7 How to select a suitable model or theory

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Outline of content

Imagine you are a clinical nurse who has been asked by her unit manager to select a suitable theory for application in the unit. Your immediate thought is that it is a great honour to be asked to do this and you set about the task with enthusiasm. You soon discover that there are around 50 grand nursing theories and almost as many mid-range nursing theories. How do you decide which one to choose? This chapter will help you do this. It will start off by describing how the selection process was done in the UK. It will then progress to identifying criteria that you could use to select an appropriate nursing theory. Along the way, it will deal with the problems you might come across and how the process will be viewed by other nurses and health professionals.

Learning outcomes

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

* 1. Describe how nursing theories were introduced in clinical settings
* 2. Outline the 12 potential problems when selecting a nursing theory
* 3. Understand the roles of grand and mid-range theories in theory selection
* 4. Identify the criteria used to select a suitable theory
* 5. Discuss the role of the metaparadigm in theory selection
* 6. Understand who are the best people to select a theory for practice
* 7. Explain the advantages and disadvantages of borrowed theory.

Introduction

You will recall from [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) that we all use theories in our daily life, either knowingly or unknowingly. Our conversations will be underpinned by communication theories or interpersonal theories. Our choice of what to purchase in a shop may be influenced by financial theory or decision theory. Even when climbing a ladder or boarding a plane, we will take account of the theory of gravity! It is surprising, then, that UK nurses in the late 20th century did not accept nursing theories more readily. With hindsight, it is perhaps not surprising; after all, they were mainly imposed on practising nurses by nurse educators and nurse managers. Nursing theories (at that time they were mostly called nursing models) were the new fashion to hit UK nursing; there were dozens of books written about them, and most nursing journals and professional magazines published articles about them (see [**Key Concepts 7.1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5593)). Being so popular, they were obviously perceived as good. Invariably, clinical settings were perceived as not being up to date unless the nurses were using a nursing theory to guide their practice. If the hospital in the next town was using one, we were behind the times if we weren’t doing so. Nurse managers returned from nursing theory conferences loaded down with templates of care plans for one theory or another.

 Key Concepts 7.1

**Nursing theories:** assist nurses in using the nursing process to assess needs, plan care, intervene and evaluate the outcomes of care

In addition, and several years previously, the ‘nursing process’ had been introduced. By all accounts, it too was the great saviour for patient care. It seemed simple enough: you assessed your patient’s needs, planned the care, implemented the care plan and evaluated whether the patient’s need had been met. But for some reason it, too, was having difficulty taking root in most clinical settings. Then the proponents of nursing theories spotted what was wrong. In order to make the nursing process work, a theory was required to give it structure. In fact, it had been argued that the implementation of the nursing process without a theory to underpin it was an empty approach, often described as ‘practising in the dark’ (Aggleton and Chalmers [**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524): 22). As a result, nursing theories were perceived as the saviour of good care planning and they were imposed uncritically onto hard-pressed clinical nurses.

Reflective Exercise 7.1: Change

If you wish to change someone’s behaviour, you need to change their beliefs and attitudes. Otherwise they will not enthusiastically adopt a new way of working.

Consider how you would implement a new evidence-based procedure to change the way nurses in a clinical setting practised. How would you approach the problem?

You will get some ideas if you read the seminal work of Everett M. Rogers ([**1962**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9349)), *The Diffusion of Innovations.* See also [**http://en.wikipedia.org/wiki/Everett\_M.\_Rogers**](http://en.wikipedia.org/wiki/Everett_M._Rogers) and [**http://en.wikipedia.org/wiki/Diffusion\_of\_Innovations**](http://en.wikipedia.org/wiki/Diffusion_of_Innovations).

It was not unusual for clinical nurses to be informed by managers that they were to introduce a nursing theory to guide their practice by the following week. A common motive for imposing a theory on an unsuspecting workforce was that nurse teachers in the local school of nursing were teaching the specific theory to their students or it underpinned the curriculum. Clinical nurses soon realised that if they were going to have to use nursing theories, it would be better if they could select one that was appropriate for their type of clinical setting.

Selecting an appropriate nursing theory

It is surprising that the choice of a nursing theory took little account of patient needs and views or the clinical specialism (see [**Reflective Exercise 7.2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5624)). You will recall from the previous chapter that the theories selected most often had more than a passing resemblance to the biomedical model. For instance, Henderson’s ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881)) and Roper et al.’s ([**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9374)) theories were the most popular choices. This was the case regardless whether the patient population comprised people with mental health problems, women in labour, sick children or older people. Peter Wimpenny ([**2002**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9604)) rightfully criticised this, pointing to the advantage in matching particular theories to particular clinical specialities. After all, he argued, different theories had been developed from particular experiential perspectives.

Reflective Exercise 7.2

It is interesting that nurses did not involve patients or patient pressure groups in the selection of nursing theories. Think about this and try to understand why. Your answer may reflect the fact that this was the 1980s and 1990s. Why?

McKenna and Slevin ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9110)) noted that there were over 50 grand theories of nursing and a growing number of mid-range theories. Since assessments of patient need, planning care, interventions and evaluation of care differ depending on what nursing theory is being used, a new awareness exists as to the necessity of making the right choice. The alternative is to have a nursing theory that moulds practice to fit it, rather than the other way around. However, there is a dearth of research evidence available to help practising nurses decide which theory is best suited for which clinical speciality. For instance, in a psychiatric unit, where the development of interpersonal relationships is important, would Peplau’s theory ([**1992**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9298)) be most appropriate? But the theories of Orlando ([**1961**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9235)), Travelbee ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9536)), King ([**1968**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8982)), Wiedenbach ([**1964**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9594)) and Paterson and Zderad ([**1976**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9272)) also focus on interpersonal relationships. As a result, choosing the most relevant theory is a daunting task and must be carried out with care.

You will recall from [**Chapter 3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_004.xhtml#eid2686) that grand theories are broad conceptualisations of a discipline. In nursing, they deal with everything from self-care to adaptation, and nurse-patient interaction to activities of daily living. It could be argued that grand theories are so all-encompassing in their scope, they should be applicable in any setting where nursing is taking place. For instance, Orem’s self-care theory (Denyes et al. [**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8701)) could be used in any setting where the patients were being encouraged to be independent. This would give it wide applicability. So, is sorting through theories to find a suitable one a waste of your valuable time? Barbara Stevens Barnum (2006) did not think so; she asserted that there was a need to employ different theories to suit different patient settings. We would concur with this view and argue that the choice of one theory for application throughout a hospital is imprudent and perhaps even dangerous. Should patients and staff have to put up with a theory that has a less desirable ‘fit’ for the sake of conformity to management or educational dictates? Fitting the patient’s problems to a theory rather than the theory fitting the patient’s problems is a foolish and labour-intensive exercise.

As stated many times in this book, grand theories are broad frameworks and are often well recognised and publicised (e.g. self-care, adaptation, activities of living etc.). By contrast, mid-range theories are those that have more limited scope and less abstraction, address specific phenomena or concepts and reflect best practice (see [**Key Concepts 7.2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5648)). Invariably, they are based on evidence that emerges out of research studies. Examples of mid-range theories were given in [**Chapter 3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_004.xhtml#eid2686). Others include mid-range theories of information-seeking behaviour of newly diagnosed cancer patients (McCaughan and McKenna [**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9057)), comfort (Kolcaba [**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8989)), quality caring (Duffy [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8731)) and self-transcendence (Runquist and Reed [**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9403)). You should refer back to [**Chapter 3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_004.xhtml#eid2686) if you need to update yourself on the difference between grand and mid-range theories. However, regardless of whether we are dealing with grand or mid-range theories, we believe that there are 11 potential problems to acknowledge when selecting an appropriate one for your practice. Some of these reflect the limitations of theory outlined in [**Table 5.2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_003.xhtml#eid2056) (p. 004).

 Key Concepts 7.2

**Grand theories:** broad frameworks that may be widely applicable

**Mid-range theories:** these are very specific and are appropriate for a more focused area of care

Potential problems when selecting a nursing theory

American or UK nursing theories?

* England and America are two countries separated by a common language. (George Bernard Shaw, 1856-1950)

Although Florence Nightingale ([**1859**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9214)) can be credited with being the first nurse theorist, most modern nurse theorists are based in the United States (see [**Reflective Exercise 7.3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5675)). A question has been posed as to whether their nursing theories are transferable to nursing practice in the Europe (Cutcliffe et al. [**2009**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8686)). There is nothing wrong with nurses from different countries exchanging ideas, but the application of one group’s practices to another group may not always be appropriate. After all, as has been pointed out in earlier chapters, the UK has a different health care system from the US, a different nurse education system and a different culture (see [**Key Concepts 7.3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5685)). Therefore, it is understandable that American theories may not always be the best choice for nursing care in other parts of the world. If nurses in different countries continually look towards the America for conceptual guidance, any selected theory will have to be manipulated so as to fit their health services. Of the 50 or so well-known grand nursing theories, about 12 were formulated in the UK. By far the most popular of these is that of Roper et al. (Holland et al. [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8904)).

Reflective Exercise 7.3: Why America?

It is a truism that even though the first nursing theory by Nightingale was British, US nurse theorists have taken the lead in the development of modern nurse theories. Most of the 50 grand theories and many of the 40 or so mid-range theories are American in origin.

In addition, Peplau developed her interpersonal nursing theory in the 1950s in the US; this was followed by many other US theories in the 1960s, 1970s and 1980s. By contrast, nursing theories only emerged in the UK in the 1980s and 1990s.

Think about why this might be the case and why UK nurse theorists were less willing to call their work theory - preferring the word model. Discuss your conclusions with other students and compare views.

Some of the content in [**Chapter 5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4079) may be helpful for this exercise.

 Key Concepts 7.3

Nurses in various parts of the world are attracted to American nursing theories. This may be because they view US nursing as being more advanced. However, it may be inappropriate to impose a US theory on a non-US health care system.

Ethical and moral issues

The selection of a nursing theory is value-laden. It follows, therefore, that the choice will be influenced by a nurse’s beliefs about and attitude towards the nature of patients, people and health care. For instance, Orem’s ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232)) self-care theory would not be a nurse’s first choice if he or she held the view that patients are dependent and should adopt the sick role and do as little for themselves as possible. On the other hand, if a nurse were to select a theory that encourages dependency, this could do a great deal of damage to the patient’s rehabilitation and self-esteem.

Over a number of years, the psychologist Richard Lynn ([**2010**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9040)) wrote that black people were less intelligent than white people and that men were more intelligent that women. The selection of Lynn’s theory to frame policy would have implications for hiring employees, providing educational opportunities and for the self-esteem of many people. This would be highly unethical. Similarly, the rigid application of the theories that the Earth was flat and the Sun orbited the Earth led to people like Galileo Galilei (1564-1642) being imprisoned and victimised (see [**Reflective Exercise 7.4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5699)).

Reflective Exercise 7.4: Ethical considerations

In [**Chapter 6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_007.xhtml#eid4907), you will recall, we discussed the barriers to the use of interactional theories to build interpersonal relationships. Among other things, we mentioned the fast pace of modern health care and the increasing use of technology.

Later on in this chapter, we will show that when using a nursing theory, a nurse undertakes a comprehensive and detailed assessment and identifies many actual and potential physical, social and psychological problems. However, in the modern health care system, the patient will only be in hospital for a short length of stay.

Write a one-page account of the ethical implications of these issues for nursing care.

Length of patient stay

Time is an important factor when selecting a theory. For example, a theory used in a long-stay ward for the care of older people would not work in a very rushed emergency room setting. In the former, a human needs theory like that of Minshull et al. ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9156)) would be appropriate, whereas the FANCAP theory (**f**luids, **a**eration, **n**utrition, **c**ommunication, **a**ctivity, and **p**ain) would be more appropriate in the emergency room. To implement Roy’s theory correctly it has been calculated that 16 A4 pages of a care plan would be required (McKenna & Slevin, [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9110)).

It was noted in [**Chapter 6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_007.xhtml#eid4907) that the pace of hospital treatment has increased and that these days patients are often discharged home once they are over the acute phase of their illness. This has implications for the choice of nursing theory. We should ask ourselves if it is morally correct to put patients through a comprehensive assessment and set goals for nursing interventions when they may not be in the clinical setting long enough to receive the interventions or have the goals of their care plan met. One obvious way to address this is to ensure there is a good discharge plan so that community nurses can pick up the care once the patient has returned home. Of course, this raises another potential complication - if community nursing staff are using a different theory from that used in hospital, the opportunities for confusion and misunderstanding are increased. You were asked to consider the ethical aspects of this example in [**Reflective Exercise 7.4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5699).

Nurses’ knowledge of nursing theories

While the level of knowledge about different theories will influence the selection process, readers will spot the obvious flaw with this method of selection. Considering that there are over 50 nursing grand theories available, is it realistic to expect busy practising nurses to be familiar with any more than a few of the most popular ones. Their level of knowledge about theories is also biased according to which ones they were taught as students and which ones have the highest profile in the journals and books they have read. Further bias is introduced according to the journals the nurse reads and, as alluded to earlier, the predilections of her nurse educators and managers.

The growth in mid-range theories complicates the selection process. At last count there were 40 of these (see the nurses.info link in the useful web links at the end of the chapter). It is difficult enough to be up to date on the vast number of grand theories, but there are almost as many mid-range theories and the number is growing (Fawcett [**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773); Smith & Liehr [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9492)).

The implications of a wrong choice

Cutcliffe et al. ([**2009**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8686)) maintained that the quality of care would be adversely affected by an inappropriate choice of a nursing theory, while McKenna and Slevin ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9110)) maintained that an early decision on an unsuitable theory may stifle creativity. Therefore, mistakenly selecting an incompatible theory may have undesirable consequences. In [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) we used the analogy of a map. A map will help to direct you to where you want to go and there are different maps according to your specific needs. An underground rail map is different from a street map, which is also different from a map used by airline pilots. An incorrect choice of map can get you lost; the same applies to the incorrect choice of theory. Of course, the map might be the right one but you have simply read it incorrectly. Similarly, the nursing theory may be the right one for your clinical setting but you may have misunderstood it or implemented it incorrectly. However, although an unsuitable choice is regrettable, it is not an insoluble situation: as with an incorrect map, an incorrect theory can be changed (see [**Reflective Exercise 7.5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5738)).

Reflective Exercise 7.5

Think of the city or town in which you live and identify 10 different maps that could be used to understand the terrain. This should make you appreciate why there are so many different nursing theories looking at the same thing - nursing.

Hybrid nursing theories

The idea that different concepts can be chosen from several different theories and applied in the clinical area as one amalgamated theory is supported by some (Fawcett [**2004**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8767)), but is seen as totally untenable by others. However, there is a danger that such a strategy could lead to the loss of coherence and rigour, to the introduction of contradiction, and to the theoretical status being compromised. More research is being carried out on nursing theories and many of these studies show that particular theories are valid for guiding practice. For example, Anderson ([**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8546)) showed the effectiveness of using Orem’s ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232)) theory with homeless adults and 25 years of research on Roy’s theory has shown the positive outcomes of encouraging adaptation (Yeh, [**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9622)). Similarly, McKenna ([**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081)) showed that Minshull et al.’s ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9156)) human needs theory had a positive effect on quality of patient care in a mental health setting. Therefore, if bits and pieces from these theories were extracted and put together to form a hybrid theory, the validity of the parent theory could be compromised and the effectiveness demonstrated by research could no longer be assured (see [**Reflective Exercise 7.6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5754)). Fawcett ([**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)) asserted that while modification of a theory may be acceptable, the modifications should be acknowledged and consideration should be given to renaming the theory. Our suggestion is that such a hybrid theory should be retested through robust research.

Reflective Exercise 7.6

Consider [**Reflective Exercise 7.5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5738) where you looked at 10 different maps of your town or city. Imagine taking bits of these maps and putting them together in a collage. You would probably end up with a section of the bus route map, alongside a section of the sewage system map, alongside a section of the electrical grid map, alongside a section of the Ordnance Survey map and so on. In other words, it would be a confused tangle of information. The same principle might apply if you selected bits and pieces of nursing theories to form a hybrid theory.

Method of choice

It is often written that experienced nurses know their patients well and through using tacit knowledge they can almost second-guess their needs (Polanyi [**1967**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9318)). This awareness will influence the choice of theory. In [**Chapter 2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_003.xhtml#eid1599), we referred to this tacit knowledge and how nurses have a ‘gut reaction’ when it comes to assessing and providing care. But should the selection of a theory really be based upon such ‘gut reaction’, or should nurses be pursuing the best possible research evidence to choose the most appropriate theory? The former stance was supported in a seminal article by Mary Silva ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9465)). She urged nurses to value truths arrived at by intuition and introspection as much as those arrived at by scientific research. By contrast, Aggleton and Chalmers ([**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524)) stressed that preferences must be decided on more logical grounds. However, in support of Silva’s assertion, we are aware that in most cases in nursing, the theory exists before the research to test it is undertaken. Therefore, if we waited for the research to be completed in all cases, we would have little theoretical creativity or innovation.

Single or multiple theories?

Although the selection within one clinical setting of different theories for different patient groups may be a desirable and recommended stratagem (Fawcett [**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773)), it leads to complications with staff training. It could take a prolonged period of time for clinical nurses to be educated about a range of theories and then trained on how best to employ them in practice. Also, if different theories are used in the same setting, there are likely to be problems with care planning documentation. Furthermore, using a range of different theories could contribute to communication problems. For example, those staff working across a hospital site, such as managers and clinical lecturers, would require a high degree of theoretical sophistication. To the uninitiated, such a patient care system may resemble a conceptual ‘Tower of Babel’. Furthermore, communications within and between members of the multiprofessional team could be hampered by such a strategy and patients who are transferred from ward to ward or from ward to outpatient clinic as their condition changes may have trouble understanding or contributing to their care plans. Fawcett ([**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773)) pointed out that all the successful implementation projects reported in the literature tend to focus on the introduction of only one theory, rather than multiple nursing theories (see [**Key Concepts 7.4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5774)).

 Key Concepts 7.4

Theories can be complex and are developed over many years. Therefore, the expectation that a clinical nurse to have an in-depth knowledge of many theories is an unrealistic one.

Nursing theories versus midwifery theories

Although several nurse theorists are also midwives, most of the grand theories available have emanated from nursing rather than from midwifery. Midgely ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9152)) found in her study that many midwives used Orem’s ([**1980**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9226)) theory of nursing. This raises the question as to whether nursing theories can be generalised to midwifery or whether they have to be altered in the transition. If alteration is required, is the original theoretical status of the theory being compromised? But if it is felt that the grand theories of nursing are broad enough to be applied in most care settings then transference between specialities and health professions may not be an issue. A recent textbook on midwifery theories by and Bryar and Sinclair ([**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8636)) posited the view that there were theories specifically related to midwifery practice, a perspective previously put forward by Fahy and Parratt ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8760)).

Inherent limitations of theories

As stressed in [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030), all theories have their own set of assumptions. Remember, these are statements that we can take as true even though they have never been tested. An obvious one would be that all humans require sleep to enable them to function. These assumptions are the distinguishing marks of a particular theory. However, it could be argued that each theory is limited by its assumptions because no one theory will be able to deal with all eventualities. While nurses may want assurance that a so-called ‘right choice’ of a theory would eliminate all their patient’s care problems, it is possible that the limitations inherent in individual theories may burden nurses with too narrow a perspective. For example, we cannot be criticised for failing to emphasise independence in the activities of daily living (Holland et al. [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8904)) if the theory we are using stresses the manipulation of stimuli to promote adaptation (Roy [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9392)). Mid-range theories are, by their nature, even more restrictive. It is possible that a specialist nurse is using a number of different mid-range theories, as no single theory on its own will deal with the total needs of all patients in her caseload.

Social and political issues

The Austrian philosopher Paul Feyerabend ([**1977**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8795)) argued that theory and truth cannot be divorced from the social and political context in which they exist. He maintained that the theory one chooses is a matter of social convenience or political expediency. Social and political implications also have a role to play in the selection of a nursing theory. It could easily be argued that Orem’s work (Denyes et al. [**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8701)) is more suitable to the private health insurance sector because of its emphasis on the patient’s ability to undertake self-care as soon as possible. This is also the case in public sector health care, where there is a move away from patients staying in expensive acute hospitals to being cared for in their own homes. This is manifested by everything from early discharge home to the care of families to workers being encouraged to sign up to private pensions and private health insurance. In addition, the population is getting older, with more chronic conditions, and health care costs are spiralling out of control (see [**Key Concepts 7.5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5803)). You will recall from [**Chapter 6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_007.xhtml#eid4907) that ‘connected health’ is the term used in relation to supporting older and more chronically ill people in their own homes through the use of modern technology. A self-care theory would fit well into such a connected health world.

 Key Concepts 7.5

Nursing theories have political and social connotations. This will have implications for which ones are selected for practice.

There is another dimension to this political influence. The high-profile cases of professional misconduct seen at, for example, Bristol, Alder Hey and, more recently, Mid Staffordshire NHS Foundation Trust, have shaken people’s confidence in health professionals. This has also been affected by the easy access to the internet, whereby patients and their families can gain access to the latest information on diagnosis and treatment. Nurses are more accountable now than they have ever been and members of the public are rightly asking increasingly perceptive questions about their care and treatment. If nurses select a theory that will commit them to promoting adaptation, independence or self-care, they can be held accountable by the public for this particular service (see [**Reflective Exercise 7.7**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5811)).

Reflective Exercise 7.7: Biomedical model

The main home of the medical model is in the acute hospital system. But hospital care is getting more expensive and there is a trend towards shorter lengths of stay, early discharge, day care, social care and community care.

Think about whether the biomedical model is appropriate in this changing health care world. Write a short paper on this and identify a more suitable theory. Refer back to [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502) if you need to update yourself on the biomedical model.

Staff attitudes

As alluded to in the introduction to this chapter, there is often a distrust of theories in the clinical setting, an assertion supported by Steve Ersser ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8754)). It is highly likely that the previous dislike of the nursing process has been transferred to nursing theories. Although such negative views do not coincide with McKenna’s ([**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081)) research findings, they do influence the selection of theories for practice. It is a truism that if nurses have a view that theories will add more paperwork to their already busy schedule, for expedience they will select the simplest theory available and the one that is easiest to introduce and manage. The danger is that this may not be the best choice for their patients. The next section provides you with the criteria necessary to select an appropriate nursing theory to underpin your practice.

Choosing a suitable nursing theory

The criteria

Fawcett ([**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773): 40) stated that nurses should follow four steps when selecting a nursing theory:

* 1. Thoroughly analyse and evaluate several nursing theories.
* 2. Compare the content of each theory with the mission statement of the clinical setting to determine if the theory is appropriate for use with the population of patients served.
* 3. Determine if the philosophical claims underpinning each theory are congruent with the philosophy of the clinical setting.
* 4. Select the theory that most closely matches the mission of the clinical setting and the philosophy of the nursing department.

From the previous section you will have spotted the obvious flaws in Jacqueline Fawcett’s approach. As we stressed earlier, it would be difficult for busy nurses to analyse and evaluate several nursing theories and, even if they could, which ones would they analyse? In addition, steps 2 and 3 could be counter-productive. For instance, if the pervading philosophy in their unit is the biomedical model, then the nurses will select a theory that matches this way of working and so maintain the status quo. In addition, do all clinical settings have an explicit mission statement or philosophy underpinning their work? Although we are sure that Fawcett meant well, her four steps to selecting a theory may inadvertently allow the introduction of an unsuitable nursing theory. Nonetheless, we concur that there needs to be an agreed checklist to allow busy clinicians to choose the most appropriate theory for their practice. We propose that the following criteria represent such a checklist:

* • clinical setting
* • origin of the theory
* • paradigms as a basis for choice
* • simplicity
* • patients’ needs
* • understandability.

These are discussed in more detail in the following sections.

*Clinical setting*

This criterion concentrates on contextual factors in the clinical situation. This could be an emergency room, a children’s clinic, a community-based nursing home, a learning disability unit or a mental health unit. Earlier in this chapter, we likened theories to maps that guide our practice and suggested we require a different map to suit the specific terrain in which we find ourselves. This holds true for clinical settings and so staff should only select a theory if it fits well with the structure and function of that setting. This criterion reflects well the views of Anderson et al. ([**2005**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8550)) when they wanted to select a theory that would be appropriate for care of diabetic patients.

*Origin of the theory*

In [**Chapter 2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_003.xhtml#eid1599) you will recall that we distinguished between the ‘know that’ of knowledge and the ‘know how’ of knowledge. The former is the more deductive cognitive knowledge, whereas the latter is the more inductive practical knowledge. By definition, practising nurses are expected to be ‘hands on’ professionals. Therefore, they may be more attracted to a theory that has emerged from the ‘know how’ stable. By contrast, a theory formulated by academic ‘armchair theorists’ who based their work on reasoning alone may be unattractive to many clinical nurses. Therefore, when selecting a theory, nurses should take its origins into account. It is, of course, possible to identify a theory that was developed through ‘retroduction’, i.e. where both induction and deduction played a part (see [**Chapter 6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_007.xhtml#eid4907)). You will recall that Peplau ([**1962**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9281)) studied the phenomenon of interpersonal relationships over many years and began to develop her theory deductively through the influence of Henry Stack Sullivan’s ([**1953**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9511)) interpersonal relations theory, and inductively through reflecting on her clinical experience in psychiatric nursing. This gives the clinical nurses the best of both worlds - the theory has clinical credibility and is based on good science.

*Paradigms as a basis for choice*

In [**Chapter 5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4079) you were shown that every nursing theory has its roots in one or more of the following paradigms: systems, interactional, developmental and behavioural. These ‘world views’ could help nurses make some preliminary decisions about the type of theory that is most appropriate for their work. For instance, mental health nurses who support the development of interpersonal relationship with patients may find interactional theories more attractive than the more mechanical systems theories. Similarly, nurses who work with people who have severe dementia may not favour interactional theories, whereas behavioural theories that focus on meeting human needs might get their support.

*Simplicity*

It has been mentioned several times in this text that modern nursing is a complex and demanding profession. Patient throughput has increased and difficult targets have been set for patient outcomes. In such a situation, nurses do not want complex theoretical frameworks to overcomplicate the art and science of patient care. Simplicity has to be an important selection criterion, as long as this does not reflect a lack of theoretical soundness. The principle of ‘Occam’s razor’ states that ‘the simplest theory is to be selected from among all other theories that fit the facts as we know them’ (William of Occam, 1300-1349) (see [**Key Concepts 7.6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5902)). This traditional belief is synonymous with the modern idea of ‘parsimony’. Parsimony dictates that a good theory is one that is stated in the simplest terms possible. There are complex idealistic theories such as that of Rogers ([**1980**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9355)) and there are less complex but realistic theories such as that of Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881)). There is little reason to select the former if the latter will suit the clinical requirements just as well.

 Key Concepts 7.6

**Occam’s razor:** the principle that we should select the simplest theory that fits the facts as we know them

**Parsimony:** the principle that the best theory is the one that is described in the fewest and the simplest terms

*Patients’ needs*

When considering theories for practice, nurses should not be too apprehensive about which theory is popular in their hospital, country or region; rather they should be concerned with which is best for the needs of their patients. Experienced nurses know their patients and their patients’ needs. They are often best placed to be a patient advocate when patients cannot advocate for themselves. Therefore, the choice of any theory must be based on the nurses’ knowledge of their patients. In some cases a patient caseload would have people with varying needs. Therefore, the theory must also be general enough to deal with the many diverse situations the nurse comes across when dealing with a heterogeneous group of patients.

*Understandability*

Although this concept is closely related to simplicity, it merits separate consideration. A theory must be easily understood if it is get the support of busy nurses. In [**Chapter 5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4079) we referred to the complexity of Rogers’ ([**1980**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9355)) work, but we could have been writing about Parse’s ([**1981**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9266)) theory or Fitzpatrick’s ([**1982**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8798)) theory - both grew out of Roger’s theory. Nonetheless, in case we become overly critical of the complexity of theory, we should acknowledge that a theory must have an element of complexity to be significant. To get their new meaning across, theorists often have to invent new words or use complex terminology (see [**Reflective Exercise 7.8**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5929)). For instance, we learned in [**Chapter 2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_003.xhtml#eid1599) that humans have more than one dimension - they have height, width and depth. While this is understandable, clinical nurses may baulk at referring to patients as three-dimensional beings! Likewise, when you take on a new hobby, there is always a lot of new terminology to get used to, be it knitting (purl), photography (shutter speed), sailing (tack) or computing (tetrabyte). Why, then, should we expect the language of theory to be like everyday speech? As Bronowski ([**2005**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8633)) stated in *The Ascent of Man*, the language of science cannot be freed from ambiguity any more than poetry can.

Reflective Exercise 7.8: Understandability and jargon

We have noticed over the years examples of anti-intellectualism among many nurses. They complain about the big words and jargon used in nursing theories and nursing research. However, they appear to be enthusiastically fluent when it comes to knowing and reciting the long and complex names of certain diseases, medical interventions and pharmaceutical products.

Take a few minutes to consider why this is the case and what can be done to change things. Discuss with your fellow students whether this is a realistic observation of nursing behaviour or simply a biased perception on our part.

Further supporting criteria

It has been suggested that a theory will not gain a foothold in a clinical setting or in the ‘hearts and minds’ of busy clinical nurses if it is not relevant to the patients being cared for there and the practice being provided. The following list supports and adds to the previous criteria (Miller 1989: 47):

* • Does the theory have direct relevance for the way in which nursing is practised?
* • Does the theory describe real or ought-to-be care?
* • Has its assumptions and propositions been tried and tested?
* • Does it deal with the resources that are necessary for good care?
* • Does it guide the use of the nursing process?
* • Does it provide practising nurses and with good direction for clinical actions?
* • Are the concepts within the theory too abstract to be applied in practice?
* • Is the language of the theory easy to understand?
* • Does the theory coincide with the practising nurses’ ‘know how’ knowledge?

Nurses’ own philosophy as a basis for selecting a theory

If asked, all professionals would have a personal view regarding the central components of their work. This is based upon their attitudes, values and beliefs and is borne out of the education and experience they have been exposed to over a number of years. Nurses are no different and, if given time to consider, they too can describe and explain the essence of what they do. Because thoughts, beliefs and attitudes are the parents of behaviour, it is not surprising that clinical practice varies according to the thoughts, beliefs and attitudes of the nurse giving the care. These have been referred to elsewhere as the nurse’s implicit nursing theory (McKenna and Slevin, [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9110)).

Previously, Jean McFarlane ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9071): 3) wrote:

* Most (practitioners) have a rough picture of practice which includes ideas about the nature and role of the patient and the nurse, the environment … in which practice takes place, and the major field of function, i.e., health care and the nature of action.

Therefore, we would argue that each clinical nurse has a ‘personal theory’ that he or she uses as a guide to practice (see [**Key Concepts 7.7**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid5992)). As with McFarlane’s view, these personal theories incorporate assumptions concerning the four metaparadigm elements of, nursing, health, person and environment (see [**Chapter 5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4079)). The literature informs us that all formal nursing theories are also built around these four elements (Fawcett [**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773)). Therefore, it is not unreasonable to expect that if clinical nurses were able to match their personal nursing theory with an existing nursing theory they would be closer to identifying a suitable theory for practice.

 Key Concepts 7.7

Most nurses have a personal theory of nursing that has been developed over many years based on their education and experience.

If asked, most nurses are able to reveal these personal theories; they can identify their views on the elements of nursing, health, environment and person. However, in the reality of the practice situation, they are seldom articulated. It is not something that nurses talk about during their coffee break. Consequently, they are mostly hidden in the nurse’s mind rather than being made explicit.

Some of the problems with this approach to selecting a nursing theory have already been identified above. The main one is the perpetuation of the theoretical status quo. If the nurse’s personal theory is based only on being educated and experienced in the physical aspects of the biomedical model, this will reflect her choice of theory. Perhaps, this is why many clinical settings in the UK have adopted Roper’s theory with its activities relating to maintaining body temperature, breathing and eating and drinking?

There are other limitations to matching a personal theory with an established one. It is possible that ten nurses in the same clinical unit have ten different personal theories of nursing. Trying to select one to match all ten’s values and beliefs would be difficult. Also, many of these personal theories could be immature, untested, unreliable or confused. Furthermore, the internationally recognised nursing theories are by no means ‘value free’. They too were initially formulated around the personal views and preferences of their originators. By selecting these nursing theories, practising nurses may simply be exchanging their own biased view with that of another.

Nonetheless, in an era where nursing theories are often perceived to be unpopular, choosing one that best reflects a nurse’s own perception of nursing may be the best selection strategy. After all, nurses will have difficulty supporting a nursing theory unconditionally if it does not coincide with their deep-rooted views of what they believe nursing is.

A strategy for choice

From the preceding discussion we would suggest that all nurses have a personal theory pertaining to how they view the metaparadigm elements. As highlighted in [**Chapter 5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4079), all published nursing theories possess statements about the metaparadigm (Fawcett [**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773)). This means that practising nurses can choose a theory that best reflects the beliefs and values that they hold about nursing, people, health and their environment (Cutcliffe et al. [**2009**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8686)).

As mentioned earlier, Fawcett ([**2005b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8773)) maintained that the beliefs held by nurses about the person, the environment, health, and nursing will direct them to look for a theory congruent with these beliefs (see [**Key Concepts 7.8**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid6014)). Therefore, they can compare the content of theories with their beliefs and select the one that closely matches them.

As mentioned earlier, if nurses cannot accept the way some concepts are treated within a particular theory, they should reject that theory and choose another one whose concepts are more compatible with their own. In this way congruence will be reached between the nurse’s personal theory and a recognised theory. The final choice will indicate for nurses what they have always believed about their work but could not articulate in as clear and distinct manner as articulated by the selected theory (see [**Reflective Exercise 7.9**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid6018)).

Key Concepts 7.8

A nurse’s personal theory is composed of her beliefs and views about nursing, health, person and environment. Established nursing theories also make assumptions about these elements. This can form the basis for selection.

Reflective Exercise 7.9: Theory selection

Refer to any one of the following texts:

* • Fawcett, J. ([**2005**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)) *Contemporary Nursing Knowledge: Analysis and Evaluation of Nursing Models and Theories*, 2nd edition. Philadelphia: F.A. Davis Company.
* • Steven-Barnum, B. (2006) *Nursing Theory: Analysis, Application, Evaluation.* New York: Lippincott Williams & Wilkins Publishers.
* • Alligood, M.R. & Marriner Tomey, A. (2010). *Nurse Theorists and their Work.* St Louis: Mosby, Inc.
* • Meleis, A ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9133)) *Theoretical Nursing: Development and Progress*, 5th edition. New York: Lippencott Williams and Wilkins.

Using one or more of these books as sources, extract from the theories of Orem, Roy, Henderson, Rogers and Peplau what each says about the person, nursing, health and environment (the metaparadigm). Consider these and see which one matches your personal views about these four elements. Check if any other students had selected the same theory and, if so, why.

Once you have done this, repeat the exercise with five other theorists. Include one from the UK this time, such as Roper’s theory of activities of daily living or Minshull’s theory of human needs.

Who should select the theory?

As mentioned at the start of this chapter, at one time it was commonplace for nurse educators or nurse managers to select a theory for blanket application across a hospital. It is not surprising that such theories held very little weight with experienced clinically based nurses. The case has been made in preceding sections that a nursing theory has a better chance of being adopted and used if practising nurses themselves have been involved in its selection. Although this may be a lengthy process, in the end the adoption will be longer-lasting if every concerned individual has been party to the decision-making process. A decision imposed by others often means a short-lived allegiance among those who have to implement it.

A slightly more controversial notion is that the nurse sister (unit manager) of each clinical setting should select the most relevant nursing theory. This may indeed be a valid nomination, considering that this individual should have the most knowledge and influence regarding clinical work orientation and practical expertise (see [**Key Concepts 7.9**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid6056)).

There is a general absence of reports in the literature suggesting that the patient should be involved in the theory selection process. This is strange considering the emphasis on the patient as a partner in care. We would argue that when selecting a theory, the beliefs and values of the most important person concerned, the recipient of care, cannot be ignored. However, if nursing theories are viewed as confusing by many nurses, would patients not find them even more confusing? If the answer is yes then one can see why there has been little evidence of partnership between nurses and patients in the selection of a theory. However, this may say more about the unnecessary complexity of the theory than about patients’ knowledge.

 Key Concepts 7.9

The ward sister should have a major role in selecting the theory, but the involvement of patients and other nurses who work in that setting would strengthen the commitment to using the theory.

Nursing theories or theories developed by another discipline?

Villarruel et al. ([**2001**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9545)) were able to borrow a theory from another discipline and merge it with existing nursing frameworks to create an innovative way of conceptualising condom usage. While this worked for them, there is a great deal of scepticism around using non-nursing theories to guide nursing practice (McKenna & Slevin, [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9110)). Therefore, an important issue to consider when selecting a theory for nursing is whether we should borrow theories from other disciplines.

Almost 50 years ago, Wald and Leonard ([**1964**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9557)) argued that if practitioners continued to borrow theories from other disciplines, research problems based upon these theories would be phrased as questions that had little to do with nursing. For instance, using and testing sociological theories within nursing may do more for the knowledge base of sociology than for nursing. They called for the development of nursing theories rather than trying to make borrowed theories fit. But is this not too narrow a view? Should we not use whatever theory fits the patient problem and can best guide practice? (see [**Key Concepts 7.10**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid6071)).

 Key Concepts 7.10

Borrowed theory may contribute to the quality of patient care but it could also contribute to expanding the knowledge base of the discipline from which it was borrowed.

Bearing in mind the time at which Wald and Leonard were writing their paper, the early 1960s, it is possible to understand why they might have felt threatened by theories from other disciplines. After all, there were very few nursing theories available at that time. The work of Hildegard Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278)), Virginia Henderson (1955), Lydia Hall ([**1959**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8852)), Dorothea Orem ([**1959**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9223)) and Dorothy Johnson ([**1959**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8947)) were the exceptions. There were over 40 more to follow, but we can see why Wald and Leonard feared that the early conceptualisation from nurses would be swamped by an influx of outside theories.

What they may have failed to make explicit, though, was that even these new nursing theories were based on the work of theorists from other disciplines. To name a few - Peplau’s theory was based on that of Harry Stack Sullivan (see [**Chapter 6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_007.xhtml#eid4907)); Johnson’s theory was based on that of B.F. Skinner; and Virginia Henderson’s theory was based on that of Abraham Maslow.

Considering the plethora of textbooks on nursing theory that are still being published each year, it would seem that there are still nurses who would rather pursue nursing theories rather borrowed theories. There is perhaps some merit in this. Compared with sociology, psychology, medicine, law and many other professions, nursing is still a relatively new discipline. It requires a body of knowledge pertaining to its practice. We would suggest, however, that the choice should not be either/or. Nurses should formulate their own theories but they should also use and develop theories from other disciplines.

To a large extent, this corresponds to the picture in other allied health professions. Social work, for instance, began with an adherence to the biomedical model, only to supplant it with theories of its own as the discipline evolved. Similarly, occupational therapy, as one of the ‘allied health professionals’, has moved away from the biomedical model to embrace theories relating to activities of living.

In many instances, nurses borrow theories but do not bother to adapt them. This often results in theories that are incomplete and unrepresentative of nursing. To be useful, such borrowed knowledge must be reformulated and revalidated to suit the particular problems and needs of the nursing profession. For example, psychological or organisational theories are not unique to nursing, but how they are used and the perspective employed can be unique. Yet, because borrowed theories may need to undergo intensive reworking to fit nursing’s unique perspective, borrowing may not be as simple a process as it first appears - after much work and adapting, we could end up with an invalid and unreliable hybrid theory.

We should not be worried about ownership, though - theories belong to the scientific community at large, not to one particular discipline. Discovery does not confer the right of ownership. A note of caution is required here: nurses should be careful to avoid the temptation of borrowing from other disciplines without first investigating what those theories have done for their parent disciplines. If a sociological theory of family care has been rejected by sociologists, it may be foolish for nurses to borrow it for their practice unless careful consideration is given as to why it was rejected by its parent discipline. The term ‘borrowed’ suggests that it will be returned to where it came from. In this case, nursing may adapt a borrowed theory and improve upon it. As a result, the adapted theory could bring new perspectives for its parent discipline (see [**Reflective Exercise 7.10**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_008.xhtml#eid6091)).

It may not be long before other health care disciplines begin to borrow theories developed by nursing. In fact, as we outlined earlier, there is some evidence to suggest that occupational therapists and physiotherapists are already borrowing and reformulating nursing theories (e.g. self-care and activity of living theories) for their practices.

We maintain that there is nothing wrong with selecting a theory from another discipline if it can shed new light or provide a different, beneficial perspective on the provision of patient care. There is no reason why nurses should ‘reinvent the wheel’. The important question is whether selecting a ‘borrowed’ theory brings with it benefits for nursing, nurses and the people who rely on us for care.

Reflective Exercise 7.10: Borrowed theory

Take some time to consider where you work, and identify non-nursing theories that you use to do your job. These could be theories of communication, theories of management or theories of teaching.

See how many you can come up with and then identify any benefits they bring to your role.

Conclusion

Because the choice of a theory will affect how patients are assessed and how care is planned and delivered, selection should not be a process that nurses take lightly. This chapter identified several issues that must be taken into consideration when an appropriate theory is to be chosen. It outlined a range of selection criteria nurses may find useful. The issues of who should make the choice and how this should be done are also addressed. In essence, there are many selection approaches available and nurses should consider these carefully. Not to do so could waste a lot of time and end up with nurses employing an inappropriate theory to guide practice.

Theories are like maps and we require a different one depending on the terrain in which we are working. The days should be over when managers and educators choose theories for practice. Patients or their representatives should work alongside nurses in the selection process. If this occurs, the selected theory will be a realistic reflection of what those in practice see as important for quality care and the nurses will be more likely to use it enthusiastically and appropriately. Finally, there are dangers in borrowing theory from other established disciplines for application in nursing. However, if handled correctly, such borrowed theories can bring a great deal of benefit to nursing. They can also be adapted and enhanced and returned to their parent discipline in a more robust form.

Revision Points

* • Because the choice of a theory will affect how patients are assessed and how care is planned and delivered, selecting an appropriate theory is important.
* • There are 12 potential problems that must be considered when selecting a theory:
	+ • American or UK nursing theories;
	+ • ethical and moral issues;
	+ • length of patient stay;
	+ • nurses’ knowledge of nursing theories;
	+ • the implications of a wrong choice;
	+ • hybrid nursing theories;
	+ • method of choice;
	+ • single or multiple theories;
	+ • nursing theories vs midwifery theories;
	+ • inherent limitations of theories;
	+ • social and political issues;
	+ • staff attitudes.
* • There are a number of selection criteria that should be used when considering a suitable theory for practice, as follows:
	+ • clinical setting;
	+ • origin of the theory;
	+ • paradigms as a basis for choice;
	+ • simplicity;
	+ • patients’ needs;
	+ • understandability;
	+ • matching the metaparadigm to personal theories.
* • The days should be over when managers and tutors choose theories for practice. Patients or their representatives should work alongside clinical nurses in the selection process.
* • There are dangers and benefits in borrowing theory from other established disciplines for application in nursing, as follows:
	+ • If practitioners continued to borrow theories from other disciplines, research problems based upon these theories will be phrased as questions that have little to do with nursing.
	+ • Compared with sociology, psychology, medicine, law and many other professions, nursing is still a relatively new discipline. It requires its own theories.
	+ • To be useful, such borrowed knowledge must be reformulated and revalidated to suit the particular problems and needs of our discipline.
	+ • Borrowing may not be as simple a process as it first appears - after much work and adapting, we could end up with an invalid and unreliable hybrid.
	+ • Theories belong to the scientific community at large, not to one particular discipline. Discovery does not confer the right of ownership.
	+ • Nursing may adapt a borrowed theory and improve upon it. As a result, the adapted theory could bring new perspectives for its parent discipline.
	+ • There is nothing wrong with selecting a theory from another discipline if it can shed new light or provide different beneficial perspective on the provision of patient care.

Additional reading

Fawcett, J. ([**2005**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)) *Contemporary Nursing Knowledge: Analysis and Evaluation of Nursing Models and Theories*, 2nd edition. Philadelphia: F.A. Davis Company.

Polanyi, M. ([**1967**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9318)) *The Tacit Dimension.* London: Routledge and Kegan Paul.

Popper, K. ([**1965**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9321)) *Conjectures and Refutations: the Growth of Scientific Knowledge.* New York: Harper and Row.

Useful web links

[**www.nurses.info/nursing\_theory\_midrange\_theories.htm**](http://www.nurses.info/nursing_theory_midrange_theories.htm)

[**www.springerpub.com/samples/9780826119162\_chapter.pdf**](http://www.springerpub.com/samples/9780826119162_chapter.pdf)

[**http://currentnursing.com/nursing\_theory/Roy\_adaptation\_model.html**](http://currentnursing.com/nursing_theory/Roy_adaptation_model.html)

 **Don’t forget to visit to the companion website for this book:**[**www.wileyfundamentalseries.com/nursingmodels**](http://www.wileyfundamentalseries.com/nursingmodels)**where you can find self-assessment tests to check your progress.**