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Taxonomies: limitations and potential of NANDA, NIC, and NOC in multidisciplinary clinical practice

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Abstract
Language shapes clinical reality and structures disciplinary knowledge; from this premise, the analysis examines its role in the use of NANDA, NIC, and NOC taxonomies. The objective was to identify their potential and limitations, particularly the communication barriers that arise within multidisciplinary teams. The methodology consisted of a critical documentary analysis informed by philosophical approaches to language and a comparison with systems widely used in health care, such as the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. The results show that although these taxonomies strengthen consistency in documentation and care planning, they present interoperability challenges due to their terminological specificity and the limited training available for their implementation. It is concluded that the effective integration of NANDA, NIC, and NOC requires terminological convergence strategies with other health systems to enhance interprofessional collaboration and improve patientcentered care.
Keywords: Standardized Nursing Terminology. Interventions Classification. Nursing, Interdisciplinary Communication. Unified Medical Language System.

Introduction

This essay reflects on the role of language as a fundamental tool in the construction of reality and argues that it not only facilitates communication but also defines the interpretive frameworks of human experience.[1,2] In nursing, language structures and organizes knowledge, guides practice and informs decision-making. The emergence and consolidation of taxonomies, such as NANDA, NIC, and NOC, represent key advances in the systematization of care, enabling the development of diagnoses, intervention planning, and outcome evaluation.[3-5]

Nursing taxonomies, developed at the University of Iowa in the 1970s, emerged to provide the discipline with a common language, identify human responses to health problems, and guide nursing interventions. This specialized language strengthens the discipline's identity but can hinder work in multidisciplinary teams. Other diagnostic systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), have established a universal language that facilitates collaboration among health professionals.[6,7]

This divergence between the internal precision of nursing taxonomies and their limited capacity for convergence with other clinical languages raises doubts about their effectiveness in addressing the complexity of care in interprofessional settings. In this sense, the "language game" of NANDA, NIC, and NOC consists of using structured and systematized terminology. This allows knowledge to be organized and reinforced. However, this approach may limit the interpretive flexibility necessary to fully understand the subjective and contextual dimensions of the patient experience.[8,9]

This study aimed to analyze the limitations and potential of nursing taxonomies in clinical practice, with an emphasis on their integration into multidisciplinary teams. It aims to identify communication barriers arising from the use of specific terminology and suggest strategies for achieving convergence with other diagnostic systems. This analysis highlights the importance of continuous training and adaptation in language management and seeks to contribute to comprehensive patient-centered care by promoting dialogue and interoperability in the health sciences. Consequently, this study invites reconsideration of the role and scope of taxonomies in nursing.

Language and the construction of reality in nursing

Language distinguishes humanity, and its origin has generated theories divided into two approaches: on the one hand, the continuists, who see a gradual evolution from the communication systems of other primates; and on the other, the discontinuists, such as Chomsky, who argue for specific brain changes that enabled language. Both believe that language goes beyond mere communication, organizing society,

transmitting culture, and contributing to the creation of shared identities. [10-13]

From this perspective, language is not limited to a system of signs used to describe reality but actively constructs it, shaping social and cognitive interactions.[8,11] Sapir argues that each linguistic system has its own conceptual structures and categories, which generate frames of reference that condition the visibility and interpretation of phenomena.[12,14] Berger and Luckmann complement this perspective, arguing that social reality is the product of dialectical processes, which individuals internalize through language and objective realities that give coherence to their subjective identities.[15]

From this perspective, Sapir argues that each linguistic system, from linguistic relativism, uniquely delimits the perception of the world, conditioning how communities interpret their social and cultural experience.[9] According to Austin, linguistic acts not only communicate but also actively transform social reality through specific actions.[16]

In health sciences, particularly nursing, language is important because it allows for conceptual structuring of care through taxonomies. These taxonomies have historical roots in the contributions of Thomas Sydenham (1624–1689), who proposed classifying diseases according to empirically observable symptoms. Currently, the ICD, established in 1979, offers universal terms for describing clinical categories. It is constantly updated to reflect the evolution of medical knowledge.[7,17] Similarly, the DSM has established a common language for mental health. This facilitates interoperability between professionals and disciplines by standardizing the diagnostic criteria.[6]

Simultaneously, the existence of the internationally recognized DSM and ICD has contributed to the integration of clinical knowledge. This is achieved by providing a common language that transcends the terminological barriers between disciplines. From Wittgenstein's perspective and his concept of "language games,"[18] it is suggested that classification systems, such as the DSM and ICD, establish shared semantic rules in the health sciences. This allows for greater cohesion in the interprofessional communication. By defining accepted frames of reference, these taxonomies ensure that terms used in different health fields are understood and applied consistently. This avoids divergence and reduces ambiguity in clinical interpretation. In other words, the use of standard nomenclature not only simplifies communication but also facilitates understanding of the subject. It also shapes how health problems are conceptualized and addressed in each discipline.

The adoption of these taxonomies enables the consolidation of unified clinical records, promotes continuity of care, reduces errors, and optimizes healthcare outcomes.[19,20] However, from Searle's perspective, language does not merely describe reality. It also performs functions that actively transform clinical practice. This implies that imposing a shared technical language is not always beneficial. It can influence the hierarchy of knowledge within the healthcare team and promote the preeminence of certain diagnostic categories over others.[21]

NANDA, NIC, and NOC are oriented toward nursing processes and practices, which gives them specialization but makes them difficult to comprehend in interdisciplinary contexts. Berger and Luckmann explained that each discipline constructs its reality through its own language and classification systems.[15] Therefore, nursing language strengthens the discipline's identity while posing challenges for communication with other health professionals.

This phenomenon raises the need to advance the search for terminological convergence to improve dialogue and collaboration among actors in the healthcare system. Wittgenstein argues that understanding between different "language games" is achieved through shared rules. [18] In nursing, this implies that standardization should not be merely a translation but the result of conceptual negotiation to facilitate disciplinary integration.

This will facilitate the integration of the nursing perspective into multidisciplinary teams, ensuring that the richness and complexity of clinical care are addressed holistically and in a patient-centered manner.[22,23]

Origin of taxonomies in nursing

Medical terminology originates from ancient Greek (Corpus Hippocraticum), consolidating in Latin during the Middle Ages, and subsequently incorporating Arabic terms.[24] In addition to facilitating communication and systematizing care, health language shapes perceptions and approaches to illness and well-being. Nomenclatures such as NANDA, NIC, and NOC exemplify how nursing terminology not only structures clinical practice but also defines which aspects of health are recognizable, measurable, and addressable from a specific professional perspective. This impacts the clinical and social realities of healthcare, establishing a framework that, while precise, also limits interpretive flexibility across interdisciplinary contexts.[25,26]

Nightingale pioneered the conceptualization of nursing as a science through empirical and systematic recording of clinical observations.[27] This subsequently led to the development of the Nursing Care Process (NCP), consolidated by figures such as Peplau and Hall, whose objective was to systematize clinical practice through diagnoses and interventions, generating models that facilitate effective clinical communication.[28-30]

Therefore, in nursing, adopting taxonomies such as NANDA, NIC, and NOC serves a dual purpose: to facilitate the systematization of care and define recognizable aspects amenable to intervention. However, as Sapir points out, each language delimits specific interpretive frameworks, which can restrict interpretive flexibility in multidisciplinary contexts in which not all professionals share the same frame of reference.[9] Thus, terminological systematization in nursing facilitates communication, although, at the same time, it conditions the perception and assessment of health phenomena.[9,31] In short, these nomenclatures not only represent technical language but also conceptual tools that structure clinical practice, defining which dimensions of care are relevant and how they should be approached from a specific perspective.[4,5]

Potential and barriers to the use of NANDA, NIC, and NOC in clinical practice

NANDA, NIC, and NOC are the three fundamental pillars of the organization and systematic development of clini-

cal nursing practice. Their application facilitates both the planning and evaluation of care.[4,5] These classifications emerged at the University of Iowa in response to the need for a shared language to clearly identify human responses to real or potential health situations, thereby facilitating the selection of appropriate interventions. To this end, the development of NANDA International was initially promoted in the 1970s, while in 1987, McCloskey and Bulechek formalized the NIC, which was finally published in 1992, to standardize nursing actions.[3,4] Shortly thereafter, in 1991, Johnson and Maas created the NOC, published in 1997, which defined measurable criteria for the systematic evaluation of nursing care outcomes. [4] These taxonomies not only provide standardized terminology but also participate in structuring a specific reality about health and care.[31]

Consequently, nursing language reflects clinical experience through specific diagnoses that enable health problems to be organized and prioritized.[3] The NIC classifies nursing interventions, providing a framework for evidence-based clinical decision-making, whereas the NOC specifies expected outcomes, providing objective indicators for monitoring the effectiveness of care.[4,5]

While these classifications reduce ambiguity and strengthen methodological rigor in nursing, they also have limitations. According to Sapir, each linguistic system establishes specific interpretive frameworks, delimiting its own "world" that privileges certain categories over others.[14] This implies that professionals unfamiliar with NANDA, NIC, and NOC may have difficulty accurately interpreting nursing interventions or diagnoses in multidisciplinary contexts. Therefore, although standardized terminology improves the internal consistency of care, additional efforts are required to establish clear terminological equivalences that facilitate interdisciplinary communication. This situation shows how language not only passively names reality but also actively delimits and conditions it.[8]

The "language game" and the need for convergence

Wittgenstein's notion of "language games" provides a philosophical framework for understanding the limitations and potentialities of nursing language. Wittgenstein argues that the meaning of words does not reside in the words themselves, but in their practical use in specific contexts.[18] Applying this perspective to nursing, the NANDA, NIC, and NOC classifications can be conceived as a particular "language game," with defined internal rules that allow for the standardization of clinical care. However, these same rules can create communication difficulties when other healthcare professionals do not share the same conceptual or linguistic framework.[18] This implies that professionals from other health disciplines could experience a conceptual disconnect if they do not fully master nursing language, hindering cooperation and a comprehensive approach to patient care.

It can be inferred that the use of these taxonomies strengthens the identity and methodology of nursing, therefore requiring an interdisciplinary and multidisciplinary effort of negotiation and terminological adaptation to ensure effective interaction. Likewise, it can be deduced that the conceptual precision that facilitates nursing work must be accompanied by mechanisms that allow convergence with other languages and clinical perspectives, preventing terminological rigor from translating into professional isolation or communication barriers.

Recent challenges and perspectives

The challenges of standardized language in nursing have been addressed not only from philosophical perspectives but also through analyses of clinical practices. Research has highlighted communication difficulties arising from the use of taxonomies, suggesting the need for educational strategies that harmonize nursing terminology with that of other disciplines in the healthcare field.[22,23] This need is also highlighted by Alzate-Moreno et al. in highly specialized areas, such as intensive care units, where persistent communication barriers between nursing and medicine were identified due to the lack of a common terminological framework. They also highlight that these differences affect joint decision-making, which hinders the coordination of therapeutic plans in critical contexts.[24, 32] Similarly, Lavín and López pointed out that nursing can find itself "out of place" when the discourses and texts used do not reflect the real complexity of care, creating a gap between academic language and including taxonomies—and everyday practice. This gap highlights how disciplinary linguistic frameworks, far from being neutral, can reinforce conceptual distances from other professionals and hinder communication in real clinical contexts.[33-35]

In this sense, the use of NANDA, NIC, and NOC, while systematizing nursing discourse, also raises divergences stemming from the coexistence of various epistemological frameworks within multidisciplinary teams. This reinforces the communication barriers already noted among health professionals, as while NANDA, NIC, and NOC seek uniformity and conceptual clarity in nursing, other frameworks may favor different approaches, leading to differences in understanding and interdisciplinary communication. Furthermore, their implementation across different clinical settings has led to discrepancies in the perception of their usefulness and applicability. From the linguistic relativism of Sapir and Whorf, divergences in the use of NANDA, NIC, and NOC arise because language not only describes but also structures clinical perception, which generates discrepancies when confronted with other classification systems.[2,9] From Wittgenstein's standpoint, each discipline operates within its own "language game," with specific rules that can hinder interdisciplinary communication.[18] In agreement, González López et al. showed that effective clinical collaboration requires trust, symmetrical communication, and a shared vision of care. The participating nurses noted that linguistic and hierarchical barriers continued to limit their participation in decision-making, revealing that the divergence between disciplinary languages directly influenced collaborative dynamics.

For example, a study in Catalonia involving 1,813 primary care nurses identified that these languages are recognized for their ability to structure care; 81% of nurses perceived them as difficult to use in daily practice, and 78% considered that they did not adequately reflect the complexity of care and its outcomes.[35] This suggests that the effectiveness of NANDA, NIC, and NOC depends not only on their institu-

tional adoption but also on their adaptation to the dynamics of each level of care and the degree of familiarity of professionals with their use. In this sense, the lack of clarity in the application of these languages can represent a barrier to interdisciplinary communication and interoperability with other clinical communication systems, which hinders the integration of nursing into the patient-care process. Therefore, it is essential to review and optimize these taxonomies to improve their applicability across different healthcare contexts and strengthen training strategies that facilitate their effective integration into clinical practice. This aligns with a previous analysis of interprofessional communication, which found that errors in information transmission between nursing and medicine pose a direct risk to patient safety, underscoring the need for a shared language to ensure continuity of care.[37]

From a philosophical perspective, Wittgenstein argued that the meaning of language lies in its use in specific social contexts called "language games".[18] This implies that the terms used in nursing practice, such as those in NANDA, NIC, and NOC, acquire full meaning only within the internal, agreed-upon rules of the professional community that uses them.[18] This approach is consistent with the views of Sapir and Whorf, who suggested that language is not only a tool for describing reality but also actively contributes to the perceptual and conceptual configuration of the world.[2, 9] From this logic, the use of the NANDA, NIC, and NOC taxonomies conditions how care is perceived and clinically approached, defining both the visible aspects and those that fall outside the field of priority attention in nursing.[36]

Fuentes Colmenero warns of possible distortions in interpretation, pointing out that the effect of language on cognition and professional practice is sometimes overestimated.[37] Therefore, it is necessary to maintain a balanced approach that recognizes both the operational advantages of using standardized language in nursing and their limitations in interdisciplinary contexts. The critical assessment carried out by Thede and Schwirian reinforces this idea by showing that, although standardized languages are widely accepted, significant variations persist across clinical contexts, highlighting the ongoing need to adapt and contextualize these nomenclatures to specific practical realities.[38] In this way, nursing assumes responsibility for strategically managing language, ensuring its disciplinary relevance, clinical usefulness, and interprofessional acceptance.

Conclusions

The study revealed that the NANDA, NIC, and NOC taxonomies are essential tools for systematizing care and structuring knowledge in nursing, as they provide a standardized language that facilitates planning, intervention, and evaluation of clinical practice. [3,4] However, while this standardization strengthens disciplinary identity, it also creates an interpretive framework that can limit communication with other health professionals. In contrast, the taxonomies adopted in medical and psychological practice, such as the DSM and ICD, have established a common language that transcends specialties and facilitates interoperability within multidisciplinary teams.[6,7]

The apparent lower communication barrier presented by the DSM and ICD compared to nursing taxonomies can be explained, in part, by their universal nature and integration into globally recognized health systems. By addressing health conditions from a broader, more homogeneous perspective, these systems enable a shared interpretation of clinical phenomena, promoting dialogue between disciplines. In contrast, NANDA, NIC, and NOC, by focusing on the specificity of nursing language, introduce a level of detail and technicality that, while useful for the internal systematization of care, may be unclear to professionals who are unfamiliar with such terminology. This phenomenon, which manifests as communication barriers, underscores the need to rethink strategies for terminological convergence that enable greater interprofessional integration without compromising the specificity and rigor inherent in nursing.[1, 31]

It is also imperative to promote empirical research that analyzes the reasons for this linguistic gap. We propose conducting intervention studies that integrate mixed methods to evaluate the impact of training programs designed to harmonize language across disciplines to address this issue. These studies could focus on identifying barriers and facilitators of interdisciplinary communication and establishing operational protocols that enable the effective translation of nursing diagnoses, interventions, and outcomes into a common language with other health sciences. This could enhance cooperation and mutual understanding within work teams, leading to more comprehensive and patient-centered care.

Ultimately, the critical review and adaptation of these taxonomic systems must seek a balance between the technical precision required for nursing practice and the interpretative flexibility that fosters cohesion and dialogue in interprofessional teams, thereby promoting healthcare that reflects the complexity and diversity of human experiences.

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