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The case for nursing theory

Outline of content

This chapter covers the following: the case for theory; the argument that all intentional and rational actions, including nursing actions, by definition must have an underlying theory; an initial definition of theory; how theory and practice become integrated in nursing *praxis*.

Learning outcomes

At the end of this chapter you should be able to:

1. Understand what nursing theory is
2. Define theory
3. Understand the construction/development of a theory
4. Discuss the relationship between nursing theory and science
5. Evaluate the relationship between nursing theory and practice
6. Know the limitations of the nursing theory
7. Understand the importance of nursing theory for contemporary nursing

Introduction

Before nursing students and registered nurses recognise the content and function of theory, they often ask themselves questions such as the following. What are nursing theories? Why study them? What has this got to do with nursing? How can something that is divorced from action, that is by definition abstract and conjectural, be of value to something like nursing, which is one of the most practical of activities?

This book will help to answer these questions. Theories exist everywhere in society. There are numerous theories of the family, of the internal combustion engine, of how cancer cells multiply, of changes in the weather. There are even lots of theories as to who killed President John F. Kennedy or Marilyn Monroe. The world is full of theories, some tested as accurate, some untested and some speculative. It is no surprise, then, that there are theories of nursing. But what do theories do? In essence, they are simply used to describe, explain or predict phenomena (see Reflective Exercise 1.1). This will be explored in detail later.

Reflective Exercise 1.1

Theory

Write down or discuss with other people two different theories for one of the following:

- the break-up of the Beatles
- the assassination of John F. Kennedy
- global warming
- newborn babies smiling when spoken to

Consider if there is the basis of truth in any of these theories.

Now, none of the theories that you outlined for any of the topics in Reflective Exercise 1.1 may be true. In fact, they may be erroneous or downright preposterous. The point is that we all use theories to explain what goes on in our lives or in the world. But if you wanted to, you could probably test or find out whether your theories are true. Later on in this chapter we will outline what theories are made of and how they are formed.

In many ways, theories are like maps. Maps are used to give us directions or to help us find our way in a complicated landscape or terrain. Maps often make simple what is a very complex picture. At their best, nursing theories also give us directions as to how to best care for patients. But why have we got so many nursing theories (over 50 at last count)? If you take any large city, there are many maps. For instance, in London, there are street maps, underground maps, electricity supply maps, Ordnance Survey maps and so on. Consider the London Underground map or the Moscow or Paris Metro maps – they are simple and easy to follow but they do not look anything like the complex reality of the underground networks they represent. In other words, they make a complex system understandable.

Similarly, nursing is highly complex and we need different theories to help us understand what is going on. A theory that can be used in emergency care may not be much use in mental health care, and a theory that can be used to help nurses in a busy surgical ward may be of little use in community care.

Nursing theories can provide frameworks for practice and in many clinical settings they have been used in the assessment of patients' needs. For instance, in the UK one of the most popular nursing theories was designed by three nurses who worked at Edinburgh University – Nancy Roper, Winifred Logan and Alison Tierney. They based their theory on the work of an American nurse called Virginia Henderson. Her theory outlined how nurses should be focused on encouraging patients to be independent in certain activities of daily living (ADLs) such as sleeping, eating, mobilising etc. Roper et al. took this a step further by identifying 12 ADLs. They stressed that it was the nurses' role to prevent people having problems with these ADLs. If this could not be achieved then nurses should help the patients to be independent in the ADLs. If this was not possible then nurses should give the patient and/or the patient's family the knowledge and skills to cope with their dependence on the ADLs. Many clinical nurses used the ADL theory to assess patients. They simply see how independent the patient is for each ADL and then focus their care on those for which the patient is dependent.

Therefore, theory can help us to carry out an individual patient's care and can contribute to better observation and recognition of specific patient needs, be they biological, social or psychological. Nursing theories are often derived from practice. In other words, nursing theorists have constructed their theories based on what they have experienced when working with patients and their families. Understanding the basic elements of a theory and its role, as well as taking a critical view of it, can help to develop a body of knowledge that nurses need for everyday work.

In this book we want to highlight the need for and use of nursing theory and its function. We will try to convince you of the importance of nursing theories to the nursing profession, to nursing education and especially to practice. This first chapter will introduce you to new words and ideas and it will take some concentration to understand the terminology. You may decide to read it in small doses, rather than all of it in one sitting. However, once you have mastered this first chapter, the rest of the book will be relatively easy to understand and, believe it or not, enjoyable. Several aspects of nursing theory are discussed in later chapters, and when reading those, dipping back into this first chapter will be helpful. Have a look at Reflective Exercise 1.2.

Reflective Exercise 1.2

Terminology

When you get involved in a new subject, you often have to learn new words to understand the topic. If you are a nursing student, you have had to learn many new anatomical or psychological words and phrases. Also, think of all the new words you would have to learn to take on any of the following hobbies:

- photography
- astronomy
- music
- gardening

See how many more you can think of. People accept learning new terms as part of understanding something in which they have an interest. The same is true in nursing theory.

4 The necessity and meaning of theory

Some people argue that in the real world of practice most nurses are not concerned with theories and that they are of interest only to nursing academics. However, our position is that there is no such thing as nursing without theory, because there is no such thing as atheoretical nursing. Nursing is theory in action and every nursing act finds its basis in some theory. For instance, if a nurse is talking to a patient, she may be using communication theory. At its simplest, a communication theory would include a speaker, a listener, a message and understanding between the speaker and the listener. Similarly, if she is putting a dressing on a patient, she may be using a theory of asepsis from the field of microbiology. Nurses may not always have a named theory in mind or they may even reject the notion that they are using a theory at all. Yet nurses do what they do for a reason and where there is a *reason* or *purpose* in mind, there is, more often than not, a theory.

When providing care to a patient, we are doing something in a *purposeful* manner. While doing it, we are seeking to understand, to uncover meaning, to determine how we should act on the basis of our understanding. This process describes theorising or *theory construction*. In this sense, theory is not some rarefied academic pursuit, but something that every nurse employs many times a day.

From the moment we start to think about something intentionally, we are constructing a theory. When we speak of construction, we are referring to how something is built or how the parts are put together to form a whole structure. Frequently we are referring to a building that has been constructed, such as a house or a bridge. When we bring *thoughts* together to form some understanding, we are also constructing. In this instance we are producing a *mental* building that has about it a sense of wholeness, which can be explained and shared with others through language.

This draws attention to another significant aspect of this process: when we think, we do so in language. A set of symbols that label the mental images are constructed, made up of our thoughts and the connections we make between them. In daily life too, people use different words and symbols to express meaning. In the same way, all theorists constructing their own theory use their own language and symbols to express and describe the theory. For example, an American nurse theorist, Jean Watson (1979), developed a theory that differentiates nursing from medicine, and advocates a moral stance on caring and nursing as a service driven by specific value systems regarding human caring. According to this theory, the purpose of nursing is to preserve the dignity of clients.

Similarly, another American theorist, Dorothy Orem (1991) began to see that most people are self-caring, e.g. they feed themselves, they get themselves out of bed and they wash themselves. This is a normal way of living for most of the population. Orem saw that self-caring is very important for the preservation of dignity and independence. How would you feel if someone started feeding you or helping you to walk when you could do these things very well yourself? Her theory focused on encouraging patients and helping them towards as much self-caring as possible (Pajnkihar 2003).

Therefore, theory involves thinking (describing) and seeking meanings and connections (explaining), and often leads to actions (predicting). Such knowledge included in different nursing theories can help not only to describe and explain what is significant about patient care, but also to assist with the prediction of what would work with different patients' problems (Pajnkihar 2003). As we outlined earlier, there are many nursing theories to help us describe, explain or predict caring practices. However, we need to be selective in the use of

theories and this will be dealt with in a later chapter. We can, of course, adopt, adapt or develop our own theories, but many of the existing ones have been researched and found to be useful guides for practice and so might be more useful than simply constructing our own. But as with the map analogy discussed earlier, we need to consider them as guides that inform our actions (Meleis 1997, 2007). It has been said that there is nothing as practical as a good theory, so theories only have value if they can be applied in practice.

Theory defined

The issue of what theory actually *is* will be returned to frequently in this and subsequent chapters. There are almost as many definitions of theory as there are nursing theories. Various definitions are offered here with the intention of showing differences in describing and defining what a nursing theory is.

To best understand the various definitions of theory, it would be useful to describe the bits that make up a theory – the working parts of a theory. We have already alluded to some of these. For instance, theories describe, explain or predict phenomena. The singular of phenomena is phenomenon. But what, you may ask, are phenomena? Put simply, phenomena are things we witness through our senses. So a patient falling is a phenomenon, a dog barking is a phenomenon and a wet floor is a phenomenon. Kennedy's assassination was a phenomenon and wound healing is a phenomenon (see Reflective Exercise 1.3).

Reflective Exercise 1.3

Phenomena

Consider your average day in class or at work. Identify five phenomena that you have seen, heard, smelled, touched or tasted.

As you have read, theories seek to explain, describe or predict these phenomena.

When we put a name to a phenomenon, it becomes a concept. To take the examples discussed earlier of a patient falling, a dog barking, a wet floor and an assassination are all concepts. They tend to encapsulate what the phenomenon is. If we can define the concepts, they help clarify our view of the phenomena. So, concepts are the building blocks of a theory (see Reflective Exercise 1.4).

Reflective Exercise 1.4

Concepts

See if you can put a label or name to the five phenomena you identified in Reflective Exercise 1.3. If you can provide a name such that any other person hearing it would know what the phenomenon is then so much the better. Try to define each of the concepts in one sentence.

When two or more concepts are linked, this is called a proposition. The obvious proposition from one of the concepts introduced earlier would be the link between a wet floor and a patient falling. So a proposition would be that the patient fell because of the wet floor. This would be termed a causal proposition. There are different types of propositions and, as you will see in the following, they can be seen as the cement or mortar that binds the concepts (bricks) together to form the structure (a theory) (see Reflective Exercise 1.5).

Reflective Exercise 1.5

Proposition

Consider the names (concepts) you gave to your five phenomena in Reflective Exercise 1.4. Think of other possible concepts they could be linked to. For example, let's say one of your phenomena was seeing a car crash on your way to work or to class. The name you put on this to make it a concept was 'road traffic accident'. Anyone seeing this concept would know what the phenomenon was. What other concepts in the situation could be linked to this concept? Let's say that the traffic lights were not working at that junction or the road was wet and slippery. These are also phenomena and can be expressed as concepts. When you form linkages or relationships between different phenomena, you are developing propositions.

Another term that you will find when you study nursing theory is assumption. An assumption is something that you accept as true even though it has not been tested. For instance, I think readers can assume that people are composed of biological, psychological and social dimensions. If you take the example of the car crash, you may assume that the driver did not want to crash (see Key Concepts 1.1).

Key Concepts 1.1

Phenomenon: something that you experience through your senses

Concept: a name given to a phenomenon

Proposition: a statement that links concepts together different types of relationships

Assumption: something that you take for granted even though it has not been proved or tested

From these exercises you will hopefully be able to understand some of the definitions that exist to explain nursing theory. For example, Dickoff and James (1968: 105) defined nursing theory as a 'conceptual system or framework' whereas Chinn and Jacobs (1979: 2) saw theory as 'an internally consistent body of relational statements about phenomena which is useful for prediction and control'. Chinn & Jacobs later developed the definition further. The more recent definition is more complex (Chinn & Jacobs 1987), but you should understand its meaning: 'a set of concepts, definitions and propositions that project a systematic view of phenomena by designating specific interrelationships among concepts for the purpose of

describing, explaining, predicting or controlling the phenomenon'. The definition highlights the content, context and function of the theory, pointing to the construction of a theory (concepts, definitions and propositions) and the interrelationships between theory elements and functions of a theory (describing, explaining and predicting).

It is important to note here that this description is close to the original meaning of the term 'theory'. It is derived from the Ancient Greek term *theoria*, meaning a spectacle, i.e. something that is witnessed – in other words, a phenomenon!

Another definition, this time by Im and Meleis (1999: 11), drew attention to a theory as something that is purposefully structured: 'an organised, coherent and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole to describe or explain a phenomenon or a set of phenomena'. This clearly states that the theory is a body of knowledge of nursing, and provides answers to questions that are of interest to nursing.

However, more recently, Chinn and Kramer (2008: 219) defined theory as 'a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena'. Earlier in this chapter, we wrote that theories may reflect fact or, indeed, be totally untrue. When a theory is tested many times and stands up to that test, in theoretical language it is beginning to take on the shape of a law. Theofanidis and Fountouki (2008: 16) stated that a theory can be defined as 'a statement representing a law waiting to happen'. For example, let us say a theory of skin integrity led nurses to turn bed-bound patients once every two hours to prevent pressure ulcers. If this was consistently tested through research and found to be true then the theory could be taking on law-like properties.

According to these various definitions, a nursing theory is constructed out of specific nursing phenomena represented as concepts, definitions, assumptions and propositions that help describe, explain or predict how nursing may support and help patients, families or society (see Key Concepts 1.2 and Reflective Exercise 1.6).



Key Concepts 1.2

***A priori* knowledge:** knowledge that arises before experience or, more accurately, without the need for experience

***A posteriori* knowledge:** sometimes called propositional knowledge, this is where knowledge emerges from experience, and we make deductions arising from this. In this instance, it is termed *a posteriori* to denote that it is derived from empirical experience, which, in all instances, precedes it and is its source

Reflective Exercise 1.6

Defining theory

Using your learning and library resources, look up the definitions for phenomena, concepts, propositions, description, explanation and prediction. See if you can find six different definitions of a theory. They do not have to be from the nursing literature. You should find that most of the definitions are composed of the words in the list.

To summarise, the definitions point out that:

- Theory consists of an organised and coherent set of concepts (two or more), definitions and propositions (two or more) that encapsulate specific phenomena in a purposeful and systematic way.
- The proposition(s) must claim a relationship or relationships between the concepts contained in the statement.
- It is a purposeful process and demands creative and rigorous structuring and tentative description of phenomena.
- The purpose of a theory is to describe, explain and/or predict.
- Theories use specific language, ideas or sometimes symbols to give answers to practice-based nursing problems.
- Theories are made up of mental building blocks and they can be explained and shared with others through language.

Some of the definitions proposed here are rather complex. In one sense, they are certainly comprehensive, but in attempting to achieve this, they run the risk of being difficult to understand. It is important, therefore, to spend some time reflecting on the definitions and the various terms used.

Reflection on the definition

Theory often means different things to different people. For example, we have emphasised in our definition above the notion that theory requires concepts (two or more) linked by propositions (one or more) (Figure 1.1). Nevertheless, not everyone agrees with this, and in completing Reflective Exercise 1.6, you will already be aware that there is no shortage of differing definitions. We must at least be aware that there are these differences; that there *are* in fact various ways in which people use the term 'theory'.

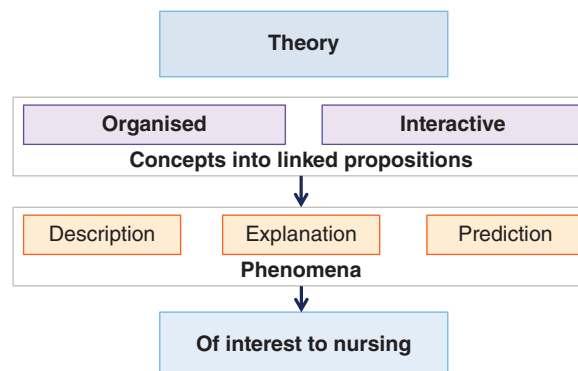


Figure 1.1 The links between theory and practice.

Theory or model

There is also some confusion about the terms *theory* and *model*. These are often used interchangeably. Some authors, such as Jacqueline Fawcett (2005a), see them as very different, whereas others, like Afaf Meleis, see them all as theories, with models simply being a theory at an earlier stage of development or not as advanced – but a theory nevertheless. Therefore, the differences between a theory and a model lie in the level of abstractedness and the level of development. Models are more abstract and are associated with notions of something practical that illustrate real situations. For example, toys (cars), anatomical models (bodies), nursing practice simulators and diagrammatic representations are all models. This difference will be explained in more detail in Chapter 5.

Construction of theory

As we saw earlier, theory consists of *concepts* linked by statements that propose particular types of connections that join these concepts together (*propositions*). Another way of expressing this is that concepts are linked by propositions that demonstrate their relationships. Extending the notion of theory as construction, we might view this in terms of the concepts (bricks) and statements (mortar or cement) metaphor shown in Figure 1.2.

The concepts (bricks) may be of different forms and levels of abstraction, from concrete to abstract (of different shapes and sizes, and made of different materials). They may be 'people' bricks, 'object' bricks or even bricks consisting of more abstract concepts such as 'love' or 'care'. They may be joined together to make descriptive, explanatory or predictive

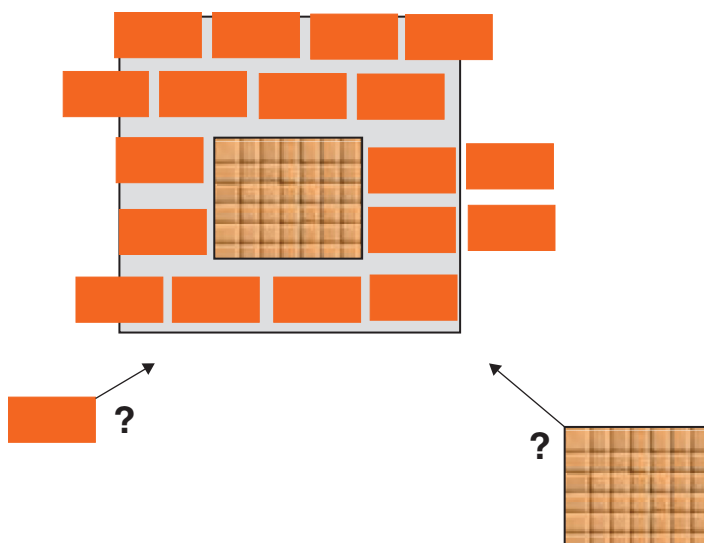


Figure 1.2 Theory as construction.

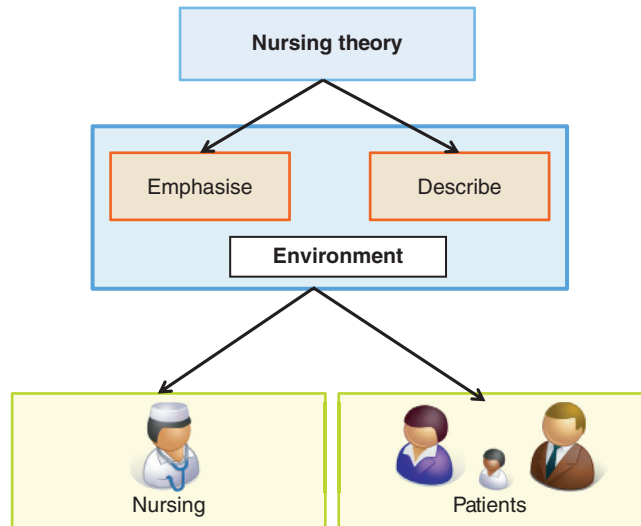


Figure 1.3 Nightingale theory of nursing.

propositional statements (mortar/cement). Additional concepts (bricks) may be added, but they must not look out of place and must adhere in a meaningful way to the propositions (mortar/cement).

The journey to theoretical understanding starts with seeing and trying to interpret phenomena. Some examples of directly observing and describing a phenomenon in practice are seen to underpin the theories of Florence Nightingale (1859) and Hildegard Peplau (1952). Nightingale described her time in the Barrack Hospital during the Crimean War: she saw the unsanitary environment as the main cause of soldiers dying unnecessarily. The old barracks across the Bosphorus from Constantinople had been set up as a hospital; it had poor ventilation and a dead horse was found in the water supply. It is not surprising that most of the soldiers died from infections rather than from the wounds of battle. Nightingale believed that such infections were caused by a 'miasma' that travelled through the air. Therefore, the phenomena she saw in her physical environment were related to better cleanliness and better ventilation. Her theory, not surprisingly, focuses mainly on getting the environment right (Figure 1.3). She wrote that the nurse's role was to place the patients in the best position to let nature cure them (Nightingale 1859).

Peplau's (1952) theory was constructed from the years she spent working as a nurse in psychiatric hospitals. She began to be convinced that the main cause of mental illness was the lack of interpersonal communications between nurses and patients; she described how nurses failed to talk to patients. Therefore, Peplau's theory is mainly centred on how to establish and sustain interpersonal relations with patients. Roper et al. (1983) observed how patients often lost independence in some of their ADLs (e.g. walking, eating or sleeping). Their theory provides nurses with knowledge on how to change dependence to independence in the ADLs (see Reflective Exercise 1.7).

Reflective Exercise 1.7

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Building theory

A cancer nurse notices that patients often become sick when a nurse is giving them chemotherapy. This is a phenomenon that the nurse observes. Her conceptual name for this phenomenon is 'chemotherapy-induced nausea'. The proposition is the link between the two concepts of nausea and chemotherapy. The theory that describes this phenomenon is that every time the patient received chemotherapy he became nauseated. Think about your work in practice, choose one event and discuss what the phenomenon is and identify the related concepts and propositions.

Theory and science of nursing

In this section, the relationship between the theory and science of nursing will be described (Figure 1.4). The starting point is that a theory represents knowledge developed by a systematic process, with the purpose of being useful and helping to improve practice. This is new knowledge, which still has to be tested (Pajnkihar 2003). Theory is best tested by research and once this has been undertaken the theory becomes part of nursing science. Therefore,

$$\text{Science} = \text{Theory} + \text{Research}$$

where theory is the knowledge and research refers to the methods used to test the theory. Karl Popper (1989) famously said the theory was like a paper boat that you placed into a pond to see if it floats or sinks. If it continued to float under different circumstances (e.g. wind or waves),

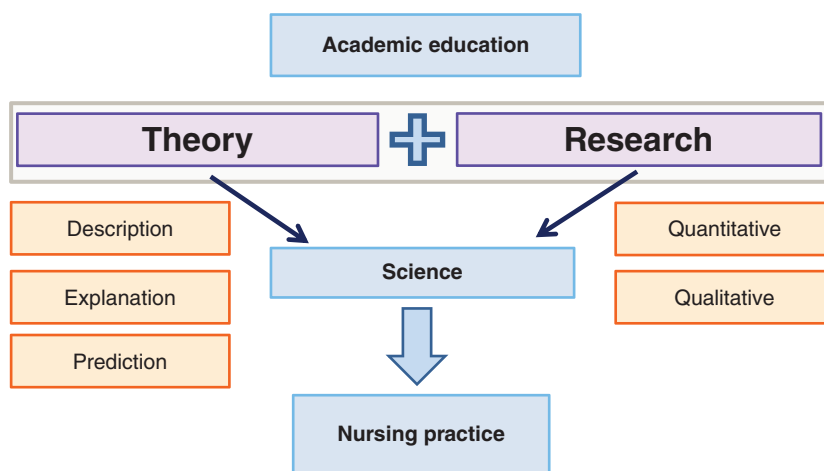


Figure 1.4 Correlation: education, science and practice.

then you could be confident that it was a good paper boat (theory). However, if it sank after many successes then there was a question over the soundness of the design. This can be also seen with nursing theory. If nurses were to research a new theory of oral hygiene for cancer patients and find it effective every time, then such a theory would enter nursing science and become standardised practice. However, if at a later date some researchers found that it did not work or was not effective with people who had a particular form of cancer then the theory would have failed and its position in nursing science would have to be re-evaluated.

From this explanation of what science is and what theory is, we can assert the following: when a nursing **theory** is developed, it forms a body of knowledge that describes, explains and/or predicts phenomena from practice and that gives nursing professional meaning and relevance. Once research shows that theory does what it should do and does so consistently – the end product contributed to nursing **science**.

For Meleis (2012: 28) science is 'a unified body of knowledge about phenomena that is supported by agreed-on evidence. Science includes disciplinary questions and provides answers to questions that are central to the discipline.' For Keck (1998: 16) science is both a 'unified body of knowledge concerned with specific subject matter and the skills and methodologies necessary to provide such knowledge'. Jacox (1974: 406) explained that science as a process incorporates 'methods or research strategies by which knowledge is developed and tested', whereas science as a product is referred to as 'a body of accumulated knowledge that purports to describe some selected aspects of the universe' (Pajnkihar 2003).

Within nursing, science is defined as 'the process, and the result of ordering and patterning the events and phenomena of concern to nursing' (Jacobs & Heuther, 1978: 66). Nursing science, therefore, can be described as a body of knowledge, developed by different methods and approaches that nurses can use to describe, explain and/or predict phenomena. When described as a product it means a theory; when described as a process it means the way (research methods used and research process) in which a theory is developed (Pajnkihar 2003).

Therefore, nursing science is simply nursing theory that has been tested. How nurses practise and how they use this knowledge in their practice to treat patients can be said to be the art of nursing. It is obvious that nursing as a science and as an art are both related to nursing research. The purpose of the science of nursing is to develop knowledge that is applicable and useful in nursing practice (Pajnkihar 2003).

There is no doubt about the worth of having reliable scientific knowledge to underpin nursing practice. Ada Sue Hinshaw (1989: 335) asserted that the nursing profession has a responsibility to society to develop a relevant, accurate and reliable knowledge base for guiding nursing practice. Not only should this knowledge be reliable, but it should also be relevant and accurate, because society's needs and problems are changeable through time. Because such changes occur in nursing care over time, a theory may be continually modified through its use in practice (Pajnkihar 2003).

The main reason for establishing the science of nursing is to acquire sound knowledge that is a relevant and reliable guide to nursing. We can agree that it should be established by way of systematic and rigorous research.

Research is essentially concerned with extending what is already known about nursing and the soundest research findings must be evaluated, published and disseminated before they influence practice. Thus, for theory-based practice, nurses need accurate and reliable knowledge and skills to evaluate evidence and to justify its application to enhance practice and care (Pajnkihar 2003). Im and Chang (2012) also pointed out that theories are essential to nursing science and research. Relationships between research and theory are explained more fully in Chapter 8.

Other interpretations of theory

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For some people, theory is simply a term that differentiates thinking (theorising) from doing (practice). This has a parallel in some people believing that poetry or art have little to do with the practicalities of the real world. When nurses say that theory is of no relevance to their work, it is often the term 'theory' that they are rejecting. An important extension of this meaning is where 'theory' is used as a synonym for the entire body of knowledge that underpins nursing. More precisely, when we speak of a discipline's *theory*, we are referring to its *body of knowledge*, whether or not this is linked to any practical value.

At the outset of this chapter we emphasised that nursing practice is based on theories, but not everyone agrees on this. Some people assert that theory has no relevance to practice and therefore to nursing. Marrs and Lowry (2006) maintained that, on the one hand, there are nursing theorists who emphasise 'knowing' and, on the other, practising nurses focus on 'doing' and deny that theories are useful to them in their everyday practice. In essence, this is separating the 'what' and 'why' of nursing from the 'how' of nursing. We would not subscribe to this view; rather we take a similar stance to Khairulnissa and Moez (2011), who argued that theory is not relevant if it cannot be directly applied and used in nursing practice.

The idea that theory is separate from practice is problematic in nursing; if theory has no relevance to practice, by definition it can have no relevance to nursing. Those who reject such a premise nevertheless recognise the problem of turning theory into practice. This is referred to as the *theory–practice gap* (see Reflective Exercise 1.8).

Reflective Exercise 1.8

The theory–practice gap

Produce a brief one-page (300 word) account of the theory–practice gap. Reflect carefully on whether this is a bad thing or a good thing in any discipline. After all, the research findings in any profession are almost always ahead of the findings being disseminated and being introduced into practice. Therefore, perhaps there will always be a theory–practice gap and it is a good thing. However, you can argue the contrary to this view. Finally, consider ways in which this problem of the gap may be overcome.

As this matter is taken up again in Chapter 3, you should retain the results of this exercise.

Jacobs and Huether (1978: 66) deny nursing the status of science on the terms outlined earlier. Rather, they favour the development of nursing practice based on a strong body of theoretical knowledge, believing that without this, nursing lacks cohesiveness. To improve this, they, along with Schwirian (1998: 37), suggested that nursing should develop scientifically, thus helping to close or minimise the gap between practice and theory.

Main paradigms and philosophies and their influence on the development of nursing science

The term 'paradigm' is closely associated with Thomas Kuhn (1970). He introduced the word to the scientific community to explain how disciplines develop their knowledge (Meleis 2012). The simplest definition of a paradigm is that it is the way in which we view the world. A nursing paradigm is considered to offer a perspective on what nursing is, and it is influenced not just by different scientific traditions but by the problems of the nursing discipline that require different perspectives for understanding (Kim 1989: 169).

Nurses practise within a particular world view, which has significant implications for the profession and patients (Nagle & Mitchell 1991). Let's look at two contradictory nursing paradigms:

- **Paradigm 1.** All patients are dependent and the nurse's role is to carry out all those activities that the patients cannot do themselves.
- **Paradigm 2.** All patients need to be independent and the nurse's role is to encourage patients to do as much as they can for themselves.

These two world views or paradigms of nursing can influence how we nurse, how we teach nursing and how we manage nursing. As Monti and Tinggen (1999) asserted, paradigms act as guidelines for resolving problems and derive theories and laws (Pajnkihar 2003). Kuhn (1970) argued that science without theory is pre-paradigmatic; that is, it is haphazard, has no guiding principles and in fact is not science at all (see Reflective Exercise 1.9).

Reflective Exercise 1.9

The theory–paradigm relationship

Each discipline or science has a particular paradigm – a conceptual orientation or way of seeing the world. The development of nursing theories will also be influenced by the prevailing paradigm within nursing. Consider the two paradigms outlined earlier. How would theories differ if the nursing profession adopted one rather than the other?

It will not surprise you to learn that there are numerous paradigms in nursing. We can classify theories into one of four influential paradigms: systems, interactional, behavioural and developmental. In later chapters you will see that some theories are affiliated to one or other of these paradigms. Certainly, we might argue that one or other paradigm is the best source of truth for nursing. The counter-argument is that none can be a 'best source' and that they are looking at different things or at the same things from different angles. This relates to one of the earlier understandings of theory we addressed in this chapter – the idea of theory as a spectacle or a view from a particular perspective. If we take the view that nursing by definition must look to the needs of the whole person within a whole physical and social world, and that its dominant orientation is *holistic*, then paradigms that fragment

the whole person into parts are counterproductive. On this argument, nursing theories that are based on the paradigms from other disciplines (psychological, biological, sociological etc.) may not be good for nursing. It could also be argued that for nurses to research these paradigms would be a case of developing those disciplines rather than nursing. But Tan (2011) claimed that, in fact, nursing knowledge is derived from various sources and different disciplines. Colley (2003) argued that we need to discover our own scientifically tested body of knowledge and Bultemeier (2012) maintained that a unique body of knowledge is important, especially if we want to share it with other nurses or professionals. This debate on borrowed theory versus home-grown theory will be returned to in Chapter 7 when we discuss how to select a suitable theory for practice.

One American theorist, Rosemary Parse (1987), has written that nursing is based on two distinct paradigms. In recognising how parts are integral to the whole person and that the whole person is greater than the sum of his or her parts, she coined the term 'simultaneity paradigm'. In contrast to this, she identified the 'totality paradigm', where the parts are more important than the whole person. In the simultaneity position, the person is seen as an irreducible whole, while in the totality paradigm, the person is seen as greater than the sum of his or her parts. This is relevant in nursing, where we deal not with simple anatomical parts but with complex persons. Nurses work in the complex world of human beings where looking at the whole person is preferable to looking only at parts, such as the heart, personality, and emotion.

One way of explaining the difference between the simultaneity and totality paradigms is through the analogy of a birthday cake. Suppose we had a birthday cake with 'Happy Birthday to Mary' written in the icing. When you slice the cake you get a number of separate parts. To Mary, the cake is greater than simply all the separate slices. It represents celebration, a happy occasion, a milestone in her life. This reflects the simultaneity paradigm, where the whole person is more than just a collection of biological, psychological and social parts. Consider the opposite view, where the slices of the cake simply make up the cake and when you look at one slice the birthday message is lost. This reflects the totality paradigm where we focus on individuals' diseases or pathologies rather than on the whole person. To a proponent of this paradigm, a coronary patient is simply that – pathology. That the presenting patient is a chief executive, has seven children and also has some financial problems are not matters worthy of consideration.

Earlier, the case was made for the value of theory and also the need to keep such theory under constant review (e.g. the paper boat sinking). Kuhn (1970) has argued that a discipline without a body of theory is unscientific. There is an element of common sense in synthesising both arguments. If we *do* need theory that is sound, tested and up-to-date, by definition we are speaking of a growing body of theory in the sense that Kuhn proposed. Yet in taking this position, we must also be cognisant of the nature of such theory and its limitations. As you saw in Reflective Exercise 1.9, theories tend to be specific within a particular paradigm or world view, and as such may provide only a partial view of the real situation.

Colley (2003: 37) stated that 'true professionalism in nursing will only occur when all nurses will take an interest in theory development and contribute to its introduction to practice'. However, Tan (2011: 34) claimed that 'nursing has generated a body of knowledge unique to its profession, and at the same time begun working collaboratively to integrate nursing knowledge with other disciplines'.

One approach for the nursing profession is to devise all-encompassing frameworks that show not only the elements that make up the totality of the body of knowledge, but also the relations and differences between these elements. This may be seen as

particularly important in nursing, where knowledge is being drawn from many different disciplines and paradigms. We call a body of knowledge so structured a *taxonomy* (from the Ancient Greek words *taxis* meaning arrangement, and *nomie* meaning method). Similarly, Carper (1978), in the nursing context, speaks of *ways of knowing* in nursing as encompassing empirics, ethics, personal knowing and aesthetic knowing. The types of knowledge that nurses might use in their practice are dealt with in Chapter 2 (see also Reflective Exercise 1.10).

Reflective Exercise 1.10

The place of theory in science

Review your literature, this time looking up the terms science, research, world view and paradigm. What you should seek are further commentaries on how theory might influence science and how science (or a particular science's world view) might influence how its practitioners construct and use theory.

Make brief notes for later reference when we expand on some of these issues in Chapter 2.

Kääriäinen et al. (2011) claim that we need tested theories to develop nursing science because they give more valid information about the concepts and their usefulness. How to select a suitable model or theory and more detailed explanation of the advantages and disadvantages of borrowed theories are given in Chapter 7.

Theory and practice of nursing

Education and research foster the conditions for knowledge development in nursing. Any theory that supports everyday nursing actions and decision-making by nurses for the benefit of clients has to emanate from practice and return to inform practice. McCrae (2012) suggested that nursing struggles to assert itself as a profession because of the need for a unique body of knowledge. Johnson (1959: 212) stated that 'no profession can exist for long without making explicit its theoretical bases for practice'. Therefore, nursing cannot claim to be a profession if it does not have a body of knowledge that guides its work. Theories are a major part of this body of knowledge and so theory helps to develop nursing (Pajnikihar 2003, 2011).

McKenna (1997) stated that nothing is more practical than nursing theory and that 'there is no such thing as nursing without theory'. A theory has to be 'alive' in order to inform practice. Nursing theory helps us to focus on the essential elements that give nursing its unique structure, character, presence and strength (Gorman 2009), and also helps us to define the unique role of nurses in the health care service (Colley 2003; Bultemeier 2012). According to Fawcett (2012b), theories are the best evidence for evidence-based nursing practice. According to Selanders (2010), nursing theory provides the guidelines for decision-making, problem-solving and intervention development, and

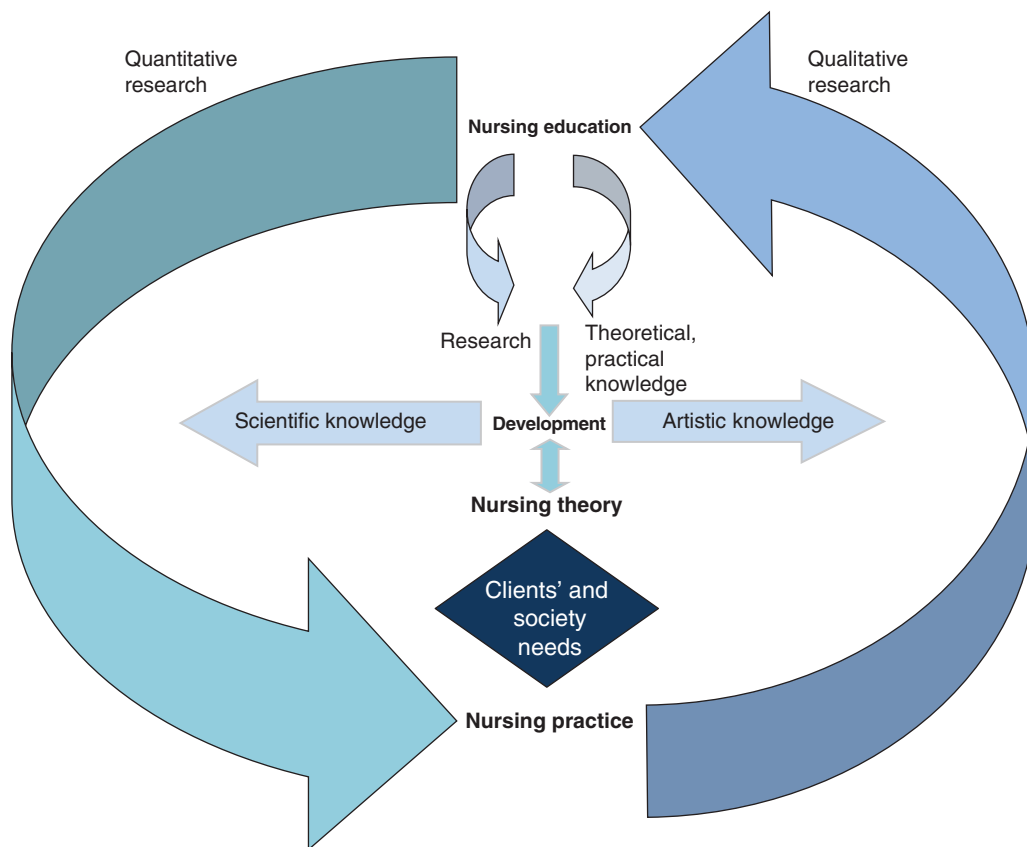


Figure 1.5 Basic structure of nursing. Reproduced from Pajnikihar M (2003) Theory development for nursing in Slovenia. *PhD thesis*. Manchester: University of Manchester, Faculty of Medicine, Dentistry, Nursing and Pharmacy.

in the long term serves as the framework for research, thus leading to the development of more refined theory (Figure 1.5).

Parker (2006: 15) asserted that practice 'must continue to contribute to thinking and theorising in nursing just as theory must be used to advance practice'. Both are guided by inherent values and beliefs. But one theory will never be able to explain the entire phenomenon of nursing (Colley 2003). Theory can never 'see' the whole, but it illuminates for us the meaning in different phenomena.

Because many nursing theories exist, they need to be reviewed, compared, analysed, evaluated and tested before being used in a care setting. Nurses have frequently selected theories uncritically without using good criteria for theory selection, analysis and evaluation, or basing their choice on scientific evidence (Pajnikihar 2003). 'Adaptation' of a theory in practice needs to be done on the basis of what patients need for best care (Pajnikihar 2009, 2011). Theory analysis, testing and evaluation are explained in greater detail in Chapter 9.

Do we really need theory?

Because we need 'a reliable body of knowledge', this means that in a constantly changing health care context it must be a *growing* body of knowledge that has to be constantly *updated* and *modified*, and continually subjected to *tests of refutation* (remember the paper boat). However, the argument here is two-fold: because we *do* need the 'tested theory', we need to continue to 'produce'. As such, theory is always open to question. We are *always* testing the theory in the live situation and each situation is to some extent unique. We have to 'fit' the theory to the situation, adapt it and look for alternatives if it is not readily applicable. In so doing we are questioning, analysing, synthesising and seeking patterns in the specific clinical situation, formulating propositional explanations and trying them out. Nurses who do this have been described as 'knowledgeable doers'. Benner et al. (1999) had spoken of 'clinical wisdom'. In our context we might describe it as the thoughtful, reflective, analytical, insightful, critical practice of nursing being a process of theorising in practice (which we refer to as *praxis* meaning 'living theory'). On this basis every competent nurse is a theorist.

Authors of books and articles on nursing theories tend to describe the unquestioning acceptance in practice of nursing theories that were developed in other countries as wrong. This is especially the case when they fail to be accepted or to be supported by practising nurses. The reasons for this lies not in the nursing theories themselves, but in the level of knowledge of nurse educators and clinical nurses and in the uncritically accepting of other people's nursing theories (Pajnkihar 2003).

Nursing theories today

It could be argued that the first nursing theory was that developed by Florence Nightingale and described in her book *Notes on Nursing* (Nightingale 1859). For some reason there was a hiatus in any further development of nursing theory for over 100 years. Then in 1952, Hildegard Peplau published her theory on interpersonal relationships in nursing. This marked the start of a further 30 years of theory development – mostly in the United States of America. This was due to a range of professional, social and political factors. There follows a brief overview of how nursing theories are accepted by nurses in different European countries. The examples are limited but the same themes can be generalised to most European countries.

Nursing theories in the United States

Most of the existing nursing theories emanated from the US. As stated previously, it started with Peplau in 1952 and continued through the 1960s, 1970s and 1980s. During this time about 40 theories were constructed. At one time there it appeared that there was a race among American academic nurses to come up with the ultimate nursing theory. Their emergence had a lot to do with the move of nurse education into the university system and a disenchantment with the biomedical model, which sees the patient as a collection of signs and symptoms, diseases and pathologies. Nursing theorists were treated like rock stars and many had their own literature and conference circuits. They even had their own followers – for example, those who supported Roger's (1980) theory were called Rogerians and those who supported Parse's (1981) theory were called Parsarians! Today, there is less hype about nursing theories in the US, but some of the more meaningful ones have stood the test of time.

I would include in this the theories of Parse, Orem, Roy and Watson (see the reference list). The main reason for their longevity and popularity is the research that has been undertaken to test and verify them.

Nursing theories in the UK

In the UK, the entrance of nursing education to universities began in the 1970s and McKenna (1997) noted that nurse teachers began to search for this unique knowledge for the discipline. For these reasons, in the 1980s and 1990s, British nurses began to develop theories. Today the most widely used nursing theory in the UK is that constructed by Roper, Logan and Tierney (RLT) (1980, 1985, 1990). It is interesting to note that the unquestioned and uncritical imposition of nursing theories in the 1980s on busy clinical nurses in the UK did theoretical nursing more harm than good. In the past they tended to be introduced by nurse academics, nurse teachers or nurse managers. Rather than clinical nurses seeing them as helpful, they were perceived as getting in the way of care. This was the result of each theory generating a large volume of paperwork. There is some evidence that there is a renewal of interest in nursing theories in the UK, with clinicians seeing them as helpful rather than a hindrance. Nonetheless, Bond et al. (2011) found that there was no increase in the use of nursing theories. The history of nursing theory development will be dealt with in greater detail in a later chapter.

Nursing theories in Slovenia

Although theories were already included in the Slovene nurse educational curriculum in the 1980s, they were not implemented in nursing practice. In the past, nurses who engaged in clinical practice had little opportunity to acquire any knowledge about nursing theories (Pajnkihar 2003). Apart from not understanding the theories in the classroom, students did not often have an opportunity to come across them in practice. Hence, graduates starting practical work inherited already established patterns of thinking and working in the clinical setting. Although they recognised the essential need for theory in practice, they also acknowledged that nursing theories currently implemented in education cannot realistically be applied in practice, because they are largely incomprehensible. The fact that they are written in English presents an additional obstacle for Slovene nurses.

However, Slovene education today is still largely based on Virginia Henderson's 'activities of living' theory and practice is widely influenced by the biomedical model. It follows that nurses cannot realistically expect to have their practice guided by a range of nursing theories. Furthermore, they cannot accept them in practice for the reason that the theories selected were developed for nurses in different health and nursing environments and cultures. It is probable that Slovene nurses *can* use different theories from other countries, but they need to be evaluated and tested in Slovene health and nursing environments before they are institutionalised (Pajnkihar 2003).

Nursing theories in Russia

In Russia, the westernised theories of Nightingale, Henderson, Orem, Roy, Allen and Neuman were introduced on the expert advice of just one internationally known Russian nurse. However, the theories are rarely used in practice. In addition, the amount of literature available in the Russia language on these theories is small (personal communication, November 2011).

Nursing theories in Poland

In Poland it has been reported that clinical nurses stay close to the biomedical model, and some use Nightingale's and Henderson's theories. However, during a research project, the authors introduced the nursing theories of Nightingale, Henderson, Orem, Roy, Neuman, Maslow and Taylor to a group of 100 Polish nurses (Zarzycka et al. 2013). The results showed that the most frequently used theory was Nightingale's, followed by Orem and Henderson.

Nursing theories in Croatia

In Croatia nursing theories were accepted into nursing education, but as with other countries they did not find acceptance in nursing practice. This was mainly because there were not enough supporters of these theories to spread knowledge and enthusiasm about them. The level of knowledge about theory is low and the amount of literature in the Croatian language on the subject is scarce. A similar problem occurs here as in other EU countries where nursing education was transferred into universities decades after it did so in the USA or in the UK. They did not go through the same theorising process. However, after being taught theories, Croatian nurses find mid-range theories very useful in supporting their practice. A more detailed description of mid-range theories will be undertaken in Chapter 3.

Level of education and knowledge development

There are big differences between the education of nurses in the USA and Europe. In the latter, nursing education was recently placed within universities, but mostly at diploma level only (Bologna Level 1 and 2). Nurses in central and eastern Europe still have to make huge efforts to introduce developments that are taken for granted elsewhere, such as doctoral education for nursing. Therefore, the shortage of nurse educators with postgraduate academic qualifications is acute. The lack of knowledge about alternative theories in nursing and the fact that there is no research on theory selection or application are big problems.

Nursing theories in contemporary nursing

Today people demand improved safety, quality, productivity, effectiveness and efficiency to maintain or improve patients' rights and equality. Due to financial and economic crises there are fewer resources and fewer nurses available in health care systems. There is a danger that individual patient-centred nursing care may disappear. Nonetheless, there is an increasing requirement for holistic, compassionate, person-centred and individualised care. Despite the criticism of nursing theories, they can help us to achieve these requirements. For example, as seen earlier, empowering patient self-care and autonomy is congruent with the theory of self-care developed by Dorothea Orem (1980, 1991). Similarly, supporting patients towards independence in their ADLs is core to Roper et al.'s theory. Callista Roy (1980) emphasised the need for patients to adapt to their environment and to their own abilities. Therefore, if used appropriately, these nursing theories and others can demonstrate cost-effectiveness through reducing dependency, encouraging self-care, and help in the early detection of patients' problems.

Caring theories could significantly advance the nurses' knowledge about their own and clients' personal values and beliefs in order to protect human dignity and respect and value

individuality. Research carried out in Slovenia into Jean Watsons' 'carative factors' of nursing care showed that nurses believed that they were especially caring when they assisted patients in fulfilling their basic human needs and in giving hope (Pajnkihar 2013).

Theories can provide a systematic basis for assessing, planning, implementing and evaluating care and offer a way to 'revitalise' the nursing process. New frameworks for our work for more holistic and individualised care can be established. In times of crisis, we can preserve or return to the fundamental values that are increasingly demanded nowadays. However, in order to do that, we first need some basic theoretical knowledge and hopefully this book will provide you with the grounding to realise the importance of nursing theory.

Conclusion

Praxis is understood as knowledge in action. We are constantly being called to 'base' or 'inform' our practice on sound evidence. In praxis, theory and theorising become integral parts of our practice, and our practice is in turn the living enactment of our theory and theorising. This chapter makes the argument that practice must be informed by theory and that theory is in turn informed by practice.

In this chapter we have argued that theory is necessary in nursing. We have defined it as a means by which we can describe, explain and predict phenomena of importance to nursing care. In so doing, we have recognised the problems that exist. There are different views about what theory actually is. There are vastly different positions ranging from the view that theory is mere conjecture and of no value at all, to the view that it is essential to the construction of knowledge and our application of this in practice. We have, nevertheless, also recognised that theory is always a view from a particular perspective and always a tentative description, explanation or prediction of reality. We are, it was argued, always called on to challenge theory and to recognise that it must be adapted to each unique patient, rather than having the patient adapt to the theory.

In one sense this opening chapter has raised many questions about nursing theory, but by doing so it has arguably met one of its main aims: the recognition that theory *is* an important issue that must be addressed in nursing. In the remaining chapters, we will describe and discuss the related issues in greater depth.

Revision Points

- Theory is a body of knowledge.
- Theory is a core part of science, wherein we formulate statements about phenomena (theories) and then test these empirically (research).
- Theory needs to be aligned to the real world and a means by which we can explain systematically things done and things observed.
- Theory is always something seen and/or thought about from a particular perspective, and thus by definition a partial and (to some extent) subjective view of the world or the phenomena within it.
- Nursing theories can contribute to new knowledge in contemporary nursing.

Additional reading

Pajnikihar M. & Butterworth T. (2005) Nursing in Slovenia: a consideration of the value of nursing theories. *Journal of Research in Nursing*, **10**(1), 45–56.

Tan K.K. (2011) The state of nursing science. *Singapore Nursing Philosophy*, **12**(1), 22–33.

Zarzycka D., Dobrowolska B., Slusarska B., Wronska I., Cuber T. & Pajnikihar M. (2013) Theoretical foundations of nursing practice in Poland *Nursing Science Quarterly*, **26**(1), 80–84.



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