NURSING PAPERS
PERSPECTIVES EN NURSING

HOLISTIC NURSING:
A BASIS FOR CURRICULUM

THREE PATIENT CONFERENCES

FAMILY HEALTH ASSESSMENT

Fall, 1975 Volume 7, No 3

NURSING PAPERS/PERSPECTIVES EN NURSING
Volume 7, Number 3 — Moyra Allen, *Editor*
Fall 1975 — Vivian Geeza, *Managing Editor*

Nursing Papers/Perspectives en Nursing is published quarterly by the School of Nursing, McGill University, 3506 University Street, Montreal, P.Q. H3A 2A7, Canada. Faculty in university schools of nursing and nurses with similar concerns are invited to contribute manuscripts, letters and ideas. We are particularly interested in articles assessing problems, posing questions, describing ideas and plans of action in research, education, administration and practice.

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NURSING PAPERS/PERSPECTIVES EN NURSING
Volume 7, Numéro 3 — Moyra Allen, *rédacteur en chef*
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La revue *Nursing Papers/Perspectives en Nursing* est publiée quatre fois l'an par l'école de Nursing de l'Université McGill, 3506 rue Université, Montréal, P.Q. H3A 2A7, Canada. Le personnel enseignant des écoles universitaires de nursing et les infirmières qui ont des intérêts similaires sont invités à soumettre des manuscrits, des lettres et des idées. Nous nous intéressons plus particulièrement aux articles faisant état de problèmes, qui soulèvent des questions ou qui soumettrent des idées et des programmes d'action en recherche, éducation, administration et pratique.

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FALL 1975

Nursing Papers/Perspectives en nursing has a new face with this issue. The new title reflects our continued commitment to inquiry and insight in nursing, a spirit without a language barrier. We shall continue to publish articles in the language in which they are written, and look into other ways to facilitate communication among all nurses.

Readers often ask what criteria are used in the selection of articles. Our basic policy has appeared regularly in this column: we are committed to publish all articles by faculty members of university schools of nursing in Canada. As more and more faculty are writing articles, we face the problem of developing more specific guidelines.

At present, an editorial committee of six persons, representing three universities, reads every article submitted. The committee has undertaken two procedures to improve the journal:

- to submit a paper, with the author's permission, to other nurses in the field and publish their responses together with the original paper; and
- to offer suggestions to assist the author to develop the paper further

In most cases the choice between these alternatives is left to the author. Do our readers have other ideas for handling this sensitive problem? We are most eager to have them.

M.A.

AUTOMNE 1975

Ce numéro de *Nursing Papers/Perspectives en nursing* vous présente le nouveau visage de notre revue. Le nouveau titre reflète notre engagement à étudier et à approfondir les problèmes de nursing dans un esprit qui ne connaît pas de barrière linguistique. Nous continuerons donc à publier les articles dans la langue adoptée par leurs auteurs tout en cherchant d'autres moyens de faciliter les communications pour tout le corps infirmier.

Nos lecteurs nous demandent souvent les critères dont nous nous servons pour le choix de nos articles. Notre politique de base à cet égard a été régulièrement exposée dans cette colonne: Nous nous sommes engagés à publier tous les articles rédigés par les professeurs des écoles de nursing des universités canadiennes. Comme le nombre d'articles soumis par ces derniers ne cesse d'augmenter, nous sommes amenés à apporter plus de précisions à nos critères à ce chapitre.

A l'heure actuelle, un comité de rédaction composé de six membres, représentant trois universités, procède à la lecture de chaque article soumis. En vue d'améliorer le journal, ce comité a adopté les deux méthodes suivantes :

- avec la permission de l'auteur, il soumet un article à d'autres infirmiers experts en la matière et publie la réponse de ces derniers en même temps que l'article original ; et
- il offre des suggestions en vue d'aider l'auteur à développer davantage le sujet.

Dans la plupart des cas, le choix entre ces deux solutions est laissé à la discrétion de l'auteur. Mais si nos lecteurs ont d'autres idées à nous suggérer sur la façon d'aborder ce problème délicat, nous les encourageons vivement à nous en faire part.

M.A.

LETTER

To the editor :

The Summer, 1974 issue of Nursing Papers has raised a number of conceptual questions in my mind which I should like to focus upon a practical situation:

> The patient approaches the reception desk, stops, places her hands on it and coughs slightly. The nurse seated there neither looks up nor greets the patient but rather, continues to devote her whole attention to the papers before her. After a wait of several minutes the patient says "Please, could you help me?" and pushes forward a card. The nurse takes it grudgingly, waves her hand toward a consultation room at the end of the corridor and says, shortly, "You're at the wrong desk. Go down there." The patient has an appointment at the eye clinic for cataracts on both eyes.

I neither claim nor fear that this situation portrays the typical nurse as she nurses. However, it describes a harsh incident which might be kept in mind as we discuss the "extended role of the nurse". Such a discussion is particularly fraught with danger as it arises from both the world of nursing practice and the world of concepts. As nurses, we are primarily a "doing" profession rather than a "word" or "theory" profession. As we struggle to operate from a scientific base and to further develop our discipline we are acquiring the skills for working with concepts as well as clients. Unless we proceed with caution, however, the very words we seek to harness will serve only to entangle and confuse us.

Any discussion of the "extended role of the nurse" faces at least the two problems of definition and value. The concept "extended

role" has taken on multiple meanings which are at times evoked sophistically by researchers, educators and administrators when they are seeking funds, justifying changes or stimulating professional interests. The nurse functioning in the community health center, attempting to provide "comprehensive care" (another concept which demands cautious consideration) plays a role very difficult to equate with that of the nurse who assumes a series of functions and/or tasks ordinarily proper to the medical profession. While either role might be particularly relevant, the two meanings must be kept discrete in any one context. One meaning may not be evoked at the beginning of a discourse and another at the end, nor one when the reader or listener is likely to understand the other.

As well as finding a clear and inclusive definition of our concept we must also be prepared to "operationalize" the concept in the world of nursing practice. How could we apply the concept in the situation we described? Can this nurse's role be extended? Can the roles most nurses play be extended? Or can we ask only how the nurses of *tomorrow* might learn to function in an "extended role"? What is the base for such an extension? In what directions can or should it proceed?

A second problem raised in considering "extended role" is that of value. As a service profession, we must be concerned with effects or products; as professionals with scientific and/or intellectual aspirations we must learn to evaluate concepts on their own merits. In both cases we must avoid valuing any idea or concept simply because of extraneous connotations and current fashions. Certain sets of words which represent productive and worthwhile ideas may at the same time possess "slogan value" which can hide or distort their true worth. The "extended role of the nurse" seems to carry with it connotations of growth, development and even evolution, notions already accorded value in our society. It may even call to mind the economic maxim that "an economy that is not expanding must contract". These phrases are very much in tune with the aspirations of a group which at this time seeks professional status. However, these connotations should be viewed as side or even untoward effects of the popularization of a concept; they must not be mistaken for the principal or desired outcome of effecting particular changes in the approach and activities of a professional group, through a rational process.

In the situation we presented at the beginning of this discussion, the concept "extended role" could only have value as a watch word or in terms of motivation. Neither of these would seem to be the purpose of those who have worked to refine and develop the "extended

role of the nurse". The incautious use of this, or any other, phrase leads to widespread lip-service rather than to the effective conceptualization and operationalization of a concept which could prove central to the growth of our profession.

Rather than applauding the intuitive worth or the intellectual elegance of a concept, we must understand and weight it. Then we can either reject the concept as inappropriate or unimportant in the practice and/or teaching of nursing, or we can accept, develop and attempt to utilize the concept in terms of its carefully measured value. We might ask ourselves: how valuable is the present role of the nurse? May it be effectively and valuably extended? And, only then, how may it be extended?

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HOLISTIC NURSING: A BASIS FOR CURRICULUM

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Dissatisfaction with the basis of curriculum designs in use, and movement of nursing education from hospitals into educational settings have led schools of nursing to experiment with their curricula. The former emphasis on diseases or conditions which patients suffer is being replaced by interest in how people function in health and illness both as individuals and members of communities. The new emphasis is brought out in various ways. One curriculum plan focuses on the kind of health care required; short term, acute care or care over a long period of time. Another concentrates on the nursing process, defining the specific care problem and seeking a solution or solutions for it(1). Still another centers around the adaptive capacity of the person when faced with challenges to his current adaptation(2). We found the following approach to curriculum design, based on Myra Levine's theory of holistic nursing, useful in a two year college nursing program. The merit of using this theory is that it provides a comprehensive yet easily understood way of looking at human response to challenges to its well-being.

Levine's theory of holistic nursing, stated in the 1960's, is that people respond physically, psychologically, and socially to changes in themselves and in their environment. While this statement is not new, her division of the individual's complex response so it can be examined and used as a basis for nursing care is unique. Levine outlined four principles which are useful in planning and implementing care. These are the individual's need for energy and for structural, personal and social integrity. The principles are called conservation principles because care is centered around the preservation of personal well-being. In the holistic approach, the goal of nursing intervention is to preserve the basic entirety of the person. In addition, a thorough reading of Levine suggests that nurses need not just help a person maintain the status quo in his adaptation to life if that adaptation is less than optimum. Levine also sees the conservation principles as guiding care so it is "kept together with" the patient's ability to participate in his care(3).

One of the positive features of using the holistic theory as a basis for a curriculum is that it not only divides nursing knowledge into comprehensible units but also provides a philosophy for care. The

philosophy growing out of this theory is that nurses work with patients in helping them preserve their personal well-being. Another positive feature of this approach is that it provides an outline for examining an individual's response to changes in his situation. When planning care the student can consider the person's condition, whether stable or changing, in light of his energy supply and his structural, personal, and social integrity. A further feature of the holistic theory is that the four principles offer a specific outline for nursing intervention. Before and during the time care is given the student must consider the sources of a person's energy and how he is using it. In thinking of a person's structural integrity, she must look at ways in which the body is threatened and how best to preserve its wholeness. Any change is a challenge to some degree to a person's idea of himself; this fact must be remembered when giving care. Nurses must also remember that each person is a member of a family and community; these may provide additional sources of strain or help. As long as one recognizes that none of the four areas considered in the conservation principles exists in isolation, one can give attention to each in turn noting how it contributes to maintaining a whole person.

The two year nursing program based on this approach to nursing is divided into six terms. The first two terms of each year are thirteen weeks long, the third terms eight weeks.

FIRST YEAR

In the first two terms the emphasis is on health; what the person needs to maintain health and cope with challenges to it. The emphasis changes the third term and throughout the rest of the course to what happens when the person is unable to cope with threats to his wholeness and how nursing care can assist in a return to health. Consideration is also given to helping patients cope with a changed life situation and find meaning in life or death.

The nursing course begins with an examination of negative feedback systems and homeostasis, the basic concept of the holistic theory. It is pointed out that society includes three groups whose maintenance of homeostasis is more precarious than the young adult's. The pregnant woman, the infant-child, and the elderly provide threads for discussion throughout the two years. Levine's theory of holistic nursing is introduced during the first weeks of the nursing course and the four conservation principles are discussed. The next step is an acknowledgement that while an energy supply and structural, personal and social integrity are all necessary and operate together, each is a process in its own right and can be studied.

The remainder of the first two terms is spent studying how a person's entirety is maintained by the processes included in each of the conservation principles. The processes which assist the individual in conserving structural integrity are the focus of the first learning experiences. Being physical, this principle is probably the easiest to comprehend and also the basis for many of the bedside nursing skills. The unit is based on the concept that the body has structural and physiological defenses by which it seeks to maintain its integrity. The nursing knowledge and skills stressed are those related to support for structural defenses, e.g. skin care and body mechanics, and support for physiological defenses, e.g. asepsis.

The maintenance of social integrity is discussed next, with the role of the family unit as the center of consideration. The basic concepts of this unit are that environment influences perception and that reproduction is both a physiological and sociological event. The normal obstetrics patient is the model used with time spent on the role of the family in a child's growth and development. Nursing skills related to obstetrics are stressed.

Conservation of energy is the third unit. The concept that the body must obtain rest and sufficient materials required by the cells in order to continue normal functioning is the basis of this unit. The focus is on nursing knowledge and skills related to nutrient and oxygen requirements, elimination and disbursement of energy. Pharmacology is more apparent in this unit than in the others as many drugs influence the supply and use of energy.

Maintaining an individual's personal integrity is the last unit. The unit is based on the concepts that people express their self-image through relatively consistent patterns of behavior, and the nurse must have adequate coping mechanisms so she can better understand and help others. By this time the student has usually overcome her initial self absorption in the clinical area and is ready to begin investigating specific ways of helping the patient preserve his identity. Because of the philosophy of nursing inherent in the holistic theory, the nurse-patient relationship is part of every unit and the student is assisted as needed to develop her ability to relate to others. The fact that the nurse works with the patient towards maintaining health is also stressed.

Objectives were defined for the first two terms and learning experiences arranged with each unit to assist the student in achieving them. A lab book was devised which outlined specific objectives and projects the student should or could do. This helped students, teachers, and people in health agencies coordinate their work.

Learning experiences in the third term center on the spectrum of health. This provides a transition from an emphasis on maintaining health to ways of assisting people whose wholeness has been impaired. Objectives were developed to aid in this change of focus. The basic pathological processes are introduced in this term as are the concepts and techniques of rehabilitation. Knowledge of the basic pathological processes helps the student understand how the body defenses have been breached. The concepts and techniques of rehabilitation provide her with additional tools in giving nursing care to a person who has been unable to cope with a threat to his wholeness.

SECOND YEAR

The emphasis during the first two terms of the second year is on the nurse's role in crisis intervention and assisting people in regaining their health. The three vulnerable groups in society, the pregnant woman, the infant-child, and the elderly, are developed into "model patients." Classroom and clinical experiences are coordinated by the use of learning packages which state specific objectives and outline projects which should or may be done.

The unit "Threats to Personal Integrity" is based on the concepts that changes in body image affect an individual's concept of self, and that acceptance of an individual involves knowing that his behavior has meaning, a cause, and serves a purpose. The models are a child in crisis — separation anxiety of a five year old female, middle child admitted to the hospital with milk allergy — and a twenty-eight year old single female with ulcerative colitis which results in an ileostomy.

Unit II, "Threats to Structural Integrity," is based on the concept that a break-down in structural and physiological defense mechanisms threatens life. The model for this unit is a twenty-six year old gravida two, para one, Rh negative mother who delivers a premature infant with symptoms of erythroblastosis fetalis.

"Threats to the Supply of Energy" is based on the concepts that improper balance between rest and activity disrupts the supply of energy, and disruption in the supply of oxygen and nutrients and in the removal of end products of metabolism will result in a disruption of homeostasis. A man in his early sixties with emphysema and an eight year old boy with diabetes are the models.

The unit "Threats to Social Integrity" is based on the concepts that deviation from societal norms threatens the individual's acceptance by others, and that society is responsible for providing resources to assist the individual to integrate when he is unable to do so himself. The models here are a thirty year old mother with multiple sclerosis and a nineteen year old exhibitionist.

The last term focuses on the meaning and role of nursing as a profession. The students have experience working all shifts and assuming leadership positions. Guidance is given as needed in helping the students integrate and apply their knowledge at the bedside. Time is also given to considering the role and responsibilities of nurses as an organized group in the field of health care and in society.

* * *

The main challenge of this curriculum design is its integration of the traditional areas of nursing and its possibilities for coordination with the sciences. Teachers in each traditional area of nursing must work very closely together in planning and implementing the course. The holistic approach requires teachers to consider their specialized knowledge in new ways and be open to new ideas. In places where biology is taught outside the nursing department, special effort must be made to coordinate anatomy and physiology with the first year nursing course. The second year nursing course is best taught with a companion pathophysiology course. Normal growth and development is seen taught by a psychology teacher so as to coordinate with the first year of the nursing course. The tasks of integration and coordination are not impossible and may prove to be exciting.

There are four main strengths in using Levine's theory of holistic nursing as the basis for curriculum design. Firstly, it is natural to include community health agencies throughout the program as all these agencies seek to help people maintain or regain well-being. Secondly, it provides a philosophy of nursing which can be easily carried from the beginning of the course to the end. Thirdly, this approach is relatively free from jargon. Time does not have to be spent teaching students a special vocabulary. Finally, the four principles of conservation provide a means of examining a person's response to change without dividing that response into so many pieces that one loses sight of the essential unity of the person.

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2. Sister Callista Roy, "Adaptation: Implications for Curriculum Change," *Nursing Outlook,* Vol. 21, No. 3, (March, 1973), 163-168.
3. Myra E. Levine, "The Four Conservation Principles of Nursing," *Nursing Forum,* Vol. VI, No. 1, (1967), 45-59.

The Committee on Nursing Papers wrote to Ms Lindstrom, asking: "What difficulties were experienced in implementing the curricular model, and how were these met? Was the experience evaluated in any way? How were the basic concepts interpreted, learned and incorporated by the faculty? Have you acquired any data on the process of implementation of this curriculum at Selkirk College?" The author responds:

Difficulties we experienced are suggested in the second paragraph of page 10 of the paper. We had one faculty member who could not see her specialty area integrated and continued to teach it as a specialty. This we dealt with by trying to integrate the concepts of the program and the content as she taught it in tutorial groups and continued in faculty discussions to try to share ideas. The faculty member being discussed left the program in late fall for health reasons so the problem didn't continue for a long period of time.

During the time I was at Selkirk we added three new faculty people. We made the articles written by Myra Levine available to them and had formal and informal discussions about her ideas. I made notes during the time the curriculum was being developed which I made available to those who wanted to read them. All of us had the philosophy that the person who happened to be our patient/client was the focus of care, and assessment, communication skills and technical skills were to be used to help the person. We all came to feel that this curriculum model kept the person of the patient/client as the focus so that students gained a patient centered philosophy of care not only by direct teaching but by example as well. Two of the faculty who came after the curriculum model was fairly complete and being implemented in year one, were the ones who did much of the work for year two.

I have no recent data on the process of implementing this curriculum at Selkirk. I left Selkirk a year after the curriculum was implemented because of my husband's job. A year later all the other faculty who were involved originally with the curriculum had also left Selkirk for reasons unrelated to the strength of the curriculum. (There were five of us on faculty). While I was at Selkirk the education consultant of the R.N.A.B.C. expressed a great deal of interest in and support for our curriculum. The students used the concepts with understanding. One graduate got involved in helping the hospital where she worked develop nursing care plans incorporating the concepts of the curriculum.

I regret not being able to stay at Selkirk long enough to really evaluate the curriculum. I see this as a weakness in putting forth

the idea that this is a valid and valuable curriculum model. However, my year using another curriculum model and working with a large faculty has reinforced my feeling that the conservation principles of Levine's holistic nursing theory are a sound basis for a curriculum.

NURSING ROLES: A BASIS FOR CURRICULUM

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IN RESPONSE TO "HOLISTIC NURSING: A BASIS FOR CURRICULUM"

The focus in nursing curricula has indeed been changing over the years — from the basic sciences and medical specialties through categories of illness to the patient with the illness, and recently, to a client in health or illness. With each step there has been more emphasis on the theory of nursing practice. Lindstrom describes a programme which uses Levine's holistic theory as an outline for nursing intervention. The curriculum is based on the client and his needs. Our faculty is presently involved in an effort to base a curriculum on what nursing is itself, or nursing roles, rather than on the client. The nursing roles offer a progressive, comprehensible pattern for learning. Also they help the student identify the role of the baccalaureate graduate compared with other levels of nursing personnel.

The student-faculty curriculum committee defined to its satisfaction seven roles involved in nursing — comforting, preventing trauma, providing therapy, teaching, counselling, collaborating and advocating. The students learn to nurse by practicing these roles in increasingly difficult situations as they progress through the programme. In view of the relevant theory, the numbers of people involved, and the usual circumstances the roles themselves become increasingly complex. Therefore, in the first year the emphasis is on learning to provide comfort and prevent trauma for individuals. The students expand their nursing in the second year to include the provision of therapy and some teaching of individuals and their families. Further knowledge of family dynamics and an introduction to group work form the basis for teaching and counselling in the third year. In the final year the roles of the nurse as collaborator and advocator are developed.

Any role may be complex and require a high degree of expertise in certain situations. Comforting a distraught parent whose child is dying, protecting patients from psychological trauma in an intensive care unit, or carrying out therapeutic measures such as hyperalimentation are examples of high level functioning in "beginning" roles. Also

the roles overlap in many situations: teaching will frequently provide psychological comfort; giving thorough hygienic care is comforting and protecting; and providing therapy may involve collaborating with other members of the health team or advocating on the clients' behalf. However the anticipated approach in their use as a curriculum framework is to discuss the theory pertinent to a given role in a given year. Opportunities would be provided to practice this role and those previously learned, and through the years the practice situations would become more complex.

In each role the students learn to assess the whole situation, with guidance initially, but with greater independence as skills of observation and communication improve and as knowledge as a base for interpretation of observations increases. Students are responsible for planning with their clients the nursing action to follow the assessment, be it a "simple" comforting action such as a back rub or a complicated action of collaborating with several health agencies to ensure continuity of care. They are also responsible for carrying out their nursing plan and evaluating the results. The nursing process is therefore a unifying thread throughout the curriculum.

Also during the four years the students add to their understanding of the factors influencing the client and his response to illness and health care. Since the client is the central focus of all nursing roles, factors affecting him constitute further curriculum threads running through the programme. They include his ability to meet his own basic needs as a result of his stage of growth and development, his degree of stress and ability to adapt, his level of health or severity of illness, and his situation in the health system.

Lindstrom says that students need nursing knowledge divided into comprehensible units. Levine's holistic theory as a way of looking at basic human needs is sound and integrative. As a curriculum framework perhaps it is too integrative. When nursing students do not have manageable units of learning they tend to become bewildered and to latch on to the medical specialties as "parts" of nursing. The writer believes that the nursing roles presented are "parts" of nursing that can be discussed and practised with a degree of discreteness. They constitute comprehensible units for students to grasp. They also help students see what their role as baccalaureate graduates will be. For these reasons they seem to offer a desirable base for the curriculum of a four-year programme.

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THREE PATIENT CONFERENCES

AGNES T. H. CHOI-LAO
Lecturer, School of Nursing
University of Ottawa

After having two years' experience as a clinical instructor on a female surgical ward, the author has often wondered if patients going to surgery have been adequately prepared for their operations. Have their questions been answered and their psychological needs been met? As students must work under the limitations of time, knowledge and skills, it is the author's intention to find a different approach to that of the traditional bed-side teaching, so that the needs of both the patient and student may be better satisfied.

In recent years, there has been an increasing number of group sessions employed in teaching-learning situations. Such experiences are integral parts of programs of nursing, medicine and other health sciences(1, 2, 3). Their use is particularly noted in clinical areas, for example the antenatal clinics, preoperative patient teaching conferences and psychosocial therapeutic sessions etc. The author does not need to belabour the advantages of group sessions; it has been widely recognized that members of a small group seek and receive support from one another. They enjoy the sense of group identity and a satisfaction of attainment of the aims and objectives of the group. Studies have revealed that many patients experience a certain amount of anxiety, preoperatively(4, 5, 6), and that such patients may obtain support and help by sharing their anticipated experiences with other patients and with a knowledgeable professional, such as a nurse(7, 8, 9, 10). Hearing others verbalize their fears, concerns and apprehensions about surgery may encourage a patient to do the same. Explanations by a nurse will help to increase, in a meaningful way, the patient's knowledge about his forthcoming surgery. It was thus decided that group sessions be tried to prepare patients for their operations.

When the proposal of a presurgical patient conference was presented to a clinical group of second year baccalaureate students, it was met with instant acceptance and great enthusiasm. Students considered this an opportunity to test their knowledge and skills in health teaching, which is a major component of nursing, and to experience group dynamics under their own leadership.

Two students immediately volunteered to conduct the first of such conferences. It was agreed that this would be a self-directed learning experience, and the instructor would merely serve as a re-

source person to provide assistance, if needed. The two students involved themselves in detailed preparation, under the guidance of their instructor. Special attention was paid to both content and method of presentation to ensure patient-centeredness. In order to facilitate patient-comprehension, medical terminology was minimized and technology simplified. The first conference was then held three days after the project was launched.

FIRST CONFERENCE: PREOPERATIVE

In forming a group, principles of group dynamics were fully utilized. Most writers agree that the essential fundamental quality of a group is the sense of a mutual goal. Accordingly, in order to form a common goal within the group, we included only those patients who were preoperative. The size of a group was also important in relation to group interaction and logistics. The group must be large enough to create a group-atmosphere, yet not too large to feel a loss of identity in the crowd. For our purposes, we invited seven patients for our first conference. The third point we deliberated was the timing of the meeting which must be acceptable to both patients and students. We contemplated a session of one-hour in the evening. The ward staff was consulted, and it was agreed that the period from 8:30 p.m. to 9:30 p.m. would be most desirable.

The two students invited patients, matching their ages and diagnoses to form a homogeneous group. As most patients were either English or French speaking, it was decided that the conference would be bilingual. The conference room was duly prepared to provide atmosphere, good visibility, comfort and opportunity for interaction. Beverages were also served to enhance atmosphere.

The speakers approached the group by introducing to each other all those present and by restating the purpose of the discussion session. It was made clear that purposes of the conference were to familiarize patients with their hospital environment, to inform them about their respective surgeries and to answer questions raised by the participants. The patients responded positively to the introduction, as one of them exclaimed: "What a good idea!" and another commented: "I have had six operations and this is the first time I am being taught something."

The group's attention was then drawn to the black-board where the content was outlined as given in table 1.

The first area dealt with the admission day for surgical patients. There was a great deal of discussion with regard to admission procedure. One patient inquired of the students if soap-suds enemas were routinely given the night before operation for minor surgeries,

TABLE 1

AGENDA FOR PRE-OPERATIVE CONFERENCE

Preoperation Day	Operation Day	Immediately Postoperation
— admission	IN THE ROOM	RECOVERY ROOM
— physical examination	— still fasting	— cared by special team
— laboratory tests: urine, blood, and chest X ray	— a good bath	— regain consciousness
— signing of surgical consent	— gowning	— back to ward
— cleansing of operative site (with soap and possibly shaved)	— removal of jewellery, pins, underwear, dentures, nail polish, make-up and other accessories	BACK TO ROOM
— enema the night before	— urinate before preanesthetic medication	— vital signs checking
— fasting from midnight	— preanesthetic medication	— bedside rails up
	— accompanied by nurse to operating room	— intravenous infusion routinely
	INTRAOPERATION	— operating room dressing
	— drowsiness	— good expansion of lungs: change position deep breathing and coughing exercises
	— the environment	— good circulatory exercises; in-bed exercises early ambulation etc..
	— the surgical team	
	— loss of consciousness	

and if so, why? Another was quick to point out that routine blood works were hemoglobin tests and not blood typing and cross-matching as stated. A third patient was concerned that if, upon physical examination, she was found unfit to receive the scheduled operation, what would then happen? Bedtime sedation and fasting after midnight, the night before operation, were also discussed. Some patients were worried about the fact that they had never slept in a strange environment and wondered whether sedatives were going to help. Others were anxious to know if a light breakfast might be provided, should the operation be scheduled in the coming afternoon.

The second part of the session dealt with the immediate preoperative preparation in the morning prior to the surgery. Group members were informed that fasting should be continued, and that maintaining cleanliness, gowning and removing all artificial accessories were to be observed. The purpose and effects of preanesthetic medication were also thoroughly explained. Patients were reassured that when sent to the operating room by stretchers, they were always to be accompanied by nurses.

Many of the patient-participants were anxious to know how soon the preanesthetic medication would be effective. Would they still be awake when arriving at the operating room? One asked how many injections she was to receive, and added that she would not mind them if she would be unconscious soon after. Practically all patients requested knowledge of the surgery itself:

— how anesthesia was given and what its effects were.
— how long a procedure of stripping and ligation of varicose veins would last.
— where on the abdomen the doctors would incise for cholecystectomy.
— whether thyroidectomy was considered a major operation.

Another area with which patients were concerned was the recovery room. Most of them were concerned about the length of time required of them to stay there. Some worried about who the experts caring for them during the semi-conscious period would be. All patients shared what they knew with each other, and the interaction was warm and cordial. The instructor added pertinent information when appropriate to clarify a point or to enhance discussion. In this capacity, she fulfilled the role as a catalyst.

The last part of the session dealt with the immediate postoperative period. Patients were informed that it was not uncommon for them to return to the ward with intravenous infusions, levine tubes, suctions etc. The purpose of each was explained and questions encouraged. Samples of gauzes, pads and bandages were presented as visual aids, and were passed around for patients to reach an understanding of their different functions. Some felt relieved, as they learned that layers of dressing, in most cases, merely serve to provide support and a sterile field, and the size of dressings was no indication of the size of the incision. When examining various dressings, one patient remarked that she was allergic to tape and she had neglected to mention this information to the nursing staff upon admission.

There were a number of questions of common interest. One patient asked why intravenous infusion was necessary and the usual location for administration of same. Another asked how soon she could begin dieting after the operation. Still another worried if she would be nauseated postoperatively, as she had always been in the past. In answering these questions, the students supported each other, and the two-way participation pattern soon became multidirectional. In assuring patients of their role in their own recovery, group members were apprised of the importance of deep breathing and coughing exercises and early ambulation. Speakers demonstrated physiotherapy exercises and patients followed. One patient asked in anxiety if she should perform the same coughing exercises, since she was to have a thyroidectomy.

As the session continued, more and more discussion was generated. Patients began to explore their feelings towards their surgeries and

began sharing their experiences. One patient stated that she was so nervous about her breast surgery that she would perspire every time she thought about it. Another responded sympathetically and said: "I know how you feel because I, too, am going to have lumps removed from my breast." At this stage, patient-members readily supported and comforted each other. The instructor and students assisted patients only when required.

When the conclusion was finally reached, it was realized that the conference had lasted approximately one hour and twenty minutes and was longer than anticipated. Patients all seemed to have enjoyed and benefited from the conference. As they left, each expressed her appreciation to the nursing members. One patient, with her right index finger raised, remarked that she would write an article on the importance of such conferences, if she were a journalist.

A brief meeting was held immediately following the patient-conference to evaluate the experiment. Students' responses were overwhelmingly positive. They were stimulated by the opportunity to assume an independent role and to challenge that role in public. Students learned, very quickly, the importance of good theoretical preparation and intellectual honesty as one remarked: "The patients know a lot. You really have to know what you are talking about, or you would not last".

The group conceded that the following points should be noted for future references:

1. A good introduction was important, as it set the pattern for the subsequent behaviour of the group
2. A unilingual conference would be preferred, since it would facilitate discussion
3. The conference be scheduled at different hours, so it should not end too late in the evening
4. Comfort measures for patients should be more carefully observed, as we neglected to elevate the legs of a patient who had varicose veins and was experiencing discomfort in the conference.

The joy of achievement soon spread to other students. In our following conferences, we had student-observers from other clinical groups.

SECOND CONFERENCE: DISCHARGE

As the preoperative conference was well received, students were now eager to explore other opportunities. The idea of preparing patients to go home was then conceived for the second conference, since it was felt that the topic of discharge would be of common interest to patients as well as students.

Two other students volunteered for the assignment and preparatory work was similar to the previous conference. As the students examined the terms of reference of the conference, it was realized that patients would have different needs and problems, based on their disease processes; homogeneity in the group regarding diagnoses was then important. Having studied the possibilities, the two students concluded that they would form a group and would invite only those who had abdominal surgery and those with venous disorders. Other patients were not considered suitable for group participation, since they either had isolated problems or were not ready to anticipate discharge.

The schedule for the conference was discussed and it was agreed to try the time between 4 P.M. and 5 P.M., immediately after students reported for their afternoon shift.

Five patients were invited to attend the conference: three with cholecystectomy, one with stripping and ligation of varicose veins and the other postoperative phlebitis. Only three students, including one observer, other than the two speakers were admitted in order not to out-number the patients.

Comfort measures were carefully observed this time with special attention to those with venous problems. Soft chairs were provided for patients and cold beverages served. The conference began with an informal introduction, and the attention was then drawn to the blackboard on which the agenda was outlined as in Table 2.

Very few questions were raised from the topic of "the day of discharge" except regarding time and arrangement. A great deal of discussion generated, however, from the item of personal care. It was obvious to the writer that patients were inadequately prepared to go home. They were concerned about when to take a bath, how to wash their hair, whether they could wear girdles with abdominal incisions, and especially how to care for the wound. One patient who had an operation for varicose veins was to be discharged with sutures in. She was very much worried about the job of taking care of the numerous small incisions on her legs.

Diet appeared to be a common interest to all females and was discussed at great length. Patients were familiar with dietary terms like low cholesterol, low fat, high protein etc., but were uncertain about right kinds of food. Examples and explanations were given by students, and a diagram was drawn to illustrate the gastrointestinal system with specific reference to cholecystectomy. Cooking and eating habits of family members were among topics discussed relating to food preparation.

TABLE 2: AGENDA FOR POST-OPERATIVE CONFERENCE

ON THE DAY OF DISCHARGE
- authorization of discharge by physician
- time of discharge
- transportation services
- payment of bills, if any
- return of safe-keeping articles, if any, including valuables and medication
- return appointments, if any

HOME PREPARATION
- transportation of patient
- domestic help: private arrangements and community resources
- preparation for receiving the patient

PERSONAL CARE
- personal hygiene
- care of the wound with and without sutures
- how to change dressings, if any
- diet
- activity
- rest and sleep
- medication, if any
- community resources for nursing services
- in case of emergency

FOLLOW-UP APPOINTMENTS
- how to obtain them
- importance of keeping appointments

Activity was an area of great concern. For example, how soon after surgery could one go back to work? What kind of domestic activity was allowed? One patient, who was an active golf player, asked how long should she wait before she could go back to the "back-swing" following cholecystectomy while another patient with the same diagnosis wondered if she could travel fifteen miles to attend a wedding in two month's time. A patient with varicose veins presented different problems: she had a family of three young children and had to help in supporting them by working as a housekeeper in a department store. It was obvious that the mother could not obtain sufficient rest after discharge. Students felt somewhat helpless to improve the situation, but, nevertheless, provided her with some practical advice. One patient, who had dehiscence of wound and was going home with gauze packings, expressed her fear of the open wound and wanted to know more about the arranged services of the Victorian Order of Nurses.

Patients all appeared to appreciate fully the importance of rest, sleep and of keeping follow-up appointments. Few questions were asked in these areas.

At our evaluation session, immediately after the patients' conference, it was generally agreed among the participants that we definitely gained some knowledge in needs of patients of which we had not been aware before, though students were not totally satisfied with the degree of success achieved from this conference. In retrospect, it was recognized that patients were worried about their individual problems, and they interacted mainly with the speakers to obtain vital information. Discussion was also interrupted by repeating whatever was said in both English and French. One patient with post-operative phlebitis did not participate actively and seemed to be isolated by her distinct disease process. Students all openly expressed their

opinions during the evaluation. One doubted the selected topic of the conference and pointed out that "going home is an individual thing." Another suggested that patients be given advance notice, so they could think of questions ahead of time. Still a third student recommended that the session be presented to patients as "a gathering to discuss the questions they had" rather than "a conference", to ensure patients' active role of participation. However, all agreed that homogeneity of the group was the paramount factor affecting group dynamics, and for future discharge conferences, the following were to be emphasized:

1. Advanced notice will be given to patients in order they might be better prepared
2. Group homogeneity should be observed in order to promote a sense of identity among members
3. The sessions should be patient-centered, rather than nurse-oriented.

It was also felt that certain topics which were not included in the discussion could be admitted in the future sessions:

For example:

— the question of pregnancy; whether it is advisable immediately following abdominal surgery
— the question of sexual activity following cholecystectomy
— patient's psychological preparation for returning home after hospitalization
— the psychological preparation of members of the family for receiving patient, especially, if patient still requires nursing care.

THIRD CONFERENCE: PREOPERATIVE

Although they felt some disappointment from the second experiment of group teaching, students were still eager to learn. A third conference on presurgery was then held in the following week.

Only one student was asked to chair the session, as the intended participants would form a unilingual group. Advance notice was given to patients, in order to prepare them psychologically, and it was emphasized that the aim of the session was to answer their questions. There were four possible candidates; three were waiting for cholecystectomy, and one for anal fistula, and none refused our invitation. The conference was held once again in the evening from 8:30 P.M. to 9:30 P.M. to avoid class conflict. Punctuality would be observed and the bed-time routines should not be disrupted.

An outline similar to the first conference was used as a guide for discussion, but a great number of questions were encouraged. All participants experienced an exceedingly relaxed atmosphere, and the interaction could be described as intimate as the conference proceeded.

It was felt that the third conference achieved a more patient-centered discussion and had achieved a greater magnitude of communication among the group. The following questions, asked by patients, exemplify the content and extent of discussion:

— I understand the anesthesia is given in the shoulder and I would be awake with it, is that true?
— Does one's blood pressure go up during the anesthesia?
— Does one have a stroke with the anesthesia? This is what I was told.
— Is there any danger of waking up during the anesthesia?
— Do the doctors give you medication to restore you to consciousness?
— How long does one usually stay in the recovery room?
— Why are there different incision lines for the same procedure of cholecystectomy?
— Is the incision long for cholecystectomy?
— Does one have a tube (a drain) in the abdomen with the above operation?
— What happens to bile following removal of the gall bladder?
— Does one get a tube (a levine tube) in the nose?
— Is the above tubing bothersome?
— Do they insert the levine while you are unconscious?
— Do we eat and drink with it in?
— Does one have a sick stomach with the levine?
— Would blood transfusion make one sick?
— Do I need a special nurse following surgery?
— Do we drink a lot of water right after operation?
— Is the operation of cholecystectomy worse than hysterectomy?
— Can you eat eggs after surgery? What about the yolk?

It was noted that patients talked, not only about their own problems, but also those of their family members and friends. For example, one patient wanted to know the purpose of a one-month-old indwelling T tube connected with a bile bag her sister-in-law had while recovering from cholecystectomy at home, and another about her husband's low cholesterol diet.

As the academic term was drawing to a close, the third conference was the last in the series. In our evaluation of the experimentation of group patient teaching, we felt that we had certainly found an approach which can better meet patients', as well as students', needs. This simultaneous satisfaction should be an integral goal to all nursing educational programs. Our rudimentary data command the attention of educators who plan for effective, self-directed learning and of administrators who aspire to provide quality care. It is hoped that our continued experimentation in this area shall provide data required to formulate guidelines for future nursing practice.

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RESPONSE TO "THREE PATIENT CONFERENCES"

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Choi-Lao's paper, "Three Patient Conferences" describes an effort to alleviate a perceived clinical problem, inadequate client education particularly in the preoperative period, by utilizing group teaching sessions. Her purpose was to enhance both client and student satisfaction by introducing an approach differing from traditional bedside teaching.

The literature supports the choice of the group process in teaching-learning situations and the benefits of mutual client support. Through experience, the students learned the importance of a homogenous group with a common goal in facilitating learning. Redman discusses the importance of analysing the milieu in which learning takes place "since it can powerfully influence behavior and potentiate or negate any teaching efforts"(1). Since fellow group members form the most

important part of this milieu, group members must be perceived as credible by each individual. Similarity of medical diagnosis would appear to increase credibility as evidenced by the third conference. Another important aspect of the client's milieu is the family, who could perhaps be included in part or all of the conference.

I was surprised to discover no mention of pain in the topics chosen for discussion in the pre-operative conference. The anticipation of pain in the post-surgical period and some doubts about one's ability to cope with the pain experience are common. Only one client question seems to be covertly exploring this dimension: "Is the operation of cholecystectomy worse than hysterectomy?"

It may be that in such a short group meeting insufficient trust is established to allow a client to express this anxiety. Egbert et al reported a study in which individuals who were given pre- and post-operative instruction on how to deal with post-surgical pain requested pain medication less frequently and were better able to deal with the pain(2). A discussion of strategies for dealing with post-operative pain might initiate discussion and enable the group to ventilate emotions and to give mutual support and decrease anxiety. Since pain is seen as a cyclical progression, with anxiety lowering the client's pain reaction threshold and initiating physiologic changes which make pain more difficult to relieve, the decrease in anticipatory anxiety would promote a less painful post-operative experience.

Choi-Lao states that patient comments were favorable concerning the innovation, but there seems to have been no data gathering in an organized fashion to validate the favorable comments. It would also be helpful to have some assessment of the group member's post-operative course. In this situation, did organized information giving make any change, i.e. were the patients better able to cough and deep breathe, were they more motivated to mobilize, or was the incidence of complications lower? The absence of this data makes evaluation of the project difficult.

An evaluation of these conferences by the registered nurses employed in the area in which the project was initiated would be interesting. If the conferences were perceived as beneficial, did any change in the usual practices of the ward take place?

The clinical teacher is a nurse with considerable expertise in her clinical speciality and has a role in improving the quality of patient care. This type of demonstration project could motivate the staff to emulate it or to attempt further problem solving.

The identification of the nurse's role as health educator, the practice in group instruction, and the observation and evaluation of group dynamics would be of great value to professional nursing students.

The project is a good illustration of working within an institution to effect change, and this aspect could be enlarged upon by involving ward staff. Since we are challenged to prepare professional students for "reality shock", an illustration of change within a bureaucratic structure to improve patient care is of great value(3).

This very interesting paper is most generative, and will encourage many nurse-educators to help students seek innovative solutions to perceived clinical problems.

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REPONSE A "THREE PATIENT CONFERENCES": L'IMPORTANCE D'EVALUER LES EFFETS D'UNE INTERVENTION

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L'initiative tentée par Miss Choi-Lao n'offre aucune caractéristique d'une expérience de recherche. Postulant que cette initiative n'en n'est pas une de recherche, il serait plus ou moins utile d'énumérer les éléments méthodologiques propres à tout projet de recherche et qui ne se retrouvent pas dans cette expérience.

Cependant certaines questions peuvent être soulevées au sujet de la démarche scientifique utilisée pour arriver à la conclusion qu'un programme d'enseignement est utile aux patients. Cette affirmation est hâtive, basée sur un nombre très limité d'essais (deux séances d'enseignement préopératoire et une au départ) et sur peu de considérations objectives.

L'auteur a pensé examiner et critiquer le contenu de l'enseignement ainsi que la stratégie pédagogique utilisée. Mais, il semble que Miss Choi-Lao n'a pas évalué les effets de son intervention i.e. le fait de donner un enseignement, sur le comportement du patient en période postopératoire ou à domicile.

Certes, il y a les commentaires favorables exprimés par les patients. Mais utilisé seul, ce moyen d'évaluation demeure très incomplet. L'enseignement peut plaire aux patients; mais, savoir s'il leur est profitable est une question d'ordre fondamental. Il eût été intéressant de connaître l'impact du programme sur les patients. Par

exemple, est-ce que les patients ont pratiqué les exercises respiratoire? Semblaient-ils moins tendus après l'opération? En d'autres termes, les objectifs du programme ont-ils été atteints? et surtout avaient-ils été clairement définis?

Il est commun d'entendre dire que le nursing a peu de contenu théorique. L'évaluation des effets d'une intervention semble être un élément de base dans la poursuite d'une action nursing rationnel.

RESPONSE TO "THREE PATIENT CONFERENCES"

JEAN GODARD*

There is a growing concern on the part of all social researchers, nurses included, that their work should contribute to the solution of practical problems. Accordingly, Ms Choi-Lao has attempted to provide for improved patient education both pre-operatively and post-operatively through the use of group discussion methods.

The problem as stated was "to find a different approach to that of traditional bedside teaching so that the needs of both the patient and the nurse might be better satisfied." Ms Choi-Lao attempts to utilize her prior knowledge of the values of group discussion in such an educational situation, but the question as put is difficult to answer. It is relatively non-specific and difficult to answer on the basis of knowledge alone, as it involves values as well, i.e. how is "better satisfied" to be defined and quantified? This paper, in fact, is a description of the vicissitudes found in an attempted introduction of change. It is difficult to see where it is more than a presentation of the values of group discussion in problem-solving for a very specific group of patients.

The author offers little description as to the planning done with the patients, if any; no attempt is offered in describing how the patients saw their needs or would attempt to solve their problems. The behavioral descriptions are non-specific, not quantified, and relate almost totally to the students and their evaluations — little validity is offered as to the value of group discussion in patient teaching of surgical patients. The statement is made, "special attention was paid to both content and method of presentation to ensure patient-centredness." Unfortunately, no specifics of description are offered the reader either as to patient participation in planning or implementation. We are told that the ward staff are consulted as to time of presentation, but no mention is made of consulting the patients. The lack of attention to patient care and consultation is

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epitomized by the neglect in the physical comfort offered to patient group members with varicosity problems.

In a review of the bibliography, I found little support in the literature for methods of change innovation, which is the essence of this report.

The design as a research paper appears non-specific, and methods of data collection and statistical verification are not described so that one cannot review how appropriate they are to the problems being studied; nor are the limitations of this study discussed by the author.

The statement on page 23 that such conferences satisfied simultaneously the needs of both patients and students leads one to ask "what needs? which students? and which patients?."

QUERY and THEORY

Query: Nurses across Canada are attempting to arrive at a systematic approach to assessing the health of families. What dimensions do you consider within the nursing framework? In other words, how do you structure a family health assessment?

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Theory: A family health assessment is necessarily comprehensive since it must assess not only one person but the health of all the members within a given family constellation. Thus an open systems approach as identified by Sutterley and Donnelly (1) is indicated. With such an approach details of each individual member can be related to the details of all the members of the family unit.

Using the four broad categories of Sutterley and Donnelly, details of assessment can be identified. (Some areas of assessment identified by the American Nurses' Association(2) provide additional detail).

1. Genetic and physiological factors.
   - A. Growth and development — body size, sex.
   - B. Physical functioning.
   - C. Physical defects — handicaps.
   - D. Performance of activities of daily living.

2. Psychological — ethical factors.
   - A. Emotional status.
   - B. Pattern of coping.
   - C. Perception of and satisfaction with health status.
   - D. Goal seeking behavior.
   - E. Intellectual development.

3. Social-Cultural factors.
   - A. Child rearing practices.
   - B. Paternal and maternal age, occupation, education and values.
   - C. Ethnic group and subcultures.
   - D. Religious beliefs.
   - E. Socioeconomic status (human and material resources).

4. Environmental factors.
   A. Physical, social, emotional, ecological.
   B. Disease, sanitation, technology.
   C. Air, water, pollution, radiation.
   D. War, famine, disaster.
   E. Population growth (family planning).

The following information is an example of a typical family interview of years past.

> Sally and Richard Wiley, 26 and 27-years respectively, are living in a single family home in Steveston. They have been married for three years and have two children — Jimmy 2 and Sally 1. Richard is a fisherman and Sally is a homemaker. Richard's father and Indian mother are living in Queen Charlotte City where he, like his son, is a fisherman. Sally's mother, to whom she is very attached, is a widow with residual paralysis and has been living with Sally and Richard for the past year. Richard is somewhat resentful of Sally's attachment to her mother.

Though such information provides a general skeletal basis of a family assessment, much further expansion is needed for a complete family health assessment. Each family member should be interviewed and assessed. Since the children are too young for much verbal response, special concern with adult response related to child rearing details is indicated. Some more specific areas of assessment(3) for each member should include:

A. Physical:
   1. Breathing.
   2. Eating.
   3. Elimination.
   4. Mobility.
   5. Sensory.
   6. Skin.
   7. Rest and sleep.
   8. Recreation.

B. Interpersonal relationships.
   1. Communication.
   2. Personality — dependent/independent; gregarious/isolation.

C. Social.
   1. Education.
   2. Work.
   3. Personal goals.

D. Presenting interference with health.
   1. Resources for coping.
   2. Home management of care of ill member.

From such a baseline of information specified for each of the five members constituting the immediate Wiley family unit, detailed data can be identified and care planned related to the specific needs of the family. Some of the difficulties assessed may be beyond the scope of dealing with in a nursing framework. However, specific care/referral for care, cannot be delineated comprehensively without a complete assessment of each member. I believe that assessment of all the dimensions indicated is within the province of nursing.

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