

10th World Congress Self-Care and Nursing - Reflecting the Past - Conquering the Future SPECIAL ISSUE

PART I

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From the Editor:

Dear readers:

Please join the IOS in welcoming the incoming Co-Editor for the journal, Virginia Keatley, DNSc, RN of the University of Tennessee Chattanooga. Virginia and I are excited about our plans to collaborate in publishing a quality journal.

Join us in celebrating the success of the *10th World Congress, Reflecting the Past - Conquering the Future*. This special World Congress issue includes proceedings' papers submitted by presenters, all abstracts approved for presentation, conference reports and photos, as well as the usual sections of the journal. Due to the size of this issue, it is published online as *Part 1* and *Part 2*. We sincerely appreciate the work of all who made this issue possible. ■

Vi Berbiglia
Editor, Self-Care, Dependent-Care & Nursing

Co-Editors:
Violeta Berbiglia and Virginia Keatley

President's Message

SELF-CARE DEFICIT NURSING THEORY – what a wonderful legacy Dorothea Orem has left to us. It was exciting to meet with so many enthusiastic scholars and practitioners at the recent International Orem Society congress in Vancouver, Canada in June of this year and to share in the memorial to Dorothea. We were especially pleased to be able to have Sarah Allison and Cora Balmat share their remembrances of Dorothea with us via the internet connection.

These conferences always seem to generate a wave of enthusiasm which I hope we can capitalize on in the coming biennium. In the early 1990's, Orem suggested that a task needing to be done was to identify knowledge related to Self-Care Deficit Nursing Theory and to organize it in some fashion. In 2004, at the 8th World Congress in Ulm, Germany the Orem study group put forth a proposal titled "*The Structure of the Discipline of Nursing with Foundational and Nursing Specific Knowledge*". This structure was revisited by Barbara Banfield and myself in our presentation at the recent congress. It is my goal that, as a society, we continue work on developing this structure, organizing the nursing-related knowledge that has been developed, and expanding that knowledge base. Integral to accomplishing this goal, is sharing our work through this journal, through face to face meetings and workshops, and producing text books and e-books. I know, that because of the lack of published texts, many nursing programs have developed their own resource materials. I realize there are copyright issues associated with these materials; but I hope that, as a society, we can identify materials that have been developed and facilitate sharing and further development of these resources.

I look forward to having the help of interested scholars and practitioners throughout this coming biennium in moving forward in relation to identifying and organizing the body of knowledge related to Self-Care Deficit Nursing Theory and to further developing and explicating the components of the theory and their relationships. ■

Kathie Renpenning

Memorial to Dorothea Orem

Sarah E. Allison

I wish to extend my **greetings to all of the participants at the 10th World Congress on the SCDNT**. The fact of your being here suggests your interest in and willingness to explore and use Orem's theory in the various aspects of nursing. I am sorry not to be with you but happy to share a few comments about Dorothea who was my mentor and friend.

Mentor

I first met Dorothea over 45 years ago, in 1961, when I was a master's degree student. She taught our seminars on administration of nursing education at The Catholic University of America and became my major professor on my dissertation. After practicing nursing in a variety of health care situations and teaching nursing in a diploma school, I thought I knew nursing. She opened my eyes to the notion of how to think about nursing in a general way versus the practical doing of nursing - how "thinking" nursing, having a clear concept of nursing can serve as guide in whatever one might choose to undertake in nursing. This awakening, learning to think intellectually about the nature and purpose of nursing, came to serve as the focus and purpose of my professional career.

Dorothea encouraged me to go on for doctoral study at a time when nurses in search of advanced study often had to seek it in a discipline other than nursing. There were a few doctoral programs in nursing. At that time, the concern was upon defining "what is nursing." There were a few nurse theorists, but Dorothea's concept made the most nursing sense to me. Few in my doctoral program knew much about nursing theory and little was done to help my thinking about nursing. Dorothea remained my mainstay and to have a consistent guide in seeking to clarify the focus of nursing and a conceptual nursing framework for the development of nursing knowledge.

In 1968, on completion of my doctoral studies, Dorothea encouraged me to establish an institute for the development and improvement of nursing practice. Her conceptualizations, naturally, were the basis for the design and development of our projects on both the inpatient and outpatient services at The Johns Hopkins Hospital in Baltimore.

About 1970, Dorothea left her faculty position to write her first book conceptualizing nursing.

She also brought together a group of nurses, The Nursing Development Conference Group (NDCG), who were concerned about the development of nursing and were willing to commit their time, money and effort to study nursing in order to help formalize nursing knowledge. Dorothea gave us the vision and was the leader and moderator for the group. She encouraged us and others to discuss nursing cases, analyze from these particular situations and identify the essence, the meaning, of what was being shared. She enabled us to generalize about nursing from our observations. Dorothea had a unique talent in that she was able to abstract and generalize meaning from particular situations. She was a deep thinker and theorizer. I recall her once saying to me, "You know, people often seem to think I can do anything because I can do this, but I can't." She knew her strengths and weaknesses. She was always deeply concerned about and dedicated to the development of nursing knowledge and nursing as a practical science. Moreover, she was interested in involving others in thinking about nursing as evidenced her study groups, including one in her later years. She respected what others had to offer, sharing their ideas, and encouraged continuing study and work toward the development of nursing.

Over the years, Dorothea frequently served as a consultant to me in nursing administration, aiding in the development of better ways to provide nursing to various patient populations. Similarly, she did so for many others, including students who would call her at home on the telephone for help or guidance.

Dorothea, herself, was the epitome of the scholar, reading and studying works from a various disciplines of knowledge and drawing upon them as needed to aid in developing nursing knowledge. She continued to write even after the publication of her last book in 2001. When I visited her home after her death, I was given her last handwritten papers which I have subsequently typed up and sent to the Alan Mason Chesney Archives of the Johns Hopkins Medical Institutions for the Orem Collection. (Copies have been shared with Kathie and Gerd). These papers reveal her continued ability to logically lay out what she had developed from her conceptual framework to be used as a basis for structuring and organizing nursing knowledge.

Friend

Dorothea was always gracious and thoughtful of others in a quiet gentle way. Even as a student, I was impressed with her cordiality and helpfulness to her students, taking us to lunch on field trips

and inviting us to her home for dinner. She not only served as a mentor but became a friend to a number of us over the years. I visited her home and she visited mine. She was my inspiration and guide in continuing to work toward improvement of nursing and to do so from a clear nursing perspective.

Though I worked with her on various projects and in the study of nursing over the years, we became closer friends after 1972 when she and Walene Shields took me into their home for over three months to help me recover from a devastating auto accident which killed two of our NDCG colleagues and I was physically incapacitated for a long period of time. Helping others when they could was typical of both Dorothea and Walene. Moreover, when the NDCG met at her house to work, she and Walene were always gracious hostesses serving us meals and often offering their home as a place to stay for members from out of town. She became a friend, involved with us both socially and professionally.

As a Person

As a person, Dorothea was kind and gentle and not one for social chit chat. When I was trying to get an oral history about Dorothea from Walene Shields, Walene she said to me that Dorothea “was not one for talk. She just didn’t talk”. She liked to cook and was an excellent one. She was quietly friendly and would say what she had to say. She was not one for negative criticism of others or their work but would give her honest opinion when asked. Dorothea had her own definite ideas and a strong sense of what was right. She was not swayed by current fads or ways of thinking. She was respectful of the ideas of others and drew upon them when needed. Dorothea had a wry sense of humor and sometimes would get a twinkle in her eye at others’ remarks and might respond with a gentle yet sharp and pertinent comment. She read deeply on many subjects from foreign affairs to politics, sociology, philosophy and other disciplines of knowledge. She particularly loved to read gourmet magazines, cook books and mystery books. She was a great lady, a strong friend and an inspiration to many.

Her Work

In the early days, Dorothea once said to me that it would take over fifty years for her work to be recognized. Needless to say, it did not take that long. A tremendous amount of work has been done by her and by a number of others (many of whom are here at this conference) who have made major contributions to her work. Dorothea has given us a

framework for nursing and a clear firm foundation for developing nursing as a practice discipline and discipline of scientific knowledge.

Recently I have been asked how her ideas about nursing might affect the development of nursing knowledge and nursing science over the next fifty years. There is much knowledge and nursing research out there, but, to date, few are working to pull that information together from a logical organized nursing framework perspective such as Orem’s. It is work that needs to be done. As Taylor, Geden and others (2001) wrote in *Nursing Science Quarterly*, (loosely quoted here), we have “the bricks in the findings from nursing research but are not building the walls” of nursing knowledge. Dorothea Orem gave us the blueprint for those walls, a way to build our house—nursing. Her work has laid the foundation upon which we all must build. The Nursing Diagnostic project (that you will hear at this conference) is evidence of continuing development. Moreover, the fact you all are here at his conference to share work, learn and seek further knowledge based on Orem’s theory is also evidence that the work is continuing to move and develop. Orem’s work has demonstrated its value and provides us a definitive framework for building the future of nursing. ■

Sarah E. Allison
June 2008

Memorial to Dorothea Orem

Cora S. Balmat

It is indeed a pleasure and an honor to be asked to express a few thoughts at this time. Dr. Allison has just presented a thorough analysis of Dorothea's impact on her experiences from a professional perspective and as a long time friend and Mentor. I was asked to write a tribute to Dorothea that was published in the last IOS journal. Those were my perceptions, thoughts and feelings that grew into admiration for one of the greatest thinkers of our time.

Many theorists in the late sixties, seventies, eighties and early nineties were focusing on Nursing and many books were written from a variety of conceptual and theoretical models. As a Professor I had an obligation to read and evaluate their usefulness in our programs of study. To me, Orem's work far surpassed others, and I could usually take the major concepts presented and fit them within Orem's models.

Dorothea continued to develop her insights and to this day, to me at least, far outshines them all. She focused on the development of practitioners who could successfully blend knowledge from the Natural, Psycho-Social and Medical Sciences into a solid foundation for Practical Nursing Science. This would prepare practitioners to become leaders in the delivery of health care. The delivery of health care was to be based on the client's abilities and limitations in meeting the requirements for recovery, or learning to live with self-care limitation if unable to recover to engage in activities and interactions that support the realities being experienced by patients and significant others.

I know Dorothea is smiling down and supporting the efforts of all here today. Do not hesitate to re-read her writings. Each word is carefully chosen and, when pondered, new insights often emerge. Continue to strive onward and upward and Nursing will survive as a leader in health care delivery.

Thank you for your time and a special thanks to Gerd and the planning committee for enabling this all to come together in this Memorial to a great Scholar, Mentor and Friend. ■

Cora S. Balmat
June, 20083

“Toast Crumbs” – Memories of Dorothea Orem

Anna Biggs

As one of the newly admitted doctoral nursing students at the University of Colorado, I was invited along with all the other current and new doctoral students and program faculty to a barbeque at Dr. Jean Watson's home along with a consultant to the CU PhD program, Dr. Martha Rogers. I thought I better read something about Dr. Rogers' nursing theory and remembered a book on nursing theories that I had received as a desk copy at my office. So I read the chapter about Rogers' theory and made a few marks (question marks...) in the margins by words like “helicy” and “resonancy” and went to the barbeque on the other side of the mountains in Colorado and then on into the doctoral courses, where, of course, we began learning about theory construction and development.

A few years later, working on my dissertation using Ricoeur's hermeneutics with Dorothea Orem's Self-Care Deficit Nursing Theory, I knew I needed to go back to the first time I'd heard of Dorothea Orem's theory. I remembered the book I'd read before the barbeque had a chapter about Orem in it and I recalled reading that chapter while nursing my infant daughter and eating breakfast, but that was all I remembered about reading that chapter on Orem. After searching through a box of books, I found the book of summaries of nursing theories and there in the chapter about Orem's theory was a picture of my daughter in her swing (a not-too-happy, frowning baby – reminds me how graduate nursing students likely view having to take a nursing theory class!) and down in the creases of the pages: toast crumbs! But more importantly, there were a number of lines emphasizing portions of the chapter with exclamation points by some of the paragraphs about self-care, self-care deficits and nursing systems. I still have the book, with the same bookmark and even a few remaining toast crumbs that remind me of the first time I ever heard of Dorothea Orem and her theory. But this “secondary source” could never do justice to the primary writings – the real thing from Orem herself!

After I finished the dissertation on metaphors of nursing in Orem's 1985 book, I submitted an abstract about hermeneutics and the metaphors to the University of Missouri – Columbia to present at their annual spring research day. When I was notified that it had been accepted for a plenary

session and would be “critiqued” by a researcher and by Dorothea Orem herself, I was both ecstatic and full of trepidation: Dorothea Orem was going to read and critique my paper! Oh, my! And, because I taught at the same university with the faculty who would do the research critique, I was asked to give her a copy of my paper. When I dropped off the copy of my paper, the response was “well, I don’t know why I am being asked to critique this since it isn’t research.” I was aware of that kind of attitude about hermeneutics and qualitative methods “not being research”. And nothing could detract from the realization that I was actually going to meet Dorothea Orem! As many other graduate students have done, I had spoken with her on the phone one time for an arranged interview and discussion of some of her concepts prior to a class discussion on how nursing theorists developed their ideas. I was impressed that Dorothea Orem gave much credit to the Nursing Development Conference Group for all the work and discussions they had put into the theory’s development. And now I would get to meet her in person!

The day came for the presentation. I had been so nervous about having my paper reviewed by Dorothea Orem, but my mother had comforted me, reminding me that with my gerontological nursing background, I would do fine with meeting “an older lady”. The presenter before me gave a very interesting report on self-care actions of young girls at menarche. Dorothea Orem complemented her on her correct use of the terms and concepts in SCDNT, but the research critique was critical of the “age” of some of the references being more than five years old. I nearly sank through my seat, since some of my references were *really* “old” - from the 1700’s! I don’t remember too much about my presentation, but I remember being awestruck when Dorothea Orem graciously commented on my presentation and the stimulation to thinking about the “world-of-nursing” as a major part of doing hermeneutics, and how Ms. Orem wrote some of her thoughts about the world-of-nursing in an IOS newsletter and in her subsequent *Nursing: Concepts of practice* books. Dr. Orem’s gentleness, kindness and graciousness took the sting out of the research criticism that followed – “it isn’t research after all.”

Over the next several years I had the privilege of observing this dynamic “older lady” (she continued to run mental circles around the younger ones!) and listening to Dorothea Orem’s presentations at the University of Missouri – Columbia Summer Institutes and the early World Congresses, as well as reading her later revisions. I have remained as awestruck at her vision, the clarity of her thinking and writing the General Theory of Nursing that is “universal” in

its global application and that has continued to guide my nursing practice, nursing research and nursing education endeavors over the past two decades. And, while I miss her as many others do, I chuckle to think that Dorothea Orem is probably engaged in very scholarly discussions with the research critique-er, enlightening her about the world-of-nursing as Dorothea Orem keeps an eye on the rest of us as we continue to use the General Theory of Nursing with the theories of self-care, self-care deficits and nursing systems. Here’s a toast to Dorothea Orem – and no “crumbs” from this toast! ■

Anna Biggs

In Remembrance

Violeta A. Berbiglia

Twenty years ago, I came here to this building to meet Dorothea Orem and her followers. I wondered “How does it feel meet a nursing theorist like Orem? What a thrill that will be!” Actually our meeting was very common place – as we stood with other women waiting for the toilet.

Later on Saturday night, Orem sat with a small group of educators and listened to my report of my dissertation. At the end she embraced me and thanked me. This week I am meeting Dorothea all over again. Martha Libster, in her Keynote, had the perfect words for this *meeting*: “The Daughters of Charity often said of a beloved deceased Sister, ‘She will not forget us,’ meaning that they knew that the Sister was still helping them on the ‘other side’. Through her connection with the Daughters’ tradition, I sense that Dorothea will not forget us and that she too may be poised to help us from the other side.” ■

Violeta A. Berbiglia

Perspectives on the History of Self-Care

Martha Libster

Abstract

Dorothea Orem's work in self-care and dependent-care nursing is examined within the historical context of her personal connection with the Vincentian-Louisiana nursing tradition of the Daughters of Charity. American self-care nursing is rooted in the work of early and mid-19th century Daughters of Charity nurses. It was during this period that self-care was the foundation of immensely popular movements for health reform and public empowerment. Early self-care themes such as domestic medicine and sickroom management and associated concepts of the five elements of care are discussed as they relate to the histories of healthcare in many cultures around the world.

MESH: Self-care; history of nursing; holistic nursing; healing environment; domestic medicine

Introduction

Thank you Barbara Banfield and the planning committee for this invitation to speak about history at this auspicious Congress in which we will celebrate past, present, and future. This is my first IOS conference and yet I have been bumping into Orem's theory for more than twenty years. I was a student at Mount St Mary's College in Los Angeles, California in the early 1980's where we studied Sister Callista Roy's Adaptation Theory; but I was intrigued that down the street at the University of California, Los Angeles, nursing students studied "Orem" and self-care. My mother and her parents raised me in a culture that valued self-care while my father and his parents valued the help of biomedicine and the wisdom of a good and learned physician. I am a product of the integration of the two but my primary interests, especially having grown up as a professional dancer, have always been in studying the body, the Self, and self-care, how to care best for the amazing gift of life in physical form. Self-care is a theme in most of my writings. But what I only realized more recently is that Orem's work and theory is mentioned in every one of my books. It is my new book on the history of the early nursing work of the American Sisters of Charity that

connected me with Barbara and this community of scholars. I am delighted to be here with people who share a passion for self-care as I do.

For this talk on *perspectives on the history of self-care* I have two purposes. First, given the occasion of the celebration of the life of Dorothea Orem, I'd like to talk about the heritage that inspired Dorothea Orem's work and perhaps many nurses' works around the globe in self-care and dependent-care nursing. Second, I will provide a historical perspective on self-care rooted in my research of early and mid-19th century American nursing. It was during this period that self-care was the foundation of immensely popular movements for health reform and public empowerment. While the focus of my talk will be primarily European and American history, the area of my research, I will also show how some of the themes from this history resonate with the histories of healthcare in many cultures around the world.

History is the record of identity. For the seeker, history reveals identity. It is the story of self; it is also the story of groups of selves. Historical research is the study of self over time. It is within the story, the details, the context, and emergent patterns that the identity of the self or selves is discovered. Historiography is the critical examination followed by creative expression of the patterns of that self over time. Every nurse has a history. And as a wise teacher once told me, "There is nothing new under the sun." But what makes nurses unique is the way in which they bring their talents to bear, how they construct *meaning* for the endeavor that is nursing.

When I was preparing for this talk, my mind kept drifting back to something I had read Dorothea Orem said that really made an impression on me. She said that nurses often "do not know how to talk about nursing."¹ Talking and language are one of the ways we make meaning of our human experience – so I can understand her concern that nurses know how to talk about themselves. It is history that gives nurses the words and the contextual framework for being able to talk about nursing. My job as a historian is

to “talk” about nursing and to provide the scaffold for the possibility of making connections between past and present wherein we can realize the role of nursing care within the greater culture and perhaps the ultimate purpose of human *being*. I propose that it is in the study of nursing history, the record of nursing’s collective professional self, that nurses find identity, the words to describe who and what we are and what we do, and the suggestion of future possibilities.

Heritage

Dorothea Orem was rooted in a nursing tradition that originated on November 29, 1633, when Vincent de Paul (1581-1660) and Louise de Marillac (1591-1660) founded the Company of the Daughters of Charity (DOC), Servants of the Sick Poor at Paris. Three years earlier Vincent had entrusted Louise with the formation and training of the young women who were volunteering to devote themselves to the work of parish-based Confraternities of Charity. Vincent had been directing Confraternities throughout the countryside of France since the movement’s inception. In 1630, Marguerite Naseau (1594-1633) of Suresnes, offered her services to Vincent to nurse the sick. Vincent sent Marguerite and others who followed her example to Louise for training in nursing and ministry. For Marguerite and the DOC throughout the years and to present day, the mission is the same:

The charity of Jesus Christ crucified, which animates and sets afire the heart of the Daughter of Charity, urges her to hasten to the relief of every type of human misery.² The DOC tradition began as a parish-based model of apostolic service founded on the teachings of Vincent de Paul and the practical preparation of Louise de Marillac in the care of the sick poor. The lived experience of the DOC was preserved in a document known as the “*Common Rules*.” Still in practice today, the *Rules* originally served as a prototype for apostolic life in the DOC company and ultimately for many religious communities and nursing leaders. In the 1990’s a genealogical study of the Vincentian heritage showed that eighty Roman Catholic institutes “substantially followed” the *Common Rules of the Daughters of Charity*. In addition seven Anglican institutes were “rooted” in the *Common Rules*.³ Nineteenth-century protestant nurse leaders such as German, Amelia Sieveking and British Florence Nightingale were also inspired by the *Common Rules* of the DOC.

Initially the sisters, called “servants of the poor,” provided nursing and home care to poor people in the towns and villages surrounding Paris. Gradually as other urgent needs arose,

Louise and Vincent diversified the service of the sisters and sent them to care for the sick in hospitals, orphanages, prisons, the battlefield, and insane asylums. The co-founders devised innovative ways to avoid the conventions of their day which confined religious women to the cloister. The DOC were neither religious nor secular; they were apostolic women who “came and went as seculars.” Service to the sick poor provided the environment for the instillation and ongoing nurturance of the virtues of charity, simplicity, and humility in novices and professed sisters.

Elizabeth Ann Seton subsequently founded the Sisters of Charity of Saint Joseph’s (SOC) near Emmitsburg, Maryland, on July 31, 1809. This was the first Roman Catholic sisterhood for religious women native to the United States. They provided care for the sick in their homes and also provided care for their own community of Sisters and the priests associated with Mt. St. Mary’s Seminary where they managed the infirmary. In 1823, the SOC took their first hospital mission at the Baltimore Infirmary in collaboration with the College of Medicine at the University of Maryland.

The SOC merged in 1850 with the founding community in France. That is when they changed their name to “Daughters of Charity” and began to wear the dress and big white cornet like the French sisters. Dorothea Orem grew up in Baltimore, went to Seton High School, and attended nursing school at Providence Hospital in Washington, D.C. where her aunt, a Daughter of Charity was operating room supervisor. Dorothea had another aunt who was also a Daughter of Charity. Dorothea said, “At old Providence, nurses were in nursing. I was brought up this way, nursing was nursing and medicine was medicine. Physicians and nurses worked together but the nurse was not under the physician in any sense of the word.”⁴ This understanding of the relationship between doctor and nurse that was taught to Dorothea was a very important part of the underlying philosophy of care that was developed during the early years of the community based upon the foundational, collaborative relationship between Vincent and Louise. Their relationship was a historical prototype for the affiliation between the DOC nurses and the priests who provided ministerial supervision and also between the DOC and physicians and hospital administrators of institutions in which they served the sick poor throughout the world.

As I look through the cultural and spiritual lens of the Daughters of Charity at the work of Dorothea Orem in the development of the notion of nursing as addressing self-care deficit, it seems clear why this would be a major focus for her.

Her heritage was grounded in the beliefs and practices of the Vincentian-Louisian tradition. The purpose of nursing was and remains to this day the care of the sick poor, those who are so destitute, so physically and mentally ill that they cannot take care of themselves. The Sister-Nurses filled a need in community by helping some of the most marginalized of society such as the insane, inebriates and those suffering from dreaded diseases, such as cholera. In fact, it was during their care for the cholera victims during the 1832 pandemic that they cinched their early American reputation as nursing experts. Although a few Sisters became ill during their heroic cholera service only two Sisters died in the temporary cholera hospitals in Philadelphia and Baltimore. Nursing care in the Vincentian-Louisian tradition is not only equated with dependent care - care provided for those who cannot care for themselves; it is equated with care provided for those for whom no one else in society will nurse. My new book *Enlightened Charity* is about that tradition and I will be referring to Dorothea Orem and the self-care, dependent care work in that publication as well.

I have not studied the Orem work as Orem Scholars have, but I have been deeply inspired by the presence of the work in the twentieth century and today. Though historians do not make their analyses through presentist eyes, present events can serve to illuminate the past. Yes, Dorothea's development had roots in dependent care of the American DOC; but the early maturation of the American DOC nurses took place within a national nineteenth-century culture which endorsed self-care practices and "being one's own doctor" as an important expression of freedom in the newly formed republic. American healthcare culture during the period had become centered upon improving public health through self-care. Society was in conflict between sustaining and improving the "system" of domestic healthcare, which had existed in America for centuries, or allowing the emergence of a dominant medical culture of what were known as "Regular" physicians, those men educated in universities who at the time provided heroic medicine, the use of an oral drink of mercury known as calomel and blood-letting patients to the point of fainting. Social leaders, such as Reverend John Wesley (1703-1791), set the stage in the late eighteenth century for mid-nineteenth century reforms when he observed that:

As theories increased, simple medicines were more and more disregarded and disused... In the room of these, abundance of new ones were introduced, by reasoning, speculative men; and those more and more difficult to be applied, as being more remote from common observation...

till at length physic became an abstruse[sic] science; quite out of the reach of ordinary men.⁵ Nineteenth-century Americans, in particular women, believed that they had the power to create a fresh culture by embracing the new health beliefs and strategies of knowledgeable health reformers. Heroic medicines had not been very successful, especially during the cholera outbreak and people were anxious to take back the power and the responsibility for their own care they had placed in the hands of physicians.

The focus of early and mid-nineteenth century healthcare reform was the promotion of social progress through individual accountability for one's health. Health reformers such as botanic physician, Samuel Thomson, healthy lifestyle teacher Sylvester Graham and water curist Mary Gove Nichols taught that improvement of the individual was a means to the larger cultural change of social regeneration. They offered the possibility not only of prevention of disease but greater wellness and the prolongation of life. The practices they espoused and taught were grounded in a long tradition of self-care known as "domestic medicine" that was carried out by both men and women. But in the nineteenth century, men went to work in the burgeoning cities leaving women to take up the majority of the work in sustaining the home and family. The American health reform movements of the nineteenth century were focused on women. The goal of the woman of the mid-nineteenth century was to become the mistress of the domestic domain. It was her belief that by achieving her goal as "moral guardian and educator in the home,"⁶ she would safeguard her family and her country. It was through the embodiment of the virtues associated with acts of goodness and charity that women were believed to have the power to save their society and promote cultural progress. All women were to care for their communities as well as their own families. Additionally, in America, self-care, taking care of oneself and one's family, was an expression of the pioneer spirit that was part of emerging national character.

Domestic Medicine

During the two previous centuries in Europe as well as in colonial America, healthcare of both rich and poor Americans was carried out in the home, most often by women. As healthcare had always been a part of the domestic work, the expanding role of domestic healthcare services paralleled the expansion of women's domestic work. At first, domestic medicine did not differ much from the medicine practice by the early physicians. Elite physicians and ordinary housewives shared a

medical paradigm and used similar remedies. A good housewife during the colonial period sought education from numerous sources to be able to create her own recipes for healing. Healthcare, medical information and resources were shared in the interest of family and community survival. Self-care was practical and simple and the tools people used most often included the natural, accessible remedies such as water and the remedies one could grow outside one's back door, such as healing plants.

For example, the extensive primary documents of sixteenth-century German noblewoman, Elizabeth, Duchess of Rochlitz, suggest that she engaged in self-care practices. She made medicines, primarily distilled waters, for herself, her household, and her friends. The majority of her remedies required medicinal herbs. Her distillation equipment was set up outside the quarters of her ladies-in-waiting who were also her nurses. Elizabeth suffered numerous infirmities that plagued her for years until her death in 1557: gout, chest pain, aching joints, chronically re-appearing dark spots on her face, eye pain, partial blindness and oozing sores on her arm and neck. Although she did engage the services of physicians and more often apothecaries, Elizabeth actually "preferred medicinal recipes to doctors' regimens."⁷

Making medicine at home was also common practice for the seventeenth and eighteenth century English housewife; it was even a duty. Elizabeth Freke of Norfolk who was born in 1641 and died in 1714, kept extensive records of the distilled waters, syrups, tinctures (which are alcohol extracts), salves, and medicinal wines that she made. Her medicines were used for a variety of ailments and were also used as ingredients in medicinal formulations. As was common of women of her day, Elizabeth gleaned her knowledge of medicine making self-care from family members and friends in her social network and also was purchased from vernacular medical books and medical consultations.

Men also participated in domestic medicine. American President Thomas Jefferson (1743 - 1826) for example, who served two terms from 1801-1809, brought to his office a strong personal belief in the importance of health promotion and self-care. In a letter to his favorite nephew and student he wrote, "Health is the first requisite after morality."⁸ He described his self-care practices to a Doctor Vine Utley saying: "I have lived temperately, eating little animal food, and that not as an aliment, so much as a condiment for the vegetables, which constitute my principle diet." He drank the weakest wines only. "Malt liquors and cider are my table drinks, and my breakfast like that also of my friend, is of tea and coffee."⁹

Jefferson was not "so regular in his sleep" – taking 5-8 hours per night. He read something "moral" for thirty to sixty minutes prior to going to sleep so that he could "ruminate on it during the intervals of sleep." Regardless of what time he went to bed Jefferson always rose with the sun. He used his spectacles only at night unless he was reading small print. He attributed the fact that he had been "free from catarrhs of the breast for 8-10 years and no fever for more than twenty-four hours except 2-3 times in his life" to the practice of bathing his feet in cold water every morning for sixty years.¹⁰ Jefferson's belief in self-care was consistent with his belief in people. "I know of no safe depository of the ultimate powers of the society but the people themselves: and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion by education."¹¹ While Jefferson had many long-time friendships with physicians, such as Benjamin Rush one of the most notable for the indoctrination of physicians in heroic medicine, he promoted self-care and self knowledge above all else.

Historical records of patient self-care beliefs and practices found in personal diaries, journals and community reports are used in constructing accounts not only of what agent was used in self-care but also how and why it was used. One journal by Homer Merriam (of the Merriam family, publishers of the now famous American dictionaries), records the use of numerous healing approaches from lifestyle changes, to diet, to regular doctoring to the herbal remedies of indigenous healers. Merriam described the healthcare choices he made in his quest for health. He began his health story with the heading "bad reading." He believed that his excessive love of reading novels or the "most exciting scenes of history" weakened his memory and mental digestion. Reading secluded him from society, gave him "false views of life," and "tended to pervert by lack of exercise the strengthening of his body."¹² In 1835, at age twenty-two, he sold his library and went to work for his brothers where unfortunately he got little more exercise than before. He would later be diagnosed with "dyspepsia, jaundice, etc."¹³

Merriam decided to change climate and he moved to Cincinnati, Ohio, where he moved in with a Quaker family on their farm. His diet consisted of "mush and hasty pudding" during that time. He described visiting some friends in Indiana where he consulted a "skillful" physician who diagnosed him with "no disease" but who said that he never knew a person able to be about with such a slow pulse as his, which gave only about thirty beats in

a minute.” That doctor advised him to return east and he reluctantly gave up the West.

When he returned home, he lived with his mother, worked a little, “rode his brother’s horse and took medicine.” He was “largely dosed” by Dr. Woodward of the Insane Hospital of Worcester without “good effects” and then advised to go on a fishing voyage, which he did. When he returned, still in 1835, he went to Saratoga, New York (now called Saratoga Springs, New York because of its healing mineral springs) and saw a physician named Weeks whom he described as, “seeming to understand my case better than any physician I had before consulted.”¹⁴ He took the waters in Saratoga for a few weeks and then went to work for his brothers in Massachusetts, testing his health. He recorded, “But on leaving Saratoga and the daily free use of the Congress water, I seemed at once to run down, my tongue becoming thickly coated, my insatiable appetite returning (this had been one of the strong symptoms of my ill health)...”¹⁵ He subsequently returned to Saratoga, this time to remain for a number of seasons during which time he married his physician’s daughter.

He was ultimately pronounced “cured” in Saratoga. But after leaving Saratoga once again he felt “run down.” In what he called “a sort of desperation” he decided to take the advice of an acquaintance with similar symptoms who had been helped by an Indian Doctress, whom historians believe to have been Rhoda Rhodes of Huntington, Massachusetts. Homer went to Norwich, Massachusetts and lived in Rhoda’s home for four months. Rhoda, according to Homer was eighty years old with a reputation in the county that was quite good in that she had “cured or helped a good many sick people.” She had a son in his fifties who gathered roots and herbs for her and prepared them as medicine. In taking the herbal remedies, Homer “improved very decidedly in health...and did not run down again as he had after leaving Saratoga, but continued in comfortable health...”¹⁶ He was able to work in his family business for twenty-four years after the healing with Rhoda.

From the seventeenth to later nineteenth centuries, women healers, water curists, bone setters, midwives, and nurses assisted people in domestic medicine practice. Martha Ballard became expert in the care of her own family and friends and then began caring for others. She began her diary, shown here, in 1785 at fifty years of age. Over the course of twenty-six years she had delivered eight hundred sixteen babies. Martha was a midwife and nurse who according to historian Laurel Thatcher Ulrich “mediated the mysteries of birth, procreation, illness, and

death. She touched the untouchable, handled excrement and vomit as well as milk, swaddled the dead as well as the newborn. She brewed medicines from plants and roots, and presided over neighborhood gatherings of women.”¹⁷ Accounts of women’s gatherings, such as those of the Ladies Physiological Institute of Boston which in 1850 had hundreds of members, demonstrate that social networks were the communication mode women used to relay self-care information and resources to each other. The Institute was founded in 1848 to promote “knowledge of the human system, the laws of life and health, and the means of relieving sickness and suffering among women.”¹⁸ The 1850 annual report of the organization describes the values of the women of the organization as promoting a spirit of “true science”, enquiry and investigation in performing their roles as “wives, mothers, nurses and guardians of youth.”¹⁹ Women depended upon each other to share time-honored as well as newer ways of caring for their families. Although medicine in the nineteenth-century public sphere stressed either reliance on a doctor or “being your own doctor”, women diplomatically did both. They were integrators of care. In addition they incorporated their own gender’s cultural healing values as well: they provided friendship, care, and support for each other so that they could indeed make the best choices for healthcare for themselves and their families.

Recipes, Remedies, and Advice Books

In addition to diaries, journals and community records, women’s recipe books, called “receipt” books, hold some of the most significant data that contributes to our knowledge of self-care practices. It is in receipt books that I found much of the evidence I have used for the past eight years in constructing a history of early and mid-nineteenth century European-American nursing. Early and mid-nineteenth century nurses and midwives supported the self-care system, the writing of its advice books, the testing and administration of its remedies and the circulation of its beliefs. Nurses during this period were cultural diplomats; they were neither fully aligned with the medical profession and the drive for professional and cultural authority nor were they simply working in the home promoting the domestic agenda. They provided self-care education and implementation support for their communities and dependent care for people whose illnesses had moved them and their families into a state wherein self-care was not possible. In the sickroom, the kitchen and also in the still, nurses, like women of previous centuries, nursed their patients often with herbal remedies

they had made for themselves and others. Many nurses and midwives in three American communities I have researched were experts in herbal medicine making.²⁰

Mormon nurse-midwife, Patty Bartlett Sessions, who started her calling to care in Maine, trekked across the country to Utah in 1847, delivered 3977 babies in her lifetime and was a leader in the Church's Councils of Health formed to promote health in the community. Patty shared her knowledge and expertise with others in her time and continues to do the same today through the published diary records of her healing recipes and practices. Anne Green Dutson Carling, also lived a rich life as a nurse and midwife in the early Mormon community. She taught herbal self-care to her family, the community and passed her nurse-herbalist tradition to her granddaughter Florence. Her recipes included onion syrup taken orally for cough and sore throat and plantain leaf steeped in new milk taken internally for dysentery.

The Shakers is a religious group led to America from England in 1774. Shakers lived in small communities networked throughout the northeast and Midwestern United States. Like the Mormon nurses, the Shaker nurses promoted herbal self-care and implemented different 19th century self-care systems, such as Thomsonianism, water cure and the Graham diet into community health practices. The Shakers were renowned herbal medicine makers and established what today is considered the foundations of the American pharmaceutical industry. The Shakers' remedies influenced self-care practices quite broadly in that they were sold nationally and internationally for decades. The Sister-Nurses participated in Shaker herbal operations from cultivation and harvest, to processing and application with patients in the infirmaries where they provided their nursing care to their communities. "The major part of the laborious and routine labor connected with the medicinal herb industry, such work as cleaning roots, picking and 'picking over' flowers and plants, cutting sage, cleaning bottles, cutting and printing labels, preparing powders and herbs, and 'dressing' or putting up extracts and ointments, was done by the sisters. They also made the ointments."²¹ It is the crude opium harvested from the poppies grown by the Sisters that was used on the battlefields of the American civil war to stay the pain of wounded soldiers. One of Sisters' remedies that is still sold today is rose water. Infirmary records and receipts books state that rosewater was applied externally to the temples of a person suffering from headache.

Americans were not only to be their own doctors; they were also to be their own nurses. The early and mid-nineteenth century was a time

when advice books were highly popular just as in seventeenth and eighteenth centuries in Europe and America. Dr. William Buchan's advice book, *Domestic Medicine or the Family Physician*, originally written and published in 1769 in Britain and later published in America, was one of the first of its genre and was still popular in mid-nineteenth century America. The subtitle of the book set the foundation for the purpose of all subsequent advice books: *Being an attempt to render the medical art more generally useful by showing the people what is in their own power both with respect to the prevention and cure of disease*. Buchan's advice centered on lifestyle and diet, in other words preventive healthcare. He wrote of the importance of proper child care as the foundation for health in adulthood. He identified the general causes of disease as "catching cold, unwholesome food, irregularities of diet, bad air, and infection"; all situations which people could control themselves. Particular causes of disease included "laborious employments, sedentary employments and intense study." He suggested that there were remedies, in particular botanical remedies, that every citizen could use in self-care such as rhubarb, senna, licorice root, wild valerian root, syrup of poppies, oranges and lemons to name a few. He noted his belief in the value of nursing practice in self-care and disease prevention when he wrote, "The first part of prophylaxis is calculated to shew the importance of proper nursing."²²

Kentucky Regular physician John Gunn and other Americans followed suit. Not long after the first American printings of Buchan's advice books, Gunn too wrote his own book, *Domestic Medicine or poor man's friend in the hours of affliction...by which the practice of medicine is reduced to principles of common sense*²³ As the "poor man's friend," Gunn provided the reader with simple remedies and explanations for disease and health promotion. The purpose of his book was to bring medical care back to the people. Following principles of Jeffersonian and Jacksonian democracy, Gunn and other early 19th century physicians who wrote advice books sought to create an image of the learned physician as teacher and advice giver. Regular's advice books were indeed very popular. While the intent of some Regular physicians, such as Buchan and Gunn, may have been to change the course of medicine as it seemed to move away from self-care support toward professional monopoly, the ultimate result of their humanitarian efforts may have actually added to the ultimate success of endearing the American public to the cause of those Regulars who strove to establish full social and cultural authority in medicine.

Domestic medicine advice books often offered self-help techniques for nursing the sick listed in chapters headed, "sickroom management." In the 19th century, books dedicated to nursing and sickroom management started to emerge. A popular authoress, social reformer and abolitionist named Lydia Maria Child wrote *The Family Nurse* in 1837.²⁴ Because Lydia Maria Child was not a nurse, had no formal or informal healthcare, medical or botanical expertise, she wrote that she relied upon medical texts as reference and a review of the book by a physician to ensure the "safety" of her advice. She also consulted "aged relatives and judicious nurses" in preparing the advice book.²⁵

The Elements of Sickroom Management

Self-care, making one's own medicine, and sickroom management exemplified the bond between people and the natural environment comprised of the elements of water, earth, air, and fire. The beliefs and practices associated with nature cures were the foundation of nineteenth-century self-care and nurses' sickroom management. In 1835, American physician Dr. Jacob Bigelow read his essay on "self-limited diseases" before the Massachusetts Medical Society in which he encouraged physicians to rethink their practice of prescribing medicine for all diseases. He stated that "some diseases are controlled by nature alone and that the physician was "but the minister and servant of nature" who was to endeavor to "aid nature in her salutary intentions, or to remove obstacles out of her path."²⁶ Lydia Maria Child, wrote in 1837, "Both doctors and nurses, as they grow older and wiser, use as little medicine as possible, and simply content themselves with recommending fasting, or such light diet as will best assist the kindly efforts of nature."²⁷ Dr. Wooster Beach, an American physician who had turned to the use of natural cures, in particular botanical remedies, wrote in 1843, "In reality we can cure nothing. We can only remove the offending cause, while nature performs a cure; and, therefore, lay it down as a fundamental maxim in medicine, that all the physician can do is, to act as a servant or handmaid to nature."²⁸ And one more recognizable quote perhaps on the subject is from Florence Nightingale who wrote in 1859: "Nature alone cures...and what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him."²⁹

Florence Nightingale's *Notes on Nursing*³⁰ published in 1859 is one of the most popular advice books on nineteenth-century sickroom management still in print today. Her book

and other sickroom management texts of the period both in Europe and America consistently demonstrated the role of the nurse as partner with nature in the creation of a healing environment for the patient. While the public engaged in being their own nurse, working with natural elements to create their medicines and healing sickrooms, nurses developed their expertise in utilizing fire, air, water and earth in the care and comfort of patients. Engaging the elements in nature was the nursing science of the period in America as well as in Britain.³¹ There is a remarkable example of the elements of care in early nursing science. For this, I return to the Sisters of Charity where this historical perspective of self-care began.

That example is an instruction book entitled *Advices Concerning the Sick* written for the SOC-Nurses by Sister Matilda Coskery who was born in 1799 and died in 1870. She was considered an "oracle" in the care of the insane by the Sisters, her physician colleagues and her patients.³² She led the SOC in the purchase and establishment of the first Catholic hospital for the insane in the United States. It is in Sister Matilda's *Advices* that we find numerous examples of the elements of care. Attention to the element fire, also referred to as "warmth," was represented in nursing interventions such as the regulation of room temperature, body heat, and preparation of the coverings on the sick bed.³³ The air element was exemplified in Matilda's *Advices* on proper ventilation of and the creation of "pure" air in the sickroom. She wrote, "Fever and other acute diseases will require a more frequent ventilation than chronic affections, except when the latter is attended by profuse and offensive discharges. Some use burning, what they call sweet herbs, rosin, sugar, tar, frankincense, etc. etc. or decomposing vinegar on a hot shovel, for the purpose of purifying the room or air, but all these or others similar to them, destroy a part of the vital air, and supply its place by what is worse."³⁴ The water element was well represented throughout the *Advices* text in her instruction on hydrotherapies such as footbaths, injections (enemas), shower baths, sweats, and sponging. She also included extensive instruction on the preparation and application of herbal teas, a healing tradition descended from the French DOC. The following excerpt demonstrates not only the importance of the water element in the form of teas in the care of the 19th century patient; it also shows the level of knowledge, experience and professionalism of some early nurses in sickroom management:

Make them strong, & in a clean vessel, have the water boiling—keep them covered while boiling or steaming. When

done, strain & cover it. In warm weather do not make too much at a time, & keep it in a cool place. Nurses are often careless in these things, thinking they are only simple matters, thus, they prepare them negligently, & are irregular in giving them—or give them after they are sour & mouldy, & this makes the stomach sick, or getting them irregular does no good. The Dr thinks it is the fault of the tonic & changes it for something stronger, perhaps brandy or some other thing that does real harm—He loses confidence in that tonic, names it to his students and Medical friends, who likewise discontinue it, in all these cases that fall into their hands, some stronger thing is given, when the thing itself was right, in right hands. How often, these, seemingly small things, are the beginnings of the death-bed & in many, many cases, Life and Death is (in) the hands of the nurses, more than in the Physicians.³⁵ The nurse's attention to the regulation of the fourth element, earth is demonstrated in Sister Matilda's application of plant remedies such as hops or corn meal mush poultices to the body of the patient, the management of the sick diet such as controlling the ingestion of animal substances and stimulating foods, and her choices regarding the specific metal (pewter and silver only) from which the spoons and cups used to administer medicaments should have been made.

The underlying philosophical understanding of applying nature's elements of care in healing is not unique to the history of nursing. These foundational principles are present in a number of ancient healing traditions, such as Traditional Chinese Medicine and the medicine of First Nation people in America. Indian Ayurvedic medicine tradition is founded on the teachings of Hindu scripture, such as the Prasna Upanishad in which the notions of the elements, the human senses and the Self are described:

All things find their final peace in their inmost Self, the Spirit: earth, water, fire, air, space and their invisible elements; sight, hearing, smell, taste, touch, and their various fields of sense; voice, hands, and all powers of action; mind, reason, the sense of 'I', thought, inner light, and their objects; and even life and all that life sustains.³⁶ In Celtic medicine the five elements of self are referred to "Doorways to an Infinite Universe."³⁷ Greek Humoral Medicine, based on Hermetic theory, is the foundation for modern medicine in the West. Fire, air, water, earth, and the fifth element ether, were known as the elements of creation.

The Greeks called the fifth element ether or vital energy "pneuma." Ether (energy) is represented in the Sister Matilda's *Advices* in the spiritual instruction she gives on the approach or intention with which the nurse cares for and comforts patients. She stressed the importance of kindness for example, writing: "And again we see the fruits of kindness for it is and forever will be the remedy of remedies"³⁸ after which she provided numerous examples of how best to demonstrate that kindness to the insane.

The five elements are recognized in many healing traditions as that substance represented in the creation of the matter universe of animals, plants, minerals, and humans. They are the elements of the self. By managing one or more of the elements, one not only alters one's health, one's Self is also changed. Nurses' self-care traditions around the world continue even in highly industrialized countries where they and their patients are challenged to find the balance between technology and nature as they seek to create healing environments. Patients continue their practices of self-care, although some sociologists have named self-care in the West, the "Hidden Health Care System."³⁹

People still pick their medicine; they still manage sickrooms; they make their own remedies. And they pass on their time honored traditions in self-care from generation to generation. The elements of self unite all peoples and therefore self-care might be described as "universal healthcare." Historically, its many tiers include individual health choices, professionally supported self-care practices, engagement of the elements of care in sickroom management, and dependent care in which people endeavor to be able to return to caring for self. Self-care is a healing tradition that Dorothea Orem and many others before and after her know provides a scaffold for the discovery of self which, according to many traditions, is the source of healing. Self-care is a universal language in healthcare.

Nursing research, education, and scholarship supporting the exploration of self-care is vital to nursing identity. It is nursing's application of the language of self-care in creating healing environments in particular that makes nurses and their health perspectives distinct from other healers and establishes nurses' role in the greater culture. Dorothea Orem raised our awareness of self-care and dependent-care. She could because it was her heritage to do so. The Sisters of Charity valued the ability to discern the need for care in the thousands of sick poor before them. Though they may not have used the words "self-care" versus

“dependent-care” to define their work, there was just too much suffering not to be able to tell the difference and then to be able to intervene for those who needed it most and also give support to those who could care for themselves and their families with the help of the Sisters’ education and resources.

The Daughters of Charity often said of a beloved deceased Sister, “She will not forget us” meaning that they knew that the Sister was still helping them on the “other side.” Through her connection with the Daughters’ tradition, I sense that Dorothea will not forget us and that she too may be poised to help us from the other side. I look forward to her continued help as we further explore the elements of Self, self-care, and creating healing environments receptive to nurses’ and patients’ self expression. Thank you again for inviting me to be part of this wonderful occasion. ■

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Identifying and Articulating the Characteristics of Nursing Agency: BSN Students' Perspective

Virginia McMahon Keatley

Abstract

Purpose: It was Orem's belief that nurses know how to do nursing but lack the ability to clearly articulate and define it to others. This paper presents a strategy for assisting BSN students describe how they use nursing agency in practice.

Methods: Students in their final clinical rotation, a capstone clinical preceptorship, were asked to keep a daily reflective journal describing their use of nursing agency in specific clinical situations.

Results: Exemplars from the students' journals reveal that students can and do identify the enabling capabilities of nursing agency and are able to describe them in great detail. They are also clearly able to discern the difference between those nurses who have the knowledge and disposition to use them and those who do not.

Discussion: Reflective journaling is a powerful way to assess growth in oneself and one's students. What these journals seemed to show was the close interdependence of the desirable nurse characteristics which, when present, are evidence of nursing agency (Orem, 2001, p. 290). Each characteristic blends and mixes with others, blurring boundaries. They are confluent, not discrete. Combined, the characteristics delineate professional nursing. With encouragement, nursing students—our future professional nurses—can become the nurses who not only do nursing, but also articulate it and advocate for it.

Key Words: Orem Self-Care Deficit Nursing Theory, nursing agency, reflective journaling

Orem defines nursing agency as, "the operations, powers, foundational human capabilities and dispositions (to perform nursing actions)" (Orem, 2001 p. 133). She articulates nursing agency, specifying social, interpersonal, and professional-technologic characteristics that, when present, "are viewed as evidence of nurses' capabilities, their power of nursing agency." (Orem, 2001, p. 290). One might argue that these characteristics actually define and delineate professional nursing.

It was Orem's belief that nurses are well aware of how to do nursing, but often lack the ability to clearly articulate it, both within the profession and to those in related health care fields and to the public. She also argued that when nurses do

talk about the domain of nursing that others are interested in it (Fawcett, Wallace, Coberg, 1988). Thus, the inability to clearly delineate what is and is not professional nursing, may well contribute to failure to fully recognize the contributions nursing makes.

In an effort to help nursing students identify and articulate the characteristics of nursing agency (and thus define professional nursing), the strategy of reflective journaling was utilized. The students involved were enrolled in a capstone course (a clinical preceptorship) in the final semester of a baccalaureate (BSN) nursing program. Each student was assigned to a specifically selected BSN prepared preceptor for 120 hours on a self-selected clinical unit. As part of the course, students were required to keep a daily clinical journal. They were asked to reflect upon what they were seeing, doing, and feeling as they went about their days and how they saw themselves using the enabling capabilities of nursing agency as they cared for their patients.

These students were enrolled in an Orem based nursing curriculum. They had prior courses exploring the enabling capabilities of nursing agency as well as courses focused on nursing systems and clinical practice. The nursing agency courses explored the desirable nurse characteristics (social, interpersonal, and professional-technologic) as explicated by Orem. The daily journals helped the students to reflect upon how nursing agency shaped their practice. After the rotation ended, the students were asked for permission to share excerpts from their journals.

It was clear that students could identify how and when they used the capabilities and dispositions of nursing agency. In addition, they were quite articulate, not only about which nurse characteristics they used, but about how using them shaped their nursing practice, and defined professional nursing.

While Orem offered eloquent words about nursing agency, for teaching and learning purposes, these students were introduced to the

desirable nurse characteristics as simplified by faculty (See Table 1). They were addressed in detail in specific nursing agency courses and woven throughout the curriculum. Thus, student reflections centered on the characteristics as taught in their curriculum.

Student reflections showed sensitivity and acuity. The selected entries, in the students' own words, described the incorporation of nurse agency characteristics into their practice.

Communication Skills

Communication, both verbal and non-verbal was the characteristic most often identified in the early days of preceptorship. For many of the students, the responsibility of being *the nurse* for a 12 hour shift opened their eyes to the complexity of sustaining communication and coming up with creative ideas when faced with obstacles.

A student working in a medical intensive care area wrote about caring for a patient who became a quadriplegic secondary to an epidural abscess. The man was intubated and received feeding via an oral-gastric tube. At times the student could read the man's lips and at other times resorted to a blinking system for yes and no answers. The student shared, "Communication was difficult with this patient because he was intubated. I spent a lot of time trying to work out a system to help understand his needs." While the student recognized and seemed proud of his creative efforts, he also expressed regret, "At times I could not read lips or guess what he was trying to say. I'm sure it was as frustrating for him as it was for me."

End of life issues abound in medical ICUs as patient census increasingly involves chronically ill patients experiencing more and more serious episodes of acute exacerbations and eventual decisions about how aggressive they want

Table 1: Desirable Nurse Characteristics

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- Repertoire of Communication Skills
 - Ability to Meet Teaching/Learning Needs of Patients
 - Knowledge of Cultural Differences and the Significance of Cultural Orientation
 - Ethical Discernment
 - Awareness of Legal Dimensions of Practice
 - Decision Making Abilities
 - Identifies, Uses, and Evaluates Research
 - Serves as a Prudent Advocate
 - Ability to Perform the Technologic Operations of Nursing Practice
-

caretakers to be. Families, also, face dilemmas in this area. One student reflected, "I think it is important for nurses to communicate what they know to the families so that the best possible decisions regarding end of life care (can be made)."

Communicating with families over entire shifts allowed students opportunities to use their knowledge to offer coping skills to them. One student described working with a family whose mother's condition had been deteriorating along with her mental status. Working with the patient to reorient her and with her very distressed daughter, explaining different ways to temporarily handle her mother's confusion, the student reflected "It seems so small, but she (the daughter) was so thankful to have someone to talk with her and hear her fears and concerns. I felt the anxiety level in the room slowly decrease, as simple reorientation and distraction techniques were being used...the situation with her anxiety and mental status was powerfully influenced by the nurse agency of communication. This made a monumental and meaningful difference." Clearly, this student identified and articulated her role as a communicator.

Students are very conscious of how nurses on the unit interact with patients, and they are quick to identify nursing agency in their preceptors and the staff on their units. One student described how difficult it was to care for a patient who had a "Do not resuscitate" order and was uncommunicative. The student described missing the "one-on-one" communication of previous semesters when assigned patients who could carry on a conversation and felt at a loss about not being able to talk with this man. The student began to observe how other nurses acted, sharing, "Although many of the patients are on the ventilator, sedated, and cannot speak, the staff talks to the patients as if they could. I saw on many occasions where the staff would tell the patient what they were about to do before beginning a task. I thought this showed a lot of respect for the patient."

Communicating with families under stress is a challenge for all nurses. One of the preceptor nurses provided a valuable lesson in the power of reflection. A student described a situation where the stress felt by the family of a patient in an intensive care unit seemed to escalate as the day went on. The family kept asking if their loved one could hear them and if he was going to die. The student observed the preceptor's responses and shared, "(K) paused for a few seconds before answering. I could tell she was reflecting and thinking hard about what she was going to say... Someday, when I am in that position, I will think carefully and reflect on what I'm about to say when

asked difficult question(s). Reflection is probably something that came with experience in working with families/people during difficult time(s)."

The importance of communication permeated the students' journals. As one student summed it up, "I still believe that the communication/social aspect of nurse agency is the most valuable thing I can offer my patient."

Ethical Dimensions

Students strive to be ethical practitioners. They are concerned about how patients are treated by nurses, physicians, and family. They agonize over inequities they observe.

One student described working with a homeless man admitted to the hospital via the emergency room. The report to the unit detailed that he had been hospitalized several times before for the same problem. Upon talking with the man, the student discovered that he had hiked to Tennessee from Missouri. After seeing that the total of all this patients' belongings fit into 2-3 bags, the student shared, "My eyes were open to a whole new world that I knew nothing about. He was just a man trying to make it from day to day." The student wrote, "Today I learned that it is *not* my job or responsibility to question why someone smokes or drinks...however, it is my responsibility to treat them equally and with respect."

Students expressed pain when the wishes of a patient are overridden by family. They identified many times when a patient who had expressed the wish to die peacefully was subjected to aggressive interventions because a member of the family requests this. "The patient's wish was not to be on the ventilator...Her family has gone against her wishes." This ethical dilemma repeats itself frequently.

Repertoire of Teaching/Learning Capabilities

Students see the importance of tailoring teaching to the needs of each patient. One student described a situation in which the family from a poor rural area "camped" in the patient's room. In their efforts to make their loved one comfortable, they often seemed to oppose the nursing staff's efforts to maintain oxygen and dietary protocols. While this angered some nurses, the student worked hard to reinforce, time and again, the need for certain restrictions while still helping the family to feel included in the care of their loved one. The student found that patience and understanding made a significant difference for this family and wrote, "So many times patient education is 'short changed'...most often due to time constraints...I feel that the most difficult cases are where you

grow in your educative abilities, because it forces creativity."

Students also reflected upon themselves as the learner. "I am trying to learn a lot during my last semester of school so I can be a good teacher to my patients when I become a nurse." They appreciated the time other nurses took to help them develop nursing skills. "I appreciate my preceptor and the other nurses not only allowing me to perfect my skills, but also teaching me why and how...I believe these experiences will stay with me and help me become the nurse I know I can and want to be."

Learning, for the student, often involves how to conduct oneself professionally, even when others act in non-professional way. Describing a day when stress on the unit was high, physicians were short with the nurses, and families were critical of the care their loved ones were receiving, the student reflected, "When I start my practice, I will try to stay calm when dealing with stressful situations and utilize others to help solve problems. It's sometimes not easy (to) stay calm when stressful situations (arise), but anger really won't help the situation."

Advocacy

The responsibility to act as the patient's advocate was articulated by the student who wrote, "Sometimes patients are helpless or unsure in certain situations and I believe this is where we as nurses, serve as their advocates with our knowledge, close contact with their situations and link to ...the team." The seriousness with which this student approached this responsibility is reflected in the words, "This level of involvement should be a must for everyone in the nursing profession. Superficial nursing, I believe, is an injustice and detriment to patient outcomes."

Although labeled as "respect" in the journal, one student described advocacy by sharing, "I try to show respect for others by understanding that people have a right to make their own decisions. My role (as) a nurse is to respect these choices and help them, when needed, to honor their decisions."

Decision Making

Initiative was addressed as being a major component of decision making. One student observed nurses during a code, and reflected that professional nurses are proactive. Reflecting upon this, the student shared, "I hope that when I graduate and gain experience that I will be the one taking the initiative to help patients during an emergency."

Another student described a patient who was experiencing severe pain but had no order for analgesics. The patient had just recently been extubated. After trying non-pharmacological methods to alleviate the pain to no avail, the student sought counsel from the preceptor and wrote, "I believed, as did my preceptor, that his vital signs were stable enough that the benefits of the pain medication would outweigh the risks. We contacted the physician and gave him the status of the patient and he agreed a pain med could be tolerated." The student administered the medication to the patient "who was grateful for my understanding and willingness to help...I was ever vigilant in assessing his respiratory and cardiac status for signs of distress." This student took action, but also assumed responsibility for that action by careful monitoring.

Significance of Cultural Differences and Orientation

Students deal with patients whose culture is often different and sometimes difficult for students to accept. Students shared stories of communicating with patients who spoke no English. They used simple phrased and signing for some, enlisted translators for others. These were difficult communication issues, but the real challenges arose when cultural ignorance or discordance arose. Students, like everyone else, bring personal baggage into their careers. For nurses, the need to be ethical advocates causes a great deal of soul searching. One student shared a painful but growing experience dealing with a patient who abused drugs and alcohol. The student wrote, "I have watched my younger brother struggle with drugs and another close family member lose everything because of alcohol...I knew that I had to check my feelings and put aside my opinions in order to care for this person...This patient required me to look deep into myself and place myself in her situation and ask the question, 'How would I want to be treated if I was lying in that bed?'" While, initially, students think of culture narrowly along racial and ethnic lines, this student struggled with a lifestyle culture and grew in understanding of its effects upon this patient.

Discussion

Reflective journaling is a powerful way to assess personal growth in students. When students compared the entries from the first day with those of the last days of the preceptorship, they were amazed at their own growth. For faculty, the journals were gratifying and provided food for thought for the curriculum development. Students

frequently started out identifying one distinct nurse characteristic, as assigned, but added others in the same story. Some were identified far more consistently than others. What the journals seemed to show was the close interdependence of the social, interpersonal, and professional-technologic nurse characteristics. Each blends and mixes with others, blurring boundaries. They are confluent, not discrete. Although the curriculum separates them out for teaching purposes, they are, in fact, a whole, greater than the sum of the individual parts. Combined, they delineate professionalism.

Conclusion

Students can and do identify the social, interpersonal and professional-technologic nurse characteristics as evidence of the capabilities of nursing agency as presented and used in the BSN curriculum. They can and do verbalize that they see the difference between those nurses who have the foundational capabilities and dispositions to perform nursing agency and those who do not. With encouragement, nursing students—our future professional nurses—can become the nurses who not only do nursing, but also articulate it and advocate for it. ■

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The Integration of a Program of Structured Simulation Experiences in a SCDNT Based Curriculum

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Abstract

With the increase in patient acuity in clinical agencies, nursing faculty, seeking meaningful clinical experiences for students, are challenged to find experiences that do not jeopardize patient safety. Further, the landmark report from the Institute of Medicine (IOM), *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000) emphasized the need for more reliable and safety-focused health care teaching methodologies. Simulation with the use of human patient simulators has been proposed as one answer to this challenge. The challenge was to integrate the use of the simulators to enhance students' capabilities and habits for nurse agency in a nursing theory-based curriculum utilizing Orem's (2001) Self-Care Deficit Nursing Theory. Two additional goals that faculty wanted to accomplish with simulation were: (1) to guarantee each student would have experience with selected critical incidents and (2) to use the experience as a formative evaluation mechanism rather than penalize students for mistakes made during the experience. This paper describes how one group of faculty achieved these goals. Student comments are presented that illustrate that students also perceive that these goals are met. Student comments are also presented that indicate the impact that these experiences may have on students and the importance of experienced faculty conducting the simulations and the debriefing following.

Key words: Nursing agency, human patient simulator, debriefing

As patient acuity increases in clinical agencies, nursing faculty, seeking meaningful clinical experiences for students, are challenged to find experiences that do not jeopardize patient safety. Further, the landmark report from the Institute of Medicine (IOM), *To Err Is Human* (Kohn, Corrigan, & Donaldson, 2000) emphasized the need for more reliable and safety-focused health care teaching methodologies. Simulation with the use of human patient simulators has been proposed as one answer to this challenge.

In early 2000, the faculty in the School of Nursing (SON) at the University of Tennessee at Chattanooga decided to move to a nursing theory-based curriculum and chose Orem's (2001) Self-care Deficit Nursing Theory. As they began to use Orem's theory in curricular revision, it became clear that the theory was very specific regarding nursing agency and the capabilities inherent in

fulfilling the role of nurse agent. Essential for assumption of this role are certain characteristics (social, interpersonal, and technologic) and habits (art and prudence) as identified by Orem (2001).

The SON had been fortunate to be able to purchase two human patient simulators but, like many other nursing programs, was unsure how to integrate their use into the curriculum. The decision was made to assign a full-time tenured faculty member to design a program of simulation that was congruent with the theory-based curriculum for the undergraduate students. Thus, the challenge was to determine how the simulators could be used to enhance students' capabilities and habits for nurse agency.

In addition to curriculum integration of the simulation experiences, there were two additional goals that faculty wanted to accomplish with simulation: (1) to guarantee each student would have experience with selected critical incidents and (2) to use the experience as a formative evaluation mechanism rather than penalize students for mistakes made during the experience. Scenarios for each semester of the undergraduate program were developed that included content from that semester's didactic material. The program admits 27 students twice per academic year. Groups of three students were scheduled to come to the simulation laboratory for a clinical day (six hours with a lunch break). In order to guarantee that each student would have experience with the selected patient situations, the same scenarios were used each time until all the students enrolled in the clinical course had an opportunity to participate. Students were cautioned to not reveal the content of the scenarios to the others so that everyone was "guaranteed" the same experience. Interestingly it has been our experience over a two year period that, based on student behavior in the simulations, the content of the scenarios is not being shared.

A concerted effort was made to assure that the goal of using the simulations for formative evaluation would be achieved. First, the simulation laboratory was named Safe Hospital © indicating

to students and faculty that the experiences were “safe” in that they were not graded and that students were free to make mistakes from which they could learn and, more importantly, that presented no danger to patients. Second, the faculty members conducting the simulations and the debriefing made a considerable and conscious effort to reassure students that mistakes made in the scenarios did not result in any penalty to the student.

The scenarios used in the first semester depict patients who require students to identify and implement the appropriate nursing systems which, at this level, are partially compensatory and supportive/educative nursing systems. These scenarios are: (1) a Hispanic women who falls on the way to the restroom, (2) a medication error, and (3) use of personal protective equipment with a patient with *C. difficile*. Nursing agency characteristics and habits are also practiced.

In the second level the focus is the perioperative experience. These simulations require the students to assess and provide appropriate interventions surrounding the universal self-care requisite, prevention of hazards. These interventions remain in the partially compensatory and supportive/educative nursing system. The scenarios in this level are: (1) a patient with a post-operative hemorrhage, (2) administering a blood transfusion in which a hemolytic reaction occurs, and (3) a patient who develops post-operative atelectasis and deep vein thrombosis.

The next two levels allow students to evaluate dependent care agency and developmental health care requisites along with health deviation self care requisites. The scenarios in the third level are: (1) a patient with pre-eclampsia presenting to the physician’s office, (2) a hospitalized patient with eclampsia who seizes, (3) a pediatric patient in acute respiratory distress in the emergency department, and (4) pediatric discharge planning. In the fourth level the students encounter (1) a patient with emergent chest pain, (2) a patient with a post coronary artery bypass graft who dislodges a chest tube, and (3) an in-patient with artrial fibrillation who develops an acute stroke. In all the levels, at least one of the students plays the role of family member and/or another nurse which allows students the opportunity to exercise the agency characteristic of communication skills with both the patient and others.

Faculty view these experiences as a way to allow students the freedom to develop nursing agency characteristics in an environment that is both safe and supportive. The objectives for the simulation experiences are that the student will demonstrate knowledge in social operations, interpersonal operations, and professional-

technologic operations. In addition, students are expected to evaluate their ability to set priorities, self-reflect and critique clinical performance/practice decisions, revisit specific content, and increase their self confidence in nursing agency.

While it is self evident that simulation would allow students the opportunity to practice the technologic skills that are of a hands-on nature, we have found that some of the social operations also lend themselves to simulation including recognition of cultural differences, communication skills, respect of others, being courteous and considerate, and accepting responsibility for provision of nursing. Evaluations of the Safe Hospital © experience that students are asked to complete anonymously at the end of each day, have indicated that they are able to practice various social operations. For example, one student stated that “the scenarios are also helpful in learning the nurse-patient interaction” while another said that “it gave me an opportunity to see my strengths and weaknesses when it comes to ...communicating”.

Interpersonal operations that can be demonstrated in simulation include: being an active participant in relationships, interpersonal skills, helping relationship, recognition of physical and emotional pain/discomfort. Students have again confirmed that they are able to demonstrate these operations. This is evidenced by one student who stated that “Seeing my reactions/behaviors (and) how it affects others” was helpful.

Students have also been able to practice nursing prudence (doing) and nursing art (creating) in Safe Hospital©. Students have stated that they have “realized how important it is to be able to be confident in the decisions (I) make” and “I like that it is safe environment for me to learn in so that if I am ever in this situation, I will know what to do”. Further they state that the simulations “help me to think so that I may work quickly and appropriately organize interventions in the order of priority”.

Faculty must be cognizant of the fact that these experiences have the potential for being very powerful and require that an experienced faculty member lead a debriefing following each scenario. In fact, these experiences may place additional self care demands on the student requiring the faculty member to become a dependent care agent for the student. Students have reported that while the experiences are both informative and fun, they also have a profound and lasting effect on them. Thus, providing debriefing is considered critical to the success of this activity.

Debriefing allows students to reflect on successes, learn from mistakes, reconsider options, and self-correct their thinking. When asked about learning from mistakes students have

reported that “most of all the experience of not always thinking clearly stood out for me...when you are in the real like situation, you forget some things that you never thought you would forget. It was very revealing to me”. Another stated that “learning how to do skills and learning how to avoid mistakes is one thing, but to actually experience what a mistake is really like, is beyond words, books, and movies. Through experience we become what we are and through mistakes we learn experience”.

The students also revealed that they were able to correct their own thinking when one wrote that “the sim lab allowed me to evaluate myself and how I can better care for the patient. It allows me to see my faults so that I can improve” while another went on “It helps determine what you need to work on before being in a real situation”.

Suspension of disbelief is a concern for faculty who are charged with developing and running simulations. We have found that often these simulations become a virtual reality experience where students become so actively involved that belief is suspended and the cognitive and emotional engagement leads many students to forget that it is not real. It is through these real life experiences that the characteristics of nursing agency are developed. Students agree that this suspension of disbelief occurs and have stated that what stood out for them was “how real the simulations seemed even though I know the people were acting” and another who said “how ‘real’ it became even though we were pretending”.

Regardless of how meaningful the previous comments shared by students are, the ones that indicate an increased self care demand for the student are particularly striking. Some of these comments shared by students are:

I ‘killed’ my patient during this experience, and I will never forget the signs and symptoms I should have been looking for so that the patient did not die. This will stand out with me for the rest of my nursing career.

I got to face my fears of medication error It is a little hard...feeling inadequate.

It felt so real that I was traumatized from giving my patient the wrong medication.

It was challenging and pushed my comfort level.

It was shocking to see how well I thought I knew the material and yet, when placed in the situation, how many mistakes I made. Bring it all together in action is much harder than knowing it all in theory.

I was upset with myself when I made careless mistakes that could have potentially risked my patient’s life.

Thus it is easy to see from these poignant comments the potential impact these simulation experiences might have on students and the necessity of having an experienced faculty member who is skilled in debriefing conduct the simulation experiences. It has been suggested that further counseling sessions might also be necessary.

The development of nursing agency requires repeated real life experiences with direct faculty guidance and debriefing sessions. A program of simulation that is integrated into a theory based curriculum is an effective way to achieve this outcome. The impact of the integration of simulation in a nursing curriculum is best summarized by Confucius who stated that “I hear and I forget. I see and I remember. I do and I understand”. ■

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The Role of Tool Development in an Orem-Based Curriculum

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Abstract

The purpose of this paper is to present tools used in one School of Nursing as the curriculum changed from "eclectic" to Orem-based. The nursing assessment and care plan (tools) from the old curriculum were not congruent with the new curriculum. The process of developing, implementing, and revising tools congruent with SCDNT helped ground faculty in the model and provide a basis for change in ontology. Language that once was foreign became everyday. The tools developed or revised and included in this paper are: (a) Curriculum Template (b) Curriculum Map, (c) Nursing Health History, (d) Nursing Care Plan, (e) Clinical Performance Evaluation Tool, and (f) Professional Technological Skills Check List.

Key Words: Clinical Tools, Orem, Curriculum

Undergoing curriculum change is fraught with difficulties even in the best of circumstances. Our curriculum had been an "eclectic," five semester program since the school's beginning 20 years previously. Eclectic meant a medical model or simply atheoretical. Five years ago, the faculty voted to revise the curriculum to reflect a nursing model. The faculty was small and most taught in both graduate and undergraduate programs; and, as most, were very busy with no prospects of "release time" for curriculum development. Furthermore, no faculty were steeped in any one of the nursing models and few had studied nursing at the doctoral level. After some preliminary exploration, Orem's (2001) Self Care Deficit Nursing Theory (SCDNT) was the model everyone could agree upon. We were unanimous in our commitment to change, but wary of the direction.

As we began to move toward this theory-based curriculum, we wondered if we had opened up a Pandora's Box! The SCDNT was much more complex than we had anticipated. We spent many hours in a retreat, a workshop, and countless meetings, focusing on how our curriculum would change (time we could ill afford). The mechanics of the model were beginning to make sense; but, as with learning a new language, each translated into her own way of thinking—not into the theoretical thinking of the model. Was it possible the ontology of a faculty would change through this

preparation? With the implementation in the fall of 2005 we found this did *not* result in an ontological shift. There were many challenges in the practical application of the model.

There was some resistance to the language of the SCDNT—"we can't communicate with other disciplines with Orem's words," or "can't we just use plain English?" Language is an important expression of thought; conversely, the use of language can help shape thinking. With students at the door, waiting to be educated in their disciplinary ontology, we needed at the very least to be speaking the same language.

As we struggled in that first semester of implementation, we began developing tools to bridge the chasm between our understanding of Orem's (2001) model and our everyday practice with students. The purpose of this paper is to present the tools used in the implementation of the SCDNT into our curriculum: (a) Curriculum Template (b) Curriculum Map, (c) Nursing Health History, (d) Nursing Care Plan, (e) Clinical Performance Evaluation Tool, and (f) Professional Technological Skills Check List.

Curriculum Template

The SCDNT provided an organizing framework that we called a curriculum template (See Table 1). "Raw" content was initially added to this through brainstorming. The structure of the template has changed since first developed as our understanding of the model has grown. Visualizing the Undergraduate curriculum as a whole was an important activity for many reasons. It involved the entire faculty which led to discussions and negotiations about content placement. The curriculum template was particularly helpful in "laying bare" the content of our curriculum. We all tried to "fit" content into our previous courses—it was difficult to let go. As we were determining what content was appropriate for the Orem concepts of nursing agency, self care agency, and health deviations, we were also determining the increasing complexity as the student progressed through the curriculum.

Table 1: Excerpts from Curriculum Template, a Working Document in the Process of Development

“Raw” content is entered here, usually before objectives are identified.

CONCEPT*	Semester 1*	Semester 2*	Semester 3*	Semester 4*	Semester 5*
Nursing Agency					
Characteristics: <i>Communication</i>	Interview skills (etc) Intro therapeutic commun / relationship	Therapeutic commun w/. psych pts.(etc)	w/ pts of all developmental stages, dyads. (etc)	In a leadership role; facilitating change (etc)	With multidisciplinary teams (etc)
Methods of Helping: <i>Teaching</i>	Principles of teaching/ learning; Orem’s power components assessment, BCF and HDSCR assessment; Teaching project: formal group project to peers	Health deviation self care requisites in pts with psychiatric disorders and with acute med/ surg diag	Developmental self care requisites: childbirth education, self and newborn care, breastfeeding, Lamaze,	Teaching to groups	Collaborating with agencies to meet self care requisites (SCR) of groups [educational awareness project at community health site]
Self Care Agency					
USCR: <i>Air</i>	Oxygenation, taking history r/t air intake,, O ₂ administration, postural drainage, O ₂ sat, inhalers, Nsg. Dx. related to oxygenation	Oral pharyngeal suctioning; specimen collection	Respiratory care in children: suctioning, tents, masks,	Trach care, trach suction, ventilator care,	Assessing quality of air in community, eg, play area for daycare
Developmental SCR	Intro to lifespan; Concepts of aging; sensory changes in the older adult; Intro to grief/loss; end- of-life care; cultural influences on death & dying;	Psychosocial theories, history of psych care- illness-diagnosis; DSM; MSE	Growth and development, family theory	Development of groups	
Health Deviation SCR	Introduced as basis for specific content teaching for patients	Used as basis for specific content teaching for adult patients	Used as basis for specific content teaching for children of all ages		
Health Deviations	Risk for Infection Risk for Injury (Falls), Risk for aspiration Pressure ulcers	Diabetes; Cancer (breast, prostate exemplars) Chemotherapy, radiation therapy	Developmental disorders; neural tube defects; CP, Failure to thrive; Congenital heart,	Acute coronary artery syndrome, Shock, burns	BCF-Patterns of living: Elderly/ abused women, substance abuses, those with disabilities, migrant health women
Assignments	Nursing Care Plan , CINAHL search group teaching project	NCP (2), video recorded interaction	Case Study, nutrition assessment lactating woman; ethics paper	Case study, research proposal	Community assessment Cultural project Life stage project
Simulation					
Focus: <i>Safety and Communication</i>	Medication error Fall Calling physician Documenting	Post-op hemorrhage Blood transfusion/ reaction Post-op DVT/PE Giving report Documenting	Eclalmpsia; HTN; Asthma Families in crises	Dysrhythmia, accidental dislodging of chest tube MD, patient, family in crisis	Proposed: Mock code run by faculty who clearly demonstrates poor practice

*Please note that none of the cells is complete.

This curriculum template has become both unwieldy and valuable. An assumption underlying this curriculum is that this model conceptualizes the whole of nursing, that “what is nursing” should fit somewhere. Conversely, if content is not conceptually congruent with any of the concepts, then perhaps it is *not* nursing. It was from this grid, the courses for each semester were developed. The number of courses did not change from the old curriculum, but the names changed as did the course descriptions and objectives. The grid is used to identify specific content within our curriculum. This becomes particularly important with respect to various standards to which we are accountable: AACN Standards, the NCLEX blueprint, IOM Safety and Quality in Health Care Education. Rather than “teaching to the standards,”

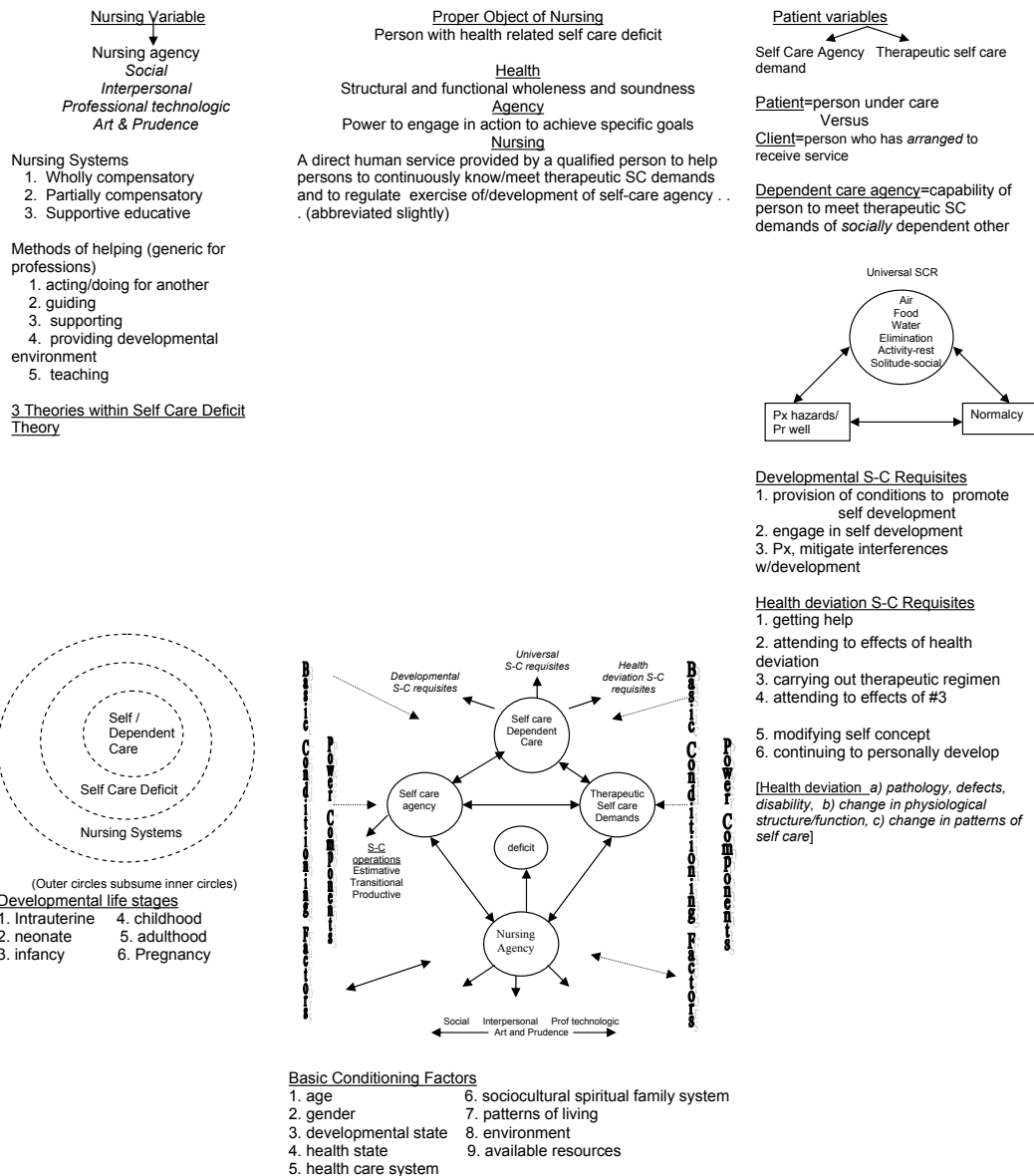
we are able to demonstrate where in the curriculum specific content addressing the standards is taught. Likewise, these standards sometimes point to a “hole” or a weakness in the curriculum—with this wholistic model it becomes evident where to add or strengthen the material. At times, this has created much discussion and reading of Orem (2001), furthering our understanding of the model. The curriculum template is always understood to be a rough draft, and its cells contain rough ideas of content. Refined objectives are developed within and across levels from the grid.

Curriculum Map

The curriculum map (See Figure 1) arose from a frustrated faculty member’s notes made while

Figure 1 Curriculum Map, a Working Document in the Process of Development

OREM (2001) CONCEPTUAL MODEL: SELF CARE DEFICIT NURSING THEORY [MODEL js]



preparing for that first class. The purpose was to put all relevant concepts, as understood at that time, on one page for easy reference when teaching. Other faculty saw it was helpful, and it was pilot tested with a class of first semester students. The curriculum map provides them with a baseline of the model, as well as definition of some concepts. The students strongly recommended continued use of the map. Now, the current students want more added (e.g., power components)! As the faculty has matured in its understanding of Orem, this map will expand to a two sided page, with self care agency more fully explicated. Since Orem's (2001) book is out of print, this "map" assumes greater authority, and thus will require greater scrutiny.

Nursing Health History

First and foremost, students must learn to determine if there is a need for nursing. A nursing health history tool is the practical application for this nursing situation. Our criteria for a tool were that the tool (a) would be adaptable to the clinical experiences in each of five semesters, and importantly, (b) include assessment of all self-care requisites as framed in the SCDNT. A search of "CINAHL" did not yield a health history form useful for our students. A simplified, but useful tool was developed (See Table 2). This is a 2-page form which provides students prompts as they gather data. Faculty from each semester adapt questions

Table 2: Nursing Health History a Working Document in the Process of Development

This form provides prompts for faculty and students at each level.

**UNIVERSITY OF TENNESSEE AT CHATTANOOGA
SCHOOL OF NURSING
NURSING HEALTH HISTORY**

A. Basic Conditioning Factors (p. 245, 248)

1. Age
2. Sex
3. Developmental state (Intrauterine, neonatal, infancy, childhood, adolescence, adulthood, pregnancy)
4. Family system:
 - a. Children
 - b. Marital status
 - c. With whom do you live?
 - d. Whom do you consider family?
 - e. What is your role in that family?
 - f. to whom do you turn to for help in times of need?
5. Sociocultural:
 - a. What is your primary language?
 - b. Do you have any trouble reading or writing?
 - c. Occupation
 - d. Is there anyone we can contact for you or any special practices that we can help you with?
6. Health State (write as a narrative)
 - a. What is your current reason for seeking care?
 - b. describe fully (include history and RoS)
 - c. list chronic, ongoing, past health deviations.
 - d. What are you most concerned about for this admission (or visit)?
 - e. Usual Health State: Rate on scale of 1-10.
 - f. Allergies (if yes, list and describe in detail the reactions for each).
 - g. Other than medications, are you under any treatments for your current illness?
 - h. Medications: List all (prescription, OTC, recreational, herbs, vitamins, alternative) and cite patient explanation for use
7. Health Care System Factors (e.g., nsg home, rehab, acute care, etc)
8. Patterns of living: a. What are your usual daily activities? Are you having difficulty managing?
9. Environmental factors: a. Is there anything in your home or work environment that contributes to (or makes worse) your current health state?

10. Resource availability/adequacy:

- a. Are your resources/finances adequate to meet your needs for medications and prescribed treatments?
- b. What sources of help do you currently use to manage your health state?

B. Universal Self Care Requisites (Abilities ----- Demands)

1. Air
2. Water
3. Food
4. Elimination
5. Activity vs. Rest
6. Solitude vs. Social Isolation
7. Prevention of Hazards
8. Normalcy

C. Developmental Self-Care Requisites (pp. 231-232) (1. that promote/engage in development, 2. overcome interferences with development [educational deprivation, prob. of social adaptation, failures of healthy individuation, loss of relatives, friends, possessions, occupational security, abrupt change of residence, status associated problems, poor health, disability, oppressive living conditions, terminal illness/impending death])

--

D. Health-Deviation Self-Care Requisites (p. 233-235)

Health deviations: list _____

1. Seeking assistance
2. Awareness of effects/results of condition
3. Carrying out prescribed measures
4. Awareness of deleterious effects of treatments
5. Modifying self concept
6. Learning to live with condition

E. Power Components (pp. 264-265) (assess for teaching/ability to engage in self care)

1. Vigilance/attention
2. Energy
3. Ability to control body/execute movements
4. Ability to reason
5. Motivation
6. Decision making
7. Technical knowledge
8. Repertoire of skills
9. Connect actions
10. Perform/integrate

pertinent to their area. Questions must be shown to be linked to one of the requisites on the health history. For example, when the student is caring for an older patient, assessing the basic conditioning factor of *Family Systems* may focus questions more on role within the family, with whom the patient lives; if the nursing situation is in a pediatric experience, more questions will focus on the dependent care agent. Dennis (1997) suggests that the patient's perception of health state is separate from the basic conditioning factors. We have included it as part of "health state." Developmental self-care requisites will change with different populations. The Nursing Health History is used with individuals, groups, and populations, in some form. First semester students, for example, methodically complete a full assessment on an individual who is meeting his/her self care requisites. In addition, they use the basic conditioning factors to compare and contrast patient populations at two or three of the clinical sites where they provide care for elderly patients.

The Nursing Health History tool is concrete, easily adaptable within the curriculum, and forms the basis of the nursing care plan. It is the starting point for the patient assessment each semester, with each semester having its own focus.

Nursing Care Plan

The Nursing Care Plan (NCP) was formerly based on Gordon's Functional Health Patterns (Gordon, 1994). Orem's (2001) self-care requisites required a new way of viewing "what is nursing." Believing a 2-page document was as long as would be advisable, a NCP format was developed based on concepts in the SCDNT (Orem, 2001; Dennis, 1997). The NCP parallels nursing process in many ways in standard text-books; it can be difficult therefore for faculty to change the traditional mindset. This basic format is used to in some fashion with individuals as well as groups and populations (See Table 3).

Table 3: Format for Nursing Care Plan a Working Document in the Process of Development

**UNIVERSITY OF TENNESSEE AT CHATTANOOGA
SCHOOL OF NURSING
NURSING CARE PLAN**

Only one written assessment of BCF, PC, and Self Care Requisites as outlined below. From this assessment you will identify subjective and objective data to support each of your patient's self care deficit statements

Basic Conditioning Factors

Power Components

Universal Self Care Requisites

Developmental Self Care Requisites

Health Deviation Self Care Requisites

***Each self care deficit will follow the pattern below beginning with the Diagnosis and Prescription**

Diagnosis and Prescription

Health Assessment

1. clearly relates and supports nursing diagnosis
2. includes defining characteristics
3. includes etiologies
4. does not include data unrelated to the self care deficit statement

**Self Care Deficit Statement (Nursing Diagnosis)

1. diagnostic label (from Carpenito) related to etiolog(y)ies
2. nurse must be able to independently assess both diagnostic label and etiology
3. nurse able to treat independently
3. includes all etiologies (from Carpenito)
4. appropriately prioritized with stated rationale
5. something for which nurse can effect change

Design and Plan

Particularized Self Care Requisite Statement(s) (Goal/Outcomes)

1. from patient's perspective ("the patient will . . .")
2. measurable (time, duration, amount, degree, and/or quality)

- 3. realistic
- 4. relates to diagnostic label

Nursing System (Wholly, Partially, Supportive/Educative)

Methods of helping with specific nursing actions

(acting/doing, guiding, supporting, providing developmental environment, teaching)

- 1. Specific nursing actions
- 2. Specify time, frequency, amount, person involved
- 3. Instruct regarding how/when to assess progress toward goal (e.g., “Temp. q 4h” for a goal: Pt. will remain afebrile until d/c)
- 4. Write interventions addressing the etiolog(ies) (monitoring, reducing, eliminating, mitigating, helping patient meet therapeutic demands resulting from etiology)
- 5. Write interventions related to the self care requisites: universal, develop., health deviation

Scientific Rationales

- 1. Clear, and in your own words as much as possible. Do not rely on extensive use of quotes.
- 2. Detailed. If intervention relates to orthostatic hypotension, explain the physiology underlying the pooling of blood in the extremities, the role of baroreceptors, and why the elderly are more prone to orthostatic hypotension. If the intervention relates to reducing falls for an elderly patient newly admitted to the hospital, give the research evidence on the risk of falls in this population and what interventions are most likely to help. (Hint: If you can ask yourself “how” or “why” at the end of your written rationale, you probably have not said enough.)
- 3. Sources cited.

Regulate and Control

Document response to interventions

Evaluate progress toward meeting particularized self care requisites.

****AND/OR**

.....

If self care deficit cannot be wholly managed by nurse and requires medical intervention, then it becomes a collaborative problem. For example, a patient with diabetes is at risk for hypoglycemia and hyperglycemia, and the nurse is primarily responsible for monitoring and teaching. The Self Care Deficit Statement then is: PC: Hypoglycemia. (See Carpenito (2006), pp17-25), Manual of Collaborative Problems begins: Carpenito, pp. 828).

Diagnosis and Prescription

Health Assessment

- 1. includes pathological condition/situation
- 2. includes supporting laboratory data
- 3. current management of problem, if appropriate (in health deviation self care requisites)

Self Care Deficit Statement. (Collaborative Problem: PC. Eg, PC: Aspiration, PC: Hemorrhage)

Design and Plan

Nursing Goal Since nurse not able to assure patient outcome, this step is from the nurse’s perspective (see Carpenito, p. 22).

Nursing System (Wholly, Partially, Supportive/Educative)

Methods of helping with specific nursing actions

(acting/doing, guiding, supporting, providing developmental environment, teaching)

- 1. Specific nursing actions
- 2. Specify time, frequency, amount, person involved

Scientific Rationales

- 1. Clear, and in your own words as much as possible. Do not rely on extensive use of quotes.
- 2. Detailed.

Regulate and Control

Document response to interventions

Evaluate progress toward meeting nursing goals

NANDA approved nursing diagnostic labels have been categorized under each of the self-care requisites as a “crutch” for students. Many of the diagnostic labels appear under several self care requisites; students have made numerous contributions to this list. The diagnostic label, together with the etiology(ies) are termed the “self care deficit statement.” This is consistent with Nursing Diagnosis; however, it seems semantically incorrect for the self care deficit statement. Further work for the faculty lies ahead here. The therapeutic self care demand is the prescription, and is written as a particularized self care requisite statement (Orem, 2001, p.224). This provides the predicted outcomes in the NCP.

Student Performance Evaluation Tool

A clinical performance tool developed by Hart and Alexander (personal communication, 2005, Jan. 11, 2008) that we adapted and modified (with

permission) is based upon criteria linked to the power components of Nursing Agency (Orem, 2001, p. 290) (See Table 4). Additionally, criteria based on the Art and Prudence of Nursing (p.293) were added. This tool is used in every semester. Another important role for this evaluation too—students can see a concrete application of the model with respect to the nursing variable.

Professional Technologic Skills. What in the past had been referred to as “psychomotor skills” are now included in “Professional Technological Skills”. Our check-off system has been changed to reflect the Orem model. The skills at present are categorized by universal self care requisites. Further development will explicate skills related to developmental self care requisites and health deviation self care requisites.

Summary

These tools are basic. Some conceptually weak or need further development, but their creation has

Table 4: Excerpts from the Clinical Performance Evaluation Tool a Working Document in the Process of Development

This clinical evaluation uses concepts from Orem’s (2001) Nursing Concepts of Practice.

Concept Definitions:

- *Nursing Agency:* Capabilities of nurses that empower them to act, know and help persons in a legitimate interpersonal relationship to meet therapeutic nursing demands.
- *Art:* An intellectual quality that allows individual to envision, design, and produce nursing assistance for others in accord with why and how persons can be helped through nursing.
- *Prudence:* The habit that disposes persons to (a) seek and take counsel, (b) make correct judgments about what to do and what to avoid in nursing situations, (c) decide to act in a particular way, (d) take action (p. 293).

The 10 Power Components (PC) of nursing agency are indicated for the clinical nursing evaluation (p. 290):

- PC 1: Valid and reliable knowledge of nursing operation.
- PC 2: Intellectual and practical skills.
- PC 3: Sustaining self as person and professional in nursing practice situations.
- PC 4: Willingness to provide nursing.
- PC 5: Ability to unify action sequences toward result achievement.
- PC 6: Consistency in performing nursing operations.
- PC 7: Making adjustments to prevailing/emerging conditions.
- PC 8: Ability to manage self as essential professional operative in nursing practice situation.
- *PC 9: Art: goal-directed “intellectual quality . . . that allows . . . creative investigations, analysis, and synthesis” (p. 293) in order to produce effective nursing systems.”
- *PC 10: Prudence: Selecting “the right reason about things to be done” (p.293)

Desired nursing characteristics/behaviors (pp. 291-293):

- *Social:* understands the nature of contractual and professional relationships and is able to perform the operations of nursing practice within limits set by these relationships.
- *Interpersonal:* accepts persons and has a repertoire of communication skills sufficient for effecting and maintaining relationships essential in nursing care.
- *Technological:* has mastery of valid and reliable techniques for nursing process for meeting the Therapeutic demands of individuals in nursing situations with confidence

Power Component 1: Valid and Reliable Knowledge of Nursing Operation	Student Rating			Faculty Rating		
	1	2	3	1	2	3
Use appropriate knowledge base for assigned patient to develop specific care plan						
Use logic, problem solving and reason in making decisions for plan of care						
Substantiate nursing actions with scientific rationale						
Power Component 2: Intellectual and Practical Skills						
Collect appropriate assessment data						
Analyze assessment data to plan patient care						
Perform client care safely (includes: medication/treatments)						
Demonstrate skill in performing nursing interventions						
Analyze the impact of values, beliefs, and culture on client care						
Accurately interpret pertinent information						
Demonstrate appropriate clinical judgment according to course level						
Use appropriate principles of communication to interact with others						
Use principles of group process as member of health care team						
Utilize cultural awareness in contact and communication with others						
Uses electronic health record as appropriate						
Maintain confidentiality of clients, families, colleagues						
Power Component 3: Sustaining Self as Person and Professional in Nursing Practice Situations						
Is courteous and considerate of others						
Promote positive image of self and nursing						
Power Component 4: Willingness to Provide Nursing Care						
Accept client and colleagues as individuals						

been important in so many ways. The tools have been developed by faculty from various levels within the curriculum and are all used in some form across all levels. They ground the faculty and students in the Orem model, providing continuity throughout the curriculum in all nursing situations. We use the tools as a touchstone, or a baseline as we move forward. Students easily grasp the concepts as presented, and at times have corrected faculty and even moved beyond faculty.

Importantly, the tools and their development and refinement have help embed Orem into *everyday* language, and thus the *thinking* of faculty and students. Evaluation of tools is an important faculty activity in any curriculum; for us, it keeps the focus on the model. Because the tools are used across the curriculum, they bring all faculty together, speaking the same language. There have been many lively and meaningful discussions, some of which have led to important changes in the curriculum, not all specifically related to the model. Terms such as Basic Conditioning Factors, Self Care Agent, Therapeutic Demand, etc., are no longer considered strange. These conversations occur on a regular basis, often related to one of the tools. Ideas introduced to the curriculum are usually framed in the Orem model, and if not initially, then another faculty raises the question. A

program assessment tool is yet to be developed; this, too, will be guided by the model.

There has been an ontological shift within the faculty. We are now at an important point in curriculum development—that is the maturing of the curriculum in its fullest sense. The next step is faculty and faculty/student research that is theoretically driven. Some small projects have already begun. The process of conceptually congruent tool development, revision, and evaluation was and is the vehicle for change in how we know nursing. New insights into the theory at the recent World Congress brought greater conceptual clarity, necessitating modification of some of the tools. Faculty engagement in revising, reversioning, and developing the tools, however, is the foundation that continues to strengthen our knowledge and commitment to a nursing model. ■

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The Reality of Learning Self-Care Needs during Hospitalization: Patients' and Nurses' Perceptions

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Abstract

Problem Statement: While patient education promotes compliance with treatment regimen and self-care ability, shorter hospital length of stay, anxiety, illness or sleep disorders can interfere with learning. However, it has not been determined how realistic it is to learn during the short hospitalization, from the perspective of nurses and patients. The aim of this study is to determine the perceived reality of learning self-care needs by congestive heart failure (CHF), from the perspective of patients and nurses.

Method: A descriptive- comparative study approach was used. Two hundred fifty-one CHF patients were recruited by convenience sampling. One hundred eighty-one nurses were selected by numerations in Tehran Cardiac Hospital of Shahid Rajaei. Data were collected using the reality part of the Congestive Heart Failure Patient Learning Needs Inventory (CHFPLNI) and were analyzed using SPSS- 11.

Results: Patients and nurses rated the subscale of *Other Information* as the most realistic self-care need to learn during hospitalization and agreed upon the reality of *Medication* as the third most important. There was no agreement on the rank of the subscales of *Diet* and *Risk Factors*. Patients and nurses perceived the subscales of *Activity*, *Psychological* and *Anatomy and Physiology* as the least realistic self-care needs to learn. Patients rated *Medication* (0.000), *Diet* (P=0.000), *Other Information* (P=0.001) and the total scale (P=0.000) as more realistic than nurses rated the same information areas. Learning of CHF self-care needs was perceived more realistic by female nurses (P=0.012) and nurses with advanced preparation (P=0.000) than others.

Discussion: The findings suggest that perhaps nurses do a disservice to patients by postponing educational content based on the assumption that it is not realistic for patients to learn their self-care needs.

Conclusion: Although learning barriers are present during hospitalization, this study supports the notion that hospitalization may be a motivator and opportunity for obtaining necessary information regarding one's disease. This study determined the self-care needs of CHF patients that are the most realistic to be learned during hospitalization.

Key words: Self-care, patient education, congestive heart failure, nurse and patient perspective

Introduction

Congestive heart failure (CHF) is a prominent health problem in the United States, with more than 400,000 new cases each year (Bubela et al., 1990).

Heart disease continues to be the leading cause of death and one of the most prevalent chronic diseases of adulthood in Iran and its prevalence has increased 16% in 1998 (Iran Ministry of Health, 1998). As more patients survive their initial cardiac event, these numbers are expected to increase. Heart failure is considered the common final pathway of all cardiac disorders. Many of the leading causes of CHF exacerbations can be prevented by nursing interventions. Learning to manage a chronic condition is the cornerstone of self-care (Wehby, Brenner, Mich, 1999). Self-care as a deliberate action to maintain optimal health and well-being (Orem, 2001) is the predominant form of health care for persons with CHF. However, many patients with heart failure are lacking adequate self-care behavior (Lainscak et al., 2007) because most of their health care is provided away from the supervision of health care providers.

Patient education standards are being challenged currently by a shorter hospital length of stay. During hospitalization, patients often lack the physical and mental capacity to concentrate on learning. Earlier discharges are occurring at a time when patients and care-givers are requiring more information about their disease and are struggling about the expectation of living with a chronic disease. As hospitalizations continue to shorten, nurses will be challenged to prioritize educational needs. A critical problem in attending to patient learning needs is identifying which learning needs are realistic to learn (Lorenz et al, 1989). Unfortunately little is known about nurses' and patients' perceptions of information realistic for CHF patients to learn while hospitalized in Iran. The nurse must be able to base decisions on research findings and not simply personal experience. This study aims to determine the perceived reality of learning needs of patients with CHF compared with nurses who care for these patients during hospitalization.

Literature Review

Meeting the educational needs of patients is not easy. Different patients have different cognitive

and physical abilities and needs. Individualizing each patient's education according to variations in values and abilities is a challenge (Luniewski, Reigle, White, 1999).

It is an accepted belief that patients with cardiac diseases need knowledge about their condition, risk factors, medications, dietary requirements and level of activity (Hagenhoff et al., 1994). Educating patients about heart failure treatment and consequences may be expected to increase self-care abilities and improve self-care behavior (Hanumanthu et al., 1997). Better self-care abilities and improved self-care behavior can give patients more control of their daily lives (Dracup et al., 1992) and it is hypothesized that a supportive educational intervention designed for patients with heart failure will increase self-care agency and self-care behavior (Jaarsma et al., 2000).

The heightened attention to health during a hospitalization for cardiac problems would seem to make the period of time during hospitalization a window of opportunity for presenting information to patients to prepare them for effective self-care at home. However, there is very little information available about the perceived learning needs of patients with diverse cardiac diseases.

Patients' perceptions of what they need to learn are important determinants of learning outcomes. Knowles (1978) described the adult learner as a person who is motivated by the immediate needs of the situation and the self-directed need to learn. When the adult learner finds himself in a situation where he is not allowed to be self-directed, a feeling of tension exist which will lead to resistance (Knowles, 1978). Therefore, nurses need information about what CHF patients believe they should learn in order to design effective educational interventions. Moreover patient education standards are currently being challenged by shorter hospital length of stay and the fact that individuals are currently hospitalized only when severely ill (Kegel, 1995). Earlier discharges may occur at a time when patients are requesting more information about the disease and are struggling with the expectation of living with a chronic disease (Bubela et al., 1990). Shorter hospitalizations decrease the opportunity to teach (Luniewski, Reigle, White, 1999). This situation is exacerbated by the stress of hospitalization which may have one of two effects on learning. To some individuals, hospitalization can provide the motivation to learn self-management strategies (Gonzalez et al., 2005). In other individuals, anxiety interferes with learning.

Although patients and nurses may believe information is important to know, both groups may doubt the ability of patients to learn all

the important information at a particular time. However, little research has addressed how realistic patients believe their education is during their hospitalization for cardiac diseases.

Chan (1990) not only studied what information patients thought was important, but also explored how realistic it was for patients to learn the information in the various phases of their recovery from myocardial infarction. In general, the findings showed a significant rise in perceived realism from the pre-discharge phase to the early convalescent phase, suggesting that patients believed they were least able to learn during their hospitalization. Hagenhoff et al. (1994) specifically addressed the perceived learning needs of patients with CHF and how realistic it was to learn during hospitalization. This single-institution study examined the perceptions of 30 hospitalized patients with CHF and 26 nurses (both licensed practical nurses (LPN_s) and registered nurses (RN_s)) to identify the congruence between nurses' and patients' perspectives. Seven educational topics (general CHF information, anatomy and physiology, risk factors, diet, medications, activity and miscellaneous information) were examined. Both groups rated most content as "quite" to "very realistic" to learn during hospitalization. The small sample size limited the generalizability of the study. Wehby et al. (1999) addressed the perceived learning needs of patients with CHF (n=84) and their nurses (n=84) and how realistic it was to learn during hospitalization. The patients perceived all eight subscales as more realistic to learn than the nurses did (P<.05). Although not in identical order, both groups ranked education related to medication and signs and symptoms as the two priority areas. Diet information was ranked eight by the patients and third by the nurses.

Unfortunately, little has been reported documenting patients' or nurses' perceptions of CHF patients' learning needs and no research has been conducted in Iran.

Theoretical Framework

Key concepts from Orem's Self-Care Deficit Nursing Theory (SCDNT) (2001) and the Knowles theory of adult learning (1978) were relevant to the development of this study.

Orem (2001) viewed individuals as having the potential to develop the intellectual skills, practical skills and motivation necessary for self-care. She also believed that cultural variables within individuals and their social group can be an impediment to self-care (Orem, 2001). The SCDNT involves three components. Self-care is the adult's recurrent contribution to continued existence, health and well-being. The practice

of self-care, when initiated and performed by the individual, assists in the maintenance of life, health, and well-being. A self-care deficit occurs when an individual is unable to care for self. Nursing systems are created when nurses prescribe, design and provide for a patient through performance of discrete actions or a combination of actions. These nursing actions assist the individuals' ability to engage in self-care activities (Tomey & Alligood, 1998).

The adult's perception of what is important should be the foundation on which the instruction plan is based. Knowles (1978) differentiated between the perceived (felt) needs and the needs that others have set for the learner (ascribed needs). The educator attempts to strike a balance between perceived and ascribed needs. Comprehensive educational plans must reflect both personal and ascribed requirements.

Purpose of the study

This study examined patient and nurse perceptions regarding how realistic it is for CHF patients to learn educational content while in the hospital.

Methodology

Design. To answer the research questions, a comparative-descriptive study design was used to examine and describe the differences in perceived realism between the patient and nurse groups.

Setting and sample. The sample included both patients (n=251) hospitalized for CHF difficulties and nurses (n=181) who provided care for CHF patients in Tehran cardiac hospital of Shahid Rajaei.

Patient sample. Potential patient subjects were identified through the daily admission lists that indicated the principal diagnosis. Patient records were reviewed to determine whether subjects met the study's inclusion criteria: (1) aged 18 years or older, (2) primary diagnosis of CHF (3) informed of the diagnosis, (4) the ability to complete a survey instrument or oral interview and (5) admitted to internal cardiac wards or post CCU. Patients who met the inclusion criteria were invited to participate on hospital day 2 or 3 until the sample size of 251 was achieved.

Nurse sample. Nurses were selected by numerations (n=181). The nurse subjects included licensed practical nurses and registered nurses employed at Shahid Rajaei hospital. Nurses who had worked in the hospital unit for less than six months were not included in the sample. Nurse

administrators (head nurses and assistant head nurses) were not invited to participate in the study.

Instrumentation. The Congestive Heart Failure Patient Learning Needs Inventory (CHFPLNI) originally developed by Hagenhoff et al. (1994) was back translated to measure Iranian nurses' and patients' perceptions of learning needs. The CHFPLNI was tested by means of a pilot study of CHF patients. Revisions to the CHFPLNI were based on pilot subject comments and were included in the final version of the CHFPLNI (Hagenhoff et al., 1994). CHFPLNI has two sections: (1) importance and (2) reality. Each section contains 44 questions. The second section contains the same items for the participant to use to rate his or her perceptions of how realistic it is to learn the 7 content areas during hospitalization. CHFPLNI contains the following categories: Anatomy and physiology, Psychological factors, Risk factors, Medication information, Diet information, Activity, and other pertinent information.

For each item on the CHFPLNI, subjects were asked to rate how realistic they believed it was for them to learn that content in the hospital. These ratings were on a 5 point Likert-type scale ranging from "not realistic" to "very realistic".

The CHFPLNI was reviewed by a panel of experts. The panel concluded that the instrument had face and content validity. For the current data set, the overall alpha coefficient was .90. The subscales had alpha coefficient ranging from .87 to .90.

Procedure. The study began after receiving approval to conduct the study from the appropriate institutional review boards. Data related to nurses were collected by one of the co-researchers. The nurses were read a statement of the research purpose, study's procedures, and the rights of human subjects. Those nurses who met the eligibility criteria and volunteered to participate were given the research instruments. The nurses completed the instruments during their work shifts. They were asked to respond to the instruments based on their experiences with CHF patients, not a specific patient.

Data related to patients were collected by four trained data collectors. As requested by patients, all instruments were read aloud to them. Data were analyzed using SPSS-11.

Demographics. The 251 subjects who completed the questionnaire had a mean age of 55.18 years (SD= 14.68, range 18-86). The sample was predominantly male (n=201, 82.4%). Most patients had completed grades 0-6 (n=153, 61%) and

had been hospitalized 1-3 times (n=137, 55.4%). The history of coronary diseases was 2-10 years in most cases (54.2%) with a mean of 10.70 (SD=14.4, range 1-83). Many subjects had had other chronic illnesses (48.6%), the most prevalent chronic diseases were diabetes mellitus (49.18%) and hypertension (46.72%).

The nurse subjects (n=181) had a mean age of 30.5 years (SD= 6.11), with a range of 22-52 years. Of the respondents, 85.6% were women. Most of them (n=171) had obtained a bachelor's degree. Their experience with the cardiac patient population ranged from .5-29 years (M= 5.51 years; SD=5.46). Seventy three nurses (41%) had completed a cardiac educator course which focused on the procedure and content for teaching the cardiac patient.

Study results. The mean scores for each information category were obtained for patient and nurse groups. Table 1 summarizes this data. Patients rated the *other* category as the most realistic category of knowledge, followed by *risk factors*, and then *medication*, to learn while they were hospitalized. Nurses also rated the *other* category followed by *diet* and *medication* as the most realistic for patients to learn while they are in the hospital. Patients and nurses rated *anatomy and physiology* as least realistic to learn during hospitalization.

Comparisons of mean ratings of informational categories were performed for patients and nurses. Most of the mean realism scores by patients were slightly higher than those of nurses, some of the differences were statistically significant. Patients rated the categories of *medication* (t= 3.64, P= 0.000), and *diet* (t= 4.83, P= 0.000), and *other* (t= 3.29, P= 0.001) significantly higher than nurses. The *other* category included taking pulse, future testing and out-patient testing, signs of other heart problems, where to learn cardiopulmonary resuscitation (CPR), why oxygen is needed for CHF, and when to call a doctor. Patients also rated

the whole scale significantly higher than nurses (t= 3.59, P= 0.000).

Future analysis was conducted to examine the relationships between demographics of patients and nurses and their perceptions of the reality of learning needs. No statistically significant differences were discovered in patient group. Two differences in realistic ratings were discovered when male and female nurses and nurses with and without advanced preparation were compared. The female nurses and the cardiac educators felt it was more realistic for the patients to learn while in the hospital than male nurses (t= -2.547, P=0.012) and non-cardiac educators (t= 4.773, P=0.000).

Discussion

The findings of this study provide important initial information about the perceived learning needs of hospitalized patients with CHF. Although some differences in the ranking of items were noted between nurses and patients, the predominant finding was that both nurses and patients rated all the content areas as *quite to very realistic* to learn during the patients' hospitalization. These findings are congruent with previous research with people with CHF and other cardiac diseases, indicating a considerable desire for patient education (Karlik et al., 1990; Hagenhoff et al., 1994).

The general trend across all patient education content areas was for patients to rate the information as more realistic to learn than nurses rated the information. These findings suggest that patients value education highly during their hospitalization for CHF, and this should continue to be an important focus of nursing care for this population.

Patients and nurses agreed in the ranking of the *other* category as the most realistic for patients to learn while hospitalized. They were also agreed about *medication* as the third realistic category to learn. These findings are not congruent with

Table 1: Rank order of perceived degree of realism subscale scores and the whole scale

Patient Perceptions			Nurse Perceptions		
Rank	Subscale	M(SD)	Rank	Subscale	M(SD)
1	Other	3.90(.90)	1	Other	3.63(.65)
2	Diet	3.89(.83)	2	Risk Factors	3.57(.68)
3	Medications	3.88(.98)	3	Medications	3.56(.68)
4	Risk Factors	3.67(1.01)	4	Diet	3.51(.65)
5	Activity	3.59(1)	5	Psychological	3.48(.71)
6	Psychological	3.57(.97)	6	Activity	3.42(.68)
7	Anatomy and physiology	3.56(1.11)	7	Anatomy and physiology	3.41(.62)
The whole scale		3.57(.81)			3.47(.56)

those reported by Hagenhoff et al. (1994). The patients and nurses in the Hagenhoff et al. (1994) study ranked *other* information as fourth and sixth realistic category respectively. Nevertheless, they were agreed upon *medication* category and rated *medication* as the most realistic category to learn. The different findings in the most realistic category may reflect the severe need of Iranian patients for primary information such as taking pulse, future testing and when to call a doctor. According to findings of Wehby et al. (1999), *medication* was the second realistic category to learn (from patients' and nurses' perspectives). Comparison among these findings about *medication* category reveals that *medication* is an important part of CHF management from both patients' and nurses' perspective.

Diet was ranked second by patients and forth by nurses; while patients and nurses in the Hagenhoff et al. (1994) study ranked *diet* as sixth and second respectively. In other words, patients of our study perceived the learning of *diet* information more realistic than nurses did and also more realistic than the patients in the above mentioned study. This finding reveals that Iranian patients have recognized *diet* information as a realistic component to learn in managing CHF and have recognized the importance of daily weights in detecting fluid retention before the development of clinical symptoms.

The significant difference between female and male nurses' perceptions of the reality of learning needs suggests that male nurses may postpone some aspects of teaching. So they need to consciously think about patients' learning priorities. Also the significant difference between nurses with and without advanced preparation indicates that cardiac education courses may decrease the risk of underestimating the realism of learning needs during hospitalization.

The lack of significant differences between patients with a cardiac history and those without a cardiac history was somewhat surprising. These findings do suggest that nurses need to provide similar information to experienced and inexperienced cardiac patients because we cannot assume that patients with previous cardiac-related hospitalization will need less or different information. Hagenhoff et al. (1994) also did not find a significant relationship in this regard.

The study findings support the premise that patient education is a vital component of nursing care during hospitalization. As hospitalizations continue to shorten, nurses will be challenged to continue to meet their patient's educational needs. Nurses need to be aware that, although they may perceive that patient education items are less realistic to learn, patients are eager to

master content and believe that it is realistic to learn during hospitalization. Perhaps nurses do a disservice to patients by postponing educational content based on the assumption that it is not realistic for patients to learn. Although learning barriers are present during hospitalization, this study supports the notion that hospitalization may be a motivator and opportunity for obtaining necessary information regarding one's disease.

Overall, the nurses and patients were in disagreement on 4 of the 7 subscales, thus indicating an imbalance between the perceived and ascribed needs for the CHF population relative to the degree of perceived realism. Nurses must attempt to strike a balance between the perceived needs of the patient and ascribed needs based on the nurses' perceptions.

As hospitalizations continue to shorten, nurses across the care continuum will be able to use this information to set priorities for patient education. The educational plan should be implemented at the time of diagnosis, regardless of the setting. Educational objectives can be developed so that the nurse will be able to ensure that baseline knowledge of CHF self-care management skills have been learned before discharge. When a patient is discharged without mastering the essential knowledge and skills, a plan must be established for acquiring the information in the community setting. For all patients, a seamless health care delivery model would be ideal, because education needs frequent reinforcement to have an impact on behavioral choices and to result in enduring behavioral changes.

The findings of this study should be interpreted considering the limitations of the research. Although the sample was large enough, the subjects were recruited from a teaching hospital. Moreover, the study was intended to describe perceived learning needs and did not address acquisition and/or retention of knowledge.

Future research

Future research should address the learning needs of CHF patients not hospitalized to determine if CHF patients, like myocardial infarction patients in Chan's (1990) study, perceive they can more realistically learn the information after hospital discharge. Future research should also study factors related to patient knowledge acquisition. Eventually nursing research must examine how patient education information affects self-care practices. Nursing research with this population is becoming increasingly important as more patients with severe cardiac disease survive through advanced medical management.

Conclusion

This descriptive study examined perceptions of hospitalized CHF patients and of nurses who care for CHF patients regarding the realism of learning typical patient education content during the patients' hospitalization. Generally, patients and nurses rated all information as moderately to very realistic to learn. There was a trend for patients to rate information as more realistic to learn than nurses rated the information. The findings of this study provide initial information about the nursing care of CHF patients and suggest directions for some future research.

Acknowledgement

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Facilitating Emerging Nursing Agency in Undergraduate Nursing Students

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Abstract

This paper describes barriers to using nursing theory and a curriculum model for integrating Orem's Self-Care Deficit Nursing Theory (SCDNT) into undergraduate curricula. Included in the model are underlying values and suggested curricular threads: 1) health promotion self-care across the lifespan, 2) health deviation self-care, and 3) patterns of self-care with chronic illness. Teaching strategies and SCDNT-related resources to help students develop nursing agency are featured. Criteria for selecting resources and examples are included. Orem's theory provides a clear nursing focus for education. Without such clarity, integrating content from nursing and other disciplines within a curriculum may obscure students' comprehension of their role and the unique contributions of nursing.

Key words: Self-Care Deficit Nursing Theory, Orem, self-care operations, nursing agency, values, self-care agency, self-care deficit, nursing diagnosis, nursing education

Introduction

Engaging nursing students in the ideas of the discipline requires helping them to develop a nursing focus. Selecting a specific nursing theory as the overarching curricular framework retains a clear purpose for practice and reinforces and reframes one's focus on patient-centered care, rather than defaulting to the more dominant disease-centered framework of medicine. Orem's Self-Care Deficit Nursing Theory (SCDNT) provides an excellent framework for thinking nursing and structuring the development of nursing agency within a curriculum. This paper discusses barriers to using nursing theory, a curriculum model for integrating Orem's theory, and criteria for selecting educational resources for learning Orem's theory. Emphasis in the diagnostic operations is placed on analyzing self-care operations to help students gain insight about patients and partner with them to meet their therapeutic self-care demands. Such a model can empower faculty and students to create nursing systems that avoid an overlay of theoretical labels and an approach that retains a medical framework of care.

Barriers to Using Nursing Theory

The challenge of facilitating the development of nursing agency within Orem's SCDNT requires overcoming barriers in the current health care system focused on a medically-dependent orientation. Faculties who are inexperienced with nursing theory and Orem's SCDNT struggle to reframe customary ways of thinking toward a perspective more consistent with nursing's values in approaches to nursing care.

Barriers in the Current Health Care System

The current health care system imposes several barriers that increase the difficulty for using nursing theory. These include: 1) complex, ever-changing technologies, 2) equating tasks performed with attaining outcomes, 3) a limited valuing of the processes needed for critical thinking, and 4) poor documentation of nursing care.

The complex, ever-changing technologies demand frequent attention and increase stresses for learning and managing the equipment. Equating tasks performed with attaining outcomes often results. The profound expertise for supporting patients toward health and well-being remains largely invisible, and therefore, unnoticed and disregarded, resulting in a limited valuing of the processes needed for critical thinking. Nurses often forget the progression of learning interventions that eventually become equated with "common sense." Poor documentation of nursing care actually performed makes it invisible, irretrievable and unappreciated. Checkmarks indicate assessments without recognition of the individualized diagnostic operations. As one senior nursing student expressed it, "What does it matter what I document; no one reads it anyway!" Students learn to discount the insightful use-of-self as intervention.

Faculties' Inexperience with Nursing Theory

The practice arena makes challenging demands on nurses for care. These demands, combined

with feelings of inadequacy about nursing theory and pressures to “cover content,” undermine faculties’ willingness to commit to an approach to nursing education that is no longer mandated by any accrediting body in the U.S. Faculties receive little reinforcement within the discipline for maintaining a curriculum framed by a nursing theory. Doctorates from other disciplines undermine faculties’ recognition of the value of using nursing’s theories as a primary framework for the curriculum.

Curriculum Model to Integrate Orem’s Theory

Although many advocate the mid-range theories, learning a grand theory provides an excellent introduction to the entire field of nursing. Cody (2003) termed such a revolutionary approach as essential for transforming health care. A SCDNT-based curriculum model is presented here. (See Figure 1)

SCDNT Philosophy and Values

Basic to adopting a nursing perspective is learning its underlying values. Learning Orem’s theory may initially result in re-labeling that which is familiar without comprehending a different way of thinking. The underlying philosophy and values of the theory help students with the meaning of the theoretical language.

Orem (2001; Taylor & Milton, 1999) identified several core values, including collaboration. Collaboration as a particular competency for development of nursing agency requires use of therapeutic communication. Foundational to all therapeutic interactions is respect for persons who have their own meanings of life. Orem also advocated persons’ freedom to learn and choose

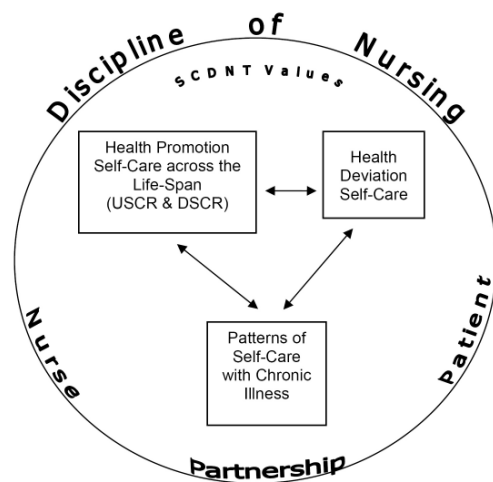
their own priorities and courses of action. Students need support from faculty as they develop the wisdom to accept different ways of living in the world.

Orem (2001) identified love as an attribute of mature persons who are concerned and care about others, also an important characteristic of nurses. The attribute of love includes four aspects: 1) care, 2) responsibility, 3) respect, and 4) knowledge, or “knowing the person” (p. 31), including oneself. Living these values results in sharing one’s expertise as a nurse with patients, rather than using one’s expertise from a position of dominance.

By passing the philosophy, values and language of nursing results in each individual learning them for oneself. The danger is that when one is unclear in one’s focus, one may adopt a nursing perspective that is either muddled or misses the special contributions of nursing in its independent as well as collaborative roles.

Curricular Threads

As the economic burden of illness care outstrips current systems of funding, faculties need to enhance students’ nursing agency in helping patients stay well and deal with chronic health states. The curriculum model suggests curricular threads that incorporate these areas: 1) health promotion across the life-span, 2) health deviation self-care and 3) patterns of self-care with chronic illness. Orem’s three articulating theories of self-care, self-care deficit, and nursing systems guide the curriculum. The theory of self-care describes persons performing self-care and dependent care to meet developmental needs and promote life, health and well-being (Orem, 2001). One of the propositions of this theory is that basic conditioning factors (BCFs) influence persons’ abilities or needs. Students gain insight about the context in which individuals learn, make decisions and carry out self-care through analyzing the BCFs. The theory of self-care deficit identifies when nursing is needed. Students learn the uniqueness of nursing’s contribution to health care by identifying patients’ self-care deficits. The theory of nursing systems directs the methods of helping and degree of assistance nurses select based on recipients’ self-care limitations. Recipients of nursing care may be individuals, dependent-care units, groups with similar limitations, families or other multi-person units, or communities (Orem, 2001, p. 395). Nursing agency involves social, interpersonal and technologic operations that reinforce working *in partnership* with patients. Social operations



Nursing Agency: Social, Technologic, & Interpersonal Operations

Figure 1: Curriculum Model

involve factors that establish a recognized, valid nurse-patient collaboration. The interpersonal operations involve the skills for establishing a partnership and are based on respect for person. The technologic operations involve the science and art of designing, carrying out and managing nursing systems of care.

Health promotion self-care across the lifespan. This curricular thread focuses on students' learning about situations and personal conditions in which problems with maintaining or enhancing healthy states may be encountered due to developmental limitations of emerging or diminishing self-care agency, as with children or elders, or new developmental challenges, like pregnancy. Situational changes may also condition persons' abilities to meet their usual self-care under conditions of changing environments or situations of living that are unfamiliar. The universal and developmental self-care requisites provide organizers for examining nursing situations of health promotion self-care. Nursing situations are likely to be identified outside acute care settings with an emphasis on dependent-care units and families.

Health deviation self-care. This thread focuses on individuals with injuries or acute illness or disease states. Students learn to appreciate patients' perspectives about health and illness with sudden changes in health state. The health deviation self-care requisites organize student's investigation of acute health situations.

Patterns of self-care in chronic illness. The third thread focuses on students' learning with persons who are dealing with ongoing self-care demands from chronic health conditions. These persons may be in acute care settings or in the community as they attempt to integrate patterns of care for chronic health states.

Teaching Strategies

Diagnostic Operations

The embedded meaning of the theory is found in its language, particularly the construct of self-care agency (SCA). SCA is a complex construct of foundational capabilities and dispositions, power components and self-care operations (Orem, 2001; Fawcett, 2005; Gast, Denyes, Campbell, Hartweg, Schott-Baer, & Isenberg, 1989). Focusing the diagnostic operations on analyzing self-care operations facilitates students' development of patient-specific nursing systems. Students learn to uncover self-care deficits with

genuine meaning for patients by focusing on knowing, judging/deciding, and acting capabilities and limitations and are less likely to fall back on rote interventions. They are also clearer about their role and how the nursing system is impacted by the medical system of care. Concepts from other disciplines can then be interpreted for how they add to development of SCA/dependent care agency.

Nursing Diagnosis

Faculty used Taylor's (1991) description of the structure of nursing diagnosis from a self-care (SC) perspective to derive a familiar format for writing nursing diagnoses (altered to be truer to the theory). Faculties accept students' diagnoses as SCDs if they include: 1) a nursing problem, which could be a NANDA diagnosis, and 2) one or more self-care limitations. An example that illustrates a SCD by a student that also includes the supporting data is:

Ineffective health maintenance related to lack of resources for SC, limited support systems to sustain SC, trouble with learning or recall (blindness) as evidenced by: states no money for medication; nobody to drive him to hemodialysis; wife does not always know how and when to give medication and works during the day; patient is blind.

Educational Resources for Learning Orem's Theory

Textbook Development

One of the practical challenges for teaching SCDNT is finding resources. Unfortunately, books that focus on one nursing theory typically have a limited life-span, especially after the death of that theorist, as with Dorothea Orem. To that end, a book introducing self-care theory was developed (Ransom, in press). The text has three major goals: 1) to introduce the discipline and the value of using nursing theory; 2) to use simple language to describe Orem's profound ideas; and 3) to limit the content to basic descriptions. See Tables 1 and 2 for an overview and evaluation of the text.

Selection of Complementary Literature

Because of the basic nature of the book by Ransom (in press), an index of over 60 articles was compiled as a resource for faculty. The index includes articles regarding Orem's SCDNT, related disciplinary articles, and articles dealing with

Table 1. Chapter Content in *Foundations of Nursing: Introduction to Nursing and Orem's SCDNT (Ransom, in press)*

Chapter	Content
1	Introduction to Nursing and Nursing Theory The Discipline of Nursing Theoretical Description of Nursing Types of Knowledge Useful to Nurses Theory Used in Nursing: Borrowed and Unique
2	Philosophical Basis and Need for Nursing Philosophical Basis and Underlying Values for Orem's SCDNT Nursing: Establishing a Need for Nursing Care
3	Theory of Self-Care Overview of Theories Within the SCDNT Theory of Self-Care: SC/DC, SCA/DCA, TSCD, BCF
4	Theory of Self-Care Deficit SC Deficit Capabilities and Limitations in Knowing Capabilities and Limitations in Judging/Deciding Capabilities and Limitations in Acting
5	Theory of Nursing Systems Focus of Care: Individuals, Families, Groups or Aggregates and Communities Nursing Agency: Social, Interpersonal, and Technologic Aspects Nursing Systems Types of Requisites: USCR, DSCR, and HDSCRs

Table 2. Evaluation of *Foundations of Nursing: Introduction to Nursing and Orem's SCDNT (Ransom, in press)*

<p>Summary from a standard CE evaluation tool, indicating satisfactorily meeting these objectives:</p> <p>The first chapter helps to distinguish the discipline of nursing from other disciplines and the purpose of using nursing theory as a basis for practice. The second chapter describes the philosophical basis for Orem's SCDNT and the underlying values of the theory, including elements of caring situations and when nursing is needed. The last three chapters clearly describe the theoretical ideas and relationships among concepts in each of the three theories by Orem.</p>
<p>Evaluative Comments from a Faculty Panel of Reviewers:</p> <ul style="list-style-type: none"> • The chapters are: a) easy to read and understand; b) well-organized & designed; c) provide good examples; d) are very applicable for students; and e) are well thought out and inclusive; so helpful for students. • Application activities are vitally important to really understanding and being able to use the theory. • This is a great resource for faculty and students and an excellent contribution to nursing practice!

concepts relevant to specific self-care operations and power components. Articles from CINAHL were identified by combining keywords of "Orem's self-care theory" and "nursing interventions." Articles were selected for their ability to help integrate Orem's theory in an undergraduate program, rather than add to the science of the discipline. Table 3 lists sample articles and selection criteria.

Conclusion

Using Orem's SCDNT offers a rich theoretical grounding in a way of thinking that can enhance students' nursing identity and preserve its unique value for patients and health care. The author's proposed curriculum model and complementary teaching strategies and resources provide a strong basis for facilitating nursing agency in undergraduate nursing students. ■

Table 3. Sample Articles and Selection Criteria

Author/Year	Title	SCDNT Concepts	Selection Criteria**
Allison, 2007	SC requirements for activity and rest	USCR-activity and rest	1,2,3,6,7
Arndt & Horodyski, 2004	Theory of dependent-care in research with parents of toddlers	Dependent care, DCA, TSCD, educative-supportive nursing system	1,2,5,6,7
Beach, Smith, Luthringer, Utz, Ahrens, & Whitmire, 1996	SC limitations of persons after acute myocardial infarction	SC limitations, HDSCR	1,2,4,6,7
Caetano & Pagliuca, 2006	SC and HIV/AIDS patients: Nursing care systematization	SC nursing process, USCR, DSCR, HDSCR, TSCD, SCDs (NANDA)	1,5,6,7
Clark, 1986	Application of Orem's theory of SC: A case study.	USCR, nursing systems, SCDs	1,3,6,7
Cox & Taylor, 2005	Orem's SCDNT: Pediatric asthma as exemplar	SC/ dependent care, TSCD, SCA, SC operations	1,2,6,7,8
Gast, Denyes, Campbell, Hartweg, Schott-Baer, & Isenberg, 1989	SC agency: Conceptualizations and operations	SCA: foundational capabilities & dispositions, power components, self-care operations; SCA measurement instruments	1,2,7,8
Hage & Lorensen, 2005	A philosophical analysis of the concept empowerment: The fundament of an education-programme to the frail elderly	Empowerment: supportive of power components & underlying values of SCDNT	2,4,6,7
Martinez, 2005	SC for stoma surgery: Mastering independent stoma SC skills in an elderly woman	SC, BCFs, nursing agency, SC nursing process	1,2,3,6,7
Odenkrants, Ehnfors & Grobe, 2005	Living with chronic obstructive pulmonary disease	Patient perspective & insight into SC capabilities & limitations	2,4
Taylor, 1991	The structure of nursing diagnosis from Orem's theory	SCDs	1,2,6,7,8
Taylor & Milton, 1999	Ethical issues: The ethics of Orem's theory	Values of SCDNT	1,2,6,7

**Selection Criteria:

¹clearly illustrates key concepts from the SCDNT, is faithful to SC theory, and integrates the theory throughout

²provides insight into concepts relevant to SCA

³case study

⁴qualitative study with participants' perspective

⁵research.

*Target audience: ⁶UG Student, ⁷ faculty

⁸in-depth study SCDNT

Contact the author for a more complete index of articles: Jane.Ransom@utoledo.edu

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IOS New Scholar Paper:

A Qualitative Study of Participants' Perceptions of the Effect of Mindfulness Meditation Practice on Self-Care and Overall Well-Being

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Abstract

This qualitative study aimed to increase understanding of healthy adults' perceptions of the effect of Mindfulness-Based Stress Reduction (MBSR) meditation practice on self-care and overall well-being. Nine community-dwelling adult participants who had previously participated in an 8-week MBSR program and continued practicing MBSR were interviewed for this study. Qualitative data were collected and transcribed, and initial themes were derived by the first author using the editing style content analysis method. Preliminary themes were then reviewed by two other members of the research team and revised, collapsing thematic categories from ten to five. Only data provided in response to self-care questions were analyzed for this presentation. MBSR meditation practice was shown to: (1) promote sense of peace and relaxation, (2) promote health awareness and self-care concern, (3) promote self-management and responsibility, (4) promote sense of giving and sharing, and (5) fulfill a basic need for health and well-being. These findings suggest that practicing mindfulness meditation is strongly related to personal self care and overall well-being. MBSR is a self care action chosen to maintain health and well-being and serves to meet existing self-care requisites in this group of community-dwelling adults.

Key words: Mindfulness-Based Stress Reduction, mindfulness meditation, qualitative study, self-care

Although arising in Buddhist teaching and having been cultivated in the Eastern culture more than 2500 years, mindfulness meditation has only been practiced in the Western culture within the past 40 years (Bonadonna, 2003; Kabat-Zinn, 2003; Matchim & Armer, 2007). It has been described as "bringing one's complete attention to the present experience on a moment-to-moment basis" and as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). To be mindful means to be present and clearly observe sensations, emotions, and thinking; to be alert and recognize distractions from experiencing the present moment; and to be willing to let the distractions go. The work of mindfulness meditation is training the mind to return to the immediacy of the breath, over and over again (Humber, 1984; Goldstein & Kornfield, 1987). Mindfulness can be achieved in several ways; and though, often fleeting, it is not an uncommon experience. Many of the world's

wisdom traditions have practices that stimulate mindfulness, such as yoga, ecstatic dance, prayer, music, and art (Bonadonna, 2003). A scene of great beauty may stimulate mindfulness, or some sort of shock, such as receiving a life-threatening diagnosis, might "wake us up" for a while and we experience the present moment. When one is mindful, life takes on an unusual intensity (Levine, 1982).

Mindfulness-Based Stress Reduction (MBSR), a form of mindfulness training which is frequently used in clinical settings, was developed in 1979 by Jon Kabat-Zinn (1982), and offered to the public through an outpatient stress reduction clinic at the University of Massachusetts Medical Center (Kabat-Zinn, 2003). To date, the MBSR is offered in hospitals and clinics, as well as in inner-city health centers and a range of other settings (Kabat-Zinn, 2003). Studies in clinical settings indicated that the MBSR is effective in: (a) reducing generalized anxiety and panic disorders (Kabat-Zinn, et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1995); (b) reducing mood disturbance and stress levels, anxiety, anger, and confusion (Specia, Carlson, Goodey, & Angen, 2000; Tacon, Caldera, & Ronaghan, 2004); (c) promoting positive effect on psychological symptoms, empathy ratings, and spiritual experiences (Astin, et al., 1999; Shapiro, Bootzin, Figueredo, Lopez, & Schwartz, 2003; Shapiro, Schwartz, & Bonner, 1998); (d) reductions of symptoms in psychological distress, promoting well-being and quality of life (Majumdar, Grossman, Dietz-Waschkowski, Kersig, & Walach, 2002); and (e) improving psychological distress and strengthening well-being (Pradhan et al., 2007).

In settings of healthy persons, studies indicated that mindfulness meditation has positive effects on increasing pain tolerance (Kingston, Chadwick, Meron, & Skinner, 2007). The possible effects may concern resetting baroreflex sensitivity, increasing the parasympathetic tone, and improving efficiency of gas exchange in the lungs (Phongsupap, Pongsupap, Chandanamatta, & Lursinsap, 2007). Furthermore, studies of the MBSR in health

care professionals indicated that the MBSR may be effective for reducing stress and increasing quality of life and self-compassion in health care professionals (Shapiro, Astin, Bishop, & Cordova, 2005). The MBSR may be an effective stress management intervention for medical students (Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003). However, there are only a few studies that attempted to develop a conceptual understanding of participants' experience and perceptions in practicing mindfulness meditation.

Mackenzie, Carlson, Munoz, and Specia (2007) conducted a qualitative study to explore self-perceived effects of MBSR in a psychoncology setting with nine cancer patients and reported five themes of effects of MBSR including: opening to change, self-control, shared experience, personal growth and spirituality. At present, no published studies have explored participants' perceptions of the effect of practicing mindfulness meditation on their ability to manage their therapeutic self-care demands and to promote self-care in meeting universal self-care requisites. Thus, this present study aimed to increase understanding of healthy adults' perceptions of practicing mindfulness meditation on self-care and overall well-being.

Qualitative inquiry was used to gain knowledge and understanding of participants' perceptions of the impact of practicing mindfulness meditation on self-care and overall well-being. Grounded theory was indicated as it is particularly useful in areas where little is known about the phenomenon of interest or where there are few existing theories to explain an individual's or group's behavior (Grbich, 2007; Stanley, 2006). Mindfulness meditation is a new area of research with few previously published qualitative studies. The ontology of this study is to understand the phenomenon. Grounded theory was used to guide the study. An in-depth interview and participant observation were used in collecting data.

Methods

Participants

Based on purposive sampling and selected inclusion criteria, nine participants were interviewed for this study. Participants who were eligible to participate in this study met these criteria: (1) community-dwelling adults who were at least 18 years old, (2) they spoke and understood English, (3) these persons had previously participated in an 8-week MBSR program and continued to practice mindfulness meditation regularly at least 2 months, (4) these persons might have underlying chronic illness, but during participation in this study, they were not receiving any active treatment or acute care, and (5) during participation in this

study, these persons perceived that they were healthy. Volunteers who practiced other forms of meditation were excluded.

Informed consent

Approval for the use of human subjects was received through the Health Sciences Institutional Review Board (IRB) office at the University of Missouri. Participants were informed about standard principles of human subjects' protection, including the right to refuse, withdraw, or stop participating in the study. All participants were provided written informed consent under principles of full disclosure and they were given a copy of the consent form. Participants also granted permission to take photos and to share their photos in the research reports.

Procedures

Potential participants were provided information about the aims of the study, inclusion and exclusion criteria, how they would be contacted, and how data were to be managed. The in-depth-interviews which lasted on average 30 minutes to 1 hour were arranged at times and locations that were convenient for each participant. All interviews were audio-taped and transcribed verbatim by the first author who participated in a mindfulness meditation class with these participants. In-depth interviews and field-notes were used to gain knowledge and understanding of participants' perceptions of the impact of practicing mindfulness meditation on self-care and overall well-being.

Opening Questions. Broad, open-ended questions were used to open the interview by focusing the participants on their experiences of practicing mindfulness meditation. For example, one such opening statement and related broad questions were: Please tell me why you first decided to practice mindfulness meditation? When did you first begin practicing mindfulness meditation? What forms of mindfulness meditation do you usually practice? How often do you meditate per week? And how long do you meditate each time?

Follow-Up Questions. After the participants' responses to these opening questions, their experiences and perceptions about practicing mindfulness meditation were explored. Key questions included: Please tell me about your experience in practicing mindfulness meditation. What pleasant and unpleasant experiences have you had in practicing mindfulness meditation? How do you feel about practicing mindfulness meditation? After practicing mindfulness meditation, have you found something has

changed in yourself, your life, your ideas, your attitudes, your feeling, and/or your perception of your life and others around you? What is the role of mindfulness meditation in helping you deal with difficult situations or your daily problems? What are your perceptions about practicing mindfulness meditation? How is mindfulness meditation related to your self-care? And how is mindfulness meditation related to your overall well-being?

Data Analysis

Qualitative data were collected and transcribed. Initial themes were derived by the first author using the editing style content analysis method of Crabtree and Miller (1999). As soon as data collection began, so too did the data analysis. After data of the first case were analyzed, the researcher began to collect data from the second case. After data analysis was completed, preliminary themes were then reviewed by two other members of the research team and revised, collapsing thematic categories from ten to five. Only data provided in response to participants' perceptions of practicing mindfulness meditation in relationship to self-care and overall well-being were analyzed and presented for this report.

Results

Subjects

Nine community-dwelling adult participants, six females (age 23-69) and three males (age 19-32), were interviewed. Participants were between 19-69 years old (average age 35.7 years). Five participants reported a change in health condition now controlled by medication and special self-care. The rest of the participants had no health problems. Four persons reported experience in practicing mindfulness meditation for ten weeks (the beginning experience), three persons reported moderate experience (8 months-3 years), and two persons reported long experience in practicing mindfulness meditation (8-9 years). Most participants usually practiced mindfulness meditation in the form of sitting meditation. The beginning participants reported they practiced 2-5 times/ week, duration of each time, 15-30 minutes. Participants with moderate experience reported they practiced 3-7 times/ week, duration of each time, 20-30 minutes. Participants with long experience reported they practiced 5-7 times/ week, duration of each time, 30 minutes.

Emerging themes

Data saturation was achieved following interviews with nine participants. A tentative preliminary

model emerged from the interview transcript. The model is composed of five major themes related to mindfulness meditation, self-care, and well-being emerged from the data. The practice of MBSR was shown to: (1) promote sense of peace and relaxation, (2) promote health awareness and self-care concerns, (3) promote self-management and responsibility, (4) promote sense of giving and sharing and (5) fulfill a basic need for health and well-being.

Theme 1. Promote sense of peace and relaxation. This theme describes participants' perceptions of the effect of mindfulness meditation practice on self-care and overall well-being after they practice mindfulness meditation. Participants indicated that a sense of peace and relaxation represents their feelings of being calm, kind, good, open and peaceful right after they meditated. This sense was also reflected in their thoughts, their perceptions of themselves and others. A sense of peace and relaxation led to a change in their reactions to other people and related situations in positive ways, even though they still experienced difficult situations in their daily living. Some participants described the occurrence of a sense of peace and relaxation, as if meditation gave them a more optimistic lens. They could see and perceive things as softer, more beautiful. Although sometimes they had to deal with disappointing situations, at these points, those participants could better learn the phenomena consciously in terms of thinking, feelings, and letting go. Table 1 shows selected participants' theme-related comments supporting this theme.

Theme summary: Participants perceived that the effects of practicing mindfulness meditation had been useful by letting them be calm, relaxed, and peaceful. As participants can place themselves in this situation, with their minds clear, without anything to worry about, they will be ready to reach appropriate behaviors to promote self-care and overall well-being. This sense also lets participants learn the phenomena of thoughts, feelings, and changing their reactions to people and situations in positive ways. Furthermore, practicing mindfulness meditation allows participants to let go of the suffering when dealing with difficult situations. All of these are a basic state for people to reach their universal self-care and overall well-being, as Orem defined a concept of health as "a state of physical, mental and social well-being and not only the absence of disease or infirmity" (Orem, 2001, p. 184), as well as speaking to the relationship between health, well-being, and being whole or sound. Through a sense of personalization, well-being is a perception of contentment, happiness, and pleasure. An individual is an integrated whole composed of internal physical, psychological, and

Table 1: Participants' Theme-Related Comments for Promote sense of peace and relaxation

Subject	Duration of MBSR Use	Comments
V-15	2.5 years	"After my meditation, I always feel so grateful. So, I think it so much does effect on me. I look at everything as softer and slow down. The meditation lets me have refreshment or a new start every day."
D-16	10 weeks	"I think I am more comfortable with life. It's kind of the naturally ten thousand lives, ten thousand enjoy. My thought is more comfortable with what just happens. And I don't have to object to myself if I did anything wrong. My thought is pretty free. And it made me less likely to judge other people."
K-18	10 weeks	"More peaceful, more positive, letting go, not getting upset when I can't control the situations. I am more accepting of myself and other people. And the spirituality is really the bigger picture than I can see. I am not resistant or fighting. So, I am learning a softer acceptance of other people and situations."
B-19	8 months	"I feel better. I don't feel depressed anymore. I am sure I get frustrated sometimes, but overall I feel pretty stable and I am in a balance, I guess. My feelings and emotions are not shifting up and down like before, pretty stable."
L-15	8 years	"It lets me see how the mind works. I see how I get caught, I see how I get attached, and I see how I suffer. I know how I suffer and therefore I know how to let go of the suffering. I mean I have tools; I have the ways that I have working in meditation practice in order to let it go. And sometimes, even though it has been hard, I know how to maintain it. It gives me a place to land."

social nature with varying degrees of self-care ability.

Theme 2. Promote health awareness and self-care concern. Participants explained that the effects of practicing mindfulness meditation let them pay more attention to their health which leads them to change their cognitive and self-care behaviors. After practicing mindfulness meditation, participants are more aware and careful in observing their health and their self-care activities. They choose to do activities that benefit their health and overall well-being, as well as balance these activities. Table 2 shows participants' theme-related comments for this theme.

Theme summary: participants perceived that practicing mindfulness meditation allows them to have more of a sense of health awareness and self-care concern. This sense leads them to pay more attention to their health and the ways to take care of themselves. They also change their behaviors and do more activities that promote their health and well-being.

Orem defined persons as human beings who are "distinguished from other living things by their capacity (a) to reflect upon themselves and their environment, (b) to symbolize what they experience, and (c) to use symbolic creations

(ideas, words) in thinking, in communicating, and in guiding efforts to do and to make things that are beneficial for themselves or others" (Orem, 2001, p 182). A person's self-care needs are met by a learned behavior. Factors which may affect individual learning include age, mental capacity, culture, society, and emotional state. The information of this theme indicated that mindfulness meditation practice is effective in enhancing one's emotional state to pay more attention and get ready to perform one's own self-care and may enhance these behaviors.

Theme 3. Promote self-management and responsibility. Participants explained that practicing mindfulness meditation lets them manage their responsibilities better, and they can get more things done. They used time more effectively. Some persons reported that they felt like they had more time, more than 24 hours a day. Table 3 shows participants' theme-related comments for this theme.

Theme summary: participants perceived that practicing mindfulness meditation allows them to have a greater sense of self-management and responsibility. This sense leads them to manage their responsibilities and balance activities in their lives. With this sense, participants can get

Table 2: Participants' Theme-Related Comments for *Promote health awareness and self-care concern*

Subject	Duration of Use of MBSR	Comments
S-17	10 weeks	"I am really conscious of everything that I use. Something that I don't use, I don't like to have excesses. I felt like I was an American girl growing up, so, shopping was something that I did a lot, especially when I did not feel good. And now I think I am mindful of what I have and make sure that I need this food that I buy. Why buy more than what you need? And that something is really good."
K-25	10 weeks	"I think it gives me a better overview of what is important in my life. And you start to see that your health is related to eating properly, relaxing, exercise properly, sleeping properly, and having fun. I am just living with more things in balance, rather than just only a few things. I am eating more healthy food, more vegetables and fruit, instead of I usually ate a lot of cereal and ice-cream that was not good for your brain or body. Now, I can sleep much better than before."
S-25	10 weeks	"I feel better. I feel more into myself, and I able to respond to my body. And that I can't do like before, like eat food, being aware of when I am hungry...when I am not, what my body does want. You know, sometimes when you are hungry, you don't eat at all or, you know, whatever might be. And mindfulness helps my well-being by feeling more energized, and feeling more like taking care about my mind basically."

Table 3: Participants' Theme-Related Comments for *Promote self-management and responsibility*

Subject	Duration of Use of MBSR	Comments
B-16	8 months	"It simplifies my life a lot because I can cast out a lot of junk in my life that I found wasn't meaningful. When I see what I don't have to do, I can cast that out."
D-16	10 weeks	"I am feeling like I have more time. That is really amazing. I don't understand that at all."
V-15	2.5 years	"If something worried me the day before and something I was facing that day, after my meditation, I feel like I could manage it now. I can deal with situations better. And I found that I did well on doing more thing"
K-15	10 weeks	"It's kind of I can keep tract with school, more grounded in the present. I can get a lot of things done. As you can do just only one thing at a time, those other things are going to stop bothering you. You will use time effectively and get more things done... like you have more than 24 hours a day."

more things done and have more time to take care of their health and overall well-being. This theme reflects the phenomenon of mindfulness meditation as "bringing one's complete attention to the present experience on a moment-to-moment basis" (Kabat-Zinn, 1994, p. 4). With this complete attention, one will be really present, not worried with the past or future. As one stays with an activity at the present moment, one will use time

effectively.

Theme 4. Promote sense of giving and sharing. Participants indicated that practicing mindfulness meditation lets them have a greater feeling of giving and sharing. They are willing to help other people. The focusing shifts from self-centered to others. Participants also reported that they have more balance in taking time with themselves and with others. These participants

choose to take their time for activities that benefit other people, such as teaching children or training in meditation practice for other people. Some persons changed their work or patterns of their activities in daily life. Table 4 shows participants' theme-related comments for this theme.

Theme summary: participants perceived that practicing mindfulness meditation allows them to have more of a sense of giving and sharing. This sense shifts them from the focusing on self to others. With this sense, participants choose to spend more time helping others and doing activities that benefit others.

Theme 5. Fulfill a basic need for health and well-being. Participants indicated that practicing mindfulness meditation is important for their health and well-being, and also benefits everyone. They perceived the practice as a basic need for health and well-being like nutrition or exercise that should

be promoted to the public in places such as clinics or hospitals. Table 5 shows participants' theme-related comments for this theme.

Theme summary: participants perceived that practicing mindfulness meditation is important for life and for everyone as a basic need for health and well-being. They also suggested that this program should be offered to the public.

Discussion

The findings indicated that participants perceived the effect of practicing mindfulness meditation as an important self-care practice that benefits their health and overall well-being. The first theme "*promote sense of peace and relaxation*" suggests mindfulness meditation practice gives participants optimistic lenses to help them clear their minds, relax, and be peaceful. The second

Table 4: Participants' Theme-Related Comments for Promote sense of giving and sharing

Subject	Duration of Use of MBSR	Comments
L-16	8 years	"It's really been dedicated in offering the practice for others. I see the benefit in this practice that I have done a number of years and I want to share this with others. So, my life has changed as a result of that."
W-17	9 years	"I realized others are parts of me too, helping others is helping myself. We are connecting although we are separated, but we share the oxygen, we share food, and we share everything pretty much. I am not happy, unless I can give my life to others. Helping others is easier and really important. Spending an hour teaching kids is a lot better than spending an hour watching TV."
V-17	2.5 years	"There are more about the ideas of servicing others. I think that is the real meaning in my life."

Table 5: Participants' Theme-Related Comments for fulfill a basic need for health and well-being

Subject	Duration of Use of MBSR	Comments
J-25	3 years	"We also talk about nutrition, exercise....I think the meditation is just as important. I am sorry that we don't give this piece for the patients, the things as professionals. I think we can offer this service sometime. But we didn't do it. I was thinking this is something that everybody can get. I think especially people who have chronic illness like diabetes or whatever. You know diabetes is the population that I work with. And that was what I think."
W-14	9 years	"I feel...it is a benefit in my life. So, it may not be necessary just to teach meditation in school, but we need to teach kids how to concentrate, and how to understand themselves, how to understand other people. Maybe we need to replace the TV time with meditation time."
M-24	10 weeks	"I am glad that I took this class. I also think of my friends and patients...so, you know this course should be provided for others too...like patients or other people."

theme “*promote health awareness and self-care concern*” suggests the practice of mindfulness meditation encourages participants to pay more attention to their health, as well as to select self-care activities that really benefit their health and overall well-being. The third theme “*promote self-management and responsibility*” suggests mindfulness meditation practice lets participants manage their responsibilities and balance activities. Participants may get activities in their life balanced and use time effectively. The fourth theme “*promote sense of giving and sharing*” suggests the outcome of mindfulness meditation reflects a state of fulfillment a person may have. As one feels full with one’s own life, one is willing to give and share with others. The fifth theme “*fulfill a basic need for health and well-being*” suggests the practice of mindfulness meditation reflects an important concern that one has for oneself and others’ health and well-being. This theme indicated how one benefits from this program as a self-care activity in daily living.

Orem stated that “self-care is the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being” (Orem, 1995, p. 104). Self-care has purpose. It is action that has pattern and sequence and, when performed effectively, contributes in specific ways to human structural integrity, human functioning, and human development. Five themes emerged as findings of this study, indicating that participants perceived that practicing mindfulness meditation served as a fundamental strategy to help them meet universal self-care requisites through changing to be more focused and aware of their health, along with choosing to do activities that promote physical and psychological well-being.

Conclusion

People may not fully understand mindfulness meditation by simply reading and discussing. Also some people may think that mindfulness meditation is not a valid daily practice. Findings of this study indicated that mindfulness meditation has potential applications as a self-care activity in holistic nursing practice that helps people meet universal self-care requisites and self-care demands during health deviations resulting from illness or disease, injury, and its treatment, as well as all paradigms of health. There is a need for further nursing research focused on the roles of mindfulness meditation in promoting self-care in meeting universal self-care requisites and self-care during health deviations resulting from illness or disease, injury, and its treatment, as well as all paradigms of health. This research might take

the form of both descriptive research and other more rigorous qualitative work, and, eventually, intervention research. ■

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IOS New Scholar Award:

Yaowarat Matchim, BSN, MS, PhD student



The IOS is pleased to announce the recipient of the 10th World Congress New Scholar Award, Yaowarat Matchim. Dr. Jane Armer's nominating letter reveals the extensive scholarship of this recipient:

April 19, 2008

Dear colleagues,

I am writing to share my strongest support for the nomination of Yaowarat Matchim for the IOS New Scholar Award. Yaowarat and I have worked closely together since she arrived in late 2005 to begin her doctoral work at the University of Missouri, where I serve as her advisor and mentor. She has worked with our NIH-funded lymphedema research project as a graduate research assistant and conducted independent studies under my guidance. I feel I can well address Yao's unique strengths and contributions that make her an outstanding candidate for this award.

Yaowarat is a remarkably bright, talented, dedicated young nursing faculty member from Prince of Songkla University in Thailand who has already demonstrated in her brief stint here in the US her great potential to succeed in the doctoral program at University of Missouri-Columbia. She is a highly intrinsically-motivated nurse scholar who is self-disciplined, focused, responsive to

feedback from mentors and faculty, and creative and innovative in her approach to both nursing and research.

In May 2007 Yao received a competitive interdisciplinary Clinical Biodefinitives fellowship at MU which supports her doctoral training and the development of the innovative cross-disciplinary work she plans in mindfulness meditation intervention with oncology and end-of-life patients. She intends to continue building her research skills in qualitative and quantitative research methodology through a rigorous set of coursework and accompanying mentoring in applied and translational research in nursing oncology and the health sciences; enhancing skills in working with and eventually leading a multidisciplinary research team, increased understanding of ethics and human subjects considerations in human research, and specific design and implementation of a research study examining outcomes of an alternative therapy intervention aimed at increasing quality of life in cancer patients- an area of great promise in contributing to the field and building a sound research trajectory.

By the end of her first year of doctoral study, Yao had accomplished several milestones that many students strive to reach upon graduation, including her fellowship funding, presentation of her preliminary work at the international biennial Oncology Nursing Society research meeting, and publication of a research paper in her area of interest in the Oncology Nursing Forum, one of the two premiere journals in oncology nursing. She has shared her preliminary work with multiple groups in seminar settings, including the mid-Missouri breast cancer support group, and has mentored colleagues in the practice of mindfulness meditation. She has participated as a member of our research team in the training provided to research sites across the country for a multi-site oncology clinical trial in lymphedema risk-reduction. She seeks educational experiences that will build her skill set as a nurse scholar and makes a substantial contribution to the research team and the classroom.

One of the most striking characteristics Yao brings to her studies and professional growth as a nurse scholar is her commitment to preparing herself for excellence in her quest to meet her goals. For example, in order to better prepare herself for her planned research in mindfulness meditation, she has chosen to study for extended (two-week) periods at the Buddhist temple in Bangkok on three different occasions, and has also enrolled in mindfulness meditation classes at MU with employees, students, and community members in order to understand, compare, and contrast the similarities and differences in the practices of our two cultures. This dedication to her own preparation and desire to assist persons going through challenging periods such as cancer treatment and end-of-life through a clinically relevant research intervention speak volumes about the caliber of person Yao is and her tremendous potential to make a significant contribution in nursing and nursing research.

In summary, I heartily support this nomination of Yaowarat Matchim for the IOS New Scholar Award. I can think of no more deserving a candidate who represents the strengths of PhD nursing students and our profession.

Please do not hesitate to contact me if further information is helpful to your positive review for this highly meritorious PhD student and budding nurse researcher. ■

Sincerely,



Jane M. Armer, RN, PhD
Professor