construct one superior, universal theory.

This development influenced immensely on nursing science and the development of nursing knowledge (Kim, 2010). Prior to the 1970s, the development of nursing theories was directed at both the practice and the discipline of nursing reflecting opposite views on whether the discipline should govern the practice or vice versa. This changed in the late 1970s where it became more viable to conceptualize nursing knowledge into general theories referred to as grand theories (Risjord, 2010). These kinds of theories consist of a set of highly abstract concepts and the relationship between them. The concepts cannot easily be operationalized into variables or used in the hypothesis, and therefore, grand theories are not testable. Nursing theories classified as grand theories consisted of, e.g., Nightingale, Orem, Henderson, Newman, Levine and Roy's theories or models. In the 1990s, middle-range theories became popular (Risjord, 2010). Middle-range theories were developed to make grand theories more concrete in order to support nursing interventions. Middle-range theories are still abstract but presumably testable by observation or experiment because the concepts, logically derived from the grand theories, have been made more concrete and specific. Thus, the theoretical focus/attention shifted from developing new grand theories to concept development, which again could be applied to the development of middle-range theories. An abundance of middle-range theories were published between 1988 and 2001, e.g., Mishel, Reed, Barker, Kolcaba and Swanson (Tomey & Alligood, 2006).

The philosophical/epistemological view of nursing knowledge and the understanding and assumptions embedded in the notion of grand theories and middle-range theories are that nursing is a basic science; scientific theories are value-free, have a distinctive logical structure and are deductively derived/conceived. This philosophical understanding of theory development was modelled after the natural sciences. This position of nursing epistemology theory had important consequences for the relation of theory to practice. The view that basic science was not supposed to provide practical guidance made nursing theory and research rather irrelevant to clinical practice (Ceci et al., 2017). The theory practice in nursing was opened and is still open due to the dominant philosophical view of science. Therefore, according to Risjord (2010) and others, it can also be closed by a different philosophical understanding of nursing science.

5 | THE ERA OF EVIDENCE-BASED PRACTICE

After the grand theory and middle-range theory period followed the political drive to "cost out" all aspects of health care including nursing. This development in society and health care led to the evidence-based practice movement and a focus in nursing on developing concrete nursing interventions and therapeutics (Kim, 2010).

The "truth" debate was reignited with the emergence of the evidence-based practice movement. The search for knowledge is one fraught with conflict, and this conflict has both political and ideological perspectives in that the critics pertain to the competition for research funds and in defining the "truth politics." The positivists assume that "truth" can transcend opinion and personal bias. The interpretivists see this as an attempt to legislate one version of truth over another.

The introduction of the concept evidence-based practice and its worldwide dissemination has greatly influenced modern healthcare practice as well as healthcare research (Porta, 2004; Taylor, 2003). Few would disagree with the notion of delivering care based on knowledge about what works, but there remain significant challenges about what evidence is and subsequently, how practitioners should use it in their clinical practice.

Within the modern version of evidence-based practice, evidence is still understood as research evidence produced from one specific/a positivist research position, i.e., the one that constitutes a randomized controlled trial (Kulkarni, 2005; Morse, 2006b; Rycroft-Malone et al., 2004; The Evidence-Based Medicine Working Group, 2002).

This view on science is taken even further in that there is not only a clear preference for evaluating treatment by means of RCTs, but RCTs are also seen as the best form of evidence that can be utilized in evidence-based practice (Dean, 2003; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The highest value has been placed on the meta-analysis of RCTs and the lowest on descriptive and qualitative studies (Eccles, Freemantle, & Mason, 1998). In this graduation of evidence, interpretivist studies do not have the same status as evidence sources in the appraisal of health research. This is illustrated in the so-called evidence hierarchy, the standard for quality of all evidence (Table 1).

As can be seen, the evidence-based approach and view on science does not allow for findings of qualitative research to be considered best evidence.

The field of qualitative research has been criticized for the lack of connection between studies and thereby functioning as "stand-alone" pieces of evidence, which was not in tune with the evidence-based practice movement and the science of summing up.

Consequently, findings from qualitative research do not easily find their way into the clinical world which is preoccupied with and heavily influenced by the evidence-based practice ideology. This makes it difficult to include research on the patient's experience of being ill, and the effect this has on a person, in an evidence-based practice. This perspective is frequently investigated using qualitative research methods.

The widespread embrace of the evidence-based epistemology leads qualitative researchers to look for other methods of including findings from qualitative research in evidence-based practice, hence the emergence of qualitative metasynthesis (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). This method emerged in the late nineties as a response to the evidence hierarchy and as an attempt to competing in the arena of the evidence hierarchy (Thorne, 2017).

Metasynthesis of findings from qualitative studies was introduced as a way to accumulate knowledge on patient's perspectives and thereby getting the patient's perspective and qualitative research findings included in evidence-based practice (Thorne, 2009).

Metasynthesis is described as being better at representing qualitative findings than primary research, and at expanding the findings beyond the original research. This is evident in the various definitions and purported purpose of metasynthesis. Here, words such as "more," "stronger," "broader," "richer," "deeper" and "superior" are

TABLE 1 The hierarchy of levels of evidence

Grade of evidence		Type of evidence
1.	A	Systematic reviews/ meta-analyses
	B	RCTs
	C	Experimental designs
2.	A	Cohort control studies
	B	Case–control studies
3.	A	Consensus conference
	B	Expert opinion
	C	Observational study
	D	Other types of study, e.g., interview based, local audit
	E	Quasi-experimental, qualitative design
4.		Personal communication

used in comparison with the purpose of primary, qualitative research (Campbell, Pound, & Pope, 2003). This kind of terminology indicates an underlying purpose of generalization of knowledge, a focus on the summing up and the accumulation of knowledge, just as it indicates metasynthesis is better than the single, context-dependent study (Green & Thorogood, 2014).

However, the synthesizing removes the findings of the included studies from the richness of the primary description and its intended impact. By definition, context is sacrificed for commonalities in metasynthesis research, being what some call "third-order constructs" (Britten et al., 2002). It therefore seems difficult, on the one hand, to preserve the integrity of the individual study and, on the other, to construct ideal types of experiences of patients that would be transferable to other contexts.

The inherent values in metasynthesis research stem from the conventional meaning of science. Even though there are many different approaches to conducting a metasynthesis, they are all modelled after the quantitative counterpart meta-analysis. Both approaches are born out of the context and demands of the evidence-based practice movement, namely that science needs to be summed up and synthesized in order to enhance the very same evidence-based practice. This also means that metasynthesis research is driven by the pressure to generalize (Green & Thorogood, 2014) by producing, e.g., theoretical abstractions like "third-order constructs" or middle-range theories (Nye, Melendez-Torres, & Bonell, 2016).

The affiliation with evidence-based practice and the use of metasynthesis in clinical practice was not the intent of the earlier metasynthesists such as Noblit and Hare (Thorne et al., 2004). They saw the synthesis enterprise as mere interpretations of interpretations. However, the development of metasynthesis was born out of the wish to synthesize qualitative findings across individual studies and thereby increase the usefulness of qualitative research. The whole industry of qualitative research synthesis has thus moved the metasynthesis genre into something completely different claiming that metasynthesis results are "better truths" and default to an aggregative logic (Noblit in Thorne et al., 2004). Therefore, the notion of metasynthesis misrepresents the entire point of what qualitative research has to offer with regard to the patient's perspective (Thorne, 2017).

6 | NURSING KNOWLEDGE AND EVIDENCE-BASED PRACTICE

The widespread influence of the evidence-based "paradigm" and its inherent epistemology has implication for the development of nursing knowledge. In a commendable effort to include patients' perspectives in evidence-based health care, a proliferation of published metasynthesis has been seen over the last decade (Thorne, 2015, 2017). This kind of aggregative knowledge production emphasizes a nursing epistemology that relies on a Socratic and conventional understanding of knowledge.

Evidence-based practice has also resulted in the need for clinical guidelines. This has put an emphasis on knowledge that pertains to general populations, which is a challenge to nurses' stated focus on the uniqueness of the individual patient (Thorne & Sawatzky, 2014). To develop clinical guidelines, you need empirical research grounded in the evidence hierarchy, and, as it has been shown, the evidence hierarchy utilizes an ideal theoretical frame and epistemic/empirical knowledge. Clinical guidelines are traditionally based on RCTs which preference biological variance to clinical diversity, population to individuals, bureaucratic ideals to clinical reality, rules and standards to context. Clinical guidelines tend to focus only on needs which entail a risk that the nurse distances herself from the patients (Delmar, 2006a). Due to the stated need for clinical guidelines, this kind of epistemology has influenced the development of nursing knowledge. Evidence is often interpreted to mean evidence of effectiveness. Thus, there is a proliferation of empirical research intended to develop evidence-based knowledge that may serve as concrete theory that explains and predicts the effect of particular nursing intervention for particular nursing problems (Willman, Bahtsevani, & Stoltz, 2007).

The problem is that such studies merely focus on the fact that something happened, not why the effect was achieved; i.e., the result is not contextualized. In other words, it does not contextualize the evidence in a broader perspective (Kitson, 2002). Furthermore, evidence-based practice treats evidence as an atheoretical entity and evidence-based practice does not support the shift to patient-centred care (Dahlberg, Todres, & Galvin, 2009; Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001; Kitson, 2002; Mitchell, 1999). This is a problem substantiated in that nursing is not simply an intervention-oriented practice, but deeply rooted in human relationships and patient-centredness. This is at odds with how evidence-based practice is being "practised," e.g., with its narrow definition of what counts as evidence and lack of focus on the perspective of the patients (Kitson, 2002).

Controversies exist regarding the conceptualization of evidence-based nursing in relation to the interpretation of what counts as evidence. Basically, evidence-based practice indicates that practice should rely solely on scientific evidence and that specifically RCTs ought to be the primary scientific source for nurses (Kim, 2006; Mitchell, 1999). If evidence-based nursing is fashioned after the dominant evidence-based medicine, it means that, in principle, nothing else qualifies as a valid basis for action. In this way, evidence can guide the nurse in how to think and act also in relation to the patient and relatives.

The development in society has implications for the development of nursing knowledge. It concerns the knowledge base of the nursing profession and the epistemological battle of the knowledge base of the profession's education in that the knowledge base of nursing is defined by the politicians and public healthcare providers. The development also impacts the development of nursing theory (Hoeck & Winther, 2012).

7 | THE FUTURE EPISTEMOLOGICAL DEVELOPMENT OF NURSING

> *The most critical and central issue the nursing profession must address internally is the issue of knowledge development in nursing*
>
> *(Kim, 2010, p. 3).*

It is important to reflect on, and be clear about what can be considered legitimate knowledge within the field of nursing, and also what kind of knowledge is necessary for nursing, e.g., theoretical, empirical or clinical knowledge (Fawcett et al., 2001). Research is generally the most accepted method of obtaining knowledge, but there are many ways of conducting research. Despite the important role quantitative research, especially RCT, has played, also in nursing, it can no longer embrace all nursing. This is, among other things, substantiated in paradigmatic changes, a change in focus from disease-centred to patient-centred care and subsequently, in the theoretical and professional development of nursing.

So what kind of knowledge does nursing need? One of the important answers to this question lies in the difference between abstract knowledge and concrete context-dependent knowledge, which is grounded in examples.

Flyvbjerg's dismissal of the concept of theory is rather radical seen in the context of nursing. Other definitions of theory could apply to nursing. Both Benner and Wrubel (2001) and Martinsen (1994) argue that the kind of knowledge associated with caring is grounded in theory, but not in ideal theory (Delmar, 2006a). Benner and Wrubel refer to theory generated from qualitative research in caring as interpretive theory in contrast to formal theory (Benner & Wrubel, 1989) or in Flyvbjerg's terminology, ideal theory. Benner (1984) wanted to "uncover the knowledge embedded in clinical nursing practice." Benner argued that knowledge development consists of extending practical knowledge, what she termed the "know-how," through theory-based scientific investigations and charting the "know-how" that nurses developed through their clinical experience in practice (Benner, 1984).

The practical human world is more complicated and dynamic than can be captured by any formal theory. Interpretive theory describes, interprets and explains the actual nursing as it is practised day-to-day, not an imagined ideal of nursing. Martinsen (1994) says that:

> *Theory can be the description of a field, a practice (…). In this sense theories can be derived out of sensuous understanding. It is theory as the articulation of impression. Theory is the linguistic expression of sensuous impression. Theory grows out of an analogous order where some things resemble other things. One identifies with the theory. It expresses the known in the specific [in contrast to theory derived from conceptual understanding] in a novel way for each situation. It is the common denominator in all situations, what reappears in its own characteristic way in each and every situation (p. 167).*

Over the last decade, there has been a reorientation within nursing and the caring sciences towards a more distinctly humanistic way of thinking (Benner & Wrubel, 1989; Delmar, 2006b; Eriksson, 2002; Martinsen, 1994; Meleis, 1992; Mitchell & Cody, 1993; Morse, 2006a; Munhall, 2001; Parse, 1992; Watson, 2005). This humanistic dimension is concerned with understanding lived experience, "the coherent nexus of life as it is humanly lived" (Dilthey 1977 cited in Mitchell & Cody, 1993, p. 55). Particular attention has been focusing on concepts such as caring, relationship-based nursing and personal experience with health (Benner, Hooper-Kyriakidis, & Stannard, 1999; Eriksson, 2002; Meleis, 2005; Naden & Eriksson, 2004; Newmann, Smith, Dexheimer Pharris, & Jones, 2008; Parse, 1998; Watson, 2005). Nursing science is therefore to do with health, illness and personal experience on the one hand and on the other hand, with caring for the patient as a unique person. Nursing evidence in this context is therefore research into personal experience of own situation and how nursing can help patients to overcome an illness and possibly learn to live with it, contextualized in a humanistic and caring perspective.

Nursing theories that are abstract, general and explanatory and where the main purpose of research is to derive and test prediction of such theories are from logical positivism. An understanding of theory as simply a set of concepts and the relationships among these, has epistemological problems concerning the lived life. This kind of theory development in nursing is difficult and maybe even absolute. Nursing also needs theories that focus on concrete descriptions and interpretation as opposed to developing abstract propositions (Maxwell & Mittapalli, 2012). Theories with the ability to elucidate the meanings, processes and contextual influences (as opposed to a causal explanation) are involved in particular events or situations.

Thus, focus on own empirical research at the expense of actual theoretical development cannot serve as the only kind of evidence in nursing. Substantial, coherent paradigmatic theories like Watson (2005), Ray (2016), Eriksson (2002) and Martinsen (2006) are also needed. These theories are grounded in philosophies but not based on empirical research in practice. They are still context-free and abstract; otherwise, nursing will remain as the only task oriented, defined by medical illnesses and thereby not oriented towards the discipline. Nursing knowledge should unfold the discipline and practice in their own right and across medical illnesses.

8 | OUR PROJECT

We need theories as a new science and we need nursing philosophies. In developing nursing theories, we suggest a kind of pendulum between philosophy, theory and practice treating all as equals like Galvin and Todres (2011) and Delmar (2016). The intentions are to create a "thinking horizon," which works more like a mindset not guidelines or a set of rules. This makes it possible to reflect with philosophy on examples from clinical practice, and thus from life that is lived.

Theories that construct the nurse's role as one of caring, nurturing and compassion and with a focus on *life phenomena* are essential. However, there is no tradition for theory development in Denmark; instead, there has been an increased focus on *empirical* research. Internationally, the use of theory and theory development seems to be more in focus in the United States, the UK and to some extent in the other Nordic countries.

Trying to meet the need for theory development in Denmark, we have established a project with the aim to investigate/describe which theory is important to develop to meet patient's and relative's needs with the purpose to create a coherent knowledge base for nursing which supports the humanizing of health care.

The project consists of four subprojects.

1. Analysis of curricula from selected nursing schools focusing on which nursing theories are being taught.
2. A description of future patients and relatives with a background in empirical projects and seen from the development of the welfare state.
3. A description of practice concepts with a background in empirical projects in selected clinics/hospitals.
4. Implementing and trying out the developed theoretical framework/foundation for nursing in clinical practice.

Focus of the project is an investigation of the present theoretical foundation of clinical nursing and nursing education and an investigation of which theoretical foundation nursing should be based on/guided by in the future. The study takes place in close cooperation with three University Colleges, three hospitals and two universities in Denmark. Nordic cooperation is to be established with similar research environment in Tromsoe in Norway, and international cooperation is established with selected research environment in the UK.

8.1 | Philosophical framework

The philosophical framework is based on Delmar's Scandinavian Model of Caring Ethics and theory of life phenomena. Our theoretical thinking is grounded within a Nordic caring-philosophical discourse and a caring-ethical practice. The philosophical foundation is based on the Danish philosopher Knud E. Loegstrup (Loegstrup, 1997) and Martinsen's development of Loegstrup's thinking into nursing (Delmar, 2016).

The theoretical framework is formed by theory on life phenomena in suffering such as life courage, trust, anxiety, which surface through illness developed by the Danish professor Delmar (2013); theories concerning the nurse–patient relationship and interaction also developed by Delmar (2016); a person-centred healthcare system inspired by the Swedish professor Inger Ekman (Ekman et al., 2011), also rooted in a caring discourse developed by the Norwegian philosopher Kari Martinsen (1994, 2006).

Life phenomena are linked to the suffering of illness and therefore highly relevant to nursing. Research on patients' experiences describes that essential life phenomena as expressed by patient and family—life courage, hope, powerlessness and despair—should not be overlooked and ignored by those who work with health, illness and suffering. This provides the rationale for the relevance of the underlying philosophy of a caring ethics with trust and power as a moral challenge (Delmar, 2013).

The phenomenology of every life phenomenon must be described empirically and theoretically. To illuminate the philosophy of life phenomena, we will describe some of the key meanings.

8.2 | Life phenomena

Life phenomena is a general term for the various ethical and existential phenomena that are a given in our lives. With its perspective on the living and the lived life, the Danish life philosophy tradition represented by K. E. Loegstrup (1905–1981) and Ludvig Feilberg (1849–1912) is pertinent in relation to the identification of life phenomena (Delmar, 2013). Ethical life phenomena are synonymous with the manifestations of life, so-called life utterances, a concept which originates in the thinking of the Danish philosopher and theologian K. E. Loegstrup in his paper "Udfordringer" ["Challenges"] (1988).

> *But there is no escaping the fact that our existence includes manifestations that have nothing to do with needs and their gratification: trust, the openness of the spoken word, compassion, mercy, indignation, hope, respect for the other's untouchable zone, to mention some of the most important ones. In order to have a word to summarize them, let us call them life utterances, to be understood as something distinctly different from needs*
>
> *(Loegstrup, 1988; p. 11 in Delmar, 2013, author's translation).*

Loegstrup chose the expression "life utterances" in order to have a term that was all embracing and, most importantly, to mark the distinction between life phenomena and needs.

To get a deeper understanding of the existential meaning of being a person with an illness, it is important to distinguish between two types of basic dimensions of human life and activity: needs and life phenomena in the context of health care (Delmar, 2013).

When a person becomes ill and their life situation changes, the life phenomena become more evident as a result of their illness, and their suffering reflecting uncertainty, transition, comfort, trust, presence, preserving self, hope, powerlessness, vulnerability and caring. To prevent the essential life phenomena expressed by the patient and family from being overlooked and ignored, those who work with health, illness and suffering must focus their attention directly on those significant life phenomena. To grasp this deeper human dimension, it calls for a "definition" of life phenomena and a distinction between two types of basic dimensions of human life and activity: life phenomena and needs (Delmar, 2013).

8.3 | Distinction between life phenomena and needs

Life phenomena and needs are part and parcel of people's participation in life. However, there are distinct differences between life phenomena and needs, differences that are significant for whether a nurse sees and hears what kind of help that the sick and vulnerable person is appealing for in the situation.

Referring to the above quote by Loegstrup (1988), existence holds phenomena that differ essentially from needs (Delmar, 2013). Needs will seek gratification, whether they are bodily, physiological or cultural. Their fluctuation creates inner tensions that strive for release (Pahuus, 1994, 1995). Needs will rise and seek gratification. Their expression is rhythmical, intensifying until satisfaction is achieved, and a new cycle begins. But existence also embraces phenomena that have nothing to do with needs and gratification. Life phenomena do not exhibit such rhythms. They do not have phases, but rather fluctuate between opposite poles, such as hope and doubt.

Technology and industrial production make a business of gratifying human needs. Needs can be refined and thus diversified. Life phenomena are not a question of the inexhaustible satisfaction of perpetually growing individual needs in a constant process of refinement. A life phenomenon is either present or absent, and life phenomena cannot be refined and diversified, whereas they become more evident when illness intrudes. Life phenomena have their origin outside the realm of technological and industrial solutions. They are not about solving problems, but about embracing the existential. Helping the patient in such matters means helping him to understand the various expressions of life phenomena in order to make space for those that are ethical and life-conducive rather than life-constraining.

Life phenomena have their place. There is a difference between being alive and living. Being alive is about survival and needs. Living is about the joy of life and life courage where one connects not only with oneself, but one also stretches beyond oneself in an open and receptive appreciation of the other. Living is connected with humanity's search for meaning and substance in existence. The connection between living and the life phenomena is thus a strong one (Pahuus, 1993).

This is not to say that needs have no place in human life; they are indeed part of being human. Needs should form part of the joy of life and life courage and are thus quite a legitimate human activity (Pahuus, 1994, 1995). Nevertheless, it is important to acknowledge the different human dimensions concerning needs and life phenomena.

The nurse's challenge lies in the very obscurity of the life phenomena, with the attendant danger that they may be overlooked and ignored—because it is in the sick and vulnerable person that life phenomena come to the fore.

Understanding that health care is more than the gratification of the patient's individual needs requires knowledge both of the characteristics of life phenomena and of their presence in our self-realization, and awareness that ethics and existence encompass more than a solely understanding of human needs.

What is it the caring a nurse ought to provide? It is a nurse who is capable of seeing and hearing the existential meaning of being a person with an illness and act on the appeal for help that the sick and vulnerable person expresses.

8.4 | The empirical studies

The empirical studies focus on the concrete and how the lived life is unfolding. This makes the developed knowledge concrete and context dependent. Thus, the empirical projects point back to the thinking horizon. This gives way to a fruitful interplay between philosophy, theory and practice and thereby developing the theoretical framework.

9 | IN CONCLUSION

The development and use of nursing theories and nursing knowledge continues to be a "hot topic" in nursing with many vested interest and opinions. Our intentions have been to call to attention some of the epistemological issues underlying the debate and suggest a way forward. We hold the view that the development of discipline specific knowledge is important. However, we point to the challenge that knowledge development in nursing both historically and at present has been and still is influenced by an epistemology that reflects a conventional, Socratic view of science. This epistemology and the derived knowledge influenced by the technical rationality is dominant in today's society and thereby health care. We are not convinced that development of this kind of nursing knowledge reflects and supports the nursing needs of patients and relatives of the future.

Considering the current political climate in society and the influence it has on health care and the development of nursing knowledge, we therefore suggest that future knowledge development in nursing be developed in an interchange between theory and practice and guided by philosophy like a kind of pendulum where all three elements are treated as equals.

It is our hope that we can succeed in establishing a framework for nursing and thereby also nursing education based on a caring-ethical practice, a theory on life phenomena in suffering and relationship-based nursing. Thereby, we may be able to help patients to be cured, to recover, to be alleviated or comforted when suffering.

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