Theoretical Perspectives in Dynamic Action-Based Professions

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ABSTRACT

This paper addresses the issue of the generation of theory from practice and outlines in some detail the process of theory development engaged in by Andersen, an Australian nurse theorist and the designer of an integrated curriculum reliant on the philosophy and methodology of Problem-based Learning. In particular, Dewey's theory in expounding the relationship between thought, judgement and action is shown to be of clear relevance to nursing practice and therefore to any reflection on that practice. Five key questions were identified as significant in directing the enquiry and reflective processes adopted.

Reviews of the collegial processes of spanning 45 years allowed identification and confirmation of key characteristics of theory development which is derived from action-taking. The outcome of the development of the initial activity is presented as a series of interactive models and frameworks which presents a systematic view of the phenomenon of nursing. This view of theory development is both explanatory and predictive and allows the structure of the discipline of nursing as both an academic and practice activity to emerge.

Keywords: Nursing theory, curriculum design, clinical judgment

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INTRODUCTION

The title of the paper makes four assumptions about health professions: first that the level of practice is that of a profession; second it is characterised by action-taking (justifying the label of a "practice'), third that the changing and interactive nature of the person-factors, circumstances and contexts involved prescribes a complex, dynamic rather than static practice. Finally, a sense of evolving rather than one of having arrived is conveyed by using the phrase theoretical perspectives rather than the term theories or theory. There is also a suggestion that any single theory alone is not sufficient to do justice to the practice of nursing. Further, it is an expressed aim to attempt to demystify the process of theorising and thereby to encourage those who may have felt that theorising should be left entirely to the experts. In doing this there is a risk of oversimplifying this challenging but rewarding activity.

Before proceeding to an outline of the processes engaged in by the theorist and her colleagues (Bujack et al. 1991; Ryan et al. 1992; McMillan et al. 1992; McMillan et al. 1994) and to a discussion of the products of that process, some general issues are raised and placed within a context of what has been said by some eminent international experts.

THEORY DEVELOPMENT

The first and fundamental issue raised in the form of a question centres on the nature of theory. Can the outcome of theorising associated with explanations about actions or the practical be accepted as valid theory? Opinions differ among the experts on this point. It would seem that the stand taken by individuals depends on the nature and context of the life-work in which the theorist has been and/ or is engaged and the educational environment in which academic perspectives have been formed.

In 1933 Dewey, an American pragmatist, sought to refocus the traditional western view of epistemology which denies the validity of the methods and products related to 'thinking out of action taking'. According to Benne (1985), Dewey and others of like persuasion sought to shift their definition of "knowing" from the products to the process and methods of knowing. In particular he suggests they set about legitimising the processes whereby action based thinkers or "knowers" confront the confused and problematic in experience and seek to restore clarity and direction to that experience.

Fundamental to the "pure" knowledge case is the belief that thinking and doing, theory and practice are antithetical. However, judgment theories establish a clear relationship between thought, judgement and action. As clinical judgement is central to the practice of, for example professional nursing, there is no case to divorce thinking from doing.

A second issue concerns the function served by theory. In the case of nursing, theory should inform practice rather than simply serve an end as an academic exercise. When it represents a valid and comprehensive analysis of practice, it allows also the structure of the discipline to emerge. The early philosopher Kant (1781) asserted that theoretical knowledge may exist without any intention of putting it into practice; practice however, simply cannot exist without theory. He goes further in ascribing values to theory and experience when setting them in a relationship with each other. It is also reported he claimed that "experience without theory is blind but theory without experience is mere intellectual play".

Third there is a need to go one step further in the theory/ practice relationship by reversing the order. In this way the starting point is practice informing theory and in turn being informed by it. Questions may arise about the different

starting point and its significance. Educators may reflect on the often repeated statement that clinical experiences are selected or sought to illustrate theory perhaps to justify a collection of various discipline experiences. However, if practice is the starting point and theory is designed to be informed by and to inform practice, then educational programs should reflect this difference.

Having raised three fundamental issues briefly, an analysis of a process of theory development (eg in relation to nursing) and some theoretical outcomes of that process is now warranted. In following this procedure it is also possible to dispel some myths about theory development and the perceived need for theories to be so complicated, learned and intricate that only academics find them of interest or worth. Indeed it is our belief that all clinicians can engage in creative and reflective activity and reach levels of theory construction that address any aspect of nursing nominated and about which they are well informed and have experience. This claim has been tested with colleagues involved in curriculum development and implementation and numerous groups of nurse teachers, administrators and researchers (Andersen 1976; McMillan et al. 1997; Conway & McMillan 2000; McMillan et al. 2001; Hunter et al. 2007; Jeong et al. 2010).

In deliberating how best to document the process a number of alternative approaches were considered, the first of which would take a standard chronological approach beginning with the early seventies and then through a series of activities up to the present. An alternative would be to reverse this process by examining the more or less end products and to backtrack in order to elicit the process. What follows is a blend of each option.

When the process engaged in is experiential, it evolves from learning by doing, then it will be most meaningful only when time is taken to review and to reflect on what has been and is being done. Out of review and reflection comes the recognition of generalisations and insights in respect of both the process and resulting theories which allow the structure of the discipline of nursing, as both an academic and practice activity, to emerge.

The reflective processes crystallise certain beliefs about theorising in nursing. First the process must be dynamic in that it represents a response to the changing demands of practice and to education for that practice. Second it is evolving, demanding ongoing responses to insights. Both these characteristics are achievable as a result of combining reflection and an "acting out" (testing) of the products of reflection in the practice arena. Finally, the theory representing practice needs to be comprehensive and therefore may best be achieved through a series of definitive models rather than a single model. The former is more difficult to accomplish in that internal consistency is essential if true inter-activeness is to be achieved. This multiple models approach however does allow for groups of people to combine their efforts by exploring in detail different key aspects. Before engaging on such a team activity, agreement needs to be reached on those key elements which constitute the superordinate framework within and out of which the group is working.

The process is indeed simple when based on experience and reflection on that experience. It is begun by asking a series of questions, (the right ones) in the right order so that the constituent parts (of practice) and their influencing variables can be identified and interpreted. This enables relationships among the parts to be determined, organised and clearly represented. In this way an interactive systematic view of the phenomenon of nursing can be achieved which is both explanatory and predictive and which also allows an organisational structure of the discipline to evolve. Street (1988) agrees these are the aims of the theorist.

Andersen's first venture into theory construction in the early 1970s was born of necessity and was guided by some particular studies in curriculum and some inspiring principles and structures espoused by the Hilda Taba (1962). John Dewey's exposition on "thinking" was equally influential. Of less conscious influence but nonetheless important were the methods of enquiry used by historians, political scientists, philosophers and sociologists in making sense of phenomena. This early work therefore resulted from two parallel but interrelated strands of activity. The two, curriculum and nursing theory development, were inextricably bound together, resulting in a conceptual framework which provided the parameters within which a course could develop, could be perceived as relevant to nursing practice and could be validated by its graduates.

When confronted with the need for a theoretical position relevant to the Australian context in 1974, it seemed essential to address the deficit personally and not simply to borrow a theory from another country. In ignorance then of theoretical systems, levels, types or abstract principles, an initial obvious and apparently simple question was posed. Out of that single question "What is the nature of nursing"? has grown 45 years of pursuit in multiple contexts of practice; a simple question but not one with a simple or single answer. This question could be applied to any of the health professions.

Addressing this question generated answers and more questions which in turn multiplied and took the exploration down branching pathways. It is an oft-quoted saying that enquiry, if well conceived, will not only come up with an answer but with something more valuable, more questions. This was true of the question first asked by Andersen, a novice at that time. Even with the passage of time she expresses some difficulty in pinpointing precisely an exact sequence of events, because a number of ideas and steps were explored or carried out

simultaneously. However answers to the first question concerning the nature of nursing allowed key organising elements to emerge, each of which generated amplifying questions. Thus the initial directions explored arose from the following questions (Andersen 1976, 1978).

1) What is the nature of nursing?
2) What is/are the goal(s) to which the practice is directed?
3) What is the nature of the person who is the recipient and/or the initiator of care?
4) What is the nature of the interaction between the initiator and the recipient?
5) What is the nature of the context within which the practice occurs?

As is the case in most enquiry activities stimulated by a modicum of imagination, the difficult part of the process is not in generating or identifying factors or answers to the questions but in seeing the relationships among sometimes apparently disparate parts. Many answers and undisciplined ideas need to be organised in order to test the validity of perceived relationships. This task was approached by adopting different strategies. In the first instance a central or focal concept or theme was sought among the answers to each of the separate questions cited above; then followed the development of schematic models and/or frameworks. These schema and frameworks served not only to reduce large quantities of ideas but to organise systematically the relationships among the key elements or ideas to identify gaps within the relationships. The final step in the initial phase of the task was the elaboration of the key concepts and the nature of their inter-activeness by a series of propositional statements sequentially organised as core ideas. Other theorists no doubt may reverse the process and choose to start with prose.

The outcome of this series of activities which centred on reflecting, asking questions, gaining answers, selecting

focal concepts and representing relationships was a series of schematic models and accompanying core ideas first published in 1976 and again in 1978, 1984, 1991. Those currently in use have undergone further refinement and/or elaboration, with revisions being carried out for the purpose of course documentation and application to research (Bujack et al. 1991; McMillan et al. 2004; Hunter et al. 2007; Jeong et al. 2010). As indicated previously this

revision process is critical to theory which is current, valid and relevant to practice.

To do justice to all models and frameworks requires more than the scope of one paper. In selecting to highlight a few in this paper we run the risk of allowing a limited appreciation of the theories because of the interactive nature of the models. A brief overview of the salient features of selected models from <Table 1> follows.

TABLE 1: Intervention Frameworks

INTERVENTION involves nursing activity necessary:
- To promote, maintain, and restore health and to prevent Health/Health Breakdown (HBD)
- When changes occur which limit or have the potential to interfere with a person's or a group of person's ability to engage in activities of daily living

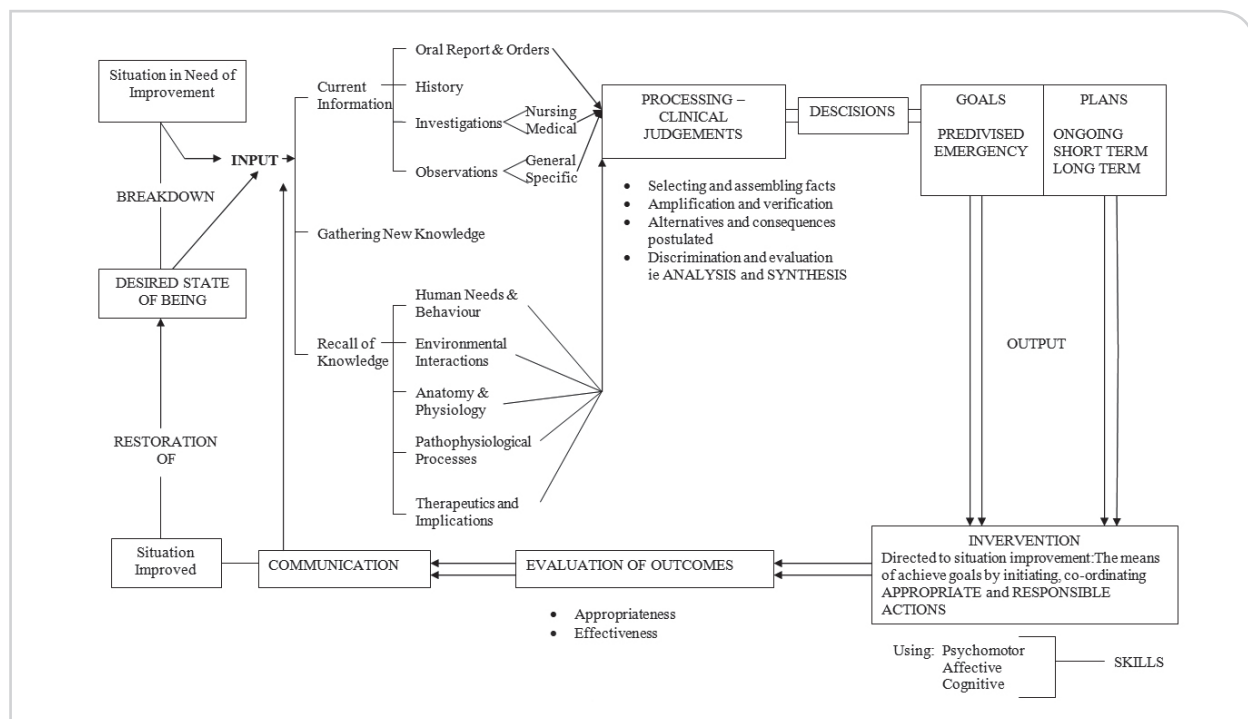| CORE STATEMENTS/ PROPOSITIONS	OPERATIONALISATION OF STATEMENTS/ PROPOSITIONS	ASSOCIATED BEHAVIOURS
Transforms action decisions into activity	· Situation Improvement Summary (SIS) · Care Activity Framework (CAF: A plan of care)	· Nursing actions which are purposeful and defensible and internally consistent between the action options identified in the SIS and the translation to behaviours in CAF
Assists people to engage in ADLs	· Assessment of level of integration of Activities of Daily Living (ADLs)	· Observation and measurement skills
Is based on four stimulus categories: needs, problems, consequences, outcomes	· CAF · SIS · Health/Health Breakdown Model (H/HBD Figure 3)	· Identification of the situation in need of improvement · Differentiation among stimulus categories
Is always oriented towards the goals of promoting, maintaining and restoring health and of preventing HBD	· SIS · H/HBD	· Use of enquiry process · Use of Health/Health Breakdown Questions Framework
Involves the two primary roles of Health Care Giver and Health Care Facilitator	· CAF · Intervention: Nursing Roles and Functions Model (INR&F Figure 2) · Facilitation Framework	· Differentiation between primary roles
Involves the sub-roles of clinician, manager, communicator, researcher, educator	· INR&F · CAF	· Identification of dominant sub-role
Involves the function categories of assessment, structuring environment, physical/behavioural care, management, communication, research, education	· CAF · INR&F	· Selection of major nursing function · Identification of nursing function category consistent with sub-role
Is characterised by the therapeutic, habilitative, rehabilitative and preventive modes	· H/HBD · SIS	· Identification of strategies on SIS · Identification and justification of dominant mode consistent with goals

Figure 1. Nursing Activity Model

The Nursing Activity Model (Andersen 1978, 1991) represents the process of enquiry as it applies to and shapes nursing intervention. It does this in that it establishes a clear relationship between thought, judgement and action taking which has as its goal situation improvement and therefore the maintenance and/or restoration of a desired state of being.

The Nursing Activity Model, was the first product of the process described above evolving from analysis of actual practice. It has been constructed to allow identification of the components which together constitute 'the nursing activity'. An attempt to produce an holistic schema has been made because the absence of any component, or the lessening of each component's importance, would change the nature of the care resulting from the activity. Because the activity is more than the sum of its parts, the relationships between the components and their underlying behaviours have been conceptualised. The

activity is expressed as a series of interrelated components – a stimulus, an input and an output component.

The stimulus which initiates the enquiry was originally perceived as "a problem" which interfered with maintaining a 'desired state of being', and which invariably occurred as a result of breakdown of health. However the stimulus may not always be the result of breakdown but of a health promotion need. As a result of clarifying elements within a curriculum philosophy of nursing and approach to education, the use of the terms "problem" and "problem solving" was discontinued because they were found to be inappropriate. This conclusion stemmed from acknowledging the realities of practice; nurses encounter people in situations which are often complex and who have needs as well as problems. To focus on a problem or a diagnosis may result in the very opposite outcome to the more holistic care claimed as characteristic of nursing. It also invariably cuts short the process of enquiry which

in turn affects the quality of judgements and therefore of actions taken or proposed. Finally many problems encountered cannot be solved; yet if we adopt the phrase the inference is that they should be. For these reasons the terminology now adopted replaces "problem" by the word "situation" and "problem solving" by "situation improvement".

The input component consists of information acquisition, recall and processing which culminates in judgment and action decisions. The output component focuses on intervention in which actions are initiated, evaluated and the outcomes communicated in terms of the situation improvement being attempted.

Judgment and decision making are the processes which link the two major components (input and output) but because of the inter-activeness of the components a return to previous step may be necessary. For example at the time of setting a goal, more information might be required, or when engaging in a care procedure further cues may lead to re-evaluation of decisions which in turn necessitate changes to the plan of care.

Successful implementation of each of the components and therefore of the total nursing activity is dependent on the utilization of a range of concepts, behaviours, skills and appropriate attitudes. More complete details may be found in Andersen (1978; 1991).

Having explored and described the broad parameters of the activity, key concepts within it required further elaboration. Therefore attention was given to the concept of "intervention" within the output component of the nursing activity. In the belief that the generic nature of practice, as an intervention activity, could be identified, questions to elicit commonalities across all fields of practice were asked. Common functions, roles, role

relationships (nurse/patient or client), goals and modes of intervention emerged from the enquiry. McMillan et al. (2001) provided a contemporary version of classification system in which two primary roles that of 'care giver' and 'care facilitator', extend to sub-roles, function categories and major nursing functions for all levels of personnel performing nursing interventions.

The application to practice of such a classification system is illustrated by the analysis of care activity (Andersen, 1991). This is a learning tool which reflects the relationships among the various roles and functions inherent in a particular intervention. It further allows the identification of the skills involved, the principles and behaviours underlying their implementation and the knowledge and concepts essential to informed practice in terms of that particular care activity.

The elaboration/enquiry process continues in that the identification of the concepts of care giver and care facilitator forces an examination of intervention also from the perspective of relationships between the initiator and recipient of care. The concepts of dependence and independence allow such relationships to be explored and a shift in different functions to be identified.

The nursing activity intervention goal, in terms of situation improvement and the maintenance or restoration of the desired state of being, can best be achieved when a further set of relationships is understood. This entails an analysis of the concept of health, and what happens when health breakdown occurs and of the relationships among health, health breakdown and nursing intervention. A Health/Health breakdown and Intervention Model (1978, 1991) facilitates analysis of individual experiences of health and illness and sets out the relationships which, because of their nature, are able to be generalised to all fields of practice.

Health as a state is relative and is reflected in an individual's capacity to engage in the activities of daily living in an integrated way, which in turn contributes to survival and fulfilment as a human being. As a process, health is dynamic and is characterised by adaptive and maladaptive responses which may or may not help maintain the desired state of equilibrium necessary to sustain a high level of wellness in each of the major domains, that is, biological, psychological, spiritual, environmental and social. There are numerous person-centred processes and mechanisms and intrinsic and extrinsic determinants which may result in variations in the level of wellness and/or in health breakdown. The relationships among these factors and the goals of nursing intervention are represented in a model of the Concept of Health and its Components.

As health is not always maintained deviations from this state must be considered. These deviations are not always due to current disease processes so the original use of the term "disease" as been replaced by the term "health breakdown". Therefore the relationship examined has been that between health and health breakdown of which disease processes, in terms of the pathophysiology or psychopathology involved, are examples. The Health Breakdown and Intervention Model (Andersen, 1991) was adapted during the 1980s and adds to the earliest version (1978) which only incorporated pathophysiological and psychopathological processes, the concepts of impairment, disability and handicap as consequences of breakdown. This became necessary when testing the transferability of the model and because it was recognized that these consequences may occur concurrently with a disease process or become apparent subsequently, that is beyond the time when the original disease or health breakdown process has passed. Further these consequences may themselves precipitate additional breakdown. As a result the individual may be disadvantaged, to greater or lesser
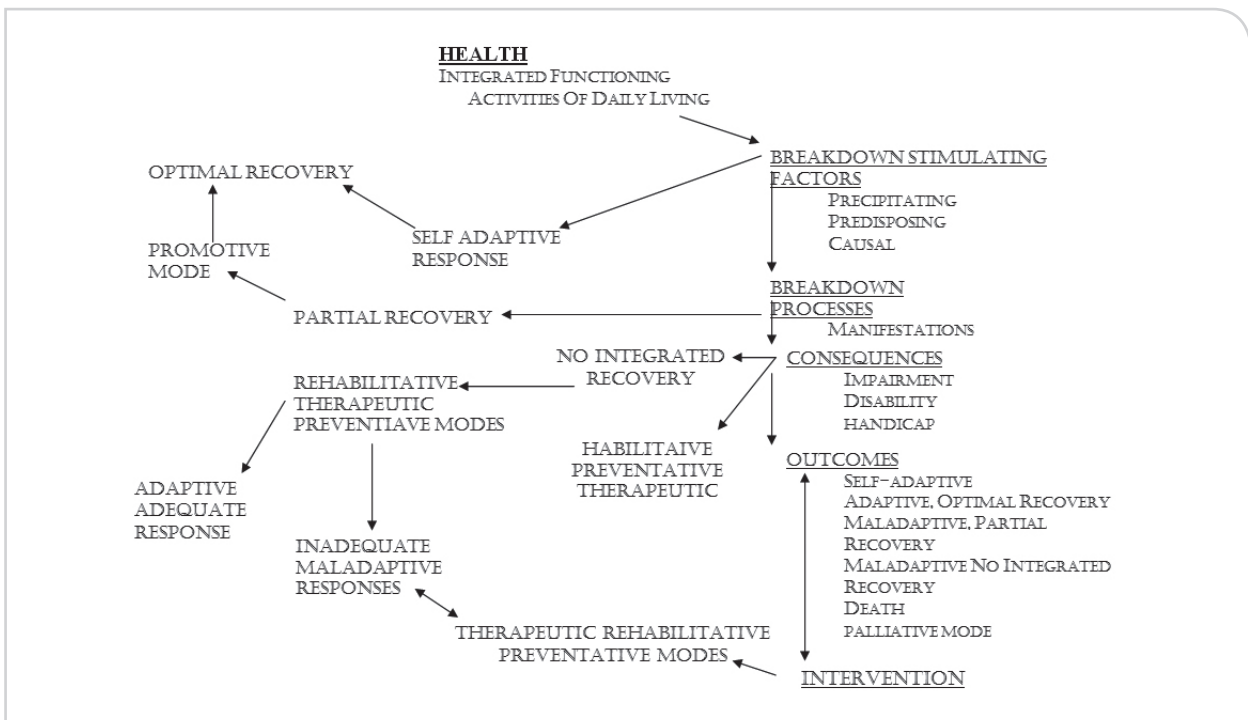

Figure 2. Health/Health Breakdown and Intervention Model

degrees relative to other individuals, in the performance of the activities of daily living. The nature of and the extent to which there is interference with an individual's ability to perform the activities of daily living will, in the main, govern the intervention process in health care delivery generally and in nursing practice in particular. Hence the desirably close relationship between intervention strategies/principles and health and health breakdown is evident.

The nature, focus and range of intervention activities will be influenced also by the time, relative to breakdown, at which intervention occurs. Similarly these considerations will determine which roles, role relationships, functions and skills will be needed and which will be dominant. For the nurse, the intervention process will therefore vary in terms of the above mentioned aspects but will be constant in respect of a number of general issues, for example individual differences and common goals.

CONCLUSION

An attempt has been made to give an overview of the essence of selected models and to demonstrate their interactive nature. This has been achieved by showing how some key concepts arising from the first theoretical position have been further elaborated. Other frameworks and elaborations have been developed and used by educators and researchers to guide students in the development in nursing skills and competencies and conceptualisations in data sets against which they can plan and/or evaluate care or develop propositions from research findings. The same applications have been tested by registered nurses in post graduate studies. The models are the product of reflection on practice, of enquiry through the exploration of fine key questions and of the systematic organisation of the resulting data. The process as outlined provides guidelines and has been presented to encourage others to begin theory development.
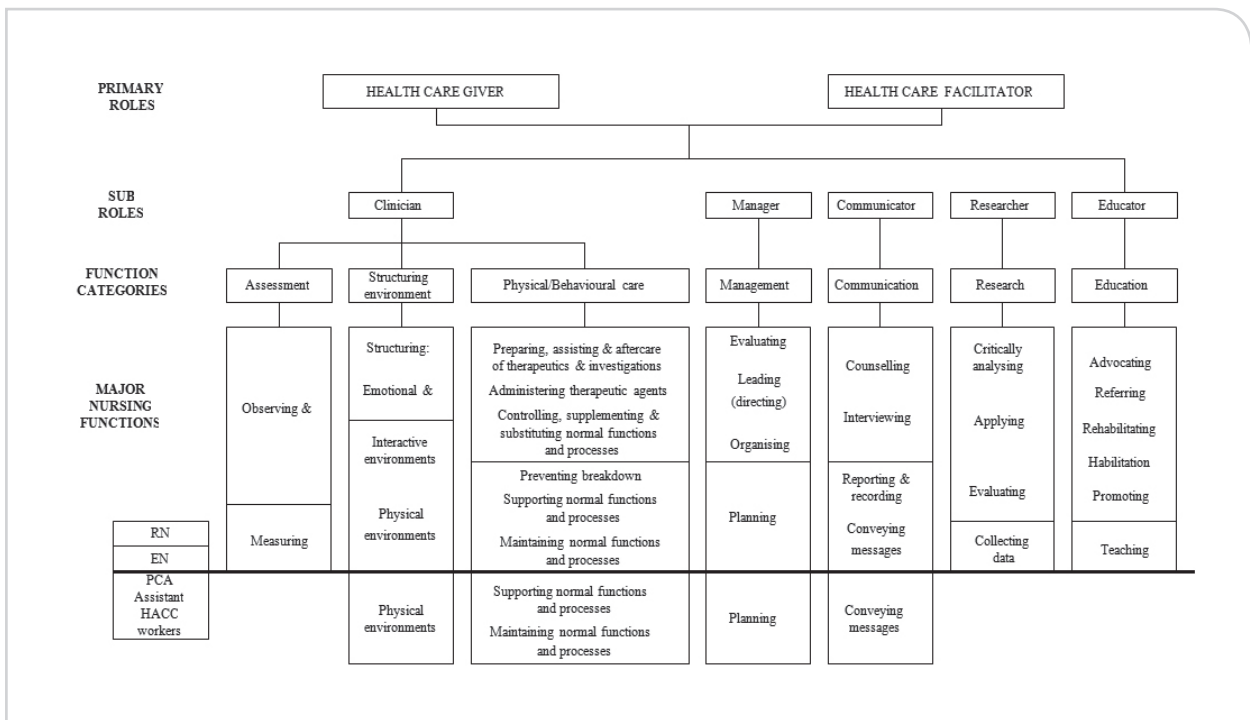

Figure 3. Roles and Functions Model

Andersen had no doubt that valid theory can be generated from practice and in adopting that position believed she was in good company. The rigour lies in pursuing appropriate lines of enquiry, in organising the answers in a series of valid relationships and in representing them in such a way that a systematic structure of the discipline can emerge – one which does justice to both the practice and academic activity of nursing.

The activity of theorising can be engaged in by all thinking persons who are prepared to follow a few simple guidelines, to learn from the process of doing and to persist in the processes of reflection and review.

REFERENCES

Andersen, B. (1976). *Basic nurse education curriculum: A research report submitted to the Commission on Advanced Education.* Sydney: Cumberland College of Health Sciences.

Andersen, B. (1978). *A basic nurse education curriculum evaluation project incorporating an investigation into the cognitive aspects of clinical judgment.* Sydney: NSW College of Nursing.

Andersen, B. (1991). *Clinical Situations: An organizational basis and learning stimulus for nurse education.* Problem-based learning as an educational strategy: Conference proceedings (p. 211- 225).

Andersen, B. (1992). Mapping the terrain of the Discipline of Nursing. In Gray, G., & Pratt, R. (Eds). *Towards a Discipline of Nursing.* Melbourne: Churchill Livingstone.

Andersen, B., & McMillan, M. (1992). Learning experiences for professional reality and responsibility. In: Mulligan, J., & Griffin, C. (Eds.) *Empowerment through Experiential Learning: Explorations of Good Practice.* London: Kogan Page.

Andersen, B. (1994). Problem-Based learning: An option in nurse education. *Annals of Community Oriented Education, 7,* 249-257.

Benne, K. (Ed.) (1985). *Educational field experience as the negotiation of different cognitive worlds* (4th ed.). New York: Holt, Rinehart & Winston.

Bujack, E., McMillan, M., Dwyer, J., & Hazelton, M. (1991). Assessing Comprehensive Nursing Performance: The Objective Structured Clinical Assessment (OSCA), Part One. *Nurse Education Today, 11*, 179-184.

Bujack, E., McMillan, M., Dwyer, J., & Hazelton, M. (1991). Assessing Comprehensive Nursing Performance: The Objective Structured Clinical Assessment (OSCA) Part Two. The Report of the Evaluation Project. *Nurse Education Today, 11*, 248-255.

Conway, J., & McMillan, M., (2000). Maximising Learning Opportunities. In: Daly, J., Speedy, S., & Jackson, D. (Eds). Contexts of Nursing: An introduction (1st ed.). Sydney: MacLennan and Petty.

Dewey, J. (1933). How we think. Boston: DC Health & Co.

Hengstberger-Sims C., & McMillan, M. (1992). Problem-based learning: Considerations for neophyte package writers. *Nurse Education Today, 13*, 73-77.

Hengstberger-Sims C., & McMillan, M. (1991). Stakeholder evaluation: A model for decision making in problem-based learning. *Nurse Education Today, 11*, 1-9.

Hunter, S., McMillan, M., & Conway, J. (2007). The Professional Development Needs of Registered Nurses in Residential Aged Care. *Collegian, 14*(2), 6-11

Jeong, S., McMillan, M., & Higgins, I. (2010). The essentials of Advance Care Planning for end-of-life care for older people. *Journal of Clinical Nursing, 19,* 389-397.

Kant, I. (Ed.). (1781). *Translation of 2nd edition by Meiklejohn* (1934) Critique of pure reason. London: JM Dent & Sons Ltd.

Little, P., McMillan, M., & Bujack E. (1994). Preparation for competent practice. In: McMillan, M., & Townsend, *J. Reflections on Contemporary Nursing*

Practice Sydney: Butterworth.

McMillan, M., Conway, J., Little, P., & Bujack, E. (2001). *Scope of Nursing Practice: Implications for Nurse Education in Australia.* Report to Department of Education Training and Youth Affairs.

McMillan, M., Baker, H., Sharkey, R., Andrews, J., & Baker, J. (1997). *Information Booklet for Community Nursing Providers.* Project to develop a community care and funding model for treatment and payment. Department of Veterans Affairs

McMillan, M., Bujack, E., & Little, P. (1994). Learning through assessment and appraisal: Development of the competent practitioner. In: Gray, G., & Pratt, R. *Issues in Australian Nursing 4*. Melbourne: Churchill Livingstone.

McMillan, M., Bujack, E., Dwyer, J., & Hazelton, M. (1990). *An evaluation of the use of the Objective Structured Clinical Assessment (OSCA) within the School of Nursing and Health Studies at the University of Western Sydney, Macarthur.* A project funded by the NSW Nurses Registration Board.

McMillan, M., & Dwyer, J. (1989). Changing times, changing paradigm (1): from hospital training to college education in Australia. *Nurse Education Today, 9,* 13-18

McMillan, M., & Dwyer, J. (1989). Changing times, changing paradigm (2): The Macarthur Experience. *Nurse Education Today, 9*, 93-99.

Peel, E. (1971). *The nature of adolescent judgment.* London: Crosby, Lockwood, Staples.

Ryan, G., Little, P., Smith, G., McMillan, M., & Hengstberger-Sims C. (1992). Implementing problem-based learning in nursing. In Gray G, Pratt R (eds.). *Issues in Australian Nursing 3*. Melbourne: Churchill Livingstone.

Street, A. (1988). *Nursing practice: High, hard ground, messy swamps and the pathways in between. Reflective Processes in Nursing.* Victoria. Deakin University, PR805.

Taba, H. (1962). *Curriculum development: Theory & practice.* New York: Harcourt, Brace & World, Inc.