The Nurse Theorists: 21st-Century Updates—Dorothea E. Orem

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Dorothea Orem, RN, MSN, Ed, FAAN, began to develop foundations for the self-care deficit theory of nursing in the 1950s, when the curriculums of most nursing education programs were based on conceptual models from medicine, psychology, and sociology. Thus, Orem is a pioneer in the development of distinctive nursing knowledge. The development of the self-care deficit theory of nursing has been described in considerable detail (Nursing Development Conference Group, 1979; Orem, 1995, in press; Orem & Taylor, 1986). The initial impetus for public articulation of the foundations and essential elements of the self-care deficit theory of nursing was the need to upgrade curriculums for practical nursing programs (Orem, 1959). Orem (1978) commented that that task required identification of the domain and boundaries of nursing as a science and an art. Continued work on the self-care deficit theory of nursing was motivated by "dissatisfaction and concern due to the absence of an organizing framework for nursing knowledge and . . . the belief that a concept of nursing would aid in formalizing such a framework" (Nursing Development Conference Group, 1973, p. ix). In particular, the self-care deficit theory of nursing was formulated and developed as a solution to the problem of "the lack of specification of, and agreement about, the general elements of nursing that give direction to (1) the isolation of problems that are specifically nursing problems and (2) the organization of knowledge accruing from research in problem areas" (Nursing Development Conference Group, 1973, p. 6).

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Ideas that helped to shape the self-care deficit theory of nursing were formulated as Orem experienced a period of intensive exposure to nurses and their endeavors from 1949 to 1957, during her tenure as a nursing consultant in the Division of Hospital and Institutional Services of the Indiana State Board of Health. Her observations led to the idea that "nursing involved both a mode of thinking and a mode of communication" (Orem & Taylor, 1986, p. 41). Orem's "interest in and insights about the domain and boundaries of nursing" (Orem, 1991, p. 60) progressed from a global focus on "preventive health care" (p. 60) to a formal search "to know nursing in a way that would enlarge and deepen its meaning" (Orem & Taylor, 1986, p. 39) and to identify a proper nursing focus. Her search for the meaning of nursing was structured by three questions: (1) What do nurses do and what should nurses do as practitioners of nursing? (2) Why do nurses do what they do? and (3) What results from what nurses do as practitioners of nursing? (Orem & Taylor, 1986, p. 39).

The answers to those questions began to emerge when Orem (1956, 1959) first articulated a definition of nursing and, then, rudimentary elements of the self-care deficit theory of nursing. Orem (1959, 1995) always has stated that human limitations for self-care associated with health situations give rise to a requirement for nursing. Orem (1995) regards that statement as the articulation of the "proper object of nursing considered as a field of knowledge and a field of practice" (p. 433).

The questions were answered more fully as Orem worked first with the Catholic University of America Nursing Model Committee and then with the Nursing Development Conference Group. Orem (1995) explained:

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> All of the conceptual elements [of the self-care deficit theory of nursing] were formalized and validated as static concepts by 1970. Since then, some refinement of expression and further development of substantive structure and continued validation have occurred, but no change of conceptual elements has been made. (p. 436)

The refinements in and the evolution of the substantive structure of the self-care deficit theory of nursing are especially evident in the five editions of Orem's book, *Nursing: Concepts of Practice*, that have been published to date (Orem, 1971, 1980, 1985, 1991, 1995).

I first interviewed Dorothea Orem in November 1987 in Savannah, Georgia. That interview is part of *The Nurse Theorists: Portraits of Excellence* series of videotapes and compact disks (Orem, 1987). This column presents the edited transcript of a telephone interview I conducted with Dorothea Orem on May 31, 2000.

On the Discipline of Nursing

JF: Dorothea, what do you think about the current state of the discipline of nursing?

DEO: The most general thought I have is that nursing is in disarray.

JF: What do you think is the source of the disarray?

DEO: I see the disarray both in education and practice situations. The disarray in education comes from the absence of a structured, practical science of nursing. In practice, the disarray can be attributed, in part, to the fact that associate degree–prepared nurses do not have enough contact with professionally qualified and practicing nurses, who bear responsibility for the design and management of nursing for patients and of working conditions.

I became aware of the absence of any structured discipline of knowledge in nursing many years ago, when I began to look at what was occurring in biology and other fields. I thought, "Well, nursing is certainly not organized." And I think that continues to be true. I think that the main reason for what I refer to as disarray is that by and large, over the years, nurses have not thought about nursing as a discipline of knowledge. That is, nurses may have used the words but their energies have not been put to work in bringing about a structure for nursing knowledge. We seem to disregard everything that other disciplines know about how to go about developing their field, their science.

On the Self-Care Deficit Theory of Nursing

JF: Do you think that the development of the self-care deficit theory of nursing has helped to avoid total chaos in the discipline?

DEO: I wouldn't say that, but I would say that the self-care deficit theory of nursing has contributed to the existence of a group of nurses who see nursing as a practical science. The development of the theory, particularly the articulation of the conceptual elements and the substantive structure of the main concepts, has resulted in the formulation of theoretical, or speculatively practical knowledge. That speculatively practical knowledge has, I think, brought unity and meaning to the universe of nursing and the domain of action of nursing. We now have a clearer view of the field. And I have been able to formalize what I see as the nursing practice sciences and the foundational nursing sciences [Orem, in press].

JF: Please tell me more about the nursing practice sciences and the foundational sciences. What have you added to the forthcoming 6th edition of your book *Nursing: Concepts of Practice?*

DEO: I have added an introductory chapter on human services to set forth what is common to all of the human health services. This is one of the things we forget; we sometimes think we are moving from outer space rather than from real-life situations. Some chapters, such as "Interpersonal Features of Nursing" and "Nursing and Society," are essentially the same as the 5th edition, but I've done major work on a number of chapters, including the chapter that presents the self-care deficit nursing theory and the chapter on therapeutic self-care demand. In addition, a group of us have done considerable work with self-care requisites, which also is included in the 6th edition.

Furthermore, I have added an essentially new chapter, "The Practical Science of Nursing," which I think should make a contribution. In that chapter, I name three practice sciences—wholly compensatory nursing science, partly compensatory nursing science, and supportive-developmental nursing science. I see that those sciences in a sense are analogous to medicine's practice sciences, such as internal medicine, surgery, and so forth; they are the way you practice. The three foundational nursing sciences we identified now are called the science of self-care, the science of the development and exercise of self-care agency, and the science of human assistance for persons with health-associated self-care deficits. All three of those sciences are put to use with the practice science.

And then, of course, for the three practice sciences (wholly compensatory nursing science, partly compensatory nursing science, and supportive-developmental nursing science), you have types of cases; you have models and rules of practice for types of cases. And, in a sense, you come up with nursing content that is analogous to what medicine has in internal medicine books, surgery books, and so forth. But we need people who are willing to do this.

One thing that I have found in all the work I have done with the theory is that if you are going to get anyplace in developing nursing science, you have to have a model of practice science. You have to have a valid, reliable, general theory of nursing. And you have to have models of

the operations of nursing practice, what people call nursing process. And, of course, you have to develop the conceptual structure of the general theory. But what you also have to do is integrate the conceptual elements of the theory with the practice operations. Unless you do that, you are not going to make the theory relevant to practice and you are not going to identify a structure of nursing science.

And early on, my colleagues in the Nursing Development Conference Group (1973, 1979) and I identified some foundational knowledge that is needed to reason correctly about nursing matters. That is important; unless you have insights and workable knowledge about humankind, deliberate action, organization, process, systems, order, and relations, you are at a loss. So, this in a sense is one kind of foundational knowledge that nurses need.

JF: Perhaps some of the members of the International Orem Society for Nursing Science and Scholarship [IOS] will do that. [For information about the IOS, contact Dr. Susan Taylor, President, S428 School of Nursing, University of Missouri, Columbia, MO 65211].

DEO: Yes.

JF: You have identified certain operations that are common to all health professions; what do you think is the unique or distinctive territory of nurses?

DEO: That is when you have to identify the proper object of nursing, the domain and boundaries of nursing. That is where the uniqueness comes in.

JF: And you always have said that the proper object of nursing is expressed in the health-associated conditions of adults and children that validate a requirement for nursing. More specifically, you have said that that condition

> in an adult is the absence of the ability to maintain continuously that amount and quality of self-care which is therapeutic in sustaining life and health, in recovering from disease or injury, or in coping with their effects. With children, the condition is the inability of the parent (or guardian) to maintain continuously for the child the amount and quality of care that is therapeutic. (Orem, 1995, pp. 53-54)

DEO: Yes. And when you say that, that gives you the domain and boundaries of nursing. Yet many nurses have refused to identify the domain and boundaries of nursing. Moreover, many nurses are trying to get the answers in philosophy. But although philosophy will help you to think about things, no philosophy will tell you your subject matter.

JF: What predictions do you have about the contributions of the self-care deficit theory of nursing to the continued advancement of the discipline of nursing?

DEO: I think that the basis for continuing development of nursing science is now evident. I know that there is a lot of nursing knowledge, and a great deal of it is practically practical. That kind of knowledge is concerned with the details of cases and encompasses the rules and standards of practice, the knowledge necessary for taking action. I think that what we have done with the self-care deficit theory of nursing shows how practically practical knowledge can be structured and shaped.

On Nursing Education and Nursing Practice

JF: Earlier, you said that nursing has not paid any attention to the way that other disciplines have developed their knowledge and their discipline. It seems to me that one of the things we have not done well, if at all, is to differentiate between entry-level and advanced education in nursing.

DEO: Unless you have a structured discipline, you have nowhere to come from or advance to.

JF: Do you make a distinction between technical and professional nursing?

DEO: If you are using technical in the sense of education, then I do make a distinction. But many nurses do not have insights about the differences between professional and technical forms of education and between practice operations of technicians (of various labels) and that of professionally qualified nurses—entry level, experienced, highly advanced.

JF: Yes, I am referring to nursing education. Do you think that the self-care deficit theory of nursing can be used in both technical and professional nursing?

DEO: They use it now, and have been over time. [See Fawcett, 2000, for citations to published reports of diploma, associate degree, baccalaureate, and continuing education nursing programs that are guided by the self-care deficit theory of nursing.]

JF: Do you think that the theory is used appropriately?

DEO: Yes, I think so, in many situations. As a general theory, the self-care deficit theory of nursing is useful in all levels of education. But you wouldn't take my entire book and place it in all types of programs. Instead, you have to look at the background of the student and educational outcomes sought before deciding which portions of the book would be appropriate. Baccalaureate students can use the book without much help if their secondary education was adequate.

JF: So, you could say that there is a certain body of knowledge within the context of the self-care deficit theory of nursing that is appropriate for technical education and a body of knowledge that is appropriate for baccalaureate education?

DEO: That's right, and I am referring to *Nursing: Concepts of Practice*, not to the theory as an isolated entity. And you even can get it down to the vocational level; I know that at a hospital outside Toronto, vocational nurses could use elements of the theory in working with patients. The self-care deficit theory of nursing is a general nursing theory; the complexity is in the cases.

JF: What does "complexity in the cases" mean?

DEO: I know that there are many cases in hospitals today where you need a master's-level education to be competent. The complexity is in what personas are experiencing and the physiologically and the psychologically described things that are going on, and the whole sociology of the situation.

JF: So, you think that at least part of the complexity comes from the clinical picture presented by the individual patient?

DEO: That's right. The same as you have in medicine. Another type of complexity is dealing with families and other aggregates. You have to expand the knowledge to those situations, as Susan Taylor and Kathie Renpenning have done for the self-care deficit theory of nursing [Taylor & Renpenning, 1995].

JF: Given that you make a distinction between technical and professional nursing education, do you think there is a difference in the practice of technically and professionally educated nurses?

DEO: Oh, yes, definitely; that already has been demonstrated. And it has been demonstrated that nurses with technical education can only advance so far without further education. We have to distinguish between how we are going to use nurses who are prepared in different types of educational programs. But we have never been willing or able to do this.

On Nursing Research

JF: Have you identified specific research methods to use with the self-care deficit theory of nursing?

DEO: No, I have not done that because I have been identifying a foundation for research. I am identifying a base from which researchers can raise questions for investigation. I needed to do what I saw as formalizing the speculatively practical nursing knowledge.

Barbara Banfield (1998) discussed some of the questions about the theory, including its philosophical foundations, views of man, and also, what would be valid research methods. She did a good analysis. Banfield sees my work as based on moderate realism, which is important; I think there is some movement in philosophy of science to look more favorably on moderate realism [see also Orem, 1997].

[Banfield (1998) concluded that descriptive, descriptive-correlational, case study, and quasi-experimental methods associated with the empiricist research paradigm are most consistent with Orem's self-care deficit theory of nursing. Furthermore, she noted that ethnographic, grounded theory, and phenomenological methods associated with the interpretive research paradigm may be consistent with Orem's theory. Methods associated with the critical theory research paradigm, according to Banfield (1998), "have limited [usefulness] for the development of the practical science of nursing" (p. 178) related to the self-care deficit theory of nursing, due to the focus of that paradigm on emancipation of the study participants "from the ideologies that function to constrain or oppress them" (p. 152), as well as to the fact that Orem does not address such major issues in the critical theory paradigm as power, control, and domination. Banfield (1998) went on to point out that data should be collected using only those instruments that are consistent with or directly derived from Orem's theory.]

Furthermore, Susan Taylor and Kathie Renpenning have been working on a book about nursing research (Taylor & Renpenning, in press). But too many nurses do not have an understanding of where research fits into a discipline.

On Nursing Theories

JF: Is there anything else you would like to tell me about the self-care deficit theory of nursing or your own work?

DEO: We have had a study group for several years. Three of us worked on self-care requisites, and five worked on dependent-care. A third group of three worked on the structure of self-care agency. [See Anderson, 2001; Denyes, Orem, & Bekel, 2001; Söderhamn & Cliffordson, 2001; Taylor, Renpenning, Geden, Neuman, & Hart, 2001.]

I think this is a very difficult time in nursing. There is so much talk about the nursing shortage. Some nurses who are leaving are associate degree nurses. If those nurses do not have an intellectual life in nursing, if they are moving clinically but not intellectually, they are not going to stay; they are not professionals with a career orientation. I think nurses must have a creative intellectual life or be satisfied to do repetitive work or they get out of nursing.

All nurses need to understand that a theory merely points to the situations you have to deal with in the real world and helps you to understand those situations. The theory comes alive in real-world situations.

One of the things we did in nursing when we first started to have theories available is to look at them as all being the same; it was up to the individual to pick one. But they are all different. Some are theories of nursing and some are theories about parts of nursing. Yet we held them up as all being the same. I think we need to look at what is out there and see what we have.

JF: Yes. Furthermore, I think that people try to fit the theory to the situation rather than use the theory to select situations for which it is appropriate. There is a tendency to say that any theory or any conceptual model will do in any situation; it is very hard to get people to say that that is not the case.

DEO: Yes, that is not good. But the self-care deficit theory of nursing will fit into any nursing situation, because it is a general theory, that is, an explanation of what is common to all nursing situations, not just an explanation of an individual situation [see Orem, 1993].

JF: I would like to thank you very, very much for your willingness to participate in this interview. It was, as always, wonderful to talk to you.

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