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What is the validity of a nursing diagnosis?[a]

O que é validade de um diagnóstico de enfermagem?

¿Qué es la validez de un diagnóstico de enfermería?

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ABSTRACT

Objective: to answer the question "What is the validity of a nursing diagnosis?" through an essay that articulates contemporary validity theory, diagnostic reasoning, and standardized languages, proposing a theoretical-conceptual organization of validity evidence. **Method:** argumentative essay based on purposive selection of classic and contemporary references from validity theory, psychometrics, diagnostic reasoning, and nursing diagnosis validation, with an argumentative path inspired by Toulmin. **Results:** validity is not a definitive seal, a universal property of a diagnostic label, or the mere result of expert consultation. Three interdependent axes (substantive theory, diagnostic content, and clinical evidence) are proposed as the authors' original theoretical-conceptual synthesis. Accuracy, reliability, and responsiveness are sources of clinical evidence whose relevance depends on the intended use, rather than constitutive components or equivalents of validity. Ethical considerations, clinical utility, professional scope, and legal legitimacy condition responsible use without being conceptually identical to validity. **Final considerations and implications for the practice:** the validity of a nursing diagnosis is proposed as the degree to which an accumulated and coherent body of substantive-theoretical, content, and clinical evidence supports the intended interpretations and uses of a diagnostic structure to infer a human response in a specific population and context.

Keywords: Nursing Assessment; Nursing Diagnosis; Nursing Process; Standardized Nursing Terminology.

RESUMO

Objetivo: responder à pergunta "O que é validade de um diagnóstico de enfermagem?" por meio de ensaio que articula teoria contemporânea da validade, raciocínio diagnóstico e linguagens padronizadas, propondo uma organização teórico-conceitual das evidências de validade. **Método:** ensaio argumentativo baseado em seleção intencional de referenciais clássicos e contemporâneos dos campos da teoria da validade, psicometria, raciocínio diagnóstico e validação de diagnósticos de enfermagem, com percurso argumentativo inspirado em Toulmin. **Resultados:** sustenta-se que validade não é selo definitivo, propriedade universal do rótulo ou simples resultado de consulta a especialistas. Propõem-se três eixos interdependentes, teoria substantiva, conteúdo diagnóstico e clínica, como síntese teórico-conceitual original dos autores. Acurácia, confiabilidade e responsividade são fontes de evidência clínica cuja pertinência depende do uso pretendido, e não componentes constitutivos ou equivalentes à validade. Considerações éticas, utilidade clínica, escopo profissional e legitimidade jurídica condicionam o uso responsável, sem se confundirem com validade. **Considerações finais e implicações para a prática:** propõe-se compreender a validade de um diagnóstico de enfermagem como o grau em que um conjunto acumulado e coerente de evidências teórico-substantivas, de conteúdo e clínicas sustenta as interpretações e os usos pretendidos de uma estrutura diagnóstica para inferir uma resposta humana em população e contexto específicos.

Palavras-chave: Avaliação em Enfermagem; Diagnóstico de Enfermagem; Processo de Enfermagem; Terminologia Padronizada em Enfermagem.

RESUMEN

Objetivo: responder a la pregunta "¿Qué es la validez de un diagnóstico de enfermería?" mediante un ensayo que articula la teoría contemporánea de la validez, el razonamiento diagnóstico y los lenguajes estandarizados, proponiendo una organización teórico-conceptual de las evidencias de validez. **Método:** ensayo argumentativo basado en la selección intencional de referentes clásicos y contemporáneos de los campos de la teoría de la validez, la psicometría, el razonamiento diagnóstico y la validación de diagnósticos de enfermería, con un recorrido argumentativo inspirado en Toulmin. **Resultados:** la validez no es un sello definitivo, una propiedad universal de la etiqueta diagnóstica ni el simple resultado de la consulta a expertos. Se proponen tres ejes interdependientes (teoría substantiva, contenido diagnóstico y clínica) como síntesis teórico-conceptual original de los autores. Exactitud, confiabilidad y capacidad de respuesta son fuentes de evidencia clínica cuya pertinencia depende del uso previsto, y no componentes constitutivos ni equivalentes de la validez. Las consideraciones éticas, la utilidad clínica, el ámbito profesional y la legitimidad jurídica condicionan el uso responsable sin confundirse conceptualmente con la validez. **Consideraciones finales e implicaciones para la práctica:** se propone comprender la validez de un diagnóstico de enfermería como el grado en que un conjunto acumulado y coherente de evidencias teórico-substantivas, de contenido y clínicas sustenta las interpretaciones y los usos previstos de una estructura diagnóstica para inferir una respuesta humana en una población y un contexto específicos.

Palabras-clave: Diagnóstico de Enfermería; Evaluación en Enfermería; Proceso de Enfermería; Terminología Normalizada de Enfermería.

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INTRODUCTION

Nursing diagnoses organize clinical reasoning, improve professional communication, guide care planning, and make it possible to evaluate nursing-sensitive outcomes. In standardized systems such as the NANDA International (NANDA-I) classification, currently maintained by the International Nursing Knowledge Association (INKA), the name adopted in 2026 by the former NANDA-I, a diagnosis condenses a clinical interpretation of human responses and therefore goes beyond a list of signs, symptoms, or related factors.[1,2] Validity becomes a decisive issue because it underpins confidence in this interpretation and defines when a diagnostic structure can be used to name a condition and guide clinical decisions.[3]

The nursing literature has accumulated methods for content validation, clinical validation, and diagnostic accuracy, but has not always addressed the question that precedes all of them: what, after all, is the validity of a nursing diagnosis? Studies may estimate sensitivity, specificity, interrater agreement, or expert judgment indices; however, these results alone do not establish whether the diagnostic inference is theoretically supported, clinically interpretable, and generalizable to the intended population and context of use.[4-6] Issues of ethical acceptability, professional scope, and consequences of use are equally relevant to responsible practice, but they must be analytically distinguished from the evidence that supports validity.

This essay answers this question by upholding the thesis that validity is a judgment about interpretations and uses, not a fixed property of the diagnostic label. It argues that supporting validity requires coherence among substantive theory, diagnostic content, and clinical evidence, in a permanently revisable process. This position incorporates contributions from contemporary validity theory and redirects them to the specific nature of nursing diagnoses: inferences about human responses, often not directly observable, made in concrete populations and contexts.[6-8]

The original contribution of this essay does not lie in proposing a new general theory of validity or in replacing established validation methods. Rather, it consists of: (a) translating the unified, interpretive conception of validity to the specific problem of nursing diagnoses; (b) proposing, as the authors' theoretical-conceptual synthesis, three axes for organizing evidence – substantive theory, diagnostic content, and clinical evidence; (c) distinguishing properties of the diagnostic inference and sources of validity evidence from conditions for responsible use; and (d) making explicit that generalization across populations and contexts is a hypothesis to be examined, not an automatically transferable property.[6-10]

METHOD

This is an argumentative essay of a theoretical-conceptual nature, based on selected literature on nursing diagnoses, validity theory, psychometrics and measurement properties, diagnostic validation, diagnostic reasoning, and standardized nursing languages. Bibliographic exhaustiveness was not sought, nor was a systematic review intended; the aim was to construct and test a conceptual thesis capable of answering the question "What is the validity of a nursing diagnosis?".

References were selected purposively according to four criteria: conceptual centrality to the definition of validity; methodological relevance for distinguishing validity, accuracy, reliability, responsiveness, and validation; historical or contemporary influence on nursing diagnosis research; and capacity to shed light on problems of interpretation, generalization, and clinical use. Priority was given to seminal or normative references in validity theory and psychometrics, classic and contemporary studies on the validation of nursing diagnoses, causal models applied to diagnoses, and current sources on standardized languages. The critical reading sought to identify convergences, conceptual tensions, and limits to transposition between these fields.[3,6,8-11]

The logical path was inspired by Toulmin's model of argumentation and organized around a central claim, the data or grounds that support it, warrants that connect the grounds to the claim, qualifiers that limit its scope, and relevant objections or rebuttals.[12] The central claim – validity as a contextualized judgment about interpretations and uses – was contrasted with three recurrent alternative positions: validity as a fixed property of the label, validation as expert consensus, and validity as equivalent to accuracy. The proposition of the three axes resulted from this contrast and is a synthesis by the authors; it was not drawn ready-made from any single existing model.

RESULTS AND DISCUSSION

Nursing diagnoses as inferences about human responses

Nursing diagnostic systems incorporate biological, psychological, social, and spiritual phenomena. Many of these phenomena are not directly observable: spiritual distress, grief, readiness for enhancement, ineffective coping, or low health self-efficacy are inferred from clinical manifestations, reports, behaviors, contextual relationships, and etiological factors. This difficulty does not stem from a weakness exclusive to nursing, but from the nature of the human phenomena that the profession assumes as its legitimate field of care.

The absence of perfect reference standards, or gold standards, is a recurrent criticism of nursing diagnosis validation studies.[3,4] This absence, however, does not prevent phenomena from being organized into classification systems. Rather, it requires greater rigor in making explicit the diagnostic perspective adopted. Without a gold standard, a diagnosis cannot be treated as a simple mechanical correspondence between indicator and condition; it must be understood as an inference justified by theory, content, and clinical evidence.

Borsboom described three ways of conceiving the relationship between observable manifestations and diagnostic constructs: the constructivist perspective, in which the diagnosis is a convenient grouping of symptoms; the diagnostic perspective, in which indicators manifest an underlying latent condition; and the dimensional perspective, in which the person is located

on a latent continuum.[13] Taking the NANDA-I classification of nursing diagnoses as an example, the diagnostic perspective appears to be the most appropriate, given the present/absent structure of many diagnoses, the dichotomous nature of clinical indicators, and the possibility that different diagnoses share clinical manifestations.

Adopting this perspective does not mean assuming immutable clinical essences. It means recognizing that a diagnosis expresses an interpretive hypothesis about the clinical status of the care recipient. Defining characteristics, related factors, associated conditions, and at-risk populations function as elements of a structure that allows an underlying human response and its causes to be inferred, but this inference must be justified in each population, culture, and context of use.

Validity: a property of the diagnosis or of interpretations?

The question of validity requires deciding whether it belongs to the diagnostic structure itself or to the interpretations and uses derived from that structure. Contemporary validity theory, especially in its interpretationist strand, holds that validity belongs to inferences and interpretations, not to the instrument in isolation; that it is a unified concept; and that it constitutes an evaluative judgment.[6,7] This formulation brings validity and diagnostic reasoning closer together, since what is judged valid is the clinical interpretation produced when certain indicators are used to assert the presence or absence of a human response.

If validity were a fixed property of the diagnosis, a diagnosis validated in one population would automatically become valid in any other. This conclusion is inadequate. A diagnosis of maladaptive grieving validated in one culture, for example, does not necessarily present the same characteristics, temporality, modes of communication, and clinical consequences in another culture. The problem is not only linguistic but substantive: values, rituals, beliefs, family norms, and social expectations modify the way a human response manifests itself and is interpreted.

Validity therefore depends on the available evidence, the population, the context, and the purpose of the interpretation or use. It is not a seal definitively granted by a single study, nor a universal attribute of the label. It is a provisional, cumulative, and self-correcting judgment. New evidence may change definitions, exclude indicators, reposition related factors, modify clinical thresholds, or show that an interpretation does not generalize as predicted; in such cases, the validity judgment must be revised.[6] Evidence of undesirable ethical or social consequences may require revision of the use, safeguards, or implementation, even if it does not in itself constitute a refutation of inferential validity.[14]

Context dependence does not imply that every validation process must start from scratch with each new population. Some components may be more stable when the meaning of the phenomenon is preserved, such as the conceptual core of the human response, the definition, and certain theoretical relationships; others tend to be more context-sensitive, such as the prevalence and salience of defining characteristics, forms of expression, relationships among factors, decision thresholds, and the clinical performance of indicators. When transferring a diagnosis to another population, culture, or care setting, it is recommended to specify which inferences will be maintained and to reexamine, according to the intended use: conceptual and linguistic equivalence; relevance and comprehensibility of the content; consistency of observations and decisions; clinical discrimination; responsiveness, when there is longitudinal follow-up; and consequences of use. Generalization should thus be treated as a claim supported by evidence, not as an automatic inheritance from a previous study.[6,10,11]

Between interpretationism, instrumentalism, and the limits of accuracy

The tension between interpretationism and instrumentalism helps delimit the problem. Interpretationism emphasizes the support for interpretations and uses; instrumentalism favors causal relationships between attributes and scores or measures.[7,15] For nursing diagnoses, neither perspective should be adopted simplistically. Validity cannot be reduced to an attribute of the diagnostic structure, but neither can it ignore that a diagnostic structure must produce testable clinical consequences.

Proposals that replace validity with accuracy and appropriateness seek to simplify a complex debate.[16] In doing so, however, they risk shifting the confusion from the term validity to the term accuracy. Accuracy is indispensable when asking whether defining characteristics clinically represent a diagnosis in terms of sensitivity and specificity; but the question of validity is broader. It includes the theory that makes the inference intelligible, the content that delimits the diagnostic structure, the reliability of the interpretation, responsiveness to clinical variation, the consequences of use, and professional responsibility.

Similarly, operational initiatives for evaluating health instruments, such as the COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN), are relevant for standardizing measurement properties, but tend to adopt narrow definitions when transposed uncritically to nursing diagnoses.[11] A diagnostic structure is not merely a measurement instrument; it is a component of a professional language that guides interpretation, communication, intervention, and accountability. For this reason, structural validity, accuracy, and reliability should not be treated as isolated types of validity, but as evidence articulated within an integrated judgment.

Three axes of the validity of a nursing diagnosis

In this essay, the validity of a nursing diagnosis is organized into three interdependent axes: substantive theory, diagnostic content, and clinical evidence. This organization is an original theoretical-conceptual proposition by the authors and functions as a heuristic for ordering sources of evidence, without claiming to be a universal taxonomy of "types of validity." Its derivation combines three movements: the contemporary conception of validity as a unitary judgment about interpretations and uses; the nursing tradition of distinguishing theoretical-conceptual analysis, content validation, and clinical validation; and the need to relate

observable indicators to the postulated human response through theoretical and causal hypotheses.[6,8-10,17-19]

Substantive theory encompasses the conceptual basis of the diagnosis: what is meant by the human response, which mechanisms or relationships make the inference intelligible, how antecedents, factors, and manifestations are related, and which conditions delimit the application of the concept. Without substantive theory, the diagnosis runs the risk of becoming a mere grouping of indicators. Issues of utility, ethics, professional scope, and legal legitimacy are relevant to the consequences and responsible use of the inference, but they are treated here separately from the evidence that supports validity itself.

Diagnostic content describes the structure of the diagnosis: label, definition, defining characteristics, related factors, associated conditions, at-risk populations, and other relevant components. Content analysis examines the relevance, completeness, clarity, and representativeness of the components, the adequacy of conceptual and operational definitions, and, where relevant, linguistic and cultural equivalence, as well as the consistency of the judgments obtained.[17-19] This step is essential but insufficient, because content that is well formulated and accepted by experts does not guarantee that the inference works clinically in real people.

The clinical axis examines whether, in a specific population and context, the diagnostic structure supports the intended inference when applied to data from real people. Depending on the validation question, evidence of accuracy, reliability, and responsiveness may contribute, as may latent class models, item response theory, causal modeling, and other strategies compatible with the nature of the diagnosis.[3,4,8] These properties are not, in themselves, constitutive "parts" of validity: they produce evidence that must be interpreted in connection with substantive theory, content, and the intended use.

Accuracy, reliability, and responsiveness as clinical evidence related to validity

Diagnostic accuracy refers to the ability of the diagnostic inference or decision to adequately discriminate the clinical status of interest. In studies with an observable reference or a defensible latent model, it can be expressed by measures such as sensitivity, specificity, and probabilities associated with the indicators.[4] Accuracy indicates whether clinical data distinguish, with sufficient precision for the proposed purpose, situations in which the human response is or is not supported. It is a property of inferential performance and an important source of evidence, but high accuracy alone does not resolve problems of conceptual definition, content representativeness, or generalization.

In this essay, reliability is not defined as the magnitude of error in the accuracy estimate. It refers to the consistency or reproducibility of diagnostic observations, classifications, or decisions under specified conditions. Depending on the study design, it may involve interrater agreement, temporal stability, measurement precision, or consistency of the attributions made.[11,20] Reliability belongs to the measurement or decision process and conditions the interpretability of certain estimates; however, high consistency does not in itself imply that the interpretation is valid.

Responsiveness, or sensitivity to change, refers to the ability of clinical data and diagnostic status to reflect clinically meaningful changes over time in a manner consistent with the theory underpinning the diagnosis.[8,11,15] Unlike accuracy and reliability, its relevance depends explicitly on the intended use: it is particularly informative when the diagnosis will be used to monitor clinical progress or responses to care. Responsiveness is therefore not a universal condition for every validity judgment, but it can provide important evidence for longitudinal interpretations.

Accuracy, reliability, and responsiveness must therefore be distinguished from one another and from validity. Accuracy provides information on discrimination of clinical status; reliability, on consistency or reproducibility; and responsiveness, when relevant, on the detection of change. The validity judgment integrates only the evidence relevant to the intended interpretation and use and examines its coherence with the three proposed axes. Figure 1 summarizes this relationship and additionally separates the validity judgment from the conditions for responsible use.

Validity, ethics, and clinical responsibility

Assigning a nursing diagnosis is not a neutral act. Naming a person, family, or community through a diagnosis produces clinical, communicative, social, and legal effects. A label can guide timely care, give visibility to neglected needs, and promote continuity of care; but it can also stigmatize, oversimplify experiences, shift responsibilities, or support inappropriate interventions. Consequences and values should therefore be examined alongside validity evidence, because they are part of the judgment about the responsible use of the interpretation, although they are not synonymous with validity.

The consequences and values associated with the use of a diagnosis are relevant to responsible practice but should not be turned into a constitutive condition of validity. A diagnosis may rest on an inference well supported by the available evidence and still be inappropriate for a given decision for ethical, legal, cultural, or professional scope reasons; conversely, a useful or legally permitted classification does not become valid if the inference supporting it is weak. Accordingly, the capacity to guide nursing intervention is understood here as a requirement of utility and actionability in the care process, not as a necessary criterion for the interpretation to be conceptually valid.[6,9,10,14]

This distinction has implications for research, teaching, and practice. Validation studies should make the substantive theory explicit, justify the content, and produce clinical evidence appropriate to the intended use, avoiding reducing validation to expert consultation or to a single index. At the same time, they should examine the consequences, acceptability, equity, professional scope, and legal conditions of use. In teaching, nurses must be trained to differentiate validity evidence, diagnostic performance, and responsible professional decision-making. In practice, diagnostic reasoning requires integrating these dimensions without treating them as synonymous.

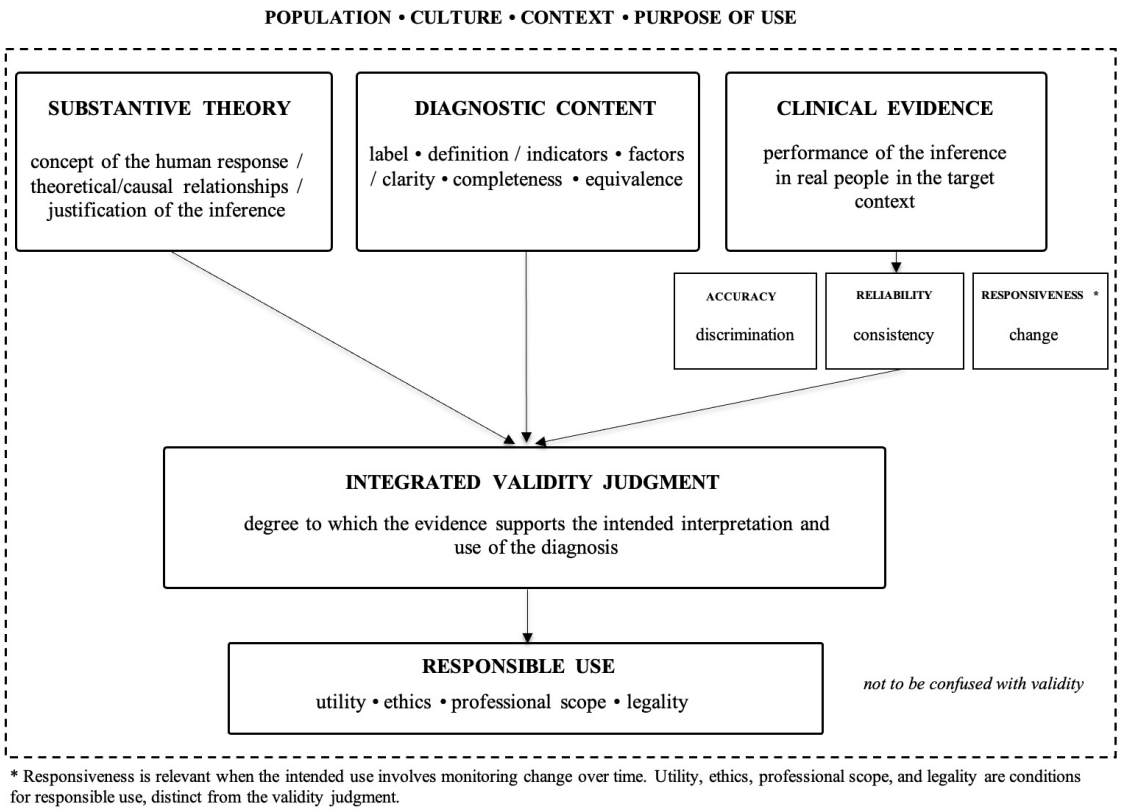

Figure 1. Theoretical-conceptual proposition of the authors for organizing validity evidence for nursing diagnoses.

NANDA 360: emerging implications for validity, accuracy, and clinical reasoning

The organizational transition from NANDA-I to INKA in 2026 is taking place in parallel with the development of NANDA 360. In the official materials consulted, NANDA 360 is described as an expanded classification and an assessment-driven, diagnosis-centered clinical reasoning framework designed to connect assessment data, diagnoses, patient goals and outcomes, and nursing actions in an integrated, evidence-based foundation.[2,21,22] It is important, however, to situate this discussion in time: as of August 2026, NANDA 360 was still under development, with pilot tests to begin in 2026 and the launch of the complete classification planned for 2027.[21] Its implications are therefore discussed here as an emerging scenario, not as a taxonomy already fully in force.

This integration may create relevant opportunities for diagnostic accuracy and validation. By making the connections between assessment data, diagnosis, outcomes, and actions more explicit, NANDA 360 may favor the traceability of reasoning, interoperability, the accumulation of evidence, and the testing of hypotheses about relationships among indicators, human responses, and the effects of care.[21,22] However, digital integration does not automatically confer validity on the proposed connections. Each link incorporated into the structure – for example, between an indicator and a diagnosis or between a diagnosis and an outcome – should be treated as a knowledge claim open to support, revision, and possible refutation.

There is also a pedagogical and epistemological tension that deserves attention. Digital systems can support clinical reasoning when they make rationales and alternatives explicit, but they can impoverish it if data and recommendations are received as ready-made answers. To avoid this shift, education in nursing diagnoses will continue to depend on substantive concepts, critical appraisal of evidence, and the ability to interpret human responses in their cultural and contextual expression. In this sense, the official commitment of NANDA 360 to evidence-based classification and clinical reasoning is compatible with the need for psychometric and clinical validation, but it neither replaces it nor implies adherence to a single validation model.[21,22]

For future research, the emergence of NANDA 360 broadens the object of validation: in addition to investigating the diagnostic structure, it will be necessary to examine empirically the quality of the links between assessment, diagnosis, goals or outcomes, and actions, including their transportability across populations and health systems. The framework may strengthen diagnostic accuracy if its connections are theoretically justified, clinically tested, and continuously updated; conversely, it may produce a false sense of security if technological integration is taken as sufficient evidence of validity. This ambivalence reinforces the

thesis of this essay that validity remains a revisable judgment about interpretations and uses, even in integrated digital ecosystems.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR THE PRACTICE

What is the validity of a nursing diagnosis? In light of this essay, we propose understanding validity as the degree to which an accumulated, coherent, and sufficiently relevant body of substantive-theoretical, content, and clinical evidence supports the intended interpretations and uses of a diagnostic structure to infer a human response in a specific population and context.

This formulation is a theoretical-conceptual proposition, not a definitive answer. It shifts validity from the label to the support for the interpretation and its use, organizes evidence into three axes proposed by the authors, and avoids reducing validity to accuracy, reliability, responsiveness, or expert consensus. The relevance of each piece of evidence depends on the clinical purpose and on the claims to be supported; therefore, different uses may require different sets of evidence.

For practice, the main implication is that nursing diagnoses should be used as justified inferences, not as automatic labels. Considerations of utility, ethics, professional scope, and legality remain indispensable for deciding whether and how a validly supported interpretation should be used, but they are not synonymous with validity. The emergence of NANDA 360 makes this distinction even more important: digital structures can increase the traceability of reasoning and evidence, provided they do not replace critical clinical judgment with predefined associations.

The limitations of this study include its essayistic nature, the absence of a systematic review and of a reproducible search protocol, and the lack of direct empirical testing of the proposition in specific diagnoses. Although the selection criteria and argumentative path have been made explicit, other theoretical traditions may produce different organizations of evidence. The propositions presented should therefore be understood as a theoretical-conceptual hypothesis intended for debate, refinement, and empirical investigation. The discussion of NANDA 360 reflects official institutional information available in August 2026 and should be updated as the classification is completed and implemented.

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DATA AVAILABILITY RESEARCH

The data underlying this research are contained in the article.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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AUTHOR'S CONTRIBUTIONS

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