Development of the Theoretical Framework of Nursing for the Whole Person at Oral Roberts University

I. Tomine Tjelta

Follow this and additional works at: https://digitalshowcase.oru.edu/confaculty

Part of the Nursing Commons
DEVELOPMENT OF THE THEORETICAL FRAMEWORK
OF NURSING FOR THE WHOLE PERSON AT
ORAL ROBERTS UNIVERSITY

A
SPEECH DELIVERED BY
DR. I. TOMINE TIELTA, FOUNDING DEAN
OCTOBER 15, 1982

© 1993
PREFACE

Among the rich legacy left the Oral Roberts University Anna Vaughn School of Nursing by its founding dean, Dr. I. Tomine Tjelta, are tapes of ten formal presentations made at the conferences on the Theory of Nursing for the Whole Person held on the ORU campus. The tapes have been carefully transcribed by the School's senior secretary, Marilyn Abbott. Her precision has proven to be of great assistance to my work, and is deeply appreciated.

I have edited the transcribed spoken word into formal paper style through a process involving listening again to the audiotape, viewing the videotape done of the first conference, and referring to Dr. Tjelta's notes where they were available. The preparatory sentences were found in her notes that illumined the present text; I took the liberty of including them. When a clarifying word, or thought, seemed consistent with what Dr. Tjelta had said in other contexts, I included, but bracketed, the added material. Attempts were made to contact persons significant in Dr. Tjelta's life for correct spelling of the proper names with which I was unfamiliar.

Interaction with the text has affirmed my sense of Dr. Tjelta's uniqueness, her characteristic openness to the Holy Spirit, and our task ahead within the School of Nursing to build wisely on the Godly foundation laid. We shall be judged in that task by the same standard that Dr. Tjelta so faithfully met: obedience to God.

- Joann Phoebe Wessman
TABLE OF CONTENTS

DEVELOPMENT OF THE THEORETICAL FRAMEWORK
OF NURSING FOR THE WHOLE PERSON AT ORU ....................... 1

  Concepts and Conceptual Statements ................................. 1

MY BELIEFS AND EXPERIENCES UNDERGIRDING THE
THEORY OF NURSING FOR THE WHOLE PERSON ......................... 2

  Spiritual Aspects: Experiences at the College of Saint Benedict ..................... 8
  Spiritual and Physical Aspects: Experiences at Oral Roberts University ............. 10

THEORY OF NURSING FOR THE WHOLE PERSON ......................... 17

  Origins of the Theory .................................................. 17
  Definition of Concepts .................................................. 19
  Conceptual Statements .................................................. 26
  Research and Practice Models ......................................... 26

CONCLUSION ............................................................................ 31
LIST OF FIGURES

Figure 1: Schematic Summary of Philosphic Views ........................................ 5
Figure 2: Conceptual Framework ................................................................. 18
Figure 3: Beliefs Reflected in Nursing for the Whole Person ....................... 20
Figure 4: Definition of Terms ................................................................. 21
Figure 5: Classification of Concepts in Theory of Nursing for the Whole Person ................................................................. 24
Figure 6: Theoretical Statements .............................................................. 27
Figure 7: Research Model ................................................................. 28
Figure 8: Illustrative Structure of Practice Model ........................................ 30
The title of this presentation indicates that there was development of the theoretical framework of Nursing for the Whole Person at ORU. Dr. Wessman defined a theoretical framework as an abstract representation of reality used to describe, explain, predict, and integrate phenomena of interest. Another distinction important in the context of theory building is the differentiation between concept and conceptual statements.

**Concepts and Conceptual Statements**

The word, "concept", in conceptual statements has been used very loosely. I can remember sitting on the edge of my chair when teachers said, "Now, we're going to talk about anxiety," and introduced anxiety as a new subject to student nurses. It is not a new subject; it is not a new concept. Students come with the concept. If they do not have anxiety, they soon will experience it. But we make the mistake of picking up something familiar, calling it a "concept" and then saying that we are presenting something new, when we are not. Very few concepts are entirely new, except to a little child.

I remember when I was younger, I went to see a neighbor across the street. Her young toddler was just starting to say words. The mother was very embarrassed then the toddler reached up to me and said, "Grandma."

She said, "No, shhh, she's not grandma, she's not grandma." The mother thought that I might feel insulted because I was not at "grandma age" at that time. She continued, "Well, grandma has just been here. Grandma is built something like you." To the toddler, the concept "grandma" was not her grandma, but a person that was built similarly, who smiled, and who reached out to her. We forget that children **learn** concepts. They call things by what they experience (learning).

---

1 Nursing for the Whole Person Theory Conference - October 15, 1982
Now, when I talk about a concept, it is not in nature a concrete entity, as you notice. A concept is a construct of something in our brain. Concepts have meaning. Concepts have feeling. Concepts elicit a symbol, or a referent. A concept cannot be literally handed from one person to another. When you see something, what does the brain tell you? What does your mind tell you? Would others experience what you do? We know that they would not. Different people experience a story differently. So it is with the concept, "nursing." We do not come to nursing void of some kind of background. We have previous learning that colors our meanings, our feelings, and our symbolic interpretations of nursing. Let us not forget that students come to nursing with learned conceptual components of the discipline.

Now, what is a conceptual statement? It is a complete descriptive statement of some object, force, or circumstance in the world. It is different from a topic. It is different from an admonition. It is different from a definition. A conceptual statement indicates very clearly what the listener, or the student, is to learn about the concept. This clarification is so important. In nursing we often forget to cast our concepts into conceptual statements. We introduce the concept, "nursing." We assume that students come to nursing because they have a positive concept of nursing. They do. They can write their concepts of nursing. When I taught fundamentals of nursing I found that one of the most interesting things I did was to sit down and read the students’ concepts of nursing. As I looked at each paper individually, I thought, "You know, this person has a long way to go before understanding what nursing is." I could not assume that the student shared my concept of nursing. Students need help to make the transfer to a professional understanding of nursing. With conceptual statements we can help them to make that transfer. We teach a concept by its use in a conceptual statement.

**My Beliefs and Experiences Undergirding the Theory of Nursing for the Whole Person**

With that clarification, then, we proceed. The purpose, as I see it for my presentation today, is twofold: to explain the philosophy or beliefs that undergird the Theory of Nursing for the
Whole Person, and to briefly outline the steps involved in developing the theory. I hope by the end of this session that you will be able to interpret the beliefs about Nursing for the Whole Person in your own mind and identify the steps of theory building as they were applied in the development of the Theory of Nursing for the Whole Person. If we accomplish this twofold purpose, I think that you will have the background needed for interpreting your own philosophy, and relating your philosophy to theory development.

It is only as we are able to identify our personal philosophy (beliefs) and differentiate it from the philosophy of others, that we are able to accept what we have chosen. One of the difficulties I had when I studied philosophy was that every philosophy I read, I wanted to believe. I wanted to be that philosophy. I finally sat down one day with others students studying philosophy. I said to a gentleman sitting next to me, "I'm having such difficulty with this philosophy. I can't believe like they do."

He responded, "The one thing to learn when you study philosophy is that you don't have to believe as each philosophy does, but you do have to understand each philosophy's beliefs." And, so, I think philosophy gives us the biggest background, the best entrance, for understanding. Philosophy is intriguing. But at times we have to separate out our beliefs and say, "why do I believe this way?" We have the right to say what we believe.

One thing I have appreciated about nursing, and appreciate in the accreditation criteria of the National League for Nursing (NLN), is the opportunity to say what one believes. The difficulty comes that after you have stated what you believe, you have to show that those beliefs influence what you do. That is where our conflict comes — in life and in nursing. We do not know exactly what we believe, so we tend not to have something to steer us. In the NLN accreditation criteria, the League tests us to see if we have used our philosophy. Have we used our conceptual framework throughout the curriculum?

Think of what it would be if we lived in a country where we had no right to say what we believed, if we did not have a chance to differ from somebody else. What if we did not have a chance to say, "I believe differently, but I hear and understand what you're saying."
I think philosophy is the best basis for understanding other people. As the sheet describing different philosophical views was passed out, you may have noticed that if you just take the key concepts along the top and differentiate among them from philosophy to philosophy, you will understand the various philosophies. (See Figure 1.) Why can a Christian be an idealist, and why can the Russian people be idealists? Ever though of that? Why can both a Christian and an atheist be an idealist? See the broad definition; the focus is on a world of mind. Remember that I said any concept was related to your interpretation of it in the brain?

Mental Aspects: Experiences at the University of Washington

I mentioned earlier that every concept involves feeling, meaning, and the symbol or referent. Let me relate some personal experiences that have influenced — and do influence — my concept of Nursing for the Whole Person—Spirit, Mind, and Body. It is difficult, and indeed, sometimes painful for me to talk about my personal experiences in public. My colleagues have insisted that I do so today, and I will try and hit some highlights.

As an elementary school teacher, I became aware of the fact that young people would learn much better if learning, and what we planned to teach them, was oriented around meaningful centers. I started to ponder that idea of "meaningful centers" and kept searching. I do not think it was until I came to the University of Washington that I was encouraged, and had the freedom, to articulate what I meant, for what I was looking. I was looking for concepts. I became brave enough to articulate concepts. I became brave enough to talk about conceptual statements.

I was even so brave that I went to Ralph Tyler and said, "Dr. Tyler, I completely believe in what you say about objectives, and planning, but you have a missing thing."

And he said, "Now, what?"

I said, "Let me give you an explanation. You're including the idea of what is to be learned but you don't give any indication of what is to be learned. You give an indication of what the outcomes are, but you don't give any indication of the substance of that learning."
Figure 1

Schematic Summary of Philosphic Views
Prepared by Dr. Tomine Tjelta

<table>
<thead>
<tr>
<th>Metaphysics</th>
<th>Epistemology</th>
<th>Axiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theories of the nature of reality</td>
<td>Theories of the nature of knowledge</td>
<td>The general theory of value</td>
</tr>
<tr>
<td>Ontology: The meaning of existing as such.</td>
<td>The study of knowing and knowledge: What is true?</td>
<td>The study of valuing and values: What is good? What is beautiful?</td>
</tr>
<tr>
<td>The study of reality: What is real?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Ethics</th>
<th>Aesthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealism</td>
<td>A world of mind</td>
<td>Truth as idea</td>
</tr>
<tr>
<td>Realism</td>
<td>A world of things</td>
<td>Truth as observable fact</td>
</tr>
<tr>
<td>Neo-Thomism</td>
<td>A world of Reason and Being/God</td>
<td>Truth as reason and intuition</td>
</tr>
<tr>
<td>Experimentalism</td>
<td>A world of experience</td>
<td>Truth as what works</td>
</tr>
<tr>
<td>Existentialism</td>
<td>A world of existing</td>
<td>Truth as existential choice, personal appropriation</td>
</tr>
</tbody>
</table>
He talked on awhile, looked at me and said, "You are the person that should go out and write that." Then he looked at me and said, "I'm serious about that." When he met me again, he said, "That 'missing thing' is a needed thing. But only you who have applied what I have taught, can identify it."

I had the unique experience of serving under Dean Mary Tschudin. I do not know if any of you know Dean Tschudin. You probably saw her name in print when that great curriculum revision was done at the University of Washington. Dean Tschudin had been a student of Ralph Tyler. And, so, Ralph Tyler was one of our consultants when we were trying to revise the curriculum. He would sit very quietly. In one conceptual statement, he would put his hand, or his finger, on what was to be done, or what was missing. He had a unique mind.

Dean Tschudin encouraged me in a way that I do not think I have ever had an educator encourage me. She did that, in some ways, from the sidelines. It was very unfortunate for us, I think, that when Dean Tschudin retired, she retired. You could hardly get her back to the school for anything. She went out with her fishing rod and caught those great big salmon. Then, she would have a salmon bake and invite us. She gardened. She was going to enjoy retirement! But she did a great job when she was dean of the School of Nursing. I mentioned that she was a student of Tyler. When she left the University and packed her things, she told Dr. Hoffman about one notebook: "There's only one person who can appreciate this work." Dean Tschudin always called me "Two-mean" -- knowing that I was as mean as two people! She said, "Tomin is the only one who'll appreciate that work."

So, I have in my possession a notebook of a course outline done by Dean Tschudin. Ralph Tyler's comments on it read, "This is the best project that I've ever had turned in to me." It is all handwritten in script, not typed. Pages are rather tattered and torn.

Dean Tschudin organized a class on curriculum to which I later was assigned as the faculty responsible for the course. Dean Tschudin would visit the class. I would ask her to do so, because the graduate students kept saying that they never saw the dean. They would
like to see the dean who "sits in that office." One time I said to Dean Tschudin, "You were basic in this course — the originator — and you're the expert in curriculum. I want you to come in and meet these people."

Her opening remarks to the class startled me: "I am no longer the expert in curriculum. Tomine Tjelta is that expert. And I want you to remember that." It was as if she told me, "You've got to live up to what I am expecting." I asked myself, "Why is she expecting that?"

This relationship with Dean Tschudin started very early as I was in my master's program and working part-time. I worked with Helen Anderson in public health on a rehabilitation project. Helen Anderson came back one day and said to me, "Tomine, do you know that the dean's got her eye on you?"

I said, "The dean doesn't even know me."

She said, "You've given her some work; that is why she's got her eye on you." Dean Tschudin evolved a trust in me. For example, I was the one who had a chance to review the whole curriculum with her to see that it was in shape.

Dean Tschudin also gave me the opportunity to lead a group that was to plan for a new foundation course. No one wanted to do it. Med-surg did not want the course. Maternity did not want it. Psych did not want it. Public Health did not want it. Yet they would say, "We want students to know 'these things' when they come to us." So, here were ten people with whom I had never worked, and I happened to chair their efforts. Well, needless to say, because we were not emotionally involved, we could finish planning for the course before those who were emotionally involved in the curriculum changes. The med-surg group could not get off the ground at all. Dean Tschudin cleverly stood before the group and said to them, "You know, time is running out. I know you're busy people. How would you like to have some help, somebody to pull the course together?" I sat there listening. Afterwards she came to me and said, "You're on half-time. How would you like to do that job?"

I said, "You've got to be kidding. I can't."
She said, "Oh, Tomine, you can."

So, that is the kind of push, the kind of expectation, the kind of encouragement that I received. I always wanted to sit on the sidelines. I did not want to come out in public. I wanted to do a good job where I was, and I did not care whether anyone knew it or not. But Dean Tschudin had other expectations. I am sure that all of you have had some Ralph Tyler’s, Dean Tschudin’s, and people in your life who have said to you, "Get out. Get out. Take the risk. Do it." Dr. Wessman in her presentation mentioned Faye Abdellah. I had the privilege of having Dr. Abdellah as my advisor when I was on my doctoral degree. Dr. Abdellah represented the federal government from whom I had received a grant. She, too, encouraged me.

I am sharing with you these experiences at the University of Washington to give a picture of the mind. I have also related some feelings. I do not believe that any of us have really taxed our minds to the fullest extent. I think we have a capacity in one area or another that we have never fully used because we have not pushed ourselves, or somebody else has not come along the way to prod us. Oh, I just remembered that Dr. Wessman said in her introduction of me, "When the faculty become comfortable, Dr. Tjelta pushes!"

**Spiritual Aspects: Experiences at the College of Saint Benedict:**

Now, the other area of experiences with which I want to deal is that of the spiritual aspect. I think it is only fair first to make a statement regarding my feelings about changes in career positions. I consider the change in a position a call to serve God in a different setting. I have always had to change positions when I have been at the peak of my success in a place. When I left the University of Washington, I had just received a $150,000 grant to revise the curriculum. And I walked away from that. I walked away from my home that was only two and one-half blocks from the lake. I felt an urge. I first visited the College of Saint Benedict only to be courteous. Someone said I ought to go out to Minnesota as a consultant and help the people at St. Benedict; they were going to develop a nursing
program. I went out as a consultant. I ended up serving as the founding director of the nursing program.

I hurt when I left the University of Washington. I hurt when I left my home. My dean at that time, Madeline Leininger, said, "You don’t know what you’re getting into. I am a Catholic. You’re not a Catholic. And, if you want to go to a Catholic institution where you will find out the handicaps of not having money, and not having what you need — you’ve got it."

I said to her, "I have to go. It’s a call. It’s not fair for the seventeen of us with doctor degrees to sit here on the University of Washington faculty. There are people out there that need somebody to help them start a nursing program."

Let me tell you that the College of St. Benedict provided for me an environment that brought out the best in me. Something happened to me when I was there. I met the Catholic sisters. When I came, the Catholic sisters just had startled to have their devotions in their own language. Formerly they had used Latin. For their meditations, they would ask me to come along. Ten of them lived in a place that had been renovated from a barn to living quarters. I felt very comfortable with these ten sisters. I was a friend. I soon started to notice that there was something peculiar in that I felt very keenly related to them in a spiritual sense. Now, you remember, that I was not a Catholic. I came with a background of being a Lutheran. Lutherans usually think, "Luther broke away from Catholicism."

Well, so what? I could not have been here at ORU if I had not been there at St. Benedict’s. Why? When I was at St. Benedict’s, I met sisters who made me stop and think, "What is it that makes them what they are? Why are they the ones that can speak to my need? Why are they the ones that have a discernment of 'knowing'?" There was a little nun who took care of the janitorial work in the nursing department. Often she would say to me, "Today, you know, we will remember you for 'this.'" I learned to love them.

I found out that these people were charismatic. I had tried to avoid charismatic meetings in Seattle. I had decided that if I went to these meetings, it would be only out of curiosity.
I had decided that "charismatic" was not my temperament. So in the midst of this searching, I said, "These people have a power. God, what have you given them?" One night as I was meditating, I though about the verse that if you ask your earthly father for bread, He will not give you a stone. Neither will your heavenly Father. He would not give me a Spirit-filled life and the prayer language that would prove to be a stone — it would be bread. I started to use the prayer language and started to sing. And I thought, "What's wrong with me?" I had never heard of anyone singing in the prayer language.

Well, I went to Sister Reneé. "Sister," I said, "something happened to me the other night. I don't know exactly what it is — what it was."

Sister Reneé laughed at me and said, "That's it, Tomine, that's it." I am talking about this experience because it is the key, at the heart, of what I did in moving from St. Benedict's to ORU. I could not have come to ORU without that experience.

We had just received accreditation of the new nursing program at the College of Saint Benedict. I had no idea of going anywhere. But when you are successful, you always will have offers to direct nursing programs. I had four — and, ORU — I did not even know about the place. I had heard the words "Oral Roberts." And then people started telling me about ORU. In the course of time, I came down here to be courteous. And I am here. When it was known that I was going to ORU, a person said, "Well, what did — did President Roberts, did Oral Roberts get ahold of you?"

I said, "I did not see Oral Roberts. I do not have to see him. If I go because I am called of God, that is God's business, and not President Roberts."

**Spiritual and Physical Aspects: Experiences at Oral Roberts University**

Tonight you will have a chance to see two of the men who interviewed me on my first visit here. Now, I will not tell you what I said not only to myself, but to others. But I will tell you one of the things. I stayed in a motel. When I got to my room, I saw a GREAT BIG roach, cockroach, in the tub. And, actually, you can believe it. I stood there and said,
"I don't have to come down here to the South to live with cockroaches." You know, I have not seen a live cockroach since I came here. But my response shows how deeply I was putting in my heels, and not wanting to move.

I probably should add a little bit to that impression. Here I came to ORU. I, with faculty, had just built one nursing program. I knew very well when I came to ORU that one cannot take what is in one place, and plunk it down into another place. That belief is a part of my philosophy of curriculum. There had to be something special. There had to be something unique. There had to be something that fit into this University. Even thought the curriculum at St. Benedict's had fit into that college, I could not take and lift it, and come with it here. As I told you, I was alone when I first came to ORU. There were no nurses around me at that time. And, I finally got to the point that I blocked. I had to give a report to the State Board and I — I blocked. And I thought, "Well, I thought I did right in coming here. I know I did right in coming here. What will I do?

One day, after a University dinner, I spoke with President Roberts. I had met him once before. He came up to me, and said how glad he was that I was here. As I stood there, I am sure blushing, I said to him, "You know, something has happened to me after I came here. I'm blocked. I can't think. I can't produce what you want me to produce." I just thought that they better know my situation. I am sort of a little bit like that: up front. University officials needed to know I was blocked so that they would not later think that I was putting on any false pretense.

President Roberts looked at me and said, "Do you use the prayer language?"

I said, "Yes, I do." (Before coming to ORU, I had read everything I could that President Oral Roberts had written, and had listened to every tape that I could on which he spoke. I knew I needed to know all about ORU that I could.) He said, "Let me tell you. You take and use the prayer language, and then wait for the interpretation to come back." I will come back to the subsequent experience a little later.
Now, remember, I said, "I could not have come here if I had not been at St. Ben's." Now you understand why I said that [the prayer language].

We talked about "healing" and our meaning of that concept. Every concept has some meaning. I had been here almost a year when one day I noticed that I was hemorrhaging from the bladder. The toilet bowl was filled with bright red blood. I had never seen such a sudden, and extensive, hemorrhage. I looked at it. I am not one to listen to voices very much, but it was just as if a voice said to me, "That is the devil trying to stop that nursing program." And I could not put it all together. I went to a doctor whose office at that time was in the University Village.

He said to me, "Do you know any other doctors here?"

I said, "No, I don't know any other doctors."

He replied, "I think you need a urologist. I'd like to recommend one to you." I went on his recommendation.

It never occurred to me what the difficulty could be, what it was. The urologist examined me. This visit was the first time that I had met this doctor. He said to me, "We have to take you to surgery for a biopsy. I know — I'm sure — that the problem is cancer."

I said, "It can't be. NO. No, it can't be." And I started to weep.

And he said, "Oh, I guess I came on too strong." You know, I should have realized that hemorrhage might have something to do with cancer. But it did not enter my mind that this could be cancer — did not enter my mind until he labeled it so. The next thing he said was, "And I'm not going to touch you until I talk to those gentlemen out at the University."

"Listen," I said, "I will tell them myself."

He replied, "No, I will not touch you. I know how long they looked for a person. I don't know you, but you must be a special person to be there, and to be there for them. I will not touch you until I call them."
His insistence was hard for me to take! I did not want the doctor to take control over my life, and control over my place. He said, "I know those men out there, and I won't touch you."

I said, "All right, you do that, and I also will do it." So we settled for that, and I went home.

Incidentally, Dr. Wessman was driving the car. When home, I called Dr. Hamilton and said I would like to see him and he said, "When do you want to come in?"

"Anytime," I responded, and came in. The first thing I remarked was, "I understand that the urologist talked to you."

He said, "Yes, he did."

I said, "Now, what I'm interested in knowing, what about that nursing school?" The students soon were scheduled to register. He said, "That'll go on."

I said, "That's what I wanted to know." Back in my mind, remember, I had heard those words, "That is the devil trying to stop that nursing program."

The day that the faculty registered the first nursing students, I was under intricate surgical intervention for five hours and twenty minutes. They removed a block, including half of the bladder. A bladder was rebuilt, and the ureter transplanted into that little bladder. I had been prayed for by President Roberts; and prayed for by Dr. Hamilton. Some of the prayers and counsel that I remember were from Dr. Ervin. I was sort of saying, "I can't — I don't understand all of this, God, but you know those men who have been praying to you. Something must come out of this."

It was after the surgery that I fully realized that this experience really was happening to me. I remember one day sitting, and in my thinking, I got a picture different of what I thought heaven would be. I thought, "God, let me go there. I cannot live on and be incontinent and involuntary." I meant it. [At this point in the tape, Dr. Tjelta's voice breaks.] I am sorry. At times you are embarrassed of the fact that you want to use heaven as an escape. The words of the song, "Because He Lives, I Can Face Tomorrow," came to
me. I said, "God, because You live, I will face this incontinence, face being involuntary." I must have been more deeply hurt about that experience than what I thought I was. Death would have been beautiful; the thought of living with being both incontinent and involuntary, I could not face. But I did, because He lives.

Let me hurry through some of this. While I was in the hospital, there were two nurses who played significant roles. One of them was my private nurse practitioner. The other one, her specialty was psychiatric nursing, elected to sit up all the first night after surgery with me. She said, "I’m just going to sit here. I’m going to be with you." Less than a year earlier these same two Tulsa nurses had taken me out to lunch to "look me over." These were the people who were at first striking out against me, and saying, "Who is this ‘weirdo’ who is coming to ORU to start a nursing program? We’ll see that we put her in her place." Less than a year later, they were of great personal support.

Through that ordeal of cancer surgery, I learned how people look at other people with cancer. I shall share some of that experience in a moment. I was back to work in less than four weeks from the day of surgery. I did not ask to go back to work. The doctor said, "With you, I think you should go to the office." Incidentally, the first time after surgery that I visited the urologist’s office, I had a bag attached to my leg and a catheter in place. He look at me and said, "With you, I’m going to get rid of all these things."

"Where will it all go, what will happen?" I thought. I got rid of the catheter. I came to work, and I was never incontinent, and I was never involuntary. And I came back in less than four weeks. The faculty in my absence had kept busy with the school. The school had gone on. I had kept in touch. I think there was only one day I did not know what was going on at school: the day of surgery. But, otherwise, I fairly well knew what was going on.

Now, what do I believe about healing? And what do I believe about prayer and medicine? What am I talking about — the whole person? Do you look at me as a person walking around with some missing parts? In the medical field we may look at me that way.
Or, do you look at me as a whole person? I could tell you stories of the things I learned. Shortly after returning to work, I attended the Holy Spirit class. President Roberts had kept his eye on me during the session and at the end, wanted to question me about something. In the introduction of me that he gave in front of the faculty, he said, "She came to us, and in less than a year she had to have this operation for malignancy." It was the first time faculty had know that I had a malignancy. After this evening, people did not know if they should greet me, or just what they should do. Before that evening they had met and talked to me. But just because the word "cancer" was attached to me they did not know how to act. They sort of said, "Good morning," but did not ask how I felt. I was doomed to die. In fact, I think there is a person sitting here in the room who was asked when he was coming to ORU to go to school, "Is that Dean who is terminal still there?" That often is our response to cancer.

Let me turn from the negative, and relate another incident. I could relate many incidents of God's healing power. But I think there is one experience that we need to look at in relation to talking about prayer. I had been warned through all of my recovery that any time that I felt a particular pain in my side, I must notify the urologist immediately. He was concerned about the small ureter that, in its healing, might close off and destroy the kidney it drained. After having been back to school, I experienced that acute pain one morning. I said to Joann, "Walk me; let's see if we can get this kink out." I knew it was different from a "kink." I would not admit it. We talked to the urologist, and I went in for an x-ray. The x-ray people would not take me for emergency x-ray, because communication with the urologist had been unclear. That wait was painful! I was kept waiting because the x-ray workers were penalizing the doctor for what he had not told them — that I was coming in for x-ray. You know such stories; you deal with those people. After awhile Joann came back from school to check on me, and saw that I was still trying to trot around to keep from having intolerable pain.
Well, finally we got ahold of the urologist, and at 11:00 a.m. I got my x-ray. I think it was about 11:00 a.m.; I had been there all morning from 8:00 a.m., in agony. After reading the x-ray, the physician said to me, "Look, that one kidney has shut down. You don't have any output. You're all right. You have one good kidney."

I said, "It can't be. It mustn't be. It can't be."

He replied, "Okay, I'll wait five minutes and I'll take another one." I put my hand on my side and I said, "God, you've got five minutes to prove whether that ureter is going to open or be closed. I don't understand it all, but I know that President Roberts prayed. I know that Dr. Hamilton prayed. I know that Dr. Ervin prayed. They all prayed that my tissue would be regenerated. On the basis of that prayer [of tissue regeneration] I ask you to honor their prayers and heal the ureter."

At the same time the students had been very concerned that I was not showing up that day at school. They had gathered together, and were praying at the time that I was praying — those same five minutes. They later said those moments were ones of the closest relationship that they had ever experienced together. In five minutes, the repeat x-ray was taken. They physician reported, "It's open. Thank God, it's open." I could go on step-by-step, and relate many little things. But I will not.

We talk about compassion. There are many people who wonder what "drives" President Oral Roberts. What drives him is compassion! Shortly after I returned to school, we had a University faculty luncheon. It was the first time that President Roberts had seen me after surgery. He came to me and said, "I want you to meet the speaker."

He asked how things were "getting along," and I said, "I am so proud of myself. I have to get up at night, sometimes every 15 minutes or every half-hour, and yet I come back to work feeling so rested." All of a sudden, his arm started to tighten. I thought, "What did I say?" His eyes closed, and he was very stiff. He opened his eyes and said, "Tome, you cannot go on that way; you will not have strength. Watch it," he continued, "it's going to be cut down to about a fourth in about a week or 10 days." And it did. That compassion — he
took on my weakness — that compassion! And he prayed through. That is why — that is why I am here [prayer].

I have no doubt in my mind, whatever, that I was healed because I was to do some work here. When the time comes, when God wants to replace me, He will have somebody who will be better than I in this place. But, as the call is upon me, I have to obey that call. And you people all know that. You are in places where you have a call. You do not know why you are there, but you are there. Now, does a concept of healing have meaning? Does it have feeling? Does it have a symbol? It does for me. So much for my experiences. Maybe those people who insisted that I relate some of my experiences now wish that I had not.

The Theory of Nursing for the Whole Person

Remember that I said one day President Roberts told me to go home and pray in the prayer language, and wait for the interpretation. As I stated previously, I had struggled and had been blank in drafting the conceptual framework. You know what it means to be blank when one is supposed to be at the place to do something. I sat down that evening and followed through on President Roberts’ instructions. Even the arcs came to me and the circles — the entire conceptual framework. (See Figure 2.) Afterwards I looked at it; it was very simple. Is it not very simple? Yet, it is very profound: "Nursing for the Whole Person — Spirit, Mind and Body." The parameters of nursing were specified as the individual, the family, and the community. Note that the arrows between parameters point both ways.

Origins of the Theory

We had the advantage of building the nursing philosophy and conceptual framework on the philosophy of the University that focused on education for the whole person. You will hear more tonight about that mission of the University, so I will not go into depth of that ORU philosophy. The foundation of the theory, Nursing for the Whole Person, was built upon beliefs interpreted from Scripture and embodied in ORU’s concepts of education for the
Figure 2

Conceptual Framework
whole person. Now, remember, that in theory building you take as many facts as you know to be true. For us, we believe that Scripture is truth. That source, then, became the foundation for our theoretical beliefs. In Figure 3, you can see our beliefs, our interpretations from Scripture.

Definitions of Concepts

From our founding of the nursing theory in the ORU philosophy, we went on to define the terms. The terms that are basic to nursing were defined: person, health, illness, and nursing. (See Figure 4). Anything that you do in health care must deal with these concepts; I do not think that we can do anything in health care unless we have understandings in our minds about these concepts. A person receives health or illness. What we believe about nursing determines our role. You may not define these terms like we do. But you will have, whether you have made them explicit or not, some meaning, some feeling and some symbol attached to each term.

One of the best guidelines for us has been the way in which we define "person." I guess I say "we," because the definition was confirmed by the nursing faculty after I articulated it. We say that a person is a spiritual being. "Ridiculous," some might say. We believe that a person is eternal. We believe that the spirit is the dominant part of a person. We believe that the spirit can unite the person, can reach out to God, and can be filled with the Spirit of God. We know that if we look at a person as a spiritual being, and the spirit as the dominant part, that people will say that we are mystical: "They're mystics." I read in Colossians just the other day where it says, "God's mystery in Christ." That mystery is the foundation of all wisdom and knowledge. One of the things we have to remember is that if we are Christians, we tend to think of the human spirit as a Christian spirit. That is not true of all mankind. There is a spirit in persons, whether they are a Christian or not. How many of you have seen two persons with the same condition in a hospital? One rises up and goes home, and the other one becomes an invalid. How many of you have seen treatment given to a person, and through the dominant spirit of that person, he or she recovers? The spirit
Man is a spiritual being who functions in an integrated biopsychosocial manner to achieve his quest for wholeness.

Health is a state of spiritual, mental, and physical wholeness. The person's pattern of interaction with his internal and external environment determines his health status.

Nursing is a goal-directed service to assist the individual, family and/or community to promote, maintain and restore health. Central to this service is the concept of "nursing for the whole person." Each person, though a unique individual, is an integral member of a family/group and community.
Definition of Terms

**Person** — a spiritual being who functions in an integrated biopsychosocial manner to achieve his quest for wholeness. A person interacts with his internal and external environment holistically. Each person, though a unique individual, is an integral member of a family and community.

**Health** — a state of spiritual, mental, and physical wholeness. The person's pattern of interaction with his internal and external environment determines his health status. Health can be qualitatively described on a continuum from maximum health to minimum health. Illness potential exists in those who are healthy.

**Illness** — a dynamic state that reflects the nature of the person's pattern of interactive patterns with stressors in his internal and external environment. Illness can be qualitatively described on a continuum from severe illness to minimum illness. Health potential exists in those who are ill.

**Nursing** — a goal-directed service to assist the individual, family, and/or community to promote, maintain, and restore health. Central to this service is the Theory of Nursing for the Whole Person. Maintenance, promotion, and restoration of health have been defined as follows:

- **Maintenance of Health** refers to those nursing activities directed toward continuing or preserving the health status of individuals, families, and/or communities.
- **Promotion of Health** refers to nursing activities contributing to a greater degree of wholeness for the individual, family, and/or community.
- **Restoration of Health** refers to those nursing activities that facilitate the return to the previously experienced levels of health to individuals, families, and/or communities.

**Parameters of Nursing** — include the individual, family/group, and community. Each of these are interrelated. Services with a focus on one parameter cannot exclude consideration of the other. These parameters are defined as follows:

- **Individual** — a spiritual being who functions in an integrated biopsychosocial manner within the family or community.
- **Family** — the basic unit of society composed of individuals mutually valued and interacting.
- **Community** — an identifiable group of persons who share a common interactive pattern and/or a geographical location.

The Theory of Nursing for the Whole Person is central to the philosophy as well as to the conceptual framework for the nursing program. Its development came through the founding dean, Dr. Tjelta, and reflects origins in revelational knowledge, scholarly inquiry, and professional competence. This theory bears a direct relationship to the theme of education for the whole person, which pervades the philosophy of Oral Roberts University. The whole person incorporates the concepts of body, mind, and spirit. In this relationship the concept "mind" includes those processes described as emotional, volitional, and intellectual; the concept "body" includes those processes which are physiological (biological) in nature; and the concept "spirit" refers to that part of man created for communion with God.
may be strong in a handicapped person. Some of the most beautiful people that I have
known were the people for whom I cared in the oncology department. We thought they were
terminal. Their spirits were strong. The emphasis on spirit was right. We have defined
man as a spirit, a spiritual being. We think that each person will live on eternally. We
believe it to be our function to appeal to that spirit of man.

But, remember, that we also define a person as a spiritual being who functions in an
integrated biopsychosocial manner to achieve his quest for wholeness: integrated
biopsychosocial functioning. You have all your natural sciences, biological sciences, and
social sciences. Integration of these sciences gives us the body of knowledge to understand
human functioning. You cannot be all "spiritual." To function as a nurse, you must have
that body of integrated scientific knowledge.

Another thing differentiates our meaning of "whole person": achievement of a quest for
wholeness. We believe that within every person is a quest to be whole. Now, you may say,
why did you wish you were dead? Because I thought that there would be wholeness in
resurrection. Those who are confused and commit suicide think that in suicide, they are
getting wholeness. Now if we look at that whole person in that relationship of questing for
wholeness, basically we are saying that nursing is helping that person in the quest to become
whole. I think you will notice in our philosophy more emphasis on health and wholeness,
than on illness. Illness is a dynamic process that reflects the nature of the person's pattern of
interaction with stressors in his internal and external environments. It is a dynamic process.

What is "nursing" in the theory? Nursing is a goal-directed service. Back a few years,
nurses were concerned that we be viewed as highly scientific and professional. We might
have said, "No service; we're not servants." However, we are in a Christian institution, and
we are servants. But it is a goal-directed service. Look at your definition. It is a goal-
directed service. So, it is not that thing done intuitively, or that thing done experientially.
It is a goal-directed service. That service includes knowledge directed to the goals of
promotion, maintenance and restoration of health. We would not have to extend our thinking
any further if we understood what these goals mean, and understand what we mean by "a whole person," in that philosophy.

Classification of Concepts

After defining terms we proceeded into the classification phase, or step, of theory building. We classified our fifteen major concepts into five triads to foster new relationships and conditions for understanding the theory. (See Figure 5.) The parameters of nursing service were identified as the individual, family, and community. The parameters are not exclusive. An individual is not excluded from a family; the family is not exclusive of its individual members. The family is made up of individuals, and is a part of the community. Remember I said that the arrows point both ways. Our concept of interaction among parameters of service has quite often been a difficulty in nursing programs. We have the person centered in a hospital. We look at that person in the hospital bed. That person is what he is — reacts to his illness in a way he does — because of membership in a particular family or group. He is taken away from his normal family support. His family is present to agitate or support him. The family influences and makes up the community. The community, in return, influences what the family is. Many times in education we look at things separately in order to understand them, when in actuality they are so interrelated that we cannot understand them in separation.

I pondered on this interrelatedness of individual, family, and community quite a bit and feel angry and a bit taken back when people stereotype too much in one area of interrelatedness, or another: "they are from this community; they live on the north side." No, people are individuals, individuals within groups. Look at some of your big leaders; look at the community from which they may have come. Individuals rise above adverse surroundings. We cannot isolate such an individual from his family or community, nor isolate his community from the family or the individual.
Figure 5

Classification of Concepts in
Theory of Nursing for the Whole Person

1. Parameters, or clientele, of nursing:
   *individuals, families, communities*

2. Goals of nursing service:
   assist individuals, families, and communities to *promote, maintain, and restore health*

3. Desired patient/client outcomes:
   *health* (physical, spiritual, and mental *wholeness*). Opposite is *illness*

4. Basis of assessment and diagnoses:
   *internal environment, external environment, patterns of interaction between the internal and external environments*

5. Nature of the internal environment of the individual:
   *body, mind, spirit*
Another triad that we have classified is the belief about the person — body, mind, and spirit. We have dealt in relation to what it means to have a body, what it means to have a mind, and what it means to have a spirit. I have given you examples from my own life and asked, "What do these contribute to that person?" We also looked at them in relation to our definition of person. Not very long ago a flyer came across my desk that said, "the whole person — body and mind." We do not say that, because we say that a person is a spiritual being.

The next triad is the possible client/patient outcomes: illness, health, and wholeness. Health and wholeness usually are spoken of as being synonymous, not as distinctively different concepts. I think in our terminology there is more of a depth in "wholeness" than in "health" or, at least in the concept of "wholeness," a different way of looking at health. Previously, I have talked about illness, health and wholeness — the triad of possible client outcomes.

The next triad identifies the goals of nursing service: promotion, maintenance, and restoration of health. We have difficulty in trying to teach nursing students that the goals of nursing are to promote, maintain, and restore health. Why? So many of their experiences are provided in the confines of an illness setting, the hospital setting. We have tried to reach out in areas of public health in the community. But even though we have a person in the hospital, we can provide experiences related to all three goals. There are areas of healthy functioning that we can promote. There are areas that we can maintain. There are areas of functioning that we can work to restore. So those concepts have a range of different meanings. We have not completely defined them. No one has. That is the beauty of theory building: you evolve and define concepts. You further define them. You apply them.

We think that there are things that determine the health status of an individual: his internal environment, external environment, and the pattern of interaction between them. I wonder if you notice a pattern that the focus on the individual permeates the theory. Interactive patterns are not controlled by the external environment. They are not controlled
by the internal environment. We talked about the spirit of man rising above things. [Is it the spirit that determines the pattern of interaction between the internal and external environments?] Each one of us behaves at times in a manner that is predictable because we have established patterns. At other times, our behavior is not predictable because we have not established patterns of behavior in the area.

Conceptual Statements

Now we come to the phase in theory building of inference and prediction (research). Statements were made to reflect relationships assumed to exist, to show cause and effect relationship, and to add pertinent facts about each of the parameters of nursing. (See Figure 6.) Five conceptual statements were articulated related to the community. At the time we wrote our first self-study report for NLN accreditation, we articulated these statements. There are several faculty present who were here the day that we did. The faculty looked puzzled at me when I said, "Let's get some statements on these concepts." Back in my mind, I knew that we would need some conceptual statement to build our graduate program. I did not dare tell them my rationale. They would have said, "Let's get this undergraduate program all phased in before we get into developing a graduate program." They were right. I did not understand exactly the relationship between the conceptual statements and our graduate program. The five statements on the individual are the ones now operational in our theory-testing at the master's level. So these were the stages of theory development related to our curriculum development.

Research and Practice Models

In the next phase, a research model was proposed. Hypothetico-deductive reasoning is used to test hypotheses derived from the theory. (See Figure 7.) In the model, research is related to theory development. The research model will be discussed in more detail later in the conference. But I am introducing it here as part of the process of theory development.
Theoretical Statements

The concepts identified, classified, and defined in the conceptual framework were interrelated into theoretical statements — five for the individual, five for the family, and five for the community. These are given below.

Theoretical Statements for the Individual:

1. The individual is a spiritual being who functions in an integrated biopsychosocial manner to achieve his quest for wholeness.
2. The individual interacts with his internal and external environments wholistically.
3. The whole person nursing approach to individuals focuses simultaneously on spiritual, mental, and physical aspects of wholeness.
4. The nurse, through the health delivery system, facilitates promotion, maintenance, and restoration of individual health.
5. As the nurse continues the quest for personal wholeness, she/he contributes to the wholeness of others.

Theoretical Statements for the Family:

1. The family, as the basic unit of society, continually shapes and is shaped by the internal and external environments.
2. The family pattern of interaction with environmental forces, both external and internal, determines the health status of the family unit as a whole.
3. Promotion, maintenance, and restoration of family health requires mobilization of all resources within the family.
4. The nurse, through the health delivery system, facilitates the promotion, maintenance, and restoration of family health.
5. As the nurse continues personal and professional growth, she or he contributes to the wholeness of the family.

Theoretical Statements for the Community:

1. Community health is influenced by and reflects the wholeness of persons within it.
2. Family health is basic to community health.
3. Promotion, maintenance, and restoration of community health requires mobilization of all resources within the community.
4. The nurse, through the health delivery system, facilitates the promotion, maintenance, and restoration of community health.
5. As the nurse continues personal and professional growth, she or he contributes to the health of the community.
Figure 7
Research Model

Possible research approaches to testing and further development of the theory:

1. relationship of theoretical to observed antecedents
2. relationship of theoretical to observed transactions
3. relationship of theoretical to observed outcomes
4. relationship of observed antecedents to observed transactions
5. relationship of observed transactions to observed outcomes
6. relationship of observed antecedents to observed outcomes

The phenomena for nursing practice were projected in another model. (See Figure 8.) The practice model again will be discussed later in the conference. Within the practice model, the implications of Nursing for the Whole Person for clinical practice were made by depicting relationships among learning objectives, standards of care and patient outcomes. Conceptual statements of relationship within the phenomena of Nursing for the Whole Person were rendered explicit. Remember that I defined "conceptual statements" earlier. Now you can see where they are used.
## Terminal Course Objectives

### 1.0 Interpret personal philosophy of nursing in light of the Theory of Nursing for the Whole Person

- **1.1** Articulate a view of the individual as a spiritual being who quests for wholeness.

### 1.2 Interpret health as spiritual, mental, and physical wholeness.

### 1.3 Value identification of the client/patient’s patterns of interaction with both the internal and external environments.

### 1.4 Value the contribution of nursing in promoting, maintaining, and restoring individual, family, and community health.

## Standards of Care

### 1.0 Nursing care is based on the philosophy of nursing for the whole person.

- **1.1** The individual is viewed as a whole person — body, mind, and spirit.

### 1.2 Health is defined as physical, spiritual, and mental wholeness.

### 1.3 Client/patient patterns of interaction in both the internal and external environments are identified.

### 1.4 Nursing contributes to promotion, maintenance, and restoration of individual, family, and community health.

## Patient Outcomes

### 1.0 The individual will define himself as an integrated whole who functions within the context of family and community.

### 1.1 The individual’s behavior indicates to a measurable degree increased wholeness — body, mind, and spirit.

### 1.2 The individual defines wholeness as physical, spiritual, and mental wholeness.

### 1.3 The individual and family recognize that patterns of both internal and external environments influence health.

### 1.4 The individual will define health care as a continuum that includes promotion, maintenance, and restoration.

## Conceptual Statements

### 1.0 The inseparable unity of spirit, body, and mind in health/illness states is a part of one’s own philosophy of nursing.

### 1.1 Man is a unitary being comprised of body, mind, and spirit.

### 1.2 Emotional, physical, and spiritual parameters of individual wholeness interrelate.

### 1.3 The internal and external environment of man are in dynamic interplay; each continually is affected by being affected by the other.

### 1.4 Nursing is a goal-directed service to assist individuals, families, and communities to promote, maintain, and restore health.
CONCLUSION

I promised that I would take you through a journey of the steps of theory building. Now for a little exam. I always feel that if you are building a concept, it is nice for the person(s) to whom you are talking to interpret that concept. The test that you have consists of a phrase that I think captures the concept of "Nursing for the Whole Person" about which I have talked. Within the following phrase taken from Mark 9:41, I think you can summarize your interpretation of the "whole person" of nursing:

For whosoever shall give you a cup of water to drink in my name, because you belong to Christ, verily I say unto you, he shall not loose his reward.

Do you interpret a conceptual framework related to Nursing for the Whole Person, and nursing activity, in that verse? The center of the philosophy of nursing, the concept of nursing, and the reason of doing nursing is because we believe that a client is a spiritual being. We believe we are spiritual beings. We believe that our students are spiritual beings. And, we believe in Christ. We believe that He gives rewards.
Inga Tomine Tjelta, the youngest child of Torger and Inger Ravnaas Lekvam Tjelta, was born September 6, 1909, at rural Radcliffe, Iowa. Dr. Tjelta received her elementary and secondary education in Hardin County, Iowa, graduating from the Radcliffe High School in May 1926. She attended the Lutheran Bible Institute in Minneapolis. She said that experience taught her "to have more fulfillment in my Christian walk."

She taught in rural schools in Hardin and Hamilton counties in Iowa. During the summer months, she taught Vacation Church Schools in Iowa and Minnesota.

In 1942, she took preparatory courses at Iowa State University prior to entering the Swedish Hospital School of Nursing in Minneapolis. She received a nursing diploma in 1946. She held positions as a staff nurse at the Eldora Memorial Hospital, Eldora, Iowa; Assistant Nursing Arts Instructor and Clinical Instructor in Surgical Nursing at Iowa Methodist Hospital, Des Moines; Nursing Arts Instructor, Allen Memorial Hospital, Waterloo; private duty nurse; staff nurse at Swedish Hospital, Seattle, Washington. After receiving a Bachelor of Science degree in Nursing, she was an Instructor of Medical Nursing at the University of Washington. While studying for graduate degrees at the University of Washington, she was an Instructor there and Curriculum Consultant at the Seattle Pacific College. She earned a Master of Arts degree in 1958 and in 1965 a Doctor of Philosophy degree. Her studies focused on counseling, teaching, and curriculum. She then felt called to facilitate the development of a Bachelor of Science degree in nursing at the College of Saint Benedict, St. Joseph, Minnesota. Oral Roberts University offered her the opportunity to found an undergraduate school of nursing. After prayerful consideration, she accepted the challenge. Dr. Tjelta was successful in founding not only an undergraduate program, but also a Master of Science degree program at the Oral Roberts University Anna Vaughn School of Nursing. She was Dean from 1974-1985. Since then, she has served as Associate Dean for undergraduate nursing education.

Because of her professional expertise in curriculum and teaching, she served as a consultant to numerous nursing schools, developing curriculum for baccalaureate and master’s programs.

She was grateful to God for the opportunity to use her nursing talents in so many places, and especially in founding a school of nursing that has a philosophy she firmly believed in — one that fosters the concept of developing the whole person — body, mind, and spirit.

Preceding her death were her parents, a sister, Anna Samson, and a brother, Andrew. Surviving are two sisters, Rachel Stole and Inger Severseike, Hubbard, Iowa; a brother, Lars Tjelta and his wife, Myrtle, Ellsworth, Iowa; a sister-in-law, Malinda Tjelta, Ridgeland, Wisconsin and many nieces and nephews.

Tome’s family is appreciative to her friends and colleagues for the Christian fellowship, love, encouragement and support given to her, especially to Dr. Joann Wessman and Dr. Hamilton.

Blessed be her memory among us.

— This tribute to Dr. Tjelta was written by her family, and appeared in the funeral service folder at the Stravanger Lutheran Church, Garden City, Iowa.