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EDITORIAL

TEAM RESEARCH ETIQUETTE: MAKING THE RULES EXPLICIT

There will always be disagreements among members of a research team. However, the most serious problems are those involving the principal investigators, and unless these problems can be sorted out, they may bring an important study to a standstill. Stories I have heard include a researcher who locked study data away from the other investigators; individuals who have submitted portions of the team's work for publication (or a course assignment, or a grant proposal) without the others' knowledge; and continuing complaints regarding the one investigator who does not carry a fair share of the day to day drudgery of running a research project.

What is behind each of these incidents? Often it is simply a misunderstanding; each investigator is operating from a different set of unwritten and undiscussed rules of behaviour. There is currently no book of etiquette for nursing researchers. Although the rules of behaviour between research team members are well developed in other disciplines, the etiquette for nursing is only now emerging. We are creating an amalgam of our own by borrowing from other disciplines, and by modifying time-proven rules from other areas of nursing.

Early in the research project we can discuss and write down the terms of reference for the responsibilities and benefits of the various team members. As people in the team change, these terms of reference need to be reviewed and revised. As an example, we have included in the appendix (see p.3) the agreement my colleagues and I drew up to clarify our roles in a current research project.

Many issues will arise in the course of a study, and some that we have encountered over the years include questions of authorship; access to the data and other project materials; topics for papers; use of grant funds (travel and supplies); use and supervision of the research assistant's time; and interviews with the press.

The issue of authorship is one example of how the nursing profession is developing its own rules. For example, some disciplines list the name of principal investigator or most-well-known-person first, whereas in nursing we are establishing the norm of placing first the name of the person who made the most significant theoretical or methodological contribution. This is usually, but not always, the person who wrote most of the paper. However, an interesting phenomenon is occurring: the predominately female profession

of nursing research is developing a sisterhood. Investigators, recognizing that a team member may need a publication credit, will often encourage that person to take on the first authorship role. I have not seen this type of generosity to the same degree in any other discipline.

Some disciplines still alphabetize the list of authors and include everyone who had anything to do with any aspect of the entire line of research. Nurses rarely use this approach to authorship; the emerging norm among nurses is that all the authors should be able to present and discuss the paper.

It has been said, "Don't read a report if there are more authors than subjects!" Increasingly we, as nurses, are using acknowledgements to give credit to those who have contributed to the success of the project, but who are not directly involved in the current paper.

New Realities for Nursing Research Teams

Other reasons for misunderstandings between team members emerge from changes in the scholarly environments in which we do our research; and from the diversity of disciplines in which we received our formal and informal research training. Changes in scholarly environments solve some problems, but create others. For example, as more of us obtain grants, there is more money to have disagreements about; as more of us work with larger and more diverse teams, there are more people with whom one might disagree; as the pressure to publish steadily increases, there is more competition for authorship. The very diversity of our research training and experience, which so enhances the quality of the project, brings with it conflicting assumptions about rules of conduct. There is also a trend toward long-term research programs which will involve more than the usual turn-over in investigators because of the successive nature of the projects. Each of these periods of transition between investigators is a potential source of stress for the project.

My colleague, Rita Maloney, has worked successfully with many different teams and she concludes that one should choose a co-investigator with the same care that one chooses a spouse. Trust and respect for the other person's skills and work are essential to the smooth functioning of the team. These, along with a regularly reviewed and explicit set of guidelines for each project, have helped me over the rough places which crop up when one works as part of a team.

Sharon Ogden Burke
Member
Review Board

APPENDIX TO EDITORIAL

Research Team Members' Guidelines: An Example of Responsibilities and Benefits

NHRDP Grant
Responsibilities and Benefits
Guidelines

Investigator

1. Guides conceptual and methodological direction of the project.
2. Guides day to day operations of the project.
3. Supervises and delegates responsibilities to project employees.
4. Coordinates collaboration of consultants and experts.
5. Responsible for financial management.
6. Has access to all data.
7. Is author on all publications emerging from the study or the data at anytime; if the investigator decides to be excluded, it must be put in writing.
8. Has access to all project materials, e.g., writing in draft form, instruments, reprints, computer searches, computer programs, etc.

Co-Investigator - A

1. Actively participates in conceptual and methodological direction of the original project.
2. Collaborates with principal and other investigators in guiding, supervising and coordinating the original project as agreed.
3. Has access to all of the data.
4. Is an author on all publications emerging from original study questions. For post hoc analyses, is acknowledged unless specifically decides to be excluded. Beyond this, authorship is negotiated on a publication by publication basis. Minimal credit would be a separate and distinct acknowledgement indicating work done on original project.
5. Has access to all or a negotiated subset of instruments, reprints, computer searches, computer programs, etc.
6. Coordinates data collection at Moose and in Ottawa.
7. Coordinates interviewer training.
8. Assumes responsibility for items 2-5 during Burke's sabbatical leave.

Co-Investigator - B

1. Provides expert advice on a specific area of the project, e.g., health beliefs and compliance
2. Has authorship in the areas of expertise.
3. Has access to data in area of expertise.
4. Is acknowledged in all publications.

Project Staff

1. Acknowledgement, authorship and access is usualy given if contributions are substantive, of high quality, significant and beyond that which is required by the job description. This is negotiated with the investigator on an individual publication or project basis.
2. A job description defines the role of the project manager; specifying areas of responsibility and duties to be performed.

General

1. Copyright generally resides in those who developed the materials and is ordinarily reflected in the title. For example, the VLES was developed by Burke and Maloney.
2. First Authorship is negotiated on a project by project basis.
3. Topics and publication target (journal or conferences) will be jointly decided. A time limit, ordinarily 1 year, will be set to complete the project. After that time, other investigators could take on the project.

Acknowledgements: Colleagues who have participated in the development of other versions of our guidelines are (in alphabetical order): Edith Costello, Malcolm Griffin, Mary Jerrett, Susan Laschinger, Carol Roberts, Allison Sayers, Nesta Wiskin, and Janet Wray. Particular thanks to Rita Maloney and Alice Baumgart who granted permission to publish our research guidelines as an example in this editorial.

ÉDITORIAL

Travailler au sein de l'équipe de recherche: formuler les règles de conduite

Il y aura toujours des mésententes au sein des équipes de recherche. Cependant, les problèmes les plus graves sont ceux qui intéressent les chercheurs, et à moins qu'ils ne soient résolus, ils peuvent mettre un frein à une étude importante. Parmi les scénarios que j'ai entendus, je mentionnerai le cas d'un chercheur qui avait mis sous clé les données de l'étude empêchant ses collègues d'y avoir accès, celui d'autres chercheurs ayant soumis des portions d'un travail d'équipe à des fins de publication (ou pour satisfaire aux exigences d'un cours ou afin d'obtenir une subvention) sans que les autres auteurs ne soient au courant; j'ai également entendu des plaintes sans fin au sujet des chercheurs qui n'assument pas une part raisonnable des travaux routiniers et quotidiens du projet de recherche.

Qu'est-ce qui est à l'origine de chacun de ces incidents? Souvent, il ne s'agit que d'un malentendu; chaque chercheur agit en fonction de règles de conduite tacites qui lui sont propres et qu'il ne partage pas avec ses collègues. Il n'existe à l'heure actuelle aucun livre sur l'étiquette de la recherche en nursing. Bien que les règles de conduite entre les membres d'une équipe de recherche soient bien établies au sein des autres disciplines, celles qui régissent le nursing ne font que commencer à prendre forme. Nous créons notre propre amalgame de règles en empruntant aux autres disciplines et en modifiant des politiques établies provenant d'autres secteurs d'activité de nursing.

Dès la mise en route du projet de recherche, on peut discuter et rédiger la délimitation des responsabilités et des avantages des différents membres de l'équipe en ce qui a trait au projet spécifique. Au fur et à mesure que changeront les membres de l'équipe, ces attributions devront être révisées. A titre d'exemple, on trouvera à la page 3 l'accord que mes collègues et moi-même avons préparé pour préciser nos rôles dans le cadre d'un projet de recherche en cours.

De nombreuses questions seront soulevés au cours d'une étude; parmi celles auxquelles nous avons fait face au cours des années, mentionnons notamment des questions de paternité des textes, l'accès aux données et autre matériel du projet; les sujets des communications; l'utilisation des fonds de subvention (déplacements et fournitures); l'utilisation du temps et l'encadrement de l'adjoint de recherche; enfin, les entrevues avec la presse.

La question des droits d'auteur illustre bien comment la profession infirmière élabore ses propres règles de conduite. Ainsi, dans certaines

disciplines, le nom du chercheur principal ou du chercheur le mieux connu apparaît en premier; dans la recherche infirmière, nous avons pris pour habitude de donner la première place au nom de la personne dont la contribution méthodologique ou théorique a été la plus importante. Il s'agit habituellement, quoique pas toujours, de l'auteur de la majeure partie de l'article. On observe cependant un phénomène intéressant: il se développe au sein de la profession de chercheur en nursing qui est essentiellement une profession féminine, un esprit de "confrérie". Les chercheurs, reconnaissant qu'un membre de l'équipe peut bénéficier de la publication d'un article, encourageront souvent cette personne à assumer le rôle d'auteur principal. Dans aucune autre discipline, n'ai-je rencontré à ce point ce type de générosité.

Dans certaines disciplines, on inscrit les auteurs par ordre alphabétique et la liste inclut toutes les personnes qui ont participé de près ou de loin à cette recherche. Cette démarche se retrouve rarement chez les infirmiers et infirmières; on admet généralement chez ces derniers, que tous les auteurs doivent être en mesure de présenter la communication et d'en discuter.

Il existe un diction en milieu universitaire qui dit: "Ne lisez pas un compte rendu s'il y a plus d'auteurs que de sujets!" De plus en plus, en notre qualité d'infirmiers ou d'infirmières, nous reconnaissons l'apport de ceux qui ont contribué au succès du project, sans toutefois avoir joué un rôle direct dans la rédaction de l'article, en leur exprimant notre reconnaissance à la rubrique intitulée remerciements.

Des réalités nouvelles pour les équipes de recherche en nursing

D'autres motifs de malentendu entre les membres d'une équipe naissent de l'évolution des milieux universitaires au sein desquels nous effectuons nos travaux de recherche; des méprises peuvent également naître de la diversité des disciplines dans lesquelles nous avons acquis notre formation en recherche, tant notre formation sur le tas que notre formation universitaire. Les modifications que connaissent les milieux universitaires permettent de résoudre certains problèmes, mais elles en soulèvent d'autres cependant. Ainsi, nous sommes plus nombreux à obtenir des subventions, mais les budgets plus importants multiplient les occasions de désaccord; nous travaillons de plus en plus au sein d'équipes plus importantes et plus diversifiées, il y a donc plus de gens avec lesquels nous pouvons avoir des mésententes; au fur et à mesure que les pressions de publication augmentent, la concurrence pour la reconnaissance de la paternité du texte se fait plus serrée. La diversité même de notre formation en recherche et de notre expérience qui enrichit tant la qualité du projet, est également la source d'interprétations contradictoires des règles de conduite. En outre, on observe une tendance vers des programmes de recherche au long cours au sein desquels

on observera un roulement de personnel plus élevé que d'habitude étant donné l'enchaînement des projets. Chacune de ces périodes de transition entre les chercheurs risque de nuire au projet.

Ma collègue, Rita Maloney, a travaillé fructueusement avec de nombreuses équipes différentes, et elle conclut que l'on doit choisir un co-chercheur avec le même soin que l'on choisit un conjoint. La confiance et le respect des compétences de l'autre et de son travail sont essentiels au bon fonctionnement de l'équipe. Ces données de départ ainsi qu'un ensemble de règles de conduite explicites revues régulièrement pour chaque projet, m'ont aidée à passer au travers des moments difficiles que l'on connaît invariablement quand on travaille au sein d'une équipe.

Sharon Ogden Burke

Remerciements: les collègues qui ont participé à l'élaboration de ces règles de conduite pour le personnel de différents projets sont, par ordre alphabétique: Edith Costello, Malcolm Griffin, Mary Jerrett, Susan Laschinger, Carol Roberts, Allison Sayers, Nesta Wiskin, et Janet Wray. Je tiens à remercier tout particulièrement Rita Maloney et Alice Baumgart qui m'ont autorisée à publier nos directives de recherche à titre d'illustration du présent éditorial.

RATE INCREASES

Please refer to the masthead for the new rates effective with the Fall 1986 issue (Vol. 18, No. 3).

AUGMENTATION DES TARIFS

Les nouveaux tarifs qui entreront en vigueur avec le numéro de l'automne 1986 (Vol. 18, no 3) sont inscrits dans les renseignements généraux.

ACADEMIC ADVISING IN A UNIVERSITY SCHOOL OF NURSING: PROBLEMS AND SOLUTIONS

Margaret M. Arklie . Suzanne Caty

Academic advising is considered an integral part of a student's university life. A major goal of academiic advising is to give students advice regarding such matters as programme requirements, course selection, academic regulations, and career counselling. Furthermore, students often seek academic advice that will improve their individual learning styles and satisfy their needs. Today students are entering nursing programmes with a greater variety of educational preparation and work related experience. This not only makes academic advising more complex, but makes it even more essential.

Our School of Nursing responded to this need by establishing an academic advising system in the mid-1970s. It was felt that this system would provide consistency in giving information about academic matters to students. From the onset, all faculty were involved in academic advising and counselled students from either the Basic or Post RN Baccalaureate Programme. As student numbers increased and faculty were obliged to advise both groups of students, faculty members needed to be well informed about the academic requirements of both programmes. Over the years, each faculty member was responsible for giving academic advice to fifteen to twenty students.

During the 1982-1983 academic year, some faculty members began to voice concerns about the efficacy and efficiency of the academic advising system. The concerns revolved around the following issues: the lack of available information necessary for academic advising; frustration and confusion on the part of both faculty and students about the difficulties in keeping abreast of academic regulations and requirements; the potential for giving wrong advice; and confusion with regard to the role and responsibilities of the advisor.

The authors of this paper were given the task of reviewing the academic advising system for the Basic Baccalaureate Programme and bringing

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recommendations to the faculty. This paper describes the steps taken in assessing the strengths and weaknesses of the system and the recommendations taken to faculty, and discusses some preliminary observations after the implementation of a core advising system in September 1984. A survey approach was used to assess the present system, as well as to ascertain ways of improving it. Answers to the following questions were sought:

1. What do students and faculty perceive as the strengths and weaknesses of the present academic advising system?

2. What suggestions do students and faculty propose to improve the academic advising system?

Literature Review

A review of the literature on academic advising within a university setting revealed common threads, concerns, and remedies. Different authors acknowledge that academic advising is given low status within universities, and is not considered highly in the tenure and promotion process (Bossenmaier, 1978, 1979; Mahoney, Borgard, & Hornbuckle, 1978; Polson, & Jurich, 1979; Wilder, 1981).

Both faculty and students report dissatisfaction with the process of academic advising (Bossenmaier, 1978, 1979; Grahn, Kahn, & Knoll, 1983; Polson & Jurich, 1979). This dissatisfaction is further accentuated by the fact that students have a different perception of the purpose of academic advising than do faculty members. Faculty see it in relation to academic matters only, while students perceive its role and purpose to include both academic and personal matters (Hornbuckle, Mahoney, & Borgard, 1979; Moore, 1976). Bossenmaier (1978) defines it as "the activity engaged in by members of the teaching faculty and directed toward assisting students with their educational and vocational concerns" (p.192). Even though the literature suggests that academic matters be the main focus, it recommends that advisors be aware of the services available on campus that could be of benefit to the students.

Bossenmaier (1979) and Mahoney et al. (1978) suggest that faculty members frequently are not knowledgeable about matters that are fundamental to academic advising. This assumption is supported in two recent documents that pertain to student services within a university setting (Matthews & Turner, 1983; and Stewart, 1983).

Bossenmaier (1978) believes that academic advisors must have certain important characteristics (such as knowledge of the curriculum and the

university), helping relationship skills, and be available. Wilder (1981) supports Bossenmaier's belief that academic advising is a time-consuming activity and that advisors must have not only a reduced teaching load but also specific preparation for the advisor role.

It is reported in the literature that both students and faculty believe that a core system is a worthwhile method to use in academic advising (Bossenmaier, 1978, 1979; Grahn et al., 1983; Habley, 1983; Mahoney et al., 1978). Findings from the Grahn et al. (1983) study demonstrated that this system was time saving for both students and faculty. An unanticipated finding in their study was that faculty members were able to share their expertise in academic advising. This led to an upgrading of the quality of advising, it facilitated orientation of new faculty to the system, and promoted a sense of community within the advising faculty.

In summary, the literature suggested that the responsibilities of academic advising needed to be considered more seriously by faculty and universities, and that a core group of advisors might be an efficient and effective way of managing this responsibility.

Method

A survey approach was used to collect that data. A questionnaire was developed using open-ended questions. The questions were reviewed by two faculty members for clarity. Respondents were asked to list three strengths and three weaknesses that they perceived in the present system, and to give suggestions for change.

Questionnaires were distributed to a total of 168 students in second, third, and fourth years during the first week of class in September. At this time, the purpose of the study was explained. Participation in the study was voluntary. At the same time, the questionnaires were distributed in the mail boxes of the 23 faculty members who had been academic advisors to the Basic students. No reminders were given to encourage either students or faculty to respond following the initial distribution of the questionnaire. Finally, using the membership list of the Canadian Association of University Schools of Nursing, a letter was sent to 23 schools of nursing asking them for information about their systems of academic advising.

Data analysis

All returned questionnaires from students and faculty were used in the data analysis. Content analysis identified themes within the noted strengths, weaknesses, and suggestions for change.

Findings

Forty-five (27%) of the students responded to the questionnaire. Even though the response rate was low, definite similarities were noted in the responses. Four major areas emerged as perceived strengths and two major areas as perceived weaknesses (Table 1).

Forty-nine percent of the respondents had no comments on possible changes in the system and 16% felt no changes were necessary. Recommendations included the need to have a more organized method of acquainting the faculty and students with the academic advising system; requiring advisors to be more knowledgeable about academic matters; and advising exclusively on academic matters in this system. A few students also raised the question of confidentiality in advisor-student meetings.

Fifty-two percent of the faculty responded to the questionnaire; they identified four major strengths and three major weaknesses in the present academic advising system (Table 2). Other areas of concern mentioned by faculty included the large numbers of students seeking advice; students "dropping in" without an appointment; difficulty contacting students; and whether or not academic advising is an effective use of faculty time.

Table 1

Major Strengths & Weaknesses Identified by Students

Strength	% of respondents	Weaknesses	% of Respondents
Assistance with choice of classes and academic requirements	61%	Difficulty contacting advisor	38%
Counselling and guidance in academic matters	51%	Advisor lacked knowledge of programme and academic requirements	29%
Personalized interest in students	24%		
Counselling and guidance in personal matters	11%		

Table 2

Major Strengths & Weaknesses Identified by Faculty

Strengths	% of Respondents	Weaknesses	% of Respondents
A resource person for the students	30%	Lack of faculty commitment to the role of academic advisor	30%
Enjoyed the student contact	30%	Poor delineation of role and functions of the advisor	40%
Required to have knowledge of academic requirements and regulations	30%	Lack of knowledge of academic requirements and regulations	40%
Sharing of the academic advising workload	20%		

Of the faculty members who made suggestions for changing the academic advising system, 60% felt that a core group should be responsible for advising students, and that this responsibility should be built into their workload. Other suggestions included group advising, with specific groups of students; providing a good orientation to the system; and keeping faculty informed of requirements and regulation changes.

Ninety-six percent of the schools of nursing responded to our letter of inquiry. Many of the responses were very detailed and indicated a strong interest in the topic. Twelve schools (55%) indicated that they use a core group of faculty to provide academic advice to their students. The composition of this core group varied from a small group of faculty or coordinators of programmes, to a position of overall undergraduate academic advisor with a faculty advisor in each year of the programme.

Six schools (27%) reported that their advisor system involved all members of their faculty; three schools (14%) reported having no academic advising

system; and one school (4%) stated that students were informed of the advisor system, but were assigned to an advisor only upon request.

The responses from the other universities suggested that academic advising was seen as being important, and that there was a great deal of interest and concern about this topic. All schools having an advisor system reported that the main focus was on academic matters and identification of problems related to this issue. Personal matters were referred to other sources for counselling.

Discussion

The low rate of response from the students is hard to understand but may have occurred because the survey was done early in September when the students might have thought that they had more important matters to address. They might also have felt that the system was not causing them any difficulties and did not feel that they needed to answer the questionnaire. The fact that 65% of the respondents had no suggestions for change, or saw no need for change, led us to believe that the students who responded were satisfied with the system and felt that the perceived strengths outweighed the weaknesses. However, the low rate of response from the students raises questions regarding the validity of the findings and the generalizability of the results.

The responses and comments from faculty were not surprising; they supported the acknowledged concerns that had led to the review of the present academic advising system. The major weaknesses identified by faculty are congruent with the suggestion made by Bossenmaier (1979) and Mahoney et al. (1978) that faculty members frequently lack knowledge about academic matters that are fundamental to academic advising.

The fact that 55% of other university schools of nursing had a core qroup of faculty designated as academic advisors re-inforces the suggestion made by 60% of our faculty that a core group of advisors would be beneficial.

In summary, the survey findings supported the major themes elicited in the literature review: academic advising is time consuming; it requires special knowledge and commitment; and it must be recognized as an important responsibility, and thus should be part of the faculty member's workload. Furthermore, the survey results also support the idea that core-advising is an effective and efficient way of handling the responsibilities that accompany academic advising.

Our experience as academic advisors and the results of this study have raised a persistent question. Is academic advising a more important issue for students or for faculty? It is our belief that, in fact, it is a greater issue for

faculty because the repercussions of giving incorrect advice and information many not only affect the student concerned, but also the faculty member and the programme. The main concerns of the students are to receive proper academic advice and to complete the academic requirements. In contrast, faculty have many responsibilities, of which this is one. Organizing this responsibility in a way that leads to optimum use of faculty time can only be beneficial to faculty and students.

Recommendations

These findings led us to recommend to the faculty that academic advising for the Basic Baccalaureate Programme be carried out by a core group of faculty members.

Other recommendations were that:

1. Responsibilities for academic advising be included in faculty workload assignments;
2. A committee consisting of three elected members of faculty and the Coordinator of the programme be formed;
3. Committee members be knowledgeable about university, faculty, and school regulations and services, have good interpersonal skills, and be available at specified times;
4. The core advising system be evaluated over the next few years.

We are pleased to report that these recommendations were accepted by the faculty in the Spring of 1984. A core group of faculty advisors, known as the Academic Advising Committee (AAC), has been functioning since September, 1984. Terms of reference which are congruent with the survey findings and the literature have been developed.

The purpose of the AAC has been defined as being, "To advise students in planning their academic programmes, approve class selection, and discuss academic progress or concerns." The AAC is now a Standing Committee of the School of Nursing, and responsible to the Executive Committee. The 240 Basic degree students have each been assigned to one of the four advisors, and were informed of the changes in the academic advising system. The committee members met initially to review the terms of reference and to discuss their roles and responsibilities. Other meetings were held during the year, as necessary, (e.g. to plan pre-registration).

Interim review

The AAC has now functioned for one year, and has carried out a formative evaluation of the revised academic advising system by seeking feedback from academic advisors, faculty, and students. These findings are encouraging. For

example, from the advisors perspective, the time commitment was not as great as anticipated. This, we believe, was because the students were well informed of the academic requirements and regulations and kept abreast of any changes. One area of concern that has arisen is that some students have tended to go to the coordinator rather than to their assigned advisor. This was due, in part, to problems of accessibility and to knowledge that the related issue would need to be discussed later with the coordinator. In the future, students will be encouraged to see their advisor directly, rather than going to the coordinator, but, this will not prevent them from approaching any faculty member for advice.

Faculty response identified two advantages of the new academic advising system: advisors were knowledgeable about academic regulations and policies, which was perceived as beneficial to the students; and not having to be an academic advisor permitted faculty to make better use of their time for other duties. Faculty identified as disadvantages the belief that they would become less knowledgeable about regulations, and the perception of a loss of personal contact with the students. However, faculty believe that the advantages outweighed the disadvantages and overwhelmingly recommended that the core advising system be continued.

The responses from the students also support the use of such a system. They perceived that the advisors were knowledgeable about academic regulations, accessible, and found that the planning for pre-registration done by the AAC greatly facilitated the entire registration process. They also noted potential problems related to the large number of students assigned to each advisor. The responses from both faculty and students indicated that the previous weaknesses have now become the strengths of the academic advising system. The current advisors support these findings and recommended that academic advising be continued by a core group of faculty.

REFERENCES

Bossenmaier, M. (1978). Faculty perceptions of academic advising. *Nursing Outlook, 26,* 191-194.

Bossenmaier, M. (1979). Students evaluate academic advising. *Nursing Outlook, 27,* 787-791.

Grahn, J., Kahn, P., & Knoll, P. (1983). Faculty team approach to group advising. *Journal of College Student Personnel,* 214-218.

Habley, W.R. (1983). Organizational structures for academic advising: Models and implications. *Journal of College Student Personnel, 24,* 535-540.

Hornbuckle, P.A., Mahoney, J., & Borgard, J.H. (1979). A structural analysis of student perceptions of faculty advising. *Journal of College Student Personnel, 20,* 296-300.

Mahoney, J., Borgard, J.H., & Hornbuckle, P.A. (1978). The relationship of faculty experience and advisee load to perceptions of academic advising. *Journal of College Student Personnel, 19,* 28-32.

Matthews, D., & Turner, K. (1983). Report of the office of the ombudsman. Dalhousie University, Halifax, N.S.

Moore, K.A. (1976). Faculty advising: Panacea or placebo. *Journal of College Student Personnel, 17,* 371-374.

Polson, C.J., & Jurich, A.P. (1979). The departmental advising centre: An alternative to faculty advising. *Journal of College Student Personnel, 20,* 249-253.

Stewart, M.J. (1983). The report of the advisory committee on relations with prospective students. Dalhousie University, Halifax, N.S.

Wilder, J.R. (1981). A successful academic advising program: Essential ingredients. *Journal of College Student Personnel, 22,* 488-492.

RÉSUMÉ

Orientation pédagogique au sein d'une école universitaire de sciences infirmières: problèmes et solutions

On admet généralement que l'orientation pédagogique fait partie intégrante de la vie universitaire de l'étudiant. La présente communication décrit les mesures prises pour évaluer les points forts et les points faibles d'un système d'orientation pédagogique au sein d'une école universitaire de sciences infirmières.

Les résultats d'un examen de la littérature pertinente ainsi que d'un sondage auprès de professeurs, d'étudiants et d'autres écoles de sciences infirmières en milieu universitaire semblent indiquer que l'orientation pédagogique doit être considérée comme une responsabilité importante des professeurs. La création d'un noyau de conseillers a semblé être une méthode efficace d'assumer cette responsabilité.

Cette démarche est entrée en vigueur en september 1984. Une évaluation préliminaire effectuée par des conseillers, des étudiants et des professeurs vient corroborer les avantages d'un système d'orientation de tronc commun et l'auteur recommande de poursuivre cette démarche.

Call For Abstracts: Poster Session

Abstracts are requested for a poster session to be held at the Boston University Fourth Annual Nursing Science Colloquium in Boston, March 19-20, 1987. The title of this year's colloquium is "Strategies for Theory Development IV: Philosophy of Science and the Development of Nursing Science".

Abstracts for posters are being sought that describe:

1. Research projects, completed or in progress, that contribute to nursing theory development,
2. Concept or theory development, and
3. Philosophy of science in nursing theory development.

Three copies of a one page, single spaced abstract should be submitted with a cover letter including name, title, and position. Deadline for submission is January 15, 1987. Applicants will be notified of abstract review results in February, 1987.

Submissions and enquiries:

Kathleen Simon, Chair
Nursing Science Colloquium Committee
Boston University School of Nursing
635 Commonwealth Avenue
Boston, MA 02215

Call For Abstracts

A CNA National Nursing Research Workshop Conference to promote collaborative efforts between nurse researchers and to facilitate successful project funding will be held May 10 to 15, 1987. The conference will be held at the University of Manitoba and will be a tutorial week.

Please submit inquiries to Ginette Coutu-Wakulczyk, Research Manager, Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario K2P 1E2, Telephone (613) 237-2133.

CLIENT PERCEPTIONS OF NURSING PRACTICE

Matt A. Elbeck

Nursing practice may be defined according to standards developed by the Canadian Nurses Association (CNA) through a process of professional nursing consensus (CNA, 1980). The modern-day tennet of consumer satisfaction has encouraged nurses and the institutions in which they work to emphasise client satisfaction in order to ensure long-term professional and institutional survival. This has prompted researchers to solicit information from clients on their perception of hospitals (Ben-Sira, 1983; Haxhe, Zumofen, De Coninck, et al., 1981) and nursing practice (Altschul, 1983; Mangen & Griffith, 1982; Weiss & Davis, 1983) as part of nursing quality assurance programmes. It has even been suggested that nursing practice be divided into two distinct roles; institutional "hostess" and "task worker" (Bokma & Timmer, 1983).

A client focus is presented in this paper, an investigation of the ways in which clients *describe* and *evaluate* nursing practice. Once the features or "dimensions" of client perceptions are known, nurses can take full advantage of this information to deliver appropriate service.

Data for this investigation were collected by means of a Nursing Environment Audit (Elbeik & McGill, 1985a; 1985b) based on standards developed by the CNA. This type of client satisfaction survey measures client perceptions of nursing practice.

Survey Administration

Responses to the 39 statement Nursing Environment Audit (NEA) were obtained from 269 clients (113 male and 156 female) from 14 nursing units in a 750 bed teaching hospital, during the months of November and December 1984. The sampling plan was a two stage cluster version: all nursing units were included with the exception of pediatrics, extended care, labour and delivery, and nurseries. Clients were selected using random numbers. The subjects were limited to those with a minimum nursing unit stay of 72 hours, an ability to read and comprehend the terms in the survey, and who were willing to participate. Each respondent was given a card which

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Table 1

Identifying Dimensions of Nursing Practice using Factor Analysis

	Factor Loadings
General dimension #1: Routine Care	
- If the room temperature is not to my liking, the nurse usually alters it for me	.820
- The nurses usually ask me whether the room temperature is to my liking	.782
- The nurses told me about the availability of the hospital Chaplains, Local clergy, or the Sister Visitor	.766
- A nurse explained safety rules about side-rails, sedation, and smoking to me	.753
- A nurse helps me with my meals soon after the trays are delivered to my room	.727
- The nurses answer my call bell quickly enough	.690
- A nurse introduced me to my roommate(s) and/or staff	.689
- The nurses try to prevent me from being bored	.686
- The nurses assist me with exercise when the physiotherapist is not here	.665
- A nurse(s) helped me with my bath or shower as requested	.597
- I am encouraged to spend time talking with my roommate/other patients and with nurses	.498
Group dimension #1: Counselling and Post-Operative Care	
- The nursing staff have provided teaching sessions or counselling in my problem areas	.754
- If I use Oxygen equipment, the nurse administers it with little discomfort	.714
- The nurse(s) assist in making arrangements should my family be unable to help at home	.686
- If I had to wait for answers from a nurse to any of my questions, it was for a reasonable length of time	.633
- If I foresee any problems adjusting when I get home, the nurses are advising me how to deal with them	.565
- If I have been transfered from another unit, the nurses have made attempts to make me feel welcome in my new surroundings	.563
Group dimension #2: Recuperation and Exercise	
- The nurses provide me with adequate opportunity to rest	.739
- I feel that the nurses ensure that I receive reasonable exercise for my condition	.655
- If I am unable to sleep, measures are taken to help me by the nurses (i.e., sedatives, quietness, dark room, etc.)	.620
- If I should be doing any special exercises, I am encouraged by the nurses to do these exercises	.548
- If I notified a nurse(s) about a problem with my bowels or bladder, the nurse(s) tried to help me	.487
- I feel my care by the nurses is being done basically in the same way every day	.455
Group dimension #3: Dignity and Respect	
- The nurse respected my privacy during my care	.875
- My rights are respected by the nurses with regard to visitors	.846
- I am satisfied with the nurse's explanation of my condition	.835
- I feel free to talk in confidence to the nurses about my problem	.808
Group dimension #4: Empathy	
- When I ask different nurses the same question, they all give a similar answer	.711
- If I have any special religious needs or beliefs, these are being respected by the nurses while I am here	.663
- If this illness/hospitalization has made me feel differently about myself, a nurse(s) discussed these changes with me.	.644
- I feel the nurses are concerned with my problems	.513
Specific dimension #1: Comfort	
- Nurses talk to me in a way I can understand	.837
- I find the nurses helpful	.754
- The nurses help me to feel relaxed most of the time	.735
- The nurses help me feel comfortable most of the time	.471
Specific dimension #2: Individuality	
- The nurses usually call me by my preferred name	.824
Specific dimension #3: Trust and Involvement	
- The nurse always checks my armband before giving me medication	.789
- The nurse gave me an opportunity to make choices during my care	.648
Specific dimension #4: Immediate Response	
- If I suffered an injury while here, a nurse(s) provided assistance promptly	.661

explained the Likert response scale used to rate each statement. The administering nurse was instructed to assure the client of complete anonymity. The completed survey was placed in an envelope, sealed, and delivered to the nursing administration office. Less than 5% of the selected clients refused to participate in this study.

The objective of the study was to identify the dimensions of nursing practice as perceived by the user of such services - the client. Factor analysis was used to obtain clusters of statements from the NEA which formed factors or dimensions describing nursing practice.

Results

The application of factor analysis

Factor analysis was applied to the NEA data and as shown in Table 1, the analysis produced nine factors or dimensions classified into three hierarchical categories: one general dimension, four group dimensions, and four specific dimensions. The author labelled the nine dimensions with respect to the nature of the supporting statements. For example, the general dimension "routine care" reflects the nature of its eleven supporting statements. This procedure was carried out for all nine dimensions, with each dimension reflecting its unique collection of statements.

Each statement's factor loading is a measure of the strength of association between the statement and its dimension. Statements with factor loading below 0.400 are normally discarded, though not one of the 39 original statements exhibited a factor loading less than 0.400. For further discussion of this factor analysis see Appendix A.

The cumulative effects of all nine dimensions which explain over eighty percent of the variation (cumulative variability) of nursing practice, as perceived by nursing unit clients throughout the hospital, are presented in Table 2. This finding showed that clients were able to describe over 80 percent of nursing practice in terms of nine dimensions.

In consequence, each dimension label reflects the totality of all its related statements. This provides the researcher with confidence about the relevance of the statements with respect to adequate factor loading, and about the ability of factor analysis to reflect the totality of nursing service as supported with the high 80.7% cumulative variance score shown in Table 2. The explained cumulative variability (cum var) allows for known separation between dimensions: the general dimension "routine care" - by far the most important dimension; followed by the group dimensions; and, finally, the specific dimensions.

Table 2

Nine Dimensions of Nursing Service as Perceived by Clients

	Cum Var	n	sd	u	u%	95% ci Range
General Dimension						
Routine care	41.2%	268	0.864	1.92	77	74.7-79.7
Group Dimension						
Counselling & post-operative care	51.0%	262	0.888	1.84	79	76.2-81.7
Recuperation & exercise	57.1%	265	0.689	1.54	86	84.5-89.5
Dignity & respect	62.1%	271	0.700	1.43	89	87.2-91.2
Empathy	66.8%	269	0.774	1.62	84	82.2-86.7
Specific Dimensions						
Comfort	71.1%	271	0.585	1.35	91	89.5-93.0
Individuality	74.8%	255	0.716	1.38	90	88.2-92.7
Trust & involvement	78.0%	267	0.601	1.44	89	87.2-90.7
Immediate response	80.7	170	0.722	1.46	88	85.7-91.2

Explanatory Notes:

Dimensions: Classified into three categories; the single general dimension which covers the 'modus operandi' of nursing practice; the group dimensions deal with better defined areas; and the specific dimensions identify highly focused areas of nursing practice.

Cum Var: Each dimension further explains client perception of nursing practice. For example, the first dimension explains 41.2% of the variability of survey response, the second dimension adding a further 9.8% (51% cumulatively), up to a total of 80.7%.

n: Number of client responses to each dimension.

sd: Standard deviation of the mean score for each dimension.

u: Mean score converted to percentage, calculated as: 5 - u x 0.25 x 100.

95% ci Range: This is an estimate at 95% certainty (alpha = 0.05) that all hospital clients will score in this range, assuming no change in nursing practice for any of the dimensions.

The application of dimensions as performance measures

Knowledge of the structure and relative importance of the derived dimensions may be used as a client-oriented measure of nursing practice. This involves calculating the multi-statement mean score for each of the nine dimensions. This information may be calculated for all the nurses in a hospital on a nursing unit basis, by nurse's age, level of experience, qualifications, etc.

The mean scores for each dimension, followed by a percentage conversion of the mean score based on the responses which ranged on a scale 1 to 5, are presented in Table 2. Any dimension with a score under 75% may be considered for investigation, the logic being that 75% translates as "Agree" on the response scale - a lower score implies indecision (unsure) or disagreement. That is, a 75% score acts as the minimum acceptable client

response score; and to ensure that scoring trends do not cross the minimum level, scores between 75% and 80% should also be scrutinized.

The selection of a 75% to 80% minimum performance cut-off value is necessary when considering the possible halo effect nurses might have on their clients. A limitation to the study concerns client reluctance to respond in a negative manner (reflecting the true state of affairs), for fear of retaliation from the nursing staff, unless great efforts are taken to ensure client confidentiality. Further, the use of concurrent questionnaire administration ensures client spontaneity of response which may not be the case with post-discharge variants.

To refine the utility of the percentage mean scores, a range was calculated for each of the dimensions at the 95% confidence interval. For example, for the general dimension of "routine care", nursing administrators have 95% certainty that all hospital clients would respond to this general dimension within a 74.7% to 79.7% range of satisfaction. As part of the scoring range falls below 75%, this dimension would require investigation. Nurses would be informed of their performance on this dimension and given the actual determinants and scores of this dimension (the eleven statements making up the general dimension).

As the scores are mean values for a particular dimension there may be individual items with scores under 75%, thus nursing administrators cannot be complacent in relation to high scoring dimensions.

Examination of the group dimensions shows mean scores above 75%. At the 95% confidence interval, the group dimension "counselling and post-operative care" has a scoring range between 76.2% and 81.7%. The nursing administrators would need to explain the nature of the first group dimension "counselling and post-operative care" to the nurses. A follow-up NEA survey would indicate whether or not nurses reacted to instructions for increased effort (satisfaction) in the two poorly scored dimensions. The remaining three group dimensions and four specific dimensions all show scores in excess of 80% at the 95% confidence interval scoring range.

Implications for Nursing Administrators

Nursing administrators can use such information to improve nursing practice by informing nursing staff of the way clients "judge" nursing practice, and as a result such information may be incorporated into quality assurance programmes. Each dimension's mean score allows nursing administrators an overview of unit or hospital-wide nursing practice from a client's point of view. Statement-specific scores should be examined on a periodic basis to isolate particular client perceptions of nursing practice.

Results presented in Table 1 suggest that clients place great emphasis on routine tasks carried out by nursing staff. The remaining eight dimensions elucidate the importance of personalized forms of nursing practice.

The nine dimensions of nursing practice developed as a result of this study and the seven standards (dimensions) developed by the CNA are compared and the findings presented in Table 3. The client developed list has known hierarchy and interval between dimensions and, as well, offers insight to the standards developed by the CNA.

Table 3

Comparing Client to Canadian Nursing Association (CNA) Dimensions of Nursing Practice

Client developed dimensions	CNA developed standards
1. Routine Care	1. Individual Rights
2. Counselling & Post-Operative Care	2. Safety Needs
3. Recuperation & Exercise	3. Physical Needs
4. Dignity & Respect	4. Psychological Needs
5. Empathy	5. Social Needs
6. Comfort	6. Spiritual Needs
7. Individuality	7. Learning Needs
8. Trust and Involvement	
9. Immediate Response	

Discussion

Which list of dimensions should the nursing administrator select? This decision should be made in light of the fact that the NEA survey was developed from standards of nursing practice developed by the CNA, the results reflecting client manipulation of the standards. This knowledge ensures satisfactory face and content validity of the findings in this paper. To establish factor reliability, the original NEA survey would be administered to another large group of clients using the same analysis as that used in this study. The client-developed dimensions carry substance with respect to conceptual models of nursing practice (e.g., CNATS; Henderson, 1966; Orem, 1980; Roy, 1976) which all rationalise themselves in terms of the client. This being the case, why not ask clients for their perception of nursing practice rather than examine nurses beliefs about what practice should be.

The importance of client perceptions of nursing practice cannot be overstressed. It is useful for nursing students and practitioners to be aware of how clients perceive nursing practice. This allows the development of methods to improve the level of nursing practice with regard to the dimensions discussed in this paper, in addition to other sources of nursing information.

REFERENCES

Altschul, A.T. (1983). The consumer's voice: Nursing implications. *Journal of Advanced Nursing, 8,* 175-183.

Ben-Sira, Z. (1983). The structure of a hospital's image. *Medical Care, 21,* 943-954.

Bokma, J., & Timmer, J. (1983). What does the family think? Results of a survey among visitors to the medical care department of a nursing home. *Tijdschr Gerontol Geriatr, 14*(2), 61-69.

Canadian Nurses Association (CNA). (1980, June). *A definition of nursing practice: Standards for nursing practice.* Canadian Nurses Association.

Canadian Nurses Association Testing Service (CNATS): *A model for nursing.* Canadian Nurses Association, forthcoming.

Elbeik, M.A., & McGill, B. (1985a). Nursing environment audits: A pragmatic evaluation and assessment. *Dimensions in Health Sersvice, 62* (6), 31-35.

Elbeik, M.A., & McGill, B. (1985b). Nursing environment audits - An empirical study for decision-making purposes. *Dimensions in Health Service, 62* (6), 31-35.

Harman, H.H. (1967). *Modern factor analysis* (2nd Ed.). Chicago: University of Chicago Press.

Haxhe, J.J., Zumofen, M., De Coninck, E., et al. (1981). L'hôpital évalué par les malades, facteur d'humanisation. *Hôpital Belge, 24* (151), 23-29.

Henderson, V. (1966). *The nature of nursing.* New York: Macmillan.

Mangen, S.P., & Griffith, J.H. (1982). Patient satisfaction with community psychiatric nursing: A prospective controlled study. *Journal of Advanced Nursing, 7,* 477-482.

Orem, D.E. (1980). *Nursing concepts of practise* (2nd Ed.). New York: McGraw-Hill.

Roy, C. (1976). *Introduction to nursing: An adaptation model.* Englewood Cliffs, NJ: Prentice-Hall.

SPSS Inc. (1983). *SPSS^x user's guide.* Statistical Package for the Social Sciences, Version Ten. McGraw-Hill.

Weiers, R.M. (1984). *Marketing research.* Englewood Cliffs, NJ: Prentice-Hall, especially 131 (sampling), 406-407 (confidence intervals), and 472-478 (factor analysis).

Weiss, S.J., & Davis, H.P. (1983). The health role expectations index: A measure of alignment, disparity and change. *Journal of Behavioral Medicine, 6* (1), 63-76.

APPENDIX A

Statistical Synopsis; At the 95% confidence interval (alpha = 0.05), the *sampling* error was calculated as 5.88% (P = 0.5 for proportionate sampling purposes), that is, with 95% certainty the survey results may be out by no more than 5.88% in the ability to forecast the responses of the hospital annual turnover of 11,505 clients. *Non-sampling* errors may be considered random and multi-directional and therefore self-cancelling. The factor analysis used to develop the dimensions in Table 1 used a listwise deletion of missing values, a principal components analysis extraction (Harman, 1967), followed by 28 iterations allowing for an orthogonal varimax rotation for maximum factor separation. For an explanation of the various statistical techniques covered in this paper, see Weiers (1984). All statistical manipulations were carried out using the University of New Brunswick IBM 3081 mainframe computer and version ten of the SPSS Inc. (1983) package.

RÉSUMÉ

Comment le client perçoit l'exercice de la profession infirmière

Cette étude souligne le besoin d'établir une taxonomie décrivant l'exercice de la profession infirmière du point de vue des clients. Les résultats d'un sondage effectué en milieu infirmier ont été soumis à une analyse de facteurs et ont donné lieu à une taxonomie en neuf points qui explique 80% de l'exercice de la profession. Les facteurs dérivés ont été comparés et exposés par rapport à d'autres modèles conceptuels. Les données de cette étude ont été recueillies auprès de 269 clients d'un hôpital régional des provinces de l'Atlantique au Canada.

In gathering the data presented in this article, the author acknowledges the support of the clients and nursing staff at the Saint John Regional Hospital, Saint John, New Brunswick.

IDENTIFICATION OF HEALTH RISK FACTORS AMONG UNDERGRADUATE UNIVERSITY STUDENTS

Stage 3: Development of a Holistic Health Assessment Tool

Anna Gupta . Sharon McMahon . Gurpal Sandhu

Research reported on by Irons and Thompson, cited in Bensley (1981), indicates that the lifestyles of college and university students could contribute to future health problems. Their study pointed out that over 29% of the students admitted having irregular dietary habits; 40% indicated that they did not engage in any form of regular strenuous exercise; 18% admitted to exceeding the speed limit when driving; and 6% admitted to driving after alcohol consumption.

The above findings were closely replicated in health assessment clinics and a Health Hazard Appraisal (HHA) of undergraduate students that we conducted at the University of Windsor (U of W). As reported in earlier articles (Gupta, McMahon, & Sandhu, 1985a, 1985b), our findings identified additional specific health risks in the U of W student population. One unexpected area of health risk was the high percentage of diabetics. Alcohol abuse, suicide attempts, and family histories of depression were other concerns revealed.

What began as field experience for post Basic Baccalaureate nursing students became an activity that reinforced our concerns about the health status and lifestyle patterns of the U of W students. Readings and research reports from other settings emphasized the need for a more holistic assessment of health and health risks of the students.

In view of the deficiencies of the standardized assessment procedures with HHA and the Canada Fitness Test and in keeping with our beliefs in holistic care and "high-level wellness", we looked for a survey format that could provide more encompassing information for the student health profiles. Our hope was that such self-appraisal of health status, of practices, of beliefs, and of perceived needs would promote students' health-seeking behaviours and increase the use of campus and community resources. Also, we hoped that data gathered through a more holistic approach would guide the "campus care-providers" in furnishing coordinated and collaborative health promotion services on campus.

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Dunn (1961) first defined high-level wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning." Hettler (1980) writes that each individual develops a unique lifestyle that changes daily in the reflection of his or her intellectual, emotional, physical, social, occupational, and spiritual dimensions, and that wellness is a positive approach that emphasizes the whole person. Milsum (1980) states that a sense of purpose is essential in the long run for any individual to maintain health. The sense of purpose is fostered in an environment having meaning and coherence. In such environments, all the classic characteristics of healthy individuals and societies - notably stimulation, challenge, love, joy, happiness, laughter, intimacy, service, wonder, and reverence - can blossom. Those whose bodies are well nourished and well exercised are also those whose brains are more effective vehicles by which these aspects flourish. Indeed, the continuing challenge is to realize the necessity for ever increasing integration of physical, mental, social, and spiritual aspects into a whole person.

Development of the Instrument

To start with, we examined several questionnaires from Canada and the United States. While some formats were detailed, many were lengthy, cumbersome, repetitive, site-specific, or not comprehensive enough. Such concerns as spiritual health, normative developmental crises, or questions about daily health patterns and practices were omitted. Hence, we decided to develop a questionnaire that might have more global applicability, yet would allow for holistic identification of student health and lifestyle patterns, learning needs, and health promotion programme desires. Hettler (1982), Flynn (1980), and Mezey and Chiamulera (1980) provided guidance and models for the development of this pilot tool.

The newly developed questionnaire, the Holistic Health-Assessment Tool (HHAT), includes routine aspects of demographics and use of campus or community health resources, as well as inquiries about daily patterns of sleep, diet, recreation, exercise, substance use, driving habits, sexual activity, emotional state, spiritual beliefs, and a life activities inventory. It also includes assessment of students' health knowledge, health interest, and their perceived needs for health promotion and health maintenance programmes on campus.

Questionnaire revision and analysis

The questionnaire was pre-tested on 155 students. Revisions were made with regard to weighting of questions, reorganization of segments, numerical sequencing, gender identification, and multiple-answer potential.

The revised survey was then administered to a convenient volunteer population of 35 nursing students. Over a ten day interval, test-retest reliability yielded a correlation coefficient of .81. This was interpreted as being significant, and reflected high reliability on all but four items in the segment titled "Psycho-Social-Emotional Aspects". The weaker test-retest reliability in this section can be interpreted, in a positive manner, as an indicator of the labile emotional responsiveness of students at varying times even days apart. This is consistent with findings by Kanner, Coyne, Schaefer, and Lazarus (1981) in their work on "uplifts" and "hassles" of daily life - particularly in college and university populations. The authors recommend the inclusion of this segment in its present form until further evaluation of the questions or testing of a reliable tool for emotional content is found.

One suggestion for further refinement might include a separate questionnaire segment for males in which questions about regular reproductive system examinations, health concerns, risks, and interests could be considered.

Others might be attempting to construct similar instruments. The questionnaire will be available to those individuals and agencies interested in using it and/or for further evaluation. Persons wishing a copy of the questionnaire may write to the authors.

Discussion

In discussing results related to student health status the following factors must be remembered. The sample is not representative of the undergraduate university students as only those volunteers taking first year courses participated in the first run, and only fourth year nursing students participated in the reliability testings. As well, the size of the sample is very small.

In spite of the stated limitations, findings related to smoking, alcohol consumption, driving and seat belt use are very similar to those obtained for the HHA. Other areas where responses were very similar were: exercise habits; concern over weight control; meal selection, food consumption, and knowledge of food risks; and sources of social and emotional support and tension.

Among specific features of this study, we found that students who responded to the items on drug or substance abuse were a minority. This could perhaps result from the fear of prosecution. Also, perhaps denial of this behaviour provides a psychological and sociological protection mechanism. Selective choice of "no response", as opposed to omission, was also noted in questions concerning sexual activity. However, the number of "no answers"

were fewer in this category, indicating perhaps that sexual activity and contraceptive measures are more acceptable to disclose and discuss.

Sleep and study habits revealed emotional and behavioural aspects of student life that could influence achievement, emotional comfort, and self-esteem.

Findings also revealed that first year students used the on-campus physician and health services more than students in other years. The majority of respondents stated that the quality of health services was satisfactory.

Over 80% of the subjects had a yearly physical examination. They were less conscientious about dental examinations.

In both the Health Hazard Appraisal (Gupta et al., 1985b) and the Holistic Health Assessment Tool (HHAT), respondents expressed desires for programming and educational services. Needs that were frequently identified were programmes for exercise and weight control; family planning; cancer prevention and risk identification; and stress management.

The researchers conclude that the common findings in the initial pilot run and in the revised test-retest assessment are supportive of the main purpose of this survey -- the development of a HHAT that would highlight and profile the health status, health risks, lifestyle patterns, and health-seeking behaviours of students, as well as their health knowledge, interests, needs, and desires.

Recommendations

The reliability and validity of the newly developed HHAT (*Stage 3*) should be evaluated further by using the tool on a larger and adequately representative sample of undergraduate students, from one or more settings.

Health Hazard Appraisal in *Stage 2* showed that further research is needed with regard to the causes and effects of student drinking. The subjects should be referred to counselling services, and the effectiveness of such services should be evaluated. As well, a study should be done to investigate the effects of regular physical activity on the health, wellness and academic achievement of students.

We also feel that a study on the effects of health promotion programmes that are based on health risk identification for undergraduate university students using the Student Academic Readjustment Scale (SARRS) (Gupta et al, 1985a), HHA, and HHAT instruments is necessary.

Dealing with health risks

Overall findings of the total project "Identification of Health Risk Factors Among Undergraduate University Students" confirm that university life exposes students to a variety of stressors, and that students are subject to a variety of serious health risks.

Hettler (1980) divides wellness into six basic dimensions: intellectual, emotional, physical, social, occupational, and spiritual. He suggests that the function of a university is to provide an atmosphere and physical environment in which the students have an opportunity to improve their knowledge, skills, and attitudes. Most colleges and universities provide the atmosphere and physical environment only for intellectual development. Few provide equal resources for fostering the other five dimensions of wellness.

Comprehensive wellness promotion on a university campus has the potential to increase students' performance in academic programmes. There is good evidence that many of the causes of death by age 40 are the result of behaviours that were established during the adolescent and young adult years. We believe that wellness promotion also improves students' chances for success and healthy lives once they have graduated.

The literature provides reports on many American university campus health promotion services organized by nursing faculties and departments (Frachel, 1984; Glanovsky & Provost, 1984; Hawkins, Kurien, Roberto, & Stanley, 1985; Mezey & Chiamulera, 1980).

We believe that, philosophically and conceptually, faculty in schools of nursing should assume active leadership roles on a personal and a professional level, to promote the "high level wellness" of the campus community, especially of the undergraduate students. Alcohol awareness and stress management sessions; spare time exercise programmes; nutrition and anti-smoking clinics; campaigns to use seat belts; and screening for hypertension, cancer, and mental health problems all need to be carried out more frequently than is at present the case in most Canadian universities.

REFERENCES

Bensley, L.B. (1981, November-December). Health risk appraisals in teaching health education in colleges and universities. *Health Education,* 31-33.

Dunn, H. (1961). *High level wellness.* Virginia: Beatty.

Flynn, P.A. (1980). *Holistic health.* Bowie, Maryland: Brady.

Frachel, R. (1984). Health hazard appraisal: Personal and professional implications. *Journal of Nursing Education, 23,* 265-276.

Glanovsky, A.R. & Provost, M.B. (1984). The Elms College Nursing Centre: An independent setting for translating theory into practice. *Journal of Nursing Education, 23,* 209-211.

Gupta, A., McMahon, S., & Sandhu, G. (1985a). Identification of health risk factors among undergraduate university students. Stage 1. *Nursing Papers, 17* (2), 22-36.

Gupta, A., McMahon, S., & Sandhu, G. (1985b). Identification of health risk factors among undergraduate university students. Stage 2. *Nursing Papers, 17* (3), 27-46.

Hawkins, J.W., Kurien, M., Roberto, D., & Stanley, L. (1985, January-February). A women's clinic in a university setting. *Nurse Educator, 10* (1), 15-17.

Hettler, B. (1980). Wellness promotion on a university campus. *Family and Communtiy Health, 3* (1), 77-92.

Hettler, B. (1982). Wellness promotion and risk reduction on a university campus. In M.M. Faber and A.M. Reinhart (Eds.). *Promoting health through risk reduction.* New York: Macmillan.

Kanner, A.D., Coyne, J.C., Schaefer, C., & Lazarus, R.S. (1981). Comparisons of two models of stress management; daily hassels and uplifts versus major life events. *Journal of Behavioral Medicine, 4* (1), 1-39.

Mezey, M., & Chiamulera, D.N. (1980). Implementation of a campus nursing and health information center in the baccalaureate curriculum. *Journal of Nursing Education, 19* (5), 7-19.

Milsum, J.H. (1980). Health risk factor reduction and lifestyle change. *Family and Community Health, 3* (1), 1-12.

RÉSUMÉ

Identification des facteurs de risque de maladies chez les étudiants de premier cycle universitaire
Stage 3: Élaboration d'un instrument d'évaluation de santé holistique

Étant donné l'absence d'instrument convenable pour une démarche holistique permettant l'identification des facteurs de risque parmi les étudiants de premier cycle universitaire, les chercheurs ont décidé de mettre au point un tel outil dans le cadre du troisième et dernier stade de leur projet. L'instrument récemment mis au point recouvre différentes sections telles que les schèmes d'alimentation, d'exercice et de sommeil; l'activité sexuelle, l'état affectif; les croyances spirituelles; la toxicomanie et le tabagisme; ainsi que d'autres inventaires du mode de vie. On a procédé à une évaluation pilote de l'instrument chez 155 sujets. L'instrument a été révisé et une étude de fiabilité test-retest a été effectuée sur un échantillon convenable de 35 étudiants en sciences infirmières; nous avons ainsi obtenu un taux de fiabilité de 0,81. Les profils de risques médicaux illustrés par les sondages pilotes et les évaluations test-retest ont confirmé le niveau de fiabilité et la validité de cet instrument d'évaluation de la santé holistique. Toutefois, l'instrument devra être soumis à une évaluation approfondie auprès d'un échantillon plus important et adéquat dans un ou plusieurs milieux. Cet instrument est accessible à ceux qui souhaitent l'utiliser ou approfondir son évaluation.

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ATTITUDES ET COMPORTEMENTS DES INFIRMIERES DU QUÉBEC Á L'ÉGARD DE L'ORIENTATION GLOBALE DE LA SANTÉ

Louise Hagan . Denise Paul . Jean Lambert

Au Québec, en 1970, la Commission Castonguay-Nepveu proposait une réforme importante de la philosophie et des politiques dans les services de santé. Essentiellement, cette réforme préconisait l'adoption d'une conception plus globale de la santé et des services. Cette nouvelle orientation consistait à accorder une importance accrue aux facteurs psycho-sociaux reliés à la santé et à la dimension préventive. On assista alors à des changements importants au niveau des structures des services de santé par la création des centres locaux de services communautaires (CLSC) et des départements de santé communautaire (DSC). Ces changements structuraux furent certes des éléments essentiels pour l'actualisation d'une nouvelle orientation dans les services de santé, mais le succès d'une réforme est aussi conditionnel à l'ouverture d'esprit et à l'engagement des professionnels, à valoriser la philosophie propice et à adopter des comportements qui traduisent cette philosophie à l'intérieur des structures.

Les infirmières constituent près de 30% de l'ensemble des professionnels de la santé au Québec et sont réparties dans la quasi-totalité des secteurs d'activité du réseau des affaires sociales. L'exercice de la profession d'infirmière implique un rapport constant avec les bénéficiaires de tous âges et à tous les stades du continuum santé-maladie. Elles ont donc un rôle déterminant dans l'application de la philosophie préconisée dans les services de santé.

Jusqu'à quel point ce groupe professionnel adhère-t-il à cette nouvelle philosophie et la traduit-il en comportements dans les tâches quotidiennes? C'est à ces questions que cette recherche tente de répondre.

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Quelques études traitent des attitudes des infirmières à l'égard de certaines dimensions reliées à l'orientation globale dans leur pratique professionnelle. Davidson et Lauver (1984) soulignent que les infirmières considèrent le support psycho-social et l'éducation santé comme des fonctions inhérentes au rôle de l'infirmière. Une étude menée par l'Ordre des infirmières et infirmiers du Québec (OIIQ) (1984) auprès des jeunes diplômés(es), révèle que les activités qu'ils (elles) pratiquent le moins dans leur milieu de travail, sont celles qui sont reliées aux dimensions psycho-sociales des soins infirmiers. Cette même étude démontre pourtant que les postes les plus convoités sont ceux qui permettent davantage de contact entre l'infirmière et le bénéficiaire. L'étude de Bradley (1983) démontre que l'établissement d'un environnement thérapeutique, le soin individualisé et la relation infirmière-bénéficiaire sont les dimensions reconnues comme les plus importantes par les infirmières dans leur pratique professionnelle. Allen, Frasure-Smith et Gottlieb (1980) pour leur part font ressortir l'impact du milieu de travail sur l'orientation professionnelle des infirmières. Elles soulignent notamment le fait que les infirmières adoptent une approche plus psycho-sociale dans leurs interventions lorsque le milieu supporte cette philosophie. Rosenthal, Marshall, MacPherson et French (1980) démontrent que les infirmières ont une perception particulière des comportements-problèmes d'origine émotive ou sociale chez les bénéficiaires. Ces infirmières considèrent que ces comportements-problèmes ne relèvent pas du domaine des soins infirmiers. Ces auteurs soulignent les incongruences entre la formation en sciences infirmières, inspirée de la philosophie de l'orientation globale de la santé, et les milieux de pratique professionnelle imprégnée de l'orientation bio-médicale traditionnelle.

Émergence de l'approche globale en sciences infirmières

Le nursing avait à ses origines une conception relativement globale des soins aux malades incluant en plus des aspects biologiques, des aspects psycho-sociaux et environnementaux. Nightingale (1859) était en effet préoccupée par les conditions sanitaires environnantes telles l'aération et la propreté de même que par les façons adéquates d'apporter un réconfort psychologique au patient.

Par ailleurs, comme le mentionne Parse (1981), tout au long de son histoire la formation en nursing a imité la formation en médecine et a par conséquent adopté un modèle de connaissances bio-médical et ce en raison du prestige et du pouvoir que détenait la médecine beaucoup plus solidement organisée comme profession. Ce modèle bio-médical a coexisté avec un modèle global à tendance psycho-sociale pendant plusieurs décennies en soins

infirmiers. En effet, alors que la formation infirmière était constituée en grande partie de cours de pathologie dispensés par des professeurs-médecins, Peplau (1952) écrivait son célèbre volume portant sur les dimensions psycho-sociales de la maladie et de la relation infirmière-client.

Henderson et Nite (1955) publiaient de leur côté une théorie des besoins fondamentaux de la personne. Leur vision des soins infirmiers était alors l'assistance du patient ou même sa suppléance lorsque nécessaire dans la satisfaction de ses 14 besoins de base dont 9 besoins étaient davantage physiques et 5 psychologiques.

La décennie suivante a vu croître et se préciser la dimension psycho-sociale avec des auteures telles Orlando (1961), Travelbee (1969), Ujheley (1968), et Wiedenbach (1964).

Au cours des années 1970, cette préoccupation pour le psycho-social s'est intégrée à des modèles bio-psycho-sociaux de soins infirmiers avec les publications d'Orem (1971), Roy (1976). Elle est ensuite devenue de plus en plus globale voire même holistique chez Krieger (1981), Newman (1979), Paterson et Zderad (1976), Rogers (1970) et plusieurs autres. La conception holistique unifie en un tout plus grand que la somme de ses parties les aspects bio-psycho-sociaux et considère l'individu dans sa relation constante avec son environnement.

Cadre théorique

L'orientation globale des soins infirmiers et de la santé s'apparente aux termes anglais "comprehensive care" ou "holistic health". L'étymologie du terme "holistic" vient du grec "holos" qui signifie la totalité ou la complétude d'une chose. Bauman, Brint, Piper, et Wright (1978) précisent des balises nous permettant de distinguer l'orientation globale ou holistique de l'orientation bio-médicale traditionnelle. La différence dans ces deux courants de pensée réside essentiellement dans les méthodes et techniques de traitement, dans le mode relationnel avec le bénéficiaire, et dans la perception de la santé et de la maladie. Bauman et al. (1978), Capra (1983), Ferguson (1981), et Frank (1981) sont parmi les auteurs, ceux qui nous ont permis d'opérationnaliser les principales distinctions entre le courant de pensée bio-médical et le courant holistique ou global. Pour une description plus détaillée de ce cadre théorique le lecteur est prié de se référer à un article précédent (Paul, Hagan & Lambert, 1985a).

But de l'étude

Le but de cette étude était d'évaluer chez les infirmières du Québec, leur niveau d'adhésion au concept d'orientation globale de la santé.

Questions de recherche:

1. Quelles sont les attitudes des infirmières du Québec à l'égard de l'orientation globale de la santé?

2. Quel est le degré d'implication des infirmières à adopter dans leur pratique professionnelle, des comportements qui s'inscrivent dans une orientation globale de la santé?

3. Existe-t-il un lien entre les caractéristiques démographiques, éducationnelles, occupationnelles et organisationnelles des infirmières et leur degré d'adhésion à l'orientation globale de la santé?

Définition des variables étudiées

Dans cette recherche les attitudes à l'égard de l'orientation globale sont définies en termes de niveaux d'accord et de désaccord avec certaines croyances inhérentes à l'orientation globale de la santé. Ces croyances sont reliées aux catégories de concepts qui définissent l'orientation globale, notamment:

- la définition de la santé et de la maladie,
- le pouvoir de décision accordé au bénéficiaire,
- la connaissance par le bénéficiaire de son état de santé,
- la multidisciplinarité,
- l'exploration et l'intervention sur les dimensions psycho-sociales des problèmes de santé,
- le potentiel d'autonomie du bénéficiaire.

Le degré d'implication des infirmières à adopter dans leur pratique professionnelle, des comportements qui s'inscrivent dans une orientation globale de la santé est mesuré par la fréquence des comportements qui traduisent l'orientation globale notamment:

- les comportements qui favorisent la prise en charge par le bénéficiaire de sa santé,
- les comportements qui démontrent une relation d'aide,
- les comportements de promotion de la santé.

Les caractéristiques démographiques sont l'âge, le sexe, le milieu socio-économique, les niveaux de scolarité du père et de la mère, la taille de la localité où l'infirmière exerce sa profession, le pays d'origine.

Les caractéristiques éducationnelles sont l'année d'obtention du permis, d'exercice de la profession d'infirmière, la formation initiale en soins infirmiers, la formation ultérieure (1er, 2e, 3e cycle).

Les caractéristiques occupationnelles sont le statut de travailleur (plein temps, temps partiel), type d'occupation, cadre ou non cadre, champ d'activité (unité de médecine, unité d'obstétrique, etc...).

Les caractéristiques organisationnelles sont le secteur de pratique (centre hospitalier, centre d'accueil, santé communautaire), milieux de formation.

Méthode

Population et échantillon

Cette étude descriptive a été réalisée sur un échantillon aléatoire systématique et stratifié de 954 sujets, constitué à partir du fichier informatisé de la population d'infirmières francophones inscrites au tableau de l'Ordre des infirmières et infirmiers du Québec (OIIQ) en 1983 (l'inscription au tableau de l'OIIQ est obligatoire pour pratiquer la profession). Les strates utilisées sont le sexe, la formation en soins infirmiers, et le domaine d'exercice professionnel. La taille de l'échantillon a été déterminée pour assurer dans chaque strate une erreur relative d'au plus 2% avec un seuil de confiance de 95% lors de l'estimation des valeurs populationnelles.

Instrument de mesure

Le questionnaire qui a été construit est constitué d'une échelle de type Likert de 36 énoncés mesurant les attitudes et dont les quatre classes ordinales varient de "fortement d'accord" à "fortement en désaccord". La fréquence des comportements est mesurée sur une échelle ordinale à quatre dimensions dont les valeurs varient de "à peu près jamais" à "à peu près toujours". Des questions fermées à choix multiples ont permis de recueillir des informations sur les variables démographiques, éducationnelles, occupationnelles et organisationnelles.

Validité

Deux épreuves ont permis de jauger la validité de contenu de l'instrument: une première a été faite chez un groupe de 16 infirmières connues personnellement des auteurs. Ces personnes représentaient une diversité dans les champs d'exercice de la profession (enseignement, milieu communautaire, santé mentale, milieu clinique) et avaient un dénominateur commun, c'est-à-dire que toutes étaient reconnues comme des infirmières adhérant aux valeurs qui sous-tendent l'orientation globale de la santé. Une deuxième épreuve a éte

Tableau 1

Distribution des moyennes ($\bar{x}$), écart-types (E.T.), étendues et intervalles de confiance (I.C.) des scores pour chaque catégorie de concepts de l'orientation globale.

N = 792

Catégories de concepts	($\bar{x}$)	E.T.	Etendue	I.C.(0.95)
Attitude globale	3.17	0.28	2.07-3.96	3.15-3.19
Conception qu'a l'infirmière de la santé et de la maladie	2.74	0.47	1.00-4.00	2.70-2.77
Le pouvoir de décision du patient	2.84	0.49	1.67-4.00	2.80-2.87
La connaissance par le patient de sa maladie ou de son problème de santé	3.34	0.45	1.75-4.00	3.31-3.38
La multidisciplinarité dans l'investigation et le traitement des problèmes de santé	3.24	0.56	1.25-4.00	3.20-3.28
L'exploration et l'intervention sur les dimensions psycho-sociales des problèmes de santé	3.37	0.39	1.83-4.00	3.34-3.40
Potentiel de prise en charge par le patient de sa santé	3.38	0.42	1.40-4.00	3.35-3.40

faite chez un groupe de 60 infirmières de divers niveaux de formation et qui comptent un nombre varié d'années d'expérience dans divers domaines d'exercice de la profession.

Nous avons recueilli leurs opinions quant à la nature des concepts mesurés et à la pertinence de la classification de ces concepts dans les catégories de concepts de l'orientation globale. La validité de construction fut assurée par une analyse factorielle faite sur l'ensemble des répondants, qui a permis d'adopter une classification définitive en six catégories d'énoncés mesurant les attitudes, et trois catégories de comportements.

Fidélité

Un test-retest à une semaine d'intervalle a été effectué sur un échantillon de 33 infirmières. En présence de distributions de fréquences très asymétriques pour les items, l'indice de concordance mesuré par la proportion des réponses identiques, a été préféré à la statistique Kappa. En ce qui concerne les résultats du prétest, l'indice de concordance moyen (± écart-type) fut de 0.65 ± 0.09 et 0.60 ± 0.10 pour les attitudes et comportements respectivement. Sans distinction entre les catégories extrêmes (i.e. "fortement d'accord" versus "d'accord", et "fortement en désaccord" versus "en désaccord"), l'indice de concordance augmente à 0.89 ± 0.08 et 0.81 ± 0.10 pour les attitudes et comportements respectivement. Ces résultats peuvent être considérés comme acceptables vu la nature du problème.

Résultats

Un total de 792 questionnaires ont été analysés, soit un taux de réponse de 83%. Les non-répondants se répartissent de façon homogène considérant les strates d'intérêt.

Attitudes des infirmières à l'égard de l'orientation globale de la santé

En ce qui concerne l'attitude globale, 219 infirmières (27.7%), sont fortement en désaccord ou en désaccord avec les énoncés, alors que 573 (72.3%) sont d'accord ou fortement d'accord avec les énoncés. Le tableau I indique la distribution des moyennes, écarts-types, étendues et intervalles de confiance pour l'ensemble des attitudes et pour chaque catégorie de concepts de l'orientation globale.

Comportements des infirmières à l'égard de l'orientation globale dans leur pratique professionnelle

Parmi les 792 répondants, 646 (81.6%) exercent actuellement la profession directement auprès des bénéficiaires, tandis que 146 (18.4%) travaillent dans

Tableau 2

Distribution des moyennes (x), écart-types (E.T.), étendues et intervalles de confiance (I.C.) de la fréquence des comportements des infirmières à l'égard de l'orientation globale

N = 646

	(x)	E.T.	Etendue	I.C.(0.95)
Comportement global	2.73	0.54	1.29-4.00	2.69-2.77
Comportements facilitant la prise en charge par le patient de sa santé	2.62	0.67	1.00-4.00	2.57-2.67
Comportements traduisant la relation d'aide de l'intervenant avec le patient	3.04	0.57	1.40-4.00	3.00-3.09
Comportement de promotion de la santé chez le patient	2.43	0.76	1.00-4.00	2.37-2.49

des secteurs de soins sans contact direct, constant avec les bénéficiaires (ex.: coordonnateur de programme, enseignants, etc..) Le tableau 2 indique la fréquence des comportements qui s'inscrivent dans l'orientation globale pour les infirmières (N=646) qui travaillent directement auprès des bénéficiaires.

Lien entre les caractéristiques des répondants et leur degré d'adhésion à l'orientation globale

Afin d'étudier le lien entre les caractéristiques des répondants et leur degré d'adhésion à l'orientation globale, des modèles de régressions multiples ont été ajustés pour chacune des variables dépendantes, i.e. les attitudes et les comportements. Suite aux analyses habituelles sur les valeurs résiduelles, ces

Tableau 3

Influence positive (+) et négative (-) des caractéristiques des répondants sur leurs attitudes et leurs comportements

Caractéristiques	Attitudes			Comportements			
	Ensemble des attitudes	Multidisciplinarité	Prise de décision du patient	Ensemble des comportements	Facilitant la prise en charge	Relation d'aide	Promotion de la santé
A) Socio-démographiques							
Sexe (Femme)		+		+		+	+
Age (an)	-	-	-				
B) Educationnelles, occupationnelles, organisationnelles							
Form. init. (univ.)	+	+	+				+
Diplôme sc. inf.							
(Ph.D.-M.Sc.)	+		+				
(B.Sc.)	+	+	+				
(certificat)	+	+					
Statut actuel							
(part., occas.)				-		-	-
Occupation							
(soignante)	-		-		-		
(enseignante)	+	+	+	+	+	+	
Secteur de pratique							
(CH)				-	-	-	-
(DSC-CLSC)	+		+	+	+	+	+
Activité actuelle							
(CH, méd., chir.)		-		-			
(SMI)							+
(psych.)						+	+
(p. âgées, long t.)				-	-		
(santé communaut.)		+					+

modèles ont démontré qu'une grande partie des attitudes s'expliquent difficilement par les caractéristiques des répondants. Des pourcentages de variance de chaque attitude expliquée par des caractéristiques varient de 5.1% à 14.4%. Les comportements s'expliquent davantage que les attitudes par les caractéristiques des répondants avec un pourcentage de variance variant de 19.1% à 38.9%.

Seuls les modèles qui expliquaient au moins 10% de la variance de la variable dépendante ont été considérés. Le tableau 3 présente l'effet des principales caractéristiques qui ont une influence sur chaque attitude ou comportement en terme de contribution positive ou négative, pour ces derniers modèles (3 attitudes, 4 comportements).

Discussion

Les résultats de cette étude indiquent qu'une grande proportion d'infirmières du Québec ont une attitude positive à l'égard d'une orientation globale dans leur pratique professionnelle. En effet 72.3% des répondants sont d'accord et parfois fortement d'accord avec les énoncés alors que 27.7% se disent en désaccord et parfois fortement en désaccord avec les énoncés lorsque ceux-ci sont considérés globalement. Certains concepts semblent moins favorisés que d'autres par les infirmières, notamment la perception de la santé et de la maladie et le pouvoir de décision du bénéficiaire. (cf. Tableau 1)

Ces dimensions de l'orientation globale sont assez récentes dans la littérature (Capra 1983; Ferguson, 1981; Krieger, 1981) et n'ont pas été explicitement définies dans le rapport Castonguay-Nepveu. Il est plausible de croire que les infirmières soient davantage en accord avec les croyances véhiculées par la réforme de la santé des années 1970, et moins imprégnées des croyances plus récentes qui ont élargi la philosophie de l'orientation globale, si l'on considère que la majorité des infirmières reçoivent une formation plus technique que philosophique, donc moins en contact avec les courants de pensée plus avant-gardistes.

En ce qui concerne l'attitude partagée des infirmières à l'égard du pouvoir de décision du patient, on peut se demander si la longue domination de la profession médicale comme décrite par Parse (1981), n'exerce pas encore aujourd'hui une influence sur un certain nombre d'infirmières. Peut-être faut-il accepter que l'accession à l'autonomie professionnelle se fasse par étape et que les effets d'incitation au conformisme qui régnait il y a vingt ans dans la formation infirmière (Paul, 1980) soient lents à disparaître. Une étude du modèle explicatif de la dimension: "Pouvoir de décision du patient" (Tableau 3) nous révèle à ce sujet que l'âge a une corrélation négative avec cette dimension alors que la formation universitaire présente une corrélation

positive. Même si ces résultats doivent être considérés avec réserve en raison du faible pourcentage de variance (14.4%), expliqué par l'ensemble des caractéristiques socio-démographiques, éducationnelles, occupationnelles et organisationnelles, il n'en demeure pas moins que ces résultats semblent confirmer l'influence conformiste de la formation antérieure et l'influence autonomiste de la formation universitaire. Le type d'occupation et le secteur de pratique semblent aussi reliés à cette dimension. Etre soignant est relié négativement au pouvoir de décision du patient alors qu'être enseignant ou oeuvrer en milieu communautaire y sont reliés positivement.

Si les infirmières ont en général, une attitude positive à l'égard de l'orientation globale, elles n'adoptent pas pour autant les comportements qui s'inscrivent dans cette orientation à une fréquence aussi élevée (Tableau 2). L'écart entre les attitudes et les comportements proviendrait-il de l'écart entre l'idéologie véhiculée dans les milieux éducatifs et la réalité vécue dans les services de santé?

Le comportement "Promotion de la santé" s'explique davantage (38.9%) par les caractéristiques des répondants. Il semble que le fait de travailler en milieu communautaire ou en psychiatrie favorise l'adoption de comportements de promotion de la santé alors que le fait de travailler en milieu hospitalier exerce une influence négative sur ce comportement. En cela nos répondants ressemblent aux répondants de l'étude d'Allen et al. (1980) qui souligne l'influence déterminante du milieu de pratique sur le modèle de dispensation des soins infirmiers.

Cette différence entre les attitudes et les comportements nous semble réfléter une réalité de la profession infirmière. En effet, il est plausible de croire que les infirmières valorisent l'orientation globale et que plusieurs obstacles s'opposent à traduire ces attitudes en comportements. Les répondants ont d'ailleurs explicité ces obstacles comme étant reliés aux conditions de travail, et au pouvoir décisionnel des infirmières dans les structures organisationnelles. Cette interprétation appelle toutefois une certaine prudence car le biais de désirabilité sociale dans les mesures d'attitudes pourrait aussi expliquer cette différence entre les attitudes et les comportements (Oppenheim, 1966; Paul, Hagan, & Lambert, 1985b).

Il est possible que la majorité des infirmières valorisent l'orientation globale peu importe leurs caractéristiques propres et que certains types d'infirmières, adoptent les comportements qui traduisent cette orientation. En effet, la formation en soins infirmiers qu'elle soit de niveau collégial ou universitaire, milite en faveur de cette orientation. Le courant de pensée véhiculé par la réforme des services de santé et la littérature nord-américaine en sciences de la santé, sont également des facteurs qui peuvent influencer les attitudes de l'ensemble des infirmières du Québec.

Certains aspects d'ordre méthodologique doivent toutefois être considérés dans l'interprétation du peu de variance sur les attitudes. Les concepts qui ont servi à définir l'orientation professionnelle ne représentent peut-être pas un échantillon valable pour cerner les attitudes des infirmières à l'égard de l'orientation globale.

L'analyse factorielle qui a servi à regrouper les énoncés dans chacun des concepts n'a peut-être pas réussi à fournir une classification valide de ces concepts, mais plutôt à regrouper les énoncés selon un facteur inconnu tel par exemple, la force de l'affirmation ou la spécificité des items.

Les modèles de régression choisis ne sont peut-être pas les modèles explicatifs les meilleurs pour vérifier la valeur prédictive des caractéristiques des répondants: la méthode utilisée, à savoir l'inclusion hiérarchique monotone, n'étudie en effet qu'un sous-ensemble restreint de modèles.

Dans le cas des comportements, le choix des caractéristiques des répondants s'avère peut-être meilleur. En effet les variables organisationnelles et occupationnelles sont susceptibles d'influencer les comportements des infirmières, si on se réfère aux commentaires des infirmières dans cette étude. Les facteurs sont en effet identifiés comme des obstacles possibles à l'orientation globale. Il est donc permis de croire que la struture organisationnelle et le secteur d'activité des infirmières permettent plus ou moins l'adoption de comportements.

Bien que le pourcentage de variance expliqué soit peu élevé en ce qui concerne les attitudes et plus important pour certains comportements, il demeure que pour les modèles de régression choisis, certaines caractéristiques expliquent davantage les attitudes et les comportements. Les liens doivent être interprétés avec prudence mais peuvent suggérer des hypothèses intéressantes qui mériteraient d'être vérifiées. Parmi ces hypothèses, l'impact du niveau de formation initiale en soins infirmiers serait particulièrement intéressant à vérifier sur les comportements qui traduisent une orientation globale dans la pratique professionnelle des infirmières. Le débat actuel sur la pertinence de la formation universitaire pour répondre davantage aux besoins de la population pourrait de ce fait être davantage documenté. Il serait également impératif de cerner de façon plus rigoureuse l'influence de la structure organisationnelle et du statut de travail sur les comportements des infirmières. Ces données permettraient d'orienter des changements organisationnels chez des groupes cibles tout en tenant compte du mouvement de rationalisation des ressources. Finalement, il serait fort intéressant de comparer l'orientation professionnelle des collègues des autres professions à celle des infirmières pour comprendre davantage le contexte de travail de ces dernières. Il est plausible de croire à une dissonnance cognitive assez marquée chez les infirmières pour la plupart intégrées dans une équipe

de travail où les objectifs poursuivis et les pouvoirs décisionnels sur les interventions et l'organisation varient considérablement. Cette dissonnance explique peut-être l'écart entre les attitudes et les comportements des infirmières à l'égard de l'orientation globale.

BIBLIOGRAPHIE

Allen, M., Frasure-Smith, N., & Gottlieb, L. (1980). *Models of nursing practice in a changing health care system:* A comparative study in these ambulatory care settings. Projet de recherche subventionné par Santé et Bien-Etre Canada, no 605-1234-46, Université McGill, Montréal, Qc.

Bauman, E., Brint, A.I., Piper, L., & Wright, P.A. (1978). *The holistic health handbook.* California: Berkeley Press.

Bradley, J.C. (1983). Nurses' attitudes toward dimensions of nursing practice. *Nursing Research, 32,* 110-114.

Capra, F. (1983). *Le temps du changement.* Monaco: Editions du rocher.

Davidson, R.A., & Lauver, D. (1984). Nurse practitioner and physician roles: Delineation and complementarity of practice. *Research in Nursing and Health, 7* (1), 3-9.

Ferguson, M. (1981). *Les enfants du verseau.* France: Calmann-Levy.

Frank, J. (1981). Holistic medicine: A view from the fence. *The Johns Hopkins Medical Journal, 149,* 222-227.

Krieger, D. (1981). *Foundations for holistic health nursing practices.* Philadelphia: Lippincott.

Henderson, V., & Nite, G. (1955). *Principles and practice of nursing.* New York: Macmillan.

Newman, M. (1979). *Theory development in nursing.* Philadelphia: Davis.

Nightingale, F. (1859). *Notes on nursing.* London: Harrison.

OIIQ. (1984, octobre). *Enquête sur l'exercice de la profession par les infirmières et infirmiers inscrits au tableau de l'Ordre depuis 1981.*

Oppenheim, A.N. (1966). *Questionary design and attitude measurement.* London: Heinemann.

Orem, D.E. (1971). *Nursing: Concepts of practice.* New York: McGraw Hill.

Orlando, Ida. (1961). *The dynamic nurse-patient relationship.* New York: Putnam.

Parse, R.R. (1981). *Man - living - health - A theory of nursing.* New York: Wiley Medical.

Paterson, J., & Zderad, L. (1976). *Humanistic nursing.* New York: Wiley Biomedical.

Paul, D. (1980). La théorie du développement de l'égo et son utilité pour la profession. *L'infirmière canadienne, 22* (6), 22-25.

Paul, D., Hagan, L., & Lambert, J. (1985a). Etude descriptive des attitudes et comportements des infirmières du Québec à l'égard de l'orientation globale de la santé et des facteurs associés à ces attitudes et comportements. Rapport de recherche présenté au Conseil québécois de la recherche sociale, RS-655-582-1, Volet infirmières.

Paul, D., Hagan, L., & Lambert, J. (1985b). Au-delà du malade. *Nursing Québec, 5* (7), 18-23.

Peplau, H. (1952). *Interpersonal relations in nursing.* New York: Putman.

Rogers, M. (1970). *An introduction to the theoretical basis of nursing.* Philadelphia: Davis.

Rosenthal, C.J., Marshall, V.W., MacPherson, A.S., & French, S.E. (1980). *Nurses patients and families.* New York: Springer.

Roy, C. (1976). *Introduction to nursing: An adaptation model.* New-Jersey: Prentice-Hall.

Ujheley, G. (1968). *Determinants of nurse patient relationship.* New York: Springer.

Travelbee, J. (1969). *Intervention in psychiatric nursing,* Philadelphia: Davis.

Wiedenbach, E. (1964). *Clinical nursing: A helping art.* New York: Springer.

ABSTRACT

Attitudes and Behaviours of Quebec Nurses Towards Holistic Health

Attitudes and behaviours of nurses towards holistic health were studied from a stratified random sample of 954 subjects in Quebec. A questionnaire with a Likert scale of 36 attitude items and 14 behaviour items was designed and tested for its reliability and validity. A total of 792 respondents (83%) completed the mailed questionnaire. Nurses scored higher on attitudes than on behaviours. Some attitudes were also scored higher than others. Scores on perception of health and illness and on the patient's decision power were less high. Nurses do not practice holistic health to the same extent as they value it. Regression analyses show that some of the circumstances characteristics of nurses can be useful to predict some of their attitudes and behaviours; namely, sex, age, education at the bachelor degree, occupation, and work setting. Methodological issues are discussed for the choice of the concepts, for the low level of explained variance, and for the value of the instrument.

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INFLUENCES OF AGE AND GENDER ON SELF-PERCEIVED COMPONENTS OF HEALTH, HEALTH CONCERNS, AND HEALTH RATINGS

Isabel MacRae . Barbara A. Johnson

The nursing study herein reported was originally motivated by an interest in elderly people, and in particular in what they perceive to be important components of health. It was quickly recognized that this information would have greater meaning if it could be compared to the perceptions of younger persons. In other words, do one's ideas of what constitutes health or well-being change as one grows older?

Literature Review

The gerontological research literature contains frequent references to the subjective quality of evaluations of well-being (Cutler, S.J., 1979; Larson, 1978; Maddox & Douglass, 1973; Palmore & Luikart, 1974; Stenback, Kumpulainen, & Vauhkonen, 1978). There is an implication that, because well-being is defined subjectively and individually, studies of the topic are somehow not quite as valid as those of some quantifiable characteristic such as blood pressure. Despite this, many facets of the topic have been researched, especially during the past decade, and both research and observation clearly indicate that a sense of well-being is fundamental to continued activity and vivacious lifestyle among the elderly (Cutler, N.E., 1979; Larson, 1978; Leviton & Santa Maria, 1979).

The literature reflects an awareness that many interdependent factors contribute to the individual's sense of well-being (Neugarten, Havighurst, & Tobin, 1961). Most of the research has been directed at those of at least 60 years of age, and correlations have been found between life satisfaction and morale and adjustment (Lohmann, 1977), activity (Maddox & Eisdorfer, 1962; Marshall, 1974), marital status, socio-economic status, formal and informal social interaction with non-kinsmen (Edwards & Klemmack, 1973), and family life participation (Medley, 1976). When health has been included as a variable, it has consistently taken first or second position among those variables most highly related to life satisfaction (Larson, 1978). Edwards and Klemmach (1973) further emphasize, as does Medley (1976), that it is the

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individuals' own perceptions of their health status that are effectively related to their sense of well-being.

Various studies have compared health self-assessment with the objective assessments of physicians. The studies consistently reveal that elderly people are accurate in their self-assessments; indeed they are somewhat more positive in assessing their health than are their physicians (Ferraro, 1980; La Rue, Bank, Jarvik, & Hetland, 1979; Maddox & Douglass, 1973; Shanas, Townsend, Wedderburn, Friss, Milhoj, & Stenhouwer, 1968).

Andrews and Withey (1976) suggest that, "One may justifiably claim that [it is] peoples' perceptions of their own well-being, or lack of well-being, that ultimately define the quality of their lives" (p.10). They divided factors contributing to life satisfaction into twelve "domains" that could be ordered in terms of closeness to self. Findings indicated that the factors closest to "self" tended to contribute most to life satisfaction. They further state that their research clearly shows that the "relationship between concerns and global well-being varies systematically according to closeness to self in perceptual space" (p.147).

In evaluating their well-being, subjects did not distinguish between tangible features and values, but rather expressed their concerns on the basis of psychological closeness to the self. The following questions then arise:

> What is closer to oneself than the function of one's physical apparatus - the body - through which contact with the physical, social, and psychological environment is mediated? Which components of that function are considered most important to persons in various phases of their lives?

N.E. Cutler (1979), in a secondary analysis of Andrews and Withey's data determined that the dimensionality of well-being is not the same for various age groups: each has a different version of "the good life". Health provides satisfaction for the young (aged 18-25) but declines as a source of satisfaction with age. The identification of health priorities at different times of life could contribute to knowledge that nurses need to develop programmes directed toward the goal of extending the healthful period of life, and thus the sense of well-being among the elderly.

A second factor has inspired this exploratory study. This is the increasing recognition of well-being as a process rather than a state. Hoke (1968) suggests that health itself is a process and that "there is a healthy way to live a disease" (p. 271). Bruhn, Cordova, Williams, and Fuentes (1977) and Bruhn and Cordova (1978) consider well-being a concept that is different from, and

larger than, health, which they define as a "state in time" in contrast to wellness, a process analagous to Erikson's (1963) achievement of ego integrity, or to Maslow's (1968) self-actualization. There have been many attempts at definitions of health but as yet no *pragmatic* definition has been widely accepted. Philosophically the Western world recognizes the well-being of the individual as a worthy goal; physical and mental health are accepted as major components of the well-being. However, it is a truism that the healthy man gives little thought to his health. It is a low-priority responsibility until some crisis develops when, as Dubos (1959) puts it, "Men as a rule find it easier to depend on healers than to attempt the more difficult task of living wisely" (p.114). The health care system sanctioned by our society supports this crisis and cure pattern and does little to assist in the management of non-crisis, long-term dysfunction of greater or less severity.

If health is a bedrock component of well-being, especially among elderly people, as Larson's (1978) review would suggest, and if learning is most effective when highly related to the experience and concerns of the learner, as Knowles (1970) and Warner (1981) indicate, effective programmes based upon the information that this survey seeks to elicit could expand the young adult's concepts of health into a larger conceptualization of wellness. It could also enable older adults to maintain and improve current levels of health and wellness by living wisely, thus extending wellness into late maturity.

Purposes and Research Questions

In this project we attempted to identify the health priorities of persons of various ages. A comprehensive population was requested to identify the degree of significance, to themselves, of selected components of physical and mental health. The immediate purposes in doing so were to categorize components of health by levels of priority for this population; to identify relationships between these components and selected demographic and health-related factors; and to provide baseline data for future research and other health-related programmes. The ultimate purpose of such research and programmes is to maintain health (or improve it), and thus extend well-being over a greater proportion of the life span.

Among the immediate questions addressed by this survey were the following:

1. Which components of health were most important to the respondents?
2. Was the importance of the component related to age or gender of the respondents?
3. What health concerns were being experienced by the respondents?
4. Were these health concerns influenced by age?
5. How did respondents rate their own current health?
6. Were these ratings related to health concerns?

Table 1

Components of Health

Physical Components

1. Energy available to do what you wish
2. Absence of pain
3. Good appetite
4. Quality of sleep
5. Sufficient breath for unusual exertion
6. Ability to hear
7. Freedom from hunger
8. Ease of breathing
9. Adequate vision
10. A satisfactory sex life
11. A well-functioning heart (unawareness of heart function)
12. Muscle strength
13. A good digestion
14. A flexible body
15. Quick reactions
16. Ability to climb steps without breathlessness
17. Absence of constipation
18. Warm hands and feet
19. Absence of varicose veins
20. Ease in moving around
21. Sensitivity to touch
22. Quickness of healing
23. Ability to delay urinating (passing water)
24. Absence of allergies
25. Condition of your skin
26. Frequency of illnesses
27. Good balance/coordination
28. Tolerance of heat/cold
29. Daily exercise
30. Freedom from infection

Psychosocial Components

1. Having time for doing the things you wish to do
2. Your community as a place to live
3. How fairly you get treated
4. The amount of fun and enjoyment you have
5. How well your dwelling fits your needs
6. The extent to which your physical needs are met
7. What you are accomplishing or have accomplished in your life
8. The presence/absence of someone to do things with
9. Your freedom to do what you want
10. Your physical condition
11. Your sense of responsibility
12. The way you handle the problems which arise in your life
13. The amount of beauty and attractiveness in your world
14. How secure you are financially
15. How creative you can be
16. The extent to which you maintain traditions and links with the past
17. The amount of friendship and love in your life
18. The sincerity and honesty of others
19. The amount of respect you get from others
20. How well you get on with others
21. The reliability of people you depend upon
22. How much you are accepted and included by others
23. How safe you feel in this neighbourhood
24. The way our national government is operating
25. Your closeness to nature
26. The amount of pressure you are under
27. A general sense of enjoyment in your life
28. The feelings that life has treated you fairly to date

It is expected that the answers to these and other exploratory questions will stimulate other questions, and that clusters of related nursing studies will develop.

Method

The sample

A questionnaire was sent to approximately 24,000 employees and pensioners of a major Canadian bank, through its internal distribution channels. The employees and pensioners were assured that their participation was voluntary and anonymous, and that no individual response would be shared with anyone at the bank. Envelopes addressed to the researchers were provided, so that bank managers would be unaware of who had participated. The sample, while not random, represented a Canada-wide population of employees and pensioners, male and female, aged from late teens to early nineties. It is reasonable to assume that these people had varied interests, lifestyles, and health conditions. They have or have had jobs of varying degrees of complexity and responsibility, having only their employer in common.

Instrument

The questionnaire developed by the investigators consisted of a list of 30 items (Table 1) related to physical health. These 30 items were derived from the literature on physiological systems, and were validated with clinical experts. The questionnaire also consisted of 28 items related to the psychosocial aspects of health that were developed and tested by Andrews and Withey (1976, pp. 32-34). For each of the 30 items related to physical health, the respondents were asked to rate, on a five point Likert-type scale, how important that item was to them in assessing their own health. The response choices were: very important, quite important, sometimes important, not very important, and not at all important. For each of the 28 items related to psychosocial health, the respondents were asked to rate, on an identical scale, how important that item was to them in judging their own feelings. The respondents were also asked for certain socio-demographic data, for a rating of their own current health, and for their major current health problem, if any. All 58 items were pretested on a small, selected group of people of various ages.

Results

Respondents

More than 6,000 responses were received. Although this is a large number, it represents only a 25% return rate and it is impossible to assess whether the people not returning the questionnaire differed systematically from those who

Table 2

Physical Components Of Health Most Often Ranked Important And Not Important

	Important	Frequency[a]
1.	Energy available to do what you wish	5544
2.	Adequate vision	5501
3.	A well-functioning heart	5303
4.	Ability to hear	5243
5.	Quality of sleep	5215
6.	Ease of breathing	5098
7.	Absence of pain	4706
8.	Sufficient breath for unusual exertion	4661
9.	Good balance/coordination	4653
10.	Freedom from infection	4644

	Not Important	Frequency[b]
1.	Absence of varicose veins	1868
2.	Ability to delay urinating	1513
3.	Absence of allergies	1444
4.	Warm hands and feet	1355
5.	Sensitivity to touch	1153
6.	Freedom from hunger	1142
7.	Good appetite	1134
8.	Absence of constipation	1037
9.	Muscle strength	941
10.	Frequency of illnesses	912

[a]Number of respondents ranking component "very important" or quite important".

[b]Number of respondents ranking component "not very important" or "not at all important".

Table 3

Pshycosocial Components Of Health Most Often Ranked Important And Not Important

	Important	Frequency[a]
1.	Your sense of responsibility	5683
2.	The amount of friendship and love in your life	5614
3.	The way you handle the problems which arise in your life	5601
4.	A general sense of enjoyment of life	5538
5.	The sincerity and honesty of others	5533
6.	Your physical condition	5528
7.	How well you get on with others	5491
8.	The reliability of people you depend upon	5384
9.	Having time for doing the things you wish to do	5361
10.	The amount of respect you get from others	5279

	Not Important	Frequency[b]
1.	The extent to which you maintain traditions and links with the past	1449
2.	Your closeness to nature	1131
3.	How creative you can be	1033
4.	The way our national government is operating	924
5.	How safe you feel in this neighbourhood	564
6.	The amount of beauty and attractiveness in your world	548
7.	Your community as a place to live	460
8.	The presence/absence of someone to do things with	442
9.	The feeling that life has treated you fairly to date	432
10.	The amount of pressure you are under	391

[a]Number of respondents ranking component "very important" or quite important".

[b]Number of respondents ranking component "not very important" or "not at all important".

Table 4

Components of Health Ranked Important by Age Group

	Age Group						
Physical Components	29 and under	30-39	40-49	50-59	60-69	70-70	80+
1. Energy available to do what you wish	90.05	91.33	89.77	91.66	88.27	87.18	81.08
2. Adequate vision	90.70	88.59	88.62	89.85	85.38	89.74	88.89
3. A well-functioning heart (unawareness of heart function)	86.01	85.67	87.93	86.91	86.25	82.91	83.33
4. Ability to hear	86.19	83.87	85.35	86.57	81.14	88.39	80.55
5. Quality of sleep	85.30	84.55	85.96	84.22	79.81	80.89	88.88
6. Ease of breathing	84.04	81.52	83.43	81.73	79.81	85.81	83.34
7. Absence of pain	76.61	76.49	77.10	78.08	79.81	75.82	77.14
8. Sufficient breath for unusual exertion	76.57	75.63	76.89	72.53	72.30	76.43	83.34
9. Good balance/coordination	77.66	74.13	75.98	76.28	75.24	76.92	65.71
10. Freedom from infection	76.74	73.98	77.48	77.48	73.59	78.71	77.77
Psychosocial Components							
1. Your sense of responsibility	92.25	93.54	93.78	93.78	90.52	91.61	100.00
2. The amount of friendship and love in your life	94.83	90.11	88.66	85.80	87.32	90.44	91.67
3. The way you handle the problems which arise in your life	91.18	91.91	92.68	92.02	90.00	88.47	86.11
4. A general sense of enjoyment in your life	93.43	88.32	88.39	84.78	86.79	86.62	83.33
5. The sincerity and honesty of others	91.73	88.50	88.87	88.46	87.26	90.45	91.43
6. Your physical condition	89.91	89.77	92.31	91.07	90.57	90.38	88.89
7. How well you get on with others	91.35	87.18	89.13	88.16	84.84	86.07	86.12
8. The reliability of people you depend upon	86.90	86.81	90.71	88.75	86.73	87.98	97.22
9. Having time for doing the things you wish to do	90.15	87.67	86.07	81.30	81.61	78.71	71.43
10. The amount of respect you get from others	88.63	85.23	84.30	79.58	75.95	79.62	86.11

Note: The numbers in the table refer to percentage of respondents in the age group indicated who ranked the component "very important" or "quite important".

The percentages in the 80+ age group are based on totals of 35-37 and must be viewed cautiously.

did. The total responses presented in the tables vary because of computer errors and instances of no response to particular questions. The respondents were predominantly women (72%). They were also predominantly young: 43% in their 20s, 31% in their 30s, 14% in their 40s, 6% in their 50s, 3% in their 60s, 2% in their 70s, and 0.5% in their 80s or older. Seventy-seven percent of the sample were presently employed full time. Sixty-seven percent were married.

Findings

The findings of the study are presented as they correspond to the questions addressed in the survey. The first and most basic question was:

Question 1: Which components of health were most important to the respondents?

In comparing the general responses to the 30 physical and the 28 psychosocial components, it seems the respondents had more intense feelings, both positively and negatively, about the physical components. There was a higher frequency of "very important" and "not at all important" ratings for the physical components, whereas the psychosocial components tended to be rated more moderately in the middle three categories.

When the first two categories, "very important" and "quite important", were combined, the aforementioned difference between the physical and psychosocial sets of components evened out. However, after combining the final two categories, "not very important" and "not at all important", the physical components still drew a higher proportion of responses at this end of the scale than did the psychosocial components.

In looking at specific components of health, the two major sets were examined separately. Ratings of "very important" and "quite important" were combined and will hereafter be referred to as "important". Ratings of "not very important" and "not at all important" were combined and will hereafter be referred to as "not important".

Tables 2 and 3 illustrate the ten most and ten least important components within each of the major divisions of physical and psychosocial health. Having energy available to do what one wishes was the physical component most frequently ranked important, whereas the absence of varicose veins was most frequently ranked not important. Among the psychosocial components, one's sense of responsibility was most frequently ranked important, whereas maintaining traditions and links from the past was most frequently ranked not important.

Question 2: Was the importance of the component related to age or gender of the respondents?

To examine whether age influenced the rankings of health components, the data for the ten most and least important components were compared with ages grouped in decades. In order to avoid small, incomplete decades, the 18 and 19 year olds were added to the 20s decade and respondents 90 years of age and older were added to the 80s decade. Table 4 illustrates the breakdown by age of the ten physical and ten psychosocial components most often ranked "important." It was found that age had little effect on the rankings of physical components but somewhat more effect on the rankings of some psychosocial components. For example, the amount of friendship and love in one's life was more important to respondents in their 20s than to respondents in all other decades; and the amount of respect one got from others was more important to respondents in the first three age groups. Also, having time for doing the things one wishes to do became increasingly less important as age advanced.

To examine whether men and women tended to rank the components differently, the data for the ten most and ten least important components were re-analyzed according to gender. Gender did seem to have a stronger influence than age on rankings of the components. Women tended to rank components "very important" more frequently than did men. Even when the top two rankings ("very important" and "quite important") were combined, there were higher percentages of women than men at this end of the scale. Since the sample was predominantly female, and gender seemed to influence ranking, it was thought women might be unduly influencing the original list of ten most and least important physical and psychosocial components. Therefore these lists were compiled again for men and women separately (Tables 5 and 6).

Some interesting results emerged. The first and second most important physical components remain the same within the subgroups as they appeared in the total group (Table 2). For the remaining eight positions, a few new components appear, but more frequently there is just a shifting of position within that range. The same is true of the ten least important physical components.

The positions of appetite and muscle strength deserve mention. Their positions among the list of ten least important physical components seem clearly to have been influenced by gender. In the female subgroup, their positions move higher (become less important) than in the total group; in the male subgroup, they are no longer among the ten least important (i.e. they have become more important). Condition of the skin is another variable clearly showing the influence of gender. For the total group it appears neither

Table 5

Physical Components of Health Most Often Ranked Important And Not Important by Men and Women

Important

Men	Women
1. Energy available to do what you wish	1. Energy available to do what you wish
2. Adequate vision	2. Adequate vision
3. A well-functioning heart	3. Quality of sleep
4. Ability to hear	4. Ability to hear
5. Ease of breathing	5. A well-functioning heart
6. Quality of sleep	6. Ease of breathing
7. Sufficient breath for unusual exertion	7. Absence of pain
8. Good balance/coordination	8. Condition of your skin
9. A good digestion	9. Ease in moving around[a]
10. Freedom from infection	10. Good balance/coordination[a]

Not important

Men	Women
1. Absence of varicose veins	1. Absence of varicose veins
2. Ability to delay urinating	2. Ability to delay urinating
3. Warm hands and feet	3. Absence of allergies
4. Absence of allergies	4. Good appetite
5. Sensitivity to touch	5. Warm hands and feet
6. Absence of constipation	6. Freedom from hunger
7. Freedom from hunger	7. Muscle strength
8. Condition of your skin	8. Sensitivity to touch
9. Tolerance of heat/cold	9. Absence of constipation
10. Frequency of illness	10. A satisfactory sex life

[a]Tied for positions 9 and 10

Table 6

Psychosocial Components of Health Most Often Ranked Important and Not Important by Men and by Women

Important

	Men		Women
1.	Your sense of responsibility	1.	How secure you are financially
2.	A general sense of enjoyment in your life	2.	The amount of friendship and love in your life
3.	The way you handle the problems in your life	3.	Your sense of responsibility
4.	Your physical condition	4.	The sincerity and honesty of others
5.	The amount of friendship and love in your life	5.	The way you handle the problems which arise in your life
6.	Having time for doing the things you wish to do	6.	How well you get on with others
7.	The reliability of people you depend upon	7.	Your physical condition
8.	What you are accomplishing or have accomplished in your life	8.	A general sense of enjoyment in your life
9.	How well you get on with others	9.	The amount of respect you get from others
10.	The sincerity and honesty of others	10.	The reliability of people you depend upon

Not Important

	Men		Women
1.	The extent to which you maintain traditions and links with the past	1.	The extent to which you maintain traditions and links with the past
2.	Your closeness to nature	2.	Your closeness to nature
3.	How creative you can be	3.	How creative you can be
4.	How safe you feel in this neighbourhood	4.	The way our national government is operating
5.	The way our national government is operating	5.	The amount of beauty and attractiveness in your world
6.	The amount of beauty and attractiveness in your world	6.	Your community as a place to live
7.	The feeling that life has treated you fairly to date	7.	The presence/absence of someone to do things with
8.	The presence/absence of someone to do things with	8.	The feeling that life has treated you fairly to date
9.	Your community as a place live	9.	How safe you feel in this neighbourhood
10.	How much you are accepted and included by others	10.	The amount of pressure you are under

among the ten most important nor among the ten least important. However, among the subgroup of women, it becomes eighth most important; among the subgroup of men, it becomes eighth least important.

The psychosocial components were similarly influenced by gender. There was more shifting of positions within the top ten and bottom ten rankings than there was appearance of new components. A notable exception is the appearance of financial security as the most important psychosocial component for women; it does not appear at all among the men's ten highest ranked components.

It must be pointed out that the lists appearing in Tables 2-6 reflect comparisons of components against each other either at the upper or lower end of the five point scale. They do not reflect comparisons within the scale for each separate component. Indeed, with one exception, even components at the top of the "not important" list were ranked "important" more often than "not important". The one exception was for "absence of varicose veins" among the male subgroup, where the "not important" ratings outnumbered the "important" ratings. The component "ability to delay urinating" was close to being the same kind of exception, again within the male subgroup. In this subgroup "not important" ratings were only slightly fewer than "important" ratings.

Question 3: What health concerns were being experienced by the respondents?

Two cautionary notes must be made before approaching the analysis of this question. The information about the respondents' health concerns came from one question only, and that question asked the respondents to name what they considered to be their major health concern. Therefore, if a respondent had multiple health concerns, the information obtained would not reflect all of the concerns. Second, it became obvious in the analysis that "health concern" had been interpreted by the respondents more broadly than the researchers had intended. The researchers had been interested in finding out about existing health problems or conditions. The respondents' answers clearly indicated they were also responding in terms of fears about developing a particular condition in the future, e.g. cancer or heart disease, and also fears about broader, environmental issues such as pollution, that have an impact on health.

The responses were categorized by a team of coders into three broad categories:

1. Physical concerns

   existing physical health problems/diseases/conditions (e.g. hypertension, arthritis, diabetes, deafness, allergies, ulcers, constipation, angina, etc.).

2. Mental health concerns

   a. existing mental health problems (e.g depression, nervousness, job stress, etc.).
   b. fear of developing problems in the future (e.g. fear of getting cancer or heart disease).
   c. generalized fear of being able to adapt to future condition (e.g. fear of aging) or of becoming a burden in the future.

3. Lifestyle concerns

   a. concerns related to one's own habits or patterns of living (e.g. smoking, exercise, general fitness, weight, diet, etc.).
   b. concerns related to environmental conditions that could affect one's own health (e.g. second-hand smoke, food additives, industrial pollution, etc.).

Table 7

Health Concerns Related To Age

	Health Concerns				
Age	Physical	Mental	Lifestyle	None	Total
29 and under	17.36%	8.21%	31.05%	43.39%	2,535
30-39	19.72%	13.71%	24.43%	42.15%	1,846
40-49	23.73%	12.92%	19.50%	43.85%	805
50-59	33.84%	13.41%	16.16%	36.59%	328
60-69	43.85%	8.33%	9.90%	38.02%	192
70-79	51.70%	7.48%	10.88%	29.93%	147
80 and above	58.06%	3.23%	-	38.71%	31
					5,884

*p < .0001 (chi square test of significance)
Contingency coefficient .225

Question 4: Were these health concerns influenced by age?

Table 7 illustrates the three categories of health concerns of the sample divided into age groups by decades. Most of the respondents in each group mentioned some kind of concern. Lifestyle concerns and physical concerns were mentioned more frequently than mental health concerns. Age appeared to be associated with the kind of health concern mentioned. Health concerns of a physical nature increased as age increased, whereas lifestyle concerns decreased with increasing age. (The small number of respondents in the 80s decade must be noted). These findings remained when gender was controlled for.

Specific concerns within the three categories were also examined with respect to age (Table 8). Within the physical concerns category, there was a steady increase in cardiovascular concerns as age increased and a sharp peak in the 80s decade in concerns related to the special senses (vision and hearing in particular). Within the mental health concerns category, fear of developing a particular disease (notably cancer and heart disease) was higher in the first four decades, especially the 30s decade. Within the lifestyle concerns category, concerns about weight were most prominent among those in their 20s and 30s and declined steadily as age increased. Similarly, concerns about smoking and fitness/exercise tended to decrease with age.

Question 5: How did respondents rate their own current health?

The respondents were asked to rate their own current health in comparison to their perceptions of the health of people of a similar age. The rating was on a four point scale ranging from excellent to poor. Most respondents rated their health as good or excellent.

Question 6: Were these ratings related to health concerns?

These ratings were cross-tabulated with the kind of major health concern reported (Table 9). Whether any concern at all was mentioned did seem to be strongly associated with health rating, in the expected direction. Fifty-six per cent of the respondents who reported excellent health mentioned a concern. This percentage increased to 93% of the respondents who rated their health as poor and who mentioned a concern. The physical concerns increased consistently as health rating decreased, and this pattern held for all age groups. Lifestyle concerns also increased as health rating decreased, although the range of change was smaller and the relationship was not consistently true across all age groups. Rather, the association was strongest in the 20s and 30s decades. Since these decades comprised 74% of the respondents, the association found in the total group was undoubtedly influenced by the association within these two decades. There was no discernible association between mental health concerns and health rating. The small number of

Table 8

Specific Health Concerns of Respondents at Various Ages

	Age Group						
Health Concern	29 and under	30-39	40-49	50-59	60-69	70-70	80+
Physical							
Cardiovascular	2.17%	3.90%	5.96%	13.41%	20.73%	19.05%	25.81%
Respiratory	1.50%	1.95%	1.49%	1.52%	2.07%	4.08%	3.23%
Digestion	1.18%	1.08%	1.12%	1.52%	1.55%	0.68%	-
Elimination	0.99%	1.19%	0.50%	0.91%	2.07%	2.04%	6.45%
Musculo-skeletal	1.97%	2.98%	4.09%	6.40%	10.36%	10.88%	3.23%
Reproductive	1.34%	0.81%	0.74%	0.30%	0.52%	0.68%	-
Special senses	1.54%	0.76%	1.86%	0.91%	2.59%	3.40%	16.13%
Allergies	1.89%	1.95%	1.86%	1.83%	-	-	-
Hormonal	1.62%	1.03%	1.36%	1.52%	2.59%	7.48%	3.23%
Cancer (unspecified site)	0.99%	1.84%	2.85%	2.13%	1.55%	2.04%	-
Headaches	0.59%	1.08%	1.24%	1.22%	-	0.68%	-
Other	1.58%	1.13%	0.74%	2.13%	-	0.68%	-
Mental Health							
Fear of specific disease	3.98%	6.77%	5.83%	5.49%	1.55%	2.72%	-
Stress/work pressure	1.65%	3.74%	3.72%	3.05%	1.04%	0.68%	-
Depression or nervousness	0.99%	1.19%	1.36%	1.52%	1.56%	-	-
Fear of incapacity or acceptance of aging	0.52%	0.76%	1.12%	2.13%	2.07%	1.36%	-
Other	1.07%	1.24%	0.87%	1.21%	2.07%	2.72%	3.23%
Lifestyle							
Weight	11.82%	11.37%	9.55%	6.10%	3.63%	3.40%	-
Fitness/exercise	7.29%	4.87%	2.73%	1.83%	2.07%	1.36%	-
Smoking	5.04%	3.36%	3.47%	2.74%	0.52%	0.68%	-
Diet	1.10%	0.54%	0.50%	0.61%	1.55%	-	-
Environmental conditions	5.79%	4.28%	3.22%	4.88%	2.08%	5.44%	-

Note: The numbers in the table refer to percentage of respondents in the age group indicated who named the corresponding health concern as their major one.

Table 9

Health Rating Related to Health Concerns

	Health Concerns				
Health Rating	Physical	Mental	Lifestyle	None	Total
Excellent	20.28%	13.19%	22.11%	44.42%	1,425
Good	23.84%	11.33%	29.54%	35.29%	3,213
Fair	34.37%	13.47%	33.85%	18.31%	579
Poor	52.17%	6.52%	34.78%	6.52%	46
					5,263

*p < .0001 (chi square test of significance)
Contingency coefficient .178

people rating their health as poor must be noted when making comparisons among health rating groups.

Limitations

The respondents in this study were all employed by the same institution, and, in comparison to the population at large, persons employed in managerial and clerical positions were probably over-represented. The proportion of elderly people and males was low. The questionnaire items related to physical health were developed by the investigators and were not pretested extensively. The question about current health concerns was somewhat ambiguously worded and did not encourage respondents to give information about multiple health problems, if they had any. Finally, this survey, like all surveys dependent on voluntary response, must acknowledge that those persons returning the questionnaire may have been different from those who did not respond at all.

Discussion

One of the main questions motivating this research was whether one's ideas of what constitutes health change as one grows older. To answer this question properly would require a longitudinal study over a period of a great number of years, where the same people would be assessed as they age. This study employed an imperfect alternative, a cross-sectional design, where

different people in various age groups were compared at one point in time. This design weakness must be kept in mind in examining the data relevant to age. For this group of respondents, age did not seem to be associated with ideas of what is involved in the physical components of health. On the other hand, it did seem to affect perception of some psychosocial components of health.

Gender seemed to have a stronger influence than age on what one considers important components of health. More women mentioned financial security as important to their psychosocial health than any other factor. It did not appear at all in the men's "top ten" list. Both men and women named energy and adequate vision as the most important physical components.

The majority of respondents in each group mentioned having some major health concern. Lifestyle concerns and physical concerns were much more prevalent than mental health concerns. Categories of health concerns were associated with age: physical concerns increasing with age and lifestyle concerns decreasing with age.

Most respondents considered themselves to be in good or excellent health. Health rating was associated with health concerns in the physical and lifestyle categories, with fewest concerns among those in excellent health.

Conclusion

This survey is a first step in determining what components of health people value, and how their perceptions are affected by various personal and health-related characteristics. It remains now for nurses to develop strategies that will motivate people to protect and maintain the components of health that have highest priority for them. Programmes could be developed on the basis of what is currently known about the effects of such variables as activity and nutrition on energy, sleep quality, and cardiac functioning, and what is known about the protection of vision and hearing. Participation in such programmes could be expected to extend well-being further into the "elderly" years.

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REFERENCES

Andrews, F.M., & Withey, S.B. (1976). *Social indicators of well-being.* New York: Plenum Press.

Bruhn, J.G., & Cordova, F.D. (1978). A developmental approach to learning wellness behavior, Part II: Adolescence to maturity. *Health Values, 2* (1), 16-21.

Bruhn, J.G., Cordova, F.D., Williams, J.A., & Fuentes, R.G. Jr. (1977). The wellness process. *Journal of Community Health, 2,* 209-221.

Cutler, N.E. (1979). Age variations in the dimensionality of life satisfaction. *Journal of Gerontology, 34,* 573-578.

Cutler, S.J. (1979). Survey research in the study of aging and adult development: A commentary. *The Gerontologist, 19,* 217-219.

Dubos, R. (1959). *Mirage of health,* Garden City, New York: Anchor Books.

Edwards, J.N., & Klemmack, D.L. (1973). Correlates of life satisfaction: A re-examination. *Journal of Gerontology, 28,* 497-502.

Erikson, E.H.. (1963). *Childhood and society* (2nd ed.). New York: W.W. Norton.

Ferraro, K.F. (1980). Self-ratings of health among the old and the old-old. *Journal of Health and Social Behavior, 21,* 377-393.

Hoke, B. (1968). Promotive medicine and the phenomenon of health. *Archives of Environmental Health, 16,* 269-278.

Knowles, M.S. (1970). *The modern practice of adult education.* Chicago:: Association Press.

La Rue, A., Bank, L., Jarvik, L. & Hetland, M. (1979). Health in old age: How do physicians' ratings and self-ratings compare? *Journal of Gerontology, 34,* 687-691.

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology, 33,* 109-125.

Leviton, D., & Santa Maria, L. (1979). The adults' health and developmental program: Descriptive and evaluative data. *The Gerontologist, 19,* 535-543.

Lohmann, N. (1977). Correlations of life satisfaction, morale and adjustment measures. *Journal of Gerontology, 32,* 73-75.

Maddox, G.L., & Douglass, E.B. (1973). Self-assessment of health. *Journal of Health and Social Behavior, 14,* 87-93.

Maddox, G.L. & Eisdorfer, C. (1962). Some correlates of activity and morale among the elderly. *Social Forces, 40,* 254-260.

Marshall, V.W. (1974). The last stand: Remnants of engagement in the later years. *Omega, 5* (1), 25-35.

Maslow, A.H. (1968). *Toward a psychology of being* (2nd ed.). New York: Von Nostrand.

Medley, M.L. (1976). Satisfaction with life among persons sixty-five years and older. *Journal of Gerontology, 31,* 448-455.

Neugarten, B.., Havighurst, R., & Tobin, S. (1961). The measurement of life satisfaction. *Journal of Gerontology, 16,* 134-143.

Palmore, E., & Luikart, C. (1974). Health and social factors related to life satisfaction. In E. Palmore (Ed). *Normal aging II* (pp. 183-201). Durham, N.C.: Duke University Press.

Shanas, E., Townsend, P., Wedderburn, D., Friss, H., Millhoj, P., & Stenhouwer, J. (1968). *Older people in three industrial societies.* New York: Atherton Press.

Stenback, A. Kumpulainen, M., & Vauhkonen, M.L. (1978). Illness and health behavior in septuagenarians. *Journal of Gerontology, 33,* 57-61.

Warner, M. (1981). Health and nursing: Evolving one concept by involving the others. *Nursing Papers, 13* (1), 10-17.

RÉSUMÉ

Perception des facteurs de santé, inquiétudes face à la santé et évaluation de la santé, selon l'âge et le sexe

Le présent travail vise à identifier de manière pragmatique les priorités en matière de santé, telles qu'elles sont perçues par des personnes d'âges variés. Un questionnaire adressé aux employés et aux retraités d'une importante banque canadienne a permis de recueillir plus de 6 000 réponses concernant l'importance attachée à de nombreux facteurs de santé physiques et psychosociaux, ainsi que les inquiétudes face à la santé et l'évaluation de la santé. Les résultats indiquent que le sexe joue un rôle plus important que l'âge dans l'importance attachée aux divers facteurs de santé. L'âge a influencé la nature des inquiétudes face à la santé. L'évaluation de la santé et les inquiétudes à ce sujet y étaient associées.

THE INCORPORATION OF CULTURAL CONCEPTS INTO BASIC NURSING TEXTS

Janice M. Morse . Jennifer English

Basic nursing texts used by first-year nursing students are a major socializing force, facilitating the students' integration into the nursing profession. These texts generally provide an overview of nursing, including a description of basic nursing assessment and skills.

Although transcultural nursing is a relatively new field, information on the cultural aspects of nursing care has been available for more than a decade. Transcultural nursing was established as a specialty more than ten years ago, and care of the culturally variant client is now recognized as a responsibility for all nurses (Leininger, 1984).

In spite of the importance of the cultural aspects of care, there is evidence that it is not included in first-year texts. Our purpose in writing this article, therefore, is to explore the *adequacy* and *method* of integration of cultural content into seven basic nursing texts. This article is not intended as a book review, but rather a content analysis of those texts that introduce the first-year student to nursing concepts. The books selected are:

Brill, E.L., & Kilts, D.R. (1980). **Foundation for Nursing**. New York: Appleton-Century-Crofts, Inc.

Du Gas, B.W. (1983). **Introduction to Patient Care: A Comprehensive Approach to Nursing** (4th Ed.). Philadelphia: W.B. Saunders Co.

Kemp, B., & Pillitteri, A. (1984). **Fundamentals of Nursing: A Framework for Practice**. Boston: Little, Brown & Co.

Krozier, B., & Erb, G. (1983). **Fundamentals of Nursing: Concepts and Procedures.** (2nd Ed.). Reading, Mass.: Addison-Wesley Publ. Co.

Lindberg, J., Hunter, M., & Kruszewski, A. (1983). **Introduction to Person-Centered Nursing**. Philadelphia: J.B. Lippincott.

Narrow, B.W., & Buschle, K.B. (1982). **Fundamentals of Nursing Practice**. New York: John Wiley & Sons.

Sorensen, K.C., & Luckmann, J. (1979). **Basic Nursing: A Psychophysiologic Approach**. Philadelphia: W.B. Saunders.

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Importance for nursing

In the Canadian multicultural society, the relevance of the cultural aspects of care in daily practice is obvious. Transcultural nursing is not an esoteric specialty that one may need if intending to practise "overseas". Furthermore, it is the client's right to have care provided that is culturally acceptable. The provision of such care increases patient compliance and decreases the stress of hospitalization.

Understanding cultural variation also increases the quality of care. For example, how can one assess pain or distress in a labouring patient, without understanding that in some cultures stoicism is the norm while in others a more verbal expression of pain is usual? Furthermore, how does a nurse do an *individual* assessment without stereotyping or applying expected group norms to the individual client?

Finally, understanding other cultures assists nurses to understand their own culture and their own cultural values. It facilitates recognition that there may not be a "right" way to express pain or grief, and with this realization the nurse gains tolerance and understanding.

When this content should be introduced to the student is an important question. Transcultural nursing is complex and there is no question that it is a graduate level specialty. However, as it is not possible to provide safe care without some knowledge of cultural concepts, it is the belief of these writers that an introduction to transcultural nursing should be included in first year and incorporated throughout the nursing curricula.

Method

Topics selected for analysis were either an integral part of the beginning nursing students curricula or concepts to which the first-year student was introduced. All topics chosen had a considerable knowledge base that had been developed in the cross-cultural literature and were considered important in the provision of nursing care.Topics selected for comparison were first located by using the index in each text. It is possible that errors may have occurred in the data analysis if the subject was included in the body of the text, but omitted from the index. If this error has occurred, however, the omission of the topic in the index is, in itself, a serious limitation for a reference book of this nature.

The topics selected and the criteria used for content evaluation are as follows:

1. *Pain:* Is there a discussion of the cultural variation in the expression of pain?

2. *Skin Assessment:* Are there instructions for the recognition of jaundice, cyanosis, and pallor in different racial groups, especially in Black and Asian clients?

3. *Hygiene:* Does the author give instrusctions for care of the skin and hair of Black patients? Is there a discussion of clothing, for example a Sikh's turban, that should not be removed? Is there a description of differing modesty norms between cultures?

4. *Growth and Development:* Is there an explanation that growth norms vary between cultures?

5. *Diet:* Is the inability of patients of different cultures to accept and eat North American food addressed? Are cultural and religious food restrictions listed? Are physiological variables that relate to diet, such as lactose deficiency, mentioned?

6. *Communication:* Are there instructions to seek the assistance of a translator if the patient speaks a language other than that of the nurse? Is the patient's right to be informed of all procedures included? Is cultural variation in non-verbal communication, such as differences in touching and eye contact, addressed?

7. *Death and Dying:* Is it stated in these texts that patients of different cultural and religious groups may have different needs at the time of actual or impending death? Is the fact that grieving families behave differently according to cultural norms included? Certain cultures have special rites and rituals to perform after death. Is this information included?

8. *Cultural Assessment:* Were patients of different cultures used in the case study examples? Was a nursing assessment described, and did this assessment include cultural variables? Were basic principles of transcultural nursing, such as ethnocentrism and cultural imposition, addressed?

Results

In this section, the cultural concepts in each of the texts will be compared. This comparison is summarized in Table 1.

1. *Pain:* The learned nature of pain expression and variation within cultural norms is mentioned in all texts. Several of the texts give a brief overview of Zborowski's (1952) classic study on the meaning of pain and one author (Du Gas, 1983, p.453) includes an example of the behaviour of the North American Indian in pain, which is sometimes interpreted as "stoical indifference". The importance of this variation in patient response for pain assessment, however, is adequately addressed in only two texts (Krozier & Erb, 1983, p.637; Lindberg, Hunter, & Kruszewski, 1983, p.532). These authors stress the importance of "not judging" a patient's response and using physiological symptoms for assessment. Lindberg and her colleagues present

Table 1

Comparison of the Adequacy of Selected Transcultural Topics in Basic Nursing Tests

	Text						
TOPIC	Brill & Kilts	Du Gas	Kemp & Pillitteri	Krozier & Erb	Lindburg, et al.	Narrow & Buschle	Soren & Luck
Pain							
Cultural variation	Yes[a]	Brief[b]	Brief	Yes	Yes	Brief	Brief
Nurse assessment	Brief	Yes	No[c]	Yes	Yes	Brief	Brief
Skin Assessment							
Jaundice	No	No	No	Yes	Yes	No	Brief
Cyanosis	No	No	Yes	Yes	Yes	No	Brief
Pallor	Brief	No	No	No	Yes	No	No
Hygiene							
Skin care	Brief	No	No	No	Brief	Brief	Brief
Hair care	Yes	No	Yes	Yes	No	Brief	Yes
Modesty norms	No	No	No	No	No	No	No
Growth Norms							
Cultural variation	No	No	Brief	Yes	No	No	No
Diet							
Food preferences	Yes	Brief	Yes	Brief	Yes	Brief	Brief
Restrictions	Brief	Brief	Yes	Brief	Brief	Brief	No
Physiological restrictions	No	Brief	Yes	Yes	No	No	No
Communication							
Meaning	Yes	Yes	No	Brief	Yes	No	No
Translators	Yes	Yes	Yes	Yes	Brief	No	Brief
Touch	No	Brief	Yes	Brief	Brief	No	No
Death & Dying							
Needs	Brief	No	No	No	Yes	Brief	Brief
Grief response	Brief	No	No	Yes	Brief	Brief	Brief
Cultural Assessment							
Case studies	Yes	No	Yes	No	Yes	No	No
Assessment tool	Brief	No	Yes	Brief	Yes	Brief	No
Principles TCN	No	No	Yes	No	Brief	No	No

[a]Topic adequately covered, and procedures (if applicable) described
[b]Tobic mentioned briefly
[c]Topic not included in the text

a case study to illustrate this point (Lindberg, Hunter, & Kruszewski, 1983, p.533). One text cites Zaborowski [sic] (Brill & Kilts, 1980, p.361), and an ambiguity in another text implies erroneously that the amount of suffering varies between cultures (Sorensen & Luckmann, 1979, p.836).

2. *Skin Assessment:* The recognition and assessment of jaundice in Asian patients, by examining the sclera of the eye and the posterior hard palate, is included in two texts (Krozier & Erb (1983, p.486; Lindberg et al., 1983, p.327). The recognition of cyanosis in the Black patient was also included in three texts (Kemp & Pillitteri, 1984, p.808; Krozier & Erb, 1983, p.486; Lindberg et al., 1983, p.326) and mentioned in Sorensen & Luckmann (1979, p.576). The most comprehensive description of the changes (a blueish tinge) in the conjunctiva lips, tongue, nailbeds, earlobes and palm creases was prepared by Lindberg and her colleagues (1983, p.327). The recognition of pallor was also best described in this volume which stressed the importance of examining the palm creases, lips and earlobes and consulting with the patient's relatives about skin colour changes, which Brill and Kilts (1980, p.449) note become grayer (or ash-coloured) rather than whiter.

3. *Hygiene:* Care of the hair of Black patients was included (Brill & Kits, 1980, p.617; Kemp & Pillitteri, 1984, p.497; Krozier & Erb, 1983, p.514; Narrow & Buschle, 1982, p.378; Sorensen & Luckmann, 1979, p.606) and excellent instructions are presented in Sorensen and Luckmann (1979, p.606). These authors suggest that the hair be brushed in small sections before combing with a "picking" action. They explain that oil applied to the scalp is part of basic care in the Black individual. The tendency for black skin to become dry with bed rest and require oiling was not mentioned.

4. *Growth Norms:* Although physical assessment is not always included in first year curricula, it is important that the student be aware of genetic or racial differences, so that the student may begin to recognize normal from abnormal, and the sick from the well. This was mentioned briefly, however, in only two of the texts (Kemp & Pillitteri, 1984, p.114; Krozier & Erb, 1983, p.239). For example, Krozier and Erb (1983) mention that "Black, American Indian, or Oriental newborns often have lower birth weights than Caucasians" (p.239).

5. *Diet:* Cultural differences in food preferences and the inability of some cultural groups to eat selected North American food was included in all texts. Most texts also included a short description of religious and cultural food restrictions, such as the prohibition in the Jewish culture for eating pork or shellfish (Du Gas, 1983, p.684). Three texts (Du Gas, 1983, p.271; Kemp & Pillitteri, 1984, p.174; Krozier & Erb, 1983, p.208) explained lactose deficiency, a physiological intolerance to milk. The enzyme lactase is missing in many Blacks, Asians, Hindus, Eskimos, American Indians and

some Europeans. This may be due to the evolutionary early cessation of feeding milk to young children in these cultures (Krozier & Erb, 1983, p.208).

6. *Communication:* Only one text (Narrow & Buschle, 1982) failed to discuss language barriers as an inhibiting factor in the nurse-patient relationship. Most texts suggested using a translator and referred to the patient's right to be advised about care procedures regardless of the individual's ability to communicate with the nurse. It was noted, however, that none of the texts discussed the appropriateness or inappropriateness of eye contact, and only three texts included a superficial discussion on cultural variation and the use of touch and personal space (Du Gas, 1983, p.182; Krozier & Erb, 1983, p.375; Lindberg et al., 1983, p.212). Du Gas notes, for example, that adult Israeli and Puerto Rican patients do not like too much touching when they are ill, whereas to a Caucasian, touch may be very soothing (1983, p.182).

7. *Death and Dying:* Although care of the dying patient is not usually the responsibility of the first-year student, all texts included this content, but omitted discussing the cultural aspects. The student's first encounter with death frequently has a great impact. When relatives behave in ways the student may not expect, such as loud vocal displays of grief, the student's stress may increase. Cultural differences in the needs of the dying patient are best discussed by Lindberg et al. (1983, pp.648-649) who describe the native American Indian custom of preparing and bringing a favourite food of the deceased to the hospital. Irish wakes and Jewish shivas that provide vigils for the dead are also described. Such traditions are mentioned in three other texts (Brill & Kilts, 1980, p.669; Narrow & Buschle, 1982, p.258; Sorensen & Luckmann, 1979, p.1250). Krozier and Erb (1983, p.919) provide an excellent description of variations of the grief response in Hispanic-American groups, and different methods of caring for the body after death are mentioned by Narrow and Buschle (1982, pp.258-259). These authors explain that prior to an anticipated death it is a nursing responsibility to inform all staff of any pertinent religious sacraments, rituals, or physical care of the body.

8. *Cultural Assessment:* Two of the seven texts reviewed present a cultural assessment tool (Kemp & Pillitteri, 1984, p. 278, 583; Lindberg et al., 1983, p.167) and three include "culture" in the general assessment (Brill & Kilts, 1980, p.122, 190; Krozier & Erb, 1983, p.122; Narrow & Buschle, 1982, p.125). The most complete instrument is presented in Lindberg (1983, p.167) and prepared by Block. This should prove useful for the beginning nurse. Two principles of transcultural nursing, ethnocentrism and cultural imposition are discussed in only two texts (Kemp & Pillitteri, 1984, p.167; Lindberg et al., 1983, p.167). Of special interest is the description of the problem of stereotyping, illustrated with an appropriate case study (Kemp &

Pillitteri, 1984, p.167) in which Japanese women are portrayed as being non-assertive. These authors point out that this demonstrates lack of knowledge of a changing culture that could lead to a nursing care plan that would be inappropriate.

Discussion

It is interesting to note how the cultural aspects of care were incorporated into the texts. Two of the texts (Du Gas, 1983; Narrow & Buschle, 1982) gave culture a token acknowledgement, and two of the texts incorporated culture throughout by addressing the cultural aspects of the major concepts briefly and superficially (Brill & Kilts, 1980; Sorensen & Luckmann, 1979). The remaining three books (Kemp & Pillitteri, 1984; Krozier & Erb, 1983; Lindberg et al., 1983) have, in addition to introducing culture throughout, addressed cultural concepts in one chapter. Interestingly, the three methods of introducing new material in the textbooks reflect the methods used frequently to incorporate cultural concepts into the curriculum: (a) ignore it as long as possible; (b) integrate culture throughout the program, adding content to all courses in all years; or (c) include the majority of the cultural material in one course.

Occasionally organization of the texts may be problematic for the reader, in that cultural concepts and the discussion of cultural variation is not presented along with the concept. For example, in one text the material on cultural response to pain is not presented within the chapter on pain assessment (Krozier & Erb, 1983, p.42, 43, 216, 631-649), and in another text the material on cultural practices for dying is not included in the chapter on death and dying (Narrow & Buschle, 1983, p.167, 615-626).

Overall, cultural concepts were scantly addressed in all of the introductory nursing texts surveyed. Although some of the texts covered some aspects of transcultural nursing adequately (for texts of this nature), it appears that transcultural nursing in general was poorly integrated into these texts. The assumption that all people are the same cannot be continued, and remedying this deficit in our approach to care should be given a high priority by nurse educators.

The inadequacies of these texts are unfortunate, as faculty have an added responsibility to provide extra transcultural readings to first-year students until revisions are made or new texts compiled. We recommend that authors of texts collaborate or consult with recognized experts in transcultural nursing, and that nurse specialists act as advisors to explore the best methods of introducing transcultural nursing content into baccalaureate curricula.

REFERENCES

Brill, E.L., & Kilts, D.F. (1980). *Foundation for nursing.* New York: Appleton-Century-Crofts.

Du Gas, B.W. (1983). *Introduction to patient care: A comprehensive approach to nursing* (4th Ed.). Philadelphia: W.B. Saunders.

Kemp, B., & Pillitteri, A. (1984). *Fundamentals of nursing: A framework for practice.* Boston: Little, Brown.

Krozier, B., & Erb, G. (1983). *Fundamentals of nursing: Concepts and procedures.* (2nd Ed.). Reading, Mass.: Addison-Wesley.

Leininger, M. (1984). Transcultural nursing: An overview. *Nursing Outlook, 32,* 72-73.

Lindberg, J., Hunter, M., & Kruszewski, A. (1983). *Introduction to person-centered nursing.* Philadelphia: J.B. Lippincott.

Narrow, B.W., & Buschle, K.B. (1982). *Fundamentals of nursing practice.* New York: John Wiley & Sons.

Sorensen, K.C., & Luckmann, J. (1979). *Basic nursing: A psychophysiologic approach.* Philadelphia: W.B. Saunders.

Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues, 8,* 16-30.

RÉSUMÉ

L'incorporation de concepts culturels dans les manuels de base de sciences infirmières

Le présent article aborde l'intégration de concepts trans-culturels dans sept manuels de base de sciences infirmières utilisés comme introduction aux sciences infirmières auprès des étudiants de première année. Bien que les aspects culturels des soins soient maintenant considérés comme une composante essentielle du programme, les sept manuels de base étudiés présentaient des carences sur le plan du contenu culturel. Les auteurs concluent que les déficiences en concepts trans-culturels imposent des responsabilités accrues aux professeurs qui doivent fournir des données trans-culturelles d'appoint.

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FAMILY CENTERED COMMUNITY HEALTH NURSING AND THE BETTY NEUMAN SYSTEMS MODEL

Eugenia Logan Story . Margaret M. Ross

Although the relationship of the use of models to the development of professional accountability is becoming increasingly evident in the nursing literature and although we are learning more about the relevance of certain models to certain approaches to nursing and to certain clinical settings, the idea of theoretical pluralism as a basis of curricular development and implementation is remarkably absent from the nursing literature. According to Roberts and Yaros (1984), a calendar review of seventeen baccalaureate programs in nursing in Canada reveals seven programs that have discernible models: four use adaptation and three use systems, self care and developmental theory respectively. There were no calendars reflecting the use of theoretical pluralism for direction in program design.

In 1984, the School of Nursing at the University of Ottawa became committed to the notion of theoretical pluralism as a major underpinning for curricular development and implementation. Pluralism provides a global perspective and requires the acceptance of a paradigm that reflects the selection and use of multiple theories for nursing practice, in accordance with the demands of a situation (McGee, 1984). It assumes a variety of situations and a variety of approaches. Given the increasing complexity of nursing practice in our ever changing society, and given the fact that the setting in part determines the nature of nursing in that setting, it does not seem reasonable to assume that one conceptual framework is adequate to prepare students for beginning professional practice in a variety of situations. Dickoff and James (1978), in a paper entitled "New Views of Traditional Roles", discussed the nature of theoretical pluralism. Acknowledging the existence of a multiplicity of conceptions regarded as nursing theory, they recommended a purposeful theoretical pluralism rather than a search for unity.

Table 1 illustrates the content focus and model selected for each of the four years of our generic baccalaureate program:

These models were selected after an analysis of the congruence of the essential units: person, environment, health, and nursing (Fawcett, 1978)

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Table 1

Content and Model of Baccalaureate Program

	Content	Model
Year I	Health of individuals	Roy
Year II	Health of expanding and child rearing families	Roy
Year III	Biophysical and psychosocial health and illness of individuals and families	Roy Orem Neuman
Year IV	Health and illness of individuals, groups and the community	Neuman

with the School's philosophy and with the overall intent and specific purposes of the various years.

This paper examines the introduction of the Neuman Systems Model to students at the Third Year level whose studies focus on the family as the unit of care in community based settings and on the secondary level of prevention. The family unit, as a natural and cost effective resource for the health and well-being of its members, and therefore as a primary focus of practice for community health nursing, has long been a concern of community health nursing practice (Clements, Eigsti, & McGuire, 1981; National Organization for Public Health Nursing, 1932; Spradley, 1985; Stanhope & Lancaster, 1984; Tinkham & Voorkies, 1984). However, the concept of "family" is not an easy one to learn about or work with. Both the tradition in nursing and the knowledge and skills that are basic to nursing do not easily, or readily, lead to the elaboration and specification of the knowledge, attitudes, and skills that are needed to nurse families. The concept of the family as the client may be unfamiliar to those who have concentrated on the care of an individual member. We are concerned with the care of the family as a whole, as well as its individual members, in the course of various events of family life.

Selection of the Model

The selection of the Neuman Systems Model for community health nursing in the third year was the result of an exploration of the model (Fig.1)

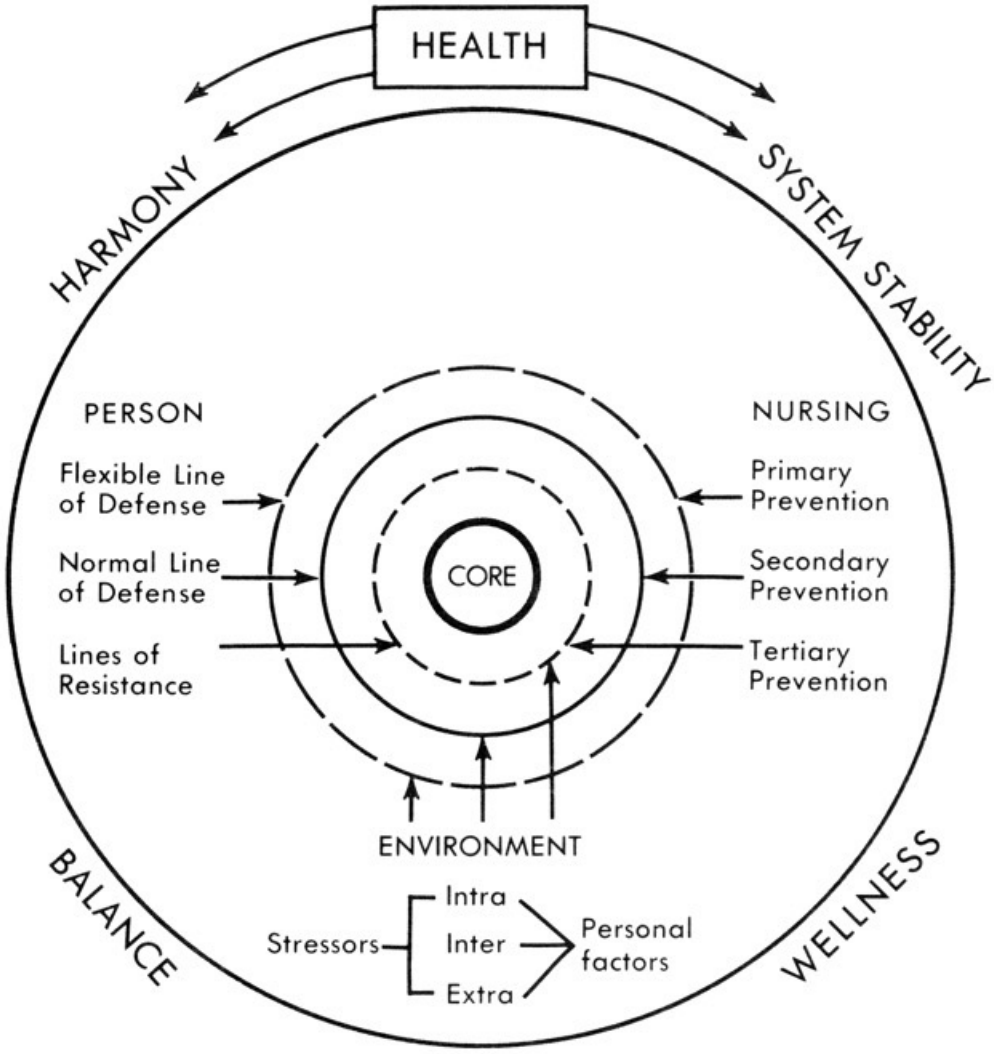

Figure 1: Elements of the Betty Neuman Systems Model

and Reed's adaptation of the model to families (Figure 2), of its congruence with our school's philosophy of nursing, of the author's personal experience with the model in practice and of the purposes of the course. Several characteristics of the Neuman Systems Model influenced our decision to use it in this instance. The model provides guidelines for the coordination of the various levels of intervention; primary, secondary, and tertiary. As well, the circuitous nature of the prevention-intervention concept in the model facilitates its use in a variety of settings and at any point in the client's life span (Bourbonnais & Ross, 1985). Because students would also be learning to nurse individuals in hospital-based settings, it seemed important to select a model with special applicability to the family unit. Reed's adaptation of the model serves us well in this respect (Reed, 1982). The versatility of the Neuman Model appealed to us and we felt that it would augur well for student learning.

There appears to be congruency between the basic elements of the model and our faculty's philosophy of nursing. The model's focus on client

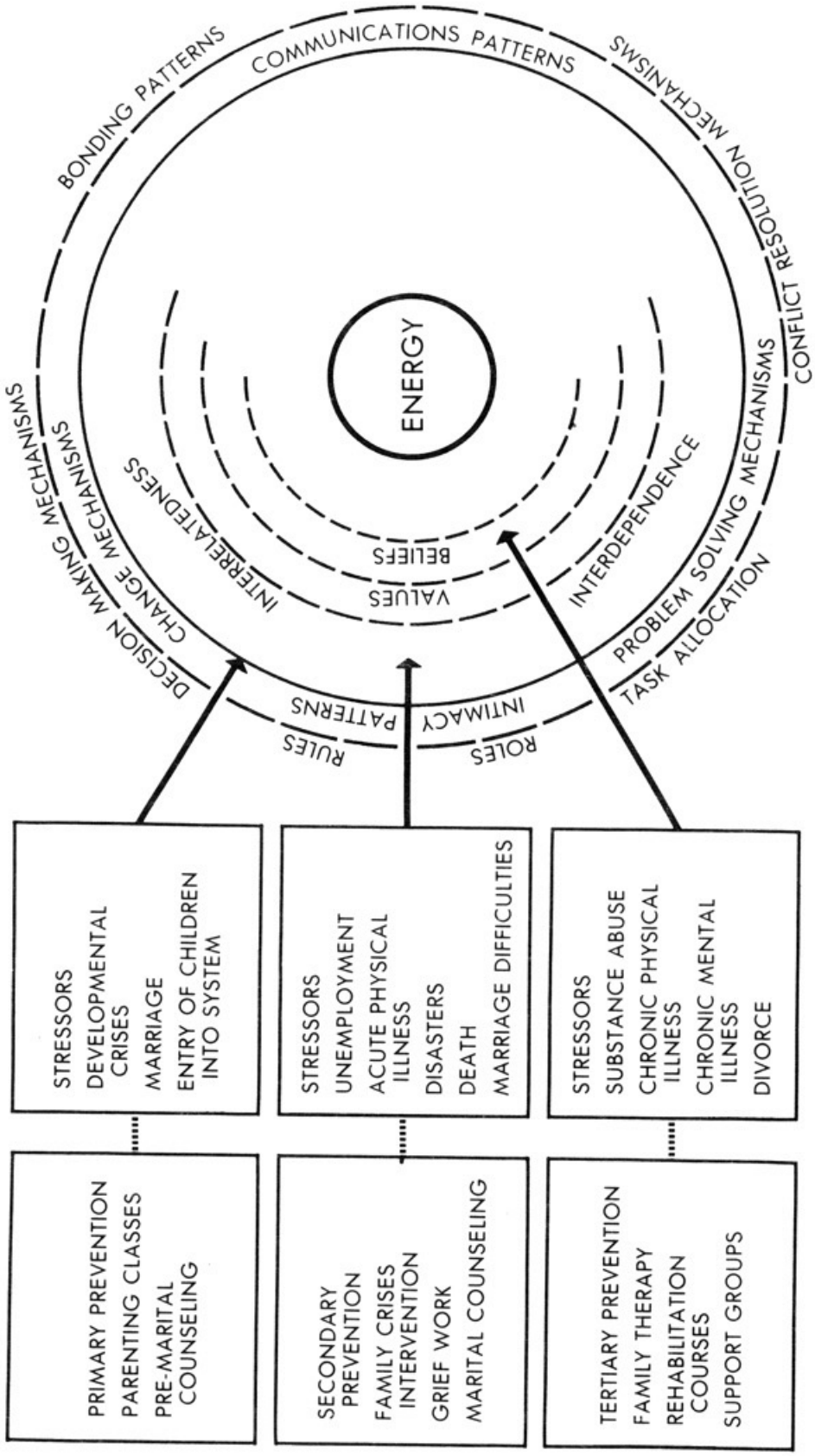

Figure 2: The Neuman Model:
A Systems Approach to Viewing Family Problems

perception emphasizes the client as a responsible and full collaborator in the nursing process. The development of the intervention model would be helpful to us in our own exploration of strategies of caring.

One of the authors tested the model in practice with both the individual and the family as client. This experience provided us with a clearer appreciation of the concepts and with an increased esteem for the approach to practice dictated by the model (Ross & Bourbonnais, 1985).

In view of the School's commitment to theoretical pluralism and bearing in mind the goals of community health nursing, it became evident that a framework to guide students in assisting families to attain optimal wellness was needed. The Neuman Model combines the large number of variables inherent in the care of families into one explanatory model, and it reveals the relationships among the categories of major variables.

Course Development and Implementation

The major emphasis in community health nursing at the Third Year level is on the effects of the illness of an individual family member on the family unit. Third-year students have a background in basic family theory. The second-year course, using Roy's model, emphasizes the normal aspects of childbearing and childrearing, and each student explores the family in relation to concepts of health promotion and with a view to the establishment of a nurse/client relationship. Consequently, in Third Year, the community health nursing course builds on knowledge and skills acquired through previous learning experiences.

Objectives

The overall intent is to assist students to learn to nurse the family that has an ill member at home in a manner consistent with the Neuman Systems Model. The major goal for students is to assist families to attain, regain, or maintain an optimal level of stability or wellness.

Specific objectives for the students include the:

1. Collection and evaluation of data that contribute to the on-going assessment of the family and its stability.
2. Analysis of the various intra-, inter- and extra-family stressors arising from the illness of a family member.
3. Identification of family responses to these stressors.
4. Application of strategies used by community health nurses that are directed toward maintaining and strengthening the family's lines of defense as well as decreasing the effect of stressors encountered.

Clinical content

There are three sources of families for students to nurse: the out-patient clinics of a teaching hospital where individuals are receiving follow-up treatment; the in-patient unit where students are learning biophysical nursing; and physicians' offices. Students make a series of home visits to selected client families. They assess the functional status of the family as a whole, its health practices and its ability to meet the health needs of its members. They identify family stressors and determine the level of actual or potential family disruption. In collaboration with the family, students develop strategies to reduce the impact of the stressors and/or strengthen the efficacy of family functioning, in a manner consistent with the Neuman Systems Model.

The following characteristics of the elements of the model are unifying themes for any client situation students are working with:

Goal: the ultimate terminus of their nursing is stability of the family.
Patiency: their focus of practice lies in the functional and structural dimensions of the family, i.e., the family's lines of defense and resistance.
Agency: through collaboration with the family in their home students strive to promote, maintain, or restore the stability of the family.
Context: within the home setting, a therapeutic relationship based on clarifying perceptions of each other is established.
Protocol: family stability is primarily accomplished through secondary levels of prevention, but also includes primary and tertiary levels of prevention and their related activities.
Dynamics: the source of power for the students' nursing activity rests in the advocacy role; interceding, supporting and providing for needs and facilitating family self help.

Course content

The community health nursing content is divided into three major units and covered during weekly periods of one and a half hours throughout the academic year.

Unit I

This unit begins with an introduction to the broad concepts that are basic to the Neuman Model (Neuman, 1982). Because the model will be reflected throughout classroom and clinical experiences, students examine it in detail. Reed's adaptation of the model (1982), as a client system and as a family theory, provides the framework for analysis of the primary model structure (Figure 1).

The inner circle or the "core" represents the energy stores that make a family a family. It includes those traits that are inherent in human beings as a species, such as the need for affiliation with a group that offers protection, security and nurturing within its boundaries. In a family, the concept of the "whole being greater than its parts" is important. The combined energy of the individual family members cannot be separated into the original energy components. The "lines of resistance" comprise concepts that protect both the family as a system and the individual members. Reed identifies the concepts of interrelatedness, interdependence, values and beliefs as the internal factors comprising a family's lines of resistance. The "normal line of defense" contains the variables that are found within the structural concepts of family theory. These variables provide a framework for the family system and include communication patterns, problem solving mechanisms, mechanisms for meeting needs for intimacy and affection and ways of dealing with loss or change. The "flexible line of defense" can be thought of as containing variables that are found in the functional concepts of family theory. These variables represent the dynamic state of the family, as it manages the on-going encounters with stressors, and include conflict resolving mechanisms, family bonding patterns, decision-making, task allotment and classification of family roles and rules (Janosik & Miller, 1980).

Unit II

At this point, the model provides a basis for examining family health (stability) and illness (instability). The concept of a family as a "client", health related reasons for viewing the family as a client and how this approach will influence the work of nursing are dealt with. Students learn about the impact of illness on families and ways that families cope with the illness of one of its members. According to the model, family stressors include environmental factors that cause a reaction within the family system. Stressors that are intrafamily, interfamily, or extrafamily in nature can be subdivided into three groups: primary, secondary, or tertiary, depending upon the type of intervention needed. These stressors identify the area for possible interventions as well as the entry point into the health care system for the client and the nurse. Primary prevention area stressors are forces that are potentially disruptive to the normal structure and function of the family. The major stressors affecting stability are in both acute and chronic physical illness, or secondary and tertiary prevention. The effects of the role conflict and changes in task allotment and role allocation that results from the impact of stressors on the family's flexible line of defense, and the resulting impact on the communication and problem-solving patterns in the family's normal line of defense leave the family's lines of resistance at risk; they are interrelated and interdependent. Students examine family disruptions and potential resolutions for the problems.

Unit III

This unit focuses on assisting the family to strengthen its lines of resistance and decrease the impact of the stressors brought about by the illness of one of its members. The Neuman assessment/intervention tool, modified by faculty for use with the client family, serves as a guideline for students. They learn to gather data that reflect the interpretations of the family and their own perceptions of the situation at hand. They learn to formulate a nursing diagnosis and in collaboration with the family, decide upon an appropriate form of intervention. Specific nursing strategies to improve the stability of families are a major thrust for this unit, most particularly those that are specific to the family structural and functional components, as identified in the Neuman model. Some of these include creative problem-solving, values clarification and time management, and relate to the variables found in the primary model.

Teaching strategies

A case study format directs student learning in the classroom. It provides students with a simulated experiential basis with which to effect a cognitive shift from nursing individuals as their clients to nursing families as the unit of care. It provides all students with the same stimulus, or client situation, with which to identify data relevant to the client's perception, a crucial aspect of the Neuman model. As well, it provides students with an opportunity to test their decision-making with respect to planning and implementing of care.

Clinical conferences provide an opportunity for students to share their client family experiences and to learn from the experiences of their peers. Attitudes, feelings and values related to nursing, to families and to learning a model surface during these conferences. They are held on a semi-weekly basis.

There are three means of asssessing student learning. Clinical papers specify students' objectives for home visiting, describe the nursing of their client and summarize the outcomes of their visits to the family. Their participation in clinical conferences is also evaluated and they write examinations.

Learning Outcomes

An analysis of evaluation data revealed the following indicators of student learning during this experience.

Data gathering

Students developed a heightened sensitivity to the client as the prime source of data for clinical decision-making. Increasingly, their focus of

practice became the family unit rather than the individual members of the family. They learned to gather data of a family nature and developed new strategies for acquiring them. For example, several students asked the children of their client families to communicate the impact of illness by means of drawings.

Focus of assessment

There were three dimensions of assessment evident in the students' data. They revealed a more deliberative focus on clarifying the meaning of the situation to their client family. As well, they sought to clarify discrepancies between the client's perceptions and their own perceptions of the situation. One student revealed her valuing of client perception by writing, "This thought and principle, so obvious and yet so overlooked, will be helpful to me in my nursing career."

Students appeared to assess the relationships within families according to the ways they communicated and interacted with each other. They looked for strengths within the family and viewed flexibility and adaptability as important indicators of family strengths. Through an exploration of health practices, they became more aware of the values and beliefs that underlie family health behaviour. The impact of culture as an underpinning of this behaviour became evident through interaction with client families from various cultural backgrounds.

Students learned about the impact of illness within the family and observed changes in role allocation and functions that resulted from the new stressors with the family. They appeared to be struck by reports of loneliness within the family as a result of the changes brought about by the illness.

Intervention

Students' data revealed interventions at the three levels of prevention. At the primary level of prevention, they sought to assist the client family to strengthen its flexible line of defense, which was being bombarded by the stressors associated with the illness of a family member. They also attempted to prevent their family's encounter with additional stressors. Health education strategies, such as providing anticipatory guidance about the illness and its possible impact on family life, formed the basis for students' interventions at this level of prevention.

At the secondary level of prevention, students sought to assist their client family to strengthen its normal line of defense and to decrease the strength of the stressor. They did this by assisting families to cope more effectively with interruptions in communication and problem-solving mechanisms and with

interruptions in communication and problem-solving mechanisms and with ways of dealing with loss and change. To this end, they developed strategies for increasing all members of the family's awareness of the meaning of the situation for each other. The judicious use of space and seating arrangements, the choice of meeting place, the method of questioning, etc. were viewed as factors contributing to an ambiance conducive to sharing and disclosure.

At the third level of prevention, students sought to assist their client families to strengthen the lines of resistance. This involved helping the family to reorganize its lifestyle to accommodate the limitations imposed by the illness of the family member. Counselling was the primary strategy to assist families to meet the objective of improved family functioning or increased family stability.

Home visiting

A major aspect of this experience was the change in context of the nurse-client relationship. Students learned about being a guest in the client's home and about the influence of this factor on the nature of their interactions. They identified a power ratio, the reverse of that existing within the hospital context, as contributing, in part, to their accountability to the particular situation. Negotiation and collaboration with their client in establishing goals for intervention became increasingly evident in their approach to the family. This reinforces the Model's emphasis on clarification of perception as a precursor to any nursing intervention. The termination of their relationship with their client family proved difficult for some students because of the close nature of the relationship that had developed. This generated an analysis of the nature of professional relationships, as compared with other kinds of relationships.

Use of resources

Students added to their repertoire of skills by learning how and when to refer clients to other health professionals. A clearer appreciation of the boundaries of nursing and of the relationship of nursing to other health professions evolved from this interaction. As well, they greatly increased their knowledge of and ability to use community services related to health promotion and health care provision. An interdependence with the larger health care system strengthened the students' view of nursing as an open system in which there is continuous flow of input and process. They were better able to articulate the essence of nursing, or its domain of practice.

Conclusion

This paper examines the use of the Betty Neuman Systems Model for the development and implementation of a baccalaureate level clinical learning experience that is designed to assist students to learn to nurse the family that has an ill member in the home. Within the context of theoretical pluralism, students had previously studied and worked with other conceptual models of nursing, specifically Roy's (1984) adaptation model and Orem's (1985) model of self care. Their knowledge of and experience with the use of models for learning to nurse provided a grounding for the introduction of a new model and facilitated their adaptation to its use in practice. Similarly, students came to the experience with a background in family theory that facilitated the process of learning to nurse the family as the unit of care. The Neuman Systems Model proved useful to students as a linkage between theory and family nursing practice. It provided students with an organizational framework to collect and analyze data systematically as well as to provide nursing care which was family-centered in nature. This new clinical learning experience allowed students to build upon and expand concepts and ideas of nursing which had previously been learned and which will continue to be developed as they move on throughout their studies.

REFERENCES

Bourbonnais, F.F., & Ross, M.M. (1985). The Neuman Systems Model in nursing education: Course development and implementation. *Journal of Advanced Nursing*. 117-123.

Clements, S.A., Eigsti, D.G., & McGuire, S.L. (1981). *Comprehensive family and community health nursing*. New York: McGraw-Hill, pp. 138-139.

Dickoff, J., & James, P. (1978). *New view of traditional roles: Theoretic pluralism and matrix of models.* Paper presented at Nurse Educator Conference, New York.

Fawcett, J. (1978). Relationship between theory and research: A double helix. *Advances in Nursing Science, 1,* 49-62.

Janosik, E., & Miller, J.R. (1980). Assessment of family function. In J.R. Miller & E. Janosik (Eds.), *Family focused care*. New York: McGraw Hill.

McGee, M. (1984). Presentation at a faculty workshop. School of Nursing, University of Ottawa.

National Organization of Public Health Nursing. (1932). *Principles and practice in public nursing*. New York: Macmillan.

Neuman, B. (1982). *The Neuman Systems Model: Application to nursing education and practice.* Connecticut: Appleton-Century-Crofts.

Orem, D. (1985). *Nursing: Concepts of pactice.* Toronto: McGraw Hill.

Reed, K. (1982). The Neuman system: A basis for family psychosocial assessment and intervention. In B. Neuman (Ed.), *The Neuman Systems Model.* Connecticut: Appleton-Century-Crofts.

Roberts, C.S., & Yaros, P.S. (1984). Theoretical pluralism and curriculum design. In M. McGee (Ed.), *Theoretical pluralism in nursing science.* Ottawa: University of Ottawa Press.

Ross, M., & Bourbonnais, F. (1985). The Betty Neuman Systems Model: A case study approach. *Journal of Advanced Nursing,* 199-207.

Roy, Sr. Callista. (1984). *Introduction to nursing: An adaptation model.* Toronto: Prentice Hall.

Spradley, B.W. (1985). *Community health nursing: Concepts and practice.* Boston: Little Brown and Co.

Stanhope, M., & Lancaster, J. (1984). *Community health nursing: Process and practice for promoting health.* Toronto: Mosby, pp. 330-332.

Tinkham, C.W., & Voorkies, E.F. (1984). *Community health nursing: Evolution and process.* New York: Appleton-Century-Crofts.

RÉSUMÉ

Les soins infirmiers communautaires axés sur la famille et le modèle des systèmes de Betty Neuman

Le document examine l'utilisation du modèle des systèmes de Betty Neuman dans l'élaboration et la mise sur pied d'un cours de sciences infirmières du niveau du baccalauréat, portant sur la santé communautaire et conçu pour aider les étudiants à axer les soins sur la famille plutôt que sur l'individu. Dans le cadre d'un programme axé sur un pluralisme théorique, les étudiants ont déjà examiné et appliqué d'autres modèles conceptuels qui ont servi de base à l'introduction d'un nouveau modèle. Le modèle de Neuman s'est révélé utile dans le rapprochement de la théorie familiale et de l'exercice des sciences infirmières chez les étudiants appliquant leur connaissance de la théorie de la famille au modèle en tant qu'outil d'amélioration de la santé des familles clientes.

The authors would like to acknowledge the feedback and encouragement offered by Betty Neuman during the preparation of this manuscript.

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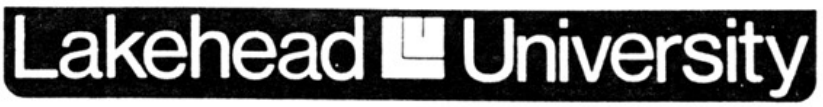

INFORMATION FOR AUTHORS

Nursing Papers/Perspectives en nursing welcomes research and scholarly manuscripts of relevance to nursing and health care. Please send manuscripts to *The Editor, Nursing Papers/Perspectives en nursing*. School of Nursing, McGill University, 3506 University Street, Montreal, QC, H3A 2A7, Canada.

Procedure

Please submit three double-spaced copies of the manuscript on 216mm x 279mm paper, using generous margins. Include a covering letter giving the name, address, present affiliation of the author(s). It is understood that articles submitted for consideration have not been simultaneously submitted to any other publication. Please include with your article a statement of ownership and assignment of copyright in the form as follows: "I hereby declare that I am the sole proprietor of all rights to my original article entitled ' ' and that I assign all rights to copyright to the School of Nursing, McGill University, for publication in *Nursing Papers/Perspectives en nursing*. Date ____, Signature_____."

Style and Format

Acceptable length of a manuscript is between 10 and 15 pages. The article may be written in English or French, and must be accompanied by a 100-200 word abstract (if possible, in the other language). Please submit original diagrams, drawn in India ink and camera-ready. Prospective authors are asked to place references to their own work on a separate sheet and to follow the style and content requirements detailed in the Publication Manual of the American Psychological Association (3rd. ed.), Washington, DC: APA, 1983.

Manuscript Review

Manuscripts submitted to *Nursing Papers/Perspectives en nursing* are assesssed anonymously by two members of a Review Board, using the following criteria:

Assessing content

Internal validity - relatedness: Is the problem the paper deals with identified? Is the design of the research or the structure of the essay appropriate to the question asked? Are the statistical, research and logical methods appropriate? Can the findings be justified by the data presented? Are the implications based on the findings?

External validity - relevance, accountability: Is the question worth asking? Is the problem of concern? Are there problems of confidentiality or ethics? Are the findings of the research or the conclusions of the essay significant? Can the findings or the conclusions be applied in other situations? Does the article contribute to knowledge in nursing? In what way?

Assessing presentation

Are the ideas developed logically? Are they expressed clearly? Is the length appropriate to the subject? Does the number of references or tables exceed what is needed?

Publication Information

On receipt of the original manuscript, the author is advised that the editorial board's response will be forwarded within six weeks. When a manuscript is returned to the author for revision, three copies of the revised manuscript (dated and marked 'revised') should be returned to the editor within four weeks. The complete procedure of review, revision, copy editing, typesetting, proofreading and printing may result in a six to eight month lapse between submission and publication.

RENSEIGNEMENTS À L'INTENTION DES AUTEURS

La revue *Nursing Papers/Perspectives en nursing* accueille avec plaisir des articles de recherche ayant trait aux sciences infirmières et aux soins de la santé. Veuillez adresser vos manuscrits à la rédactrice en chef, *Nursing Papers/Perspectives en nursing*, Ecole des sciences infirmières, Université McGill, 3506 rue University, Montréal, QC, H3A 2A7.

Modalités

Veuillez envoyer trois exemplaires de votre article dactylographié à double interligne sur des feuilles de papier de 216mm x 279mm en respectant des marges généreuses, accompagné d'une lettre qui indiquera le nom, l'adresse et l'affiliation de l'auteur ou des auteurs. Il est entendu que les articles soumis n'ont pas été simultanément présentés à d'autres revues. Veuillez inclure avec votre article une déclaration de propriété et de cession de droit d'auteur conformément à la formule suivante: "Je déclare par la présente que je suis le seul propriétaire de tous droits relatifs à mon article intitulé ' ' et je cède mon droit d'auteur à l'École des sciences infirmières de l'Université McGill, pour fins de publication dans *Nursing Papers/Perspectives en nursing*. Date _____, Signature _____."

Style de présentation

La longueur acceptable d'un article doit osciller entre 10 et 15 pages. Les articles peuvent être rédigés soit en anglais, soit en français et ils doivent être accompagnés d'un résumé de 100 à 200 mots (si possible, dans l'autre langue). Veuillez remettre l'original des schémas, dessinés à l'encre de Chine et prêts à être photographiés. Les auteurs sont tenus de fournir les références à leurs propres oeuvres sur une feuille séparée et de suivre les consignes énoncées dans le Publication Manual of the American Psychological Association (3rd. ed.), Washington, D.C.: APA, 1983, en ce qui concerne le style et le contenu de leurs articles.

Examen des manuscrits

Les manuscrits présentés à la revue *Nursing Papers/Perspectives en nursing* sont évalués de façon anonyme par deux lectrices selon les critères suivants:

Evaluation du fond

Validité interne: Le problème dont traite l'article est-il clairement défini? La forme des recherches ou la structure de l'essai sont-elles appropriées à la question soulevée? Les méthodes statistiques, logiques et les modalités de recherche sont-elles appropriées? Les conclusions peuvent-elles être justifiées à l'aide des données présentées? Les implications de l'article sont-elles fondées sur les conclusions?

Validité externe: Le problème soulevé présente-t-il un intérêt véritable? Ce problème est-il d'actualité? Existe-t-il des problèmes de divulgation ou de déontologie? Les conclusions de la recherche ou de l'article sont-elles importantes? Ces conclusions ou résultats peuvent-ils s'appliquer à d'autres situations? Est-ce que l'article contribue à l'avancement du savoir dans le domaine des sciences infirmières? De quelle façon?

Evaluation de la présentation

L'auteur développe-t-il ses idées de manière logique? Les exprime-t-il clairement? La longueur de son article est-elle appropriée au sujet abordé? Est-ce que le nombre de références ou de tableaux dépasse le strict nécessaire?

Renseignements relatifs à la publication

A la réception du manuscrit original, l'auteur est avisé que le Comité de rédaction prendra une décision au sujet de la publication de son article dans les six semaines. Lorsqu'un manuscrit est renvoyé à son auteur pour qu'il le remanie, trois exemplaires dudit manuscrit remanié (daté et portant l'inscription "revu et corrigé") doivent être renvoyés à la rédactrice en chef dans les quatre semaines. Les modalités complètes de lecture, de remaniement, d'édition, de composition et d'imprimerie expliquent qu'il s'écoule souvent de six à huit mois avant qu'un article soumis soit publié.

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Enquiries regarding **Ph.D. studies**
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