Running Head: INTERRELATIONSHIP OF THEORY, RESEARCH, & PRACTICE

Brief Paper #2: Interrelationship of Theory, Research, & Practice

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QUESTION: The third course objective for this class states that a goal is to assist students to demonstrate understanding of the interrelationship between nursing theory, research, and practice. Explain how theory, research, and practice are interrelated; give three such examples.

Nursing theory is the value-laden lens through which nurses view the world in which they practice. This set of values and beliefs affects the way they see the four meta-paradigms of nursing (person, health, environment, and nursing), through which they care for patients. These paradigms, or theories, are interrelated with both nursing research and clinical practice, as research and practice are guided by the nurses' general and specific understandings of the world (Fitzpatrick, 2005). Fitzpatrick states that theories provide the overall direction and "foundation for development of both clinical and scientific knowledge […] and the content on which we base our science and professional practice" (2005, p.3). She continues, and states that "one without the other is not sufficient to inform a clinical discipline such as nursing. Rather, clinical scholarship and research are intertwined and interdependent" (2005, p.4). To expound upon this relationship, nursing theory can be derived from research and provide the foundation for clinical practice, just as clinical practice can motivate research, and create practice-level theory. Nursing research, practice, and theory are co-dependent and simply cannot exist without each other.

There are three different types of nursing theories that guide practitioners as they strive to obtain the ultimate goal of making a positive difference in the lives of the patients they serve: grand, middle-range, and practice-level theories. Grand nursing theories are the most abstract type of theory and guide nurses as they seek to conceptualize the profession (i.e. Rogers, Watson, and Nightingale) (Whall, 2005). Conversely, practice or micro-range theories are the most concrete and are specific directions/guides for practice (i.e. policy and

procedure books). Middle-range theories are less abstract than grand theories, yet "contain concepts close to observed data, from which hypotheses may be logically derived and empirically tested" (Good and Moore, 1996, p.74).

Good and Moore (1996) propose a prescriptive middle-range theory on acute pain, which was derived from other middle-range, descriptive theories (specificity, pattern, endogenous opiates, and gate-control theories) and from practice theory (the Agency for Health Care Policy and Research's clinical practice guidelines). This middle-range theory was specifically conceptualized from both research and clinical practice, as Good and Moore (1996) clinically noted that adult surgical patients experience a great deal of acute pain post-operatively. They reviewed the literature and found very few prescriptive theories on how to manage this pain. They found "20 years of studies demonstrating that patients with severe acute pain suffer unnecessarily" and unethically and that intense pain was related to other complications (Good and Moore, 1996, p. 77). In their theory, Good and Moore propose that acute pain relief is equivalent to a balance of analgesia and side effects, and that the nurse's responsibility is to "administer potent pain medication plus pharmacologic and non-pharmacologic adjuvants" with regular re-assessments and education with patients on the necessity to participate in pain relief measures (refer to Appendix) (1996, p. 78).

In addition to the fact that this theory continues to need to be tested, there are many limitations to this study in terms of culture/ethnicity and diversity. Good and Moore state in their assumptions that "patients are adults with ability to learn, set goals, and communicate symptoms" (1996, p.78). Therefore, this theory may not be generalized to include children, adults with learning/mental disabilities, immigrants who cannot communicate in English, elders, or patients with other special medical problems as identified in the article (opiod tolerance, hepatic or renal impairment, shock, trauma, and/or burns). This theory also does

not take into account the different manners in which patients express their pain. For instance, German-American individuals tend to be "stoic" and may not overtly express their pain, and individuals with a painful chronic illness underlying their acute pain may have a higher threshold or pain tolerance than other individuals. These scenarios make it difficult for the nurse to competently assess pain control/relief in these individuals, which makes education about diversity and pain assessment a missing key factor in this theory.

This theory affects public policy in that many institutions have specific guidelines (practice-level theory) for pain control/relief, which may or may not be adequate. As patient advocates, nurses must take this middle-range theory of pain control into account and seek to change policies and practices that negatively affect their patients' well-being. They must be motivated educators to teach that addiction to pain medications is rare and advocate with physicians that patients need adequate pain relief post-operatively. They must also seek to change current policies concerning pain relief at their respective institutions with foundations based on nursing research and theory.

In conclusion, nursing practice, research, and theory are intertwined, interrelated, and interdependent, for one cannot occur without the others. Each can be derived from, or provide the foundation for, the others. As with this middle-range theory of acute pain management, which was based upon research, theories have the potential to move the discipline forward toward a base of knowledge that can be utilized in practice. If nurses want the discipline to be recognized as such, they must be advocates for integrating research, theory, and practice together in a manner which can benefit all those served by the nursing community.

Appendix

Good and Moore, 1996, p. 76

References

Fitzpatrick, J. (2005). Nursing Knowledge Development: Relationship to Science and Professional Practice. In J.J. Fitzpatrick & A.L. Whall (Ed.), *Conceptual Models of Nursing: Analysis and application* (4th ed.) (pp. 1-4). New Jersey: Pearson Prentice Hall.

Good, M. & Moore, S.M. (1996). Clinical Practice Guidelines as a New Source of Middle Range Theory: Focus on acute pain. *Nursing Outlook, 44* (2), 74-79.