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A FOND FAREWELL

Dear Colleagues:

This will be the last editorial I write in the position of Editor of the *Canadian Journal of Nursing Research*. It has indeed been an honour for me to serve Canadian nursing researchers in this capacity for the past nine years. During this period, I have come to appreciate the work of many of my colleagues in their roles as authors and/or reviewers. It has been rewarding to see the development of research and researchers in this country over these nine years. The success of the Journal is the result of the generous contribution of time and effort on the part of many people. As Editor, I wish to thank the Associate Editors, the regular and the occasional reviewers, and the authors of submitted manuscripts, for their on-going support. I am particularly indebted to the Journal staff, without whom our manuscripts would not appear in print. I would like to thank Andrew Ferguson (the Managing Editor), Linda Miller (the Subscription Manager), Sandra Knowles (the Budget Officer), and the McGill Printing Department for the final production of the journal.

The next Editor of the Journal, beginning September 1st, 1992, will be Dr. Laurie Gottlieb. Dr. Gottlieb is an Associate Professor at McGill University, School of Nursing, and has been associated with McGill for many years. Her area of research and expertise is in early family and sibling development. She has published widely and served as a regular reviewer for the *Canadian Journal of Nursing Research*. I want to thank Dr. Gottlieb for taking on this responsibility and I am confident that she will provide the necessary leadership to secure the future of the Journal.

This particular issue of the Journal has been devoted to a series of papers which are not the results of original research, but are papers related to education and research that we felt would be of interest to the readership. We receive numerous manuscripts each year that do not directly fit the mandate of the Journal, but which are considered by the reviewers to be of importance to nurse educators and scholars in Canada. The time may be approaching for Canadians to consider the publication of a journal of Nursing Education. In

the meantime, we feel a responsibility to share with the readership some of the issues considered by our colleagues to be important.

Some of the papers published in this issue might be considered controversial. In fact, many of you may wish to respond with a letter to the Editor. Critical discussion of issues is one way to interact with one another and to rethink the directions being followed by the discipline. Two of the papers relate to the accreditation of university undergraduate programs in Nursing. This is a timely topic for Canadian academic institutions, as more and more schools are applying to be accredited by the Canadian Association of University Schools of Nursing. I trust that our readers will find these papers useful in understanding the accreditation process and preparing their schools to undergo accreditation.

Again, I would like to thank all of you for your support during my term as Editor of the *Canadian Journal of Nursing Research*. I wish you success in your ongoing careers and I look forward to continuing to read the results of your endeavours in this journal.

Mary Ellen Jeans

UN TENDRE ADIEU

Chères collègues,

Ceci sera un dernier mot en ma capacité de rédactrice de la Revue canadienne de recherche en sciences infirmières. Je m'estime honorée d'avoir servi des chercheuses canadiennes en sciences infirmières pendant les neuf dernières années.

Durant cette période, j'ai beaucoup apprécié le travail de mes collègues en temps qu'auteurs et/ou correcteurs. Ce fut très satisfaisant d'observer le développement de la recherche en sciences infirmières au Canada pendant ces années. La revue doit son succès aux énormes contributions en temps et efforts de plusieurs individus. J'aimerais remercier les rédactrices adjointes, les correctrices périodiques et permanentes ainsi que les auteurs qui appuient ardemment la revue. Plus particulièrement, je dois des remerciements aux membres du personnel de la revue, à qui nous devons l'impression de chaque article. J'aimerais également remercier Andrew Ferguson (adjoint administratif), Linda Miller (adjointe aux abonnements), Sandra Knowles (responsable du budget) et le département d'imprimerie de McGill pour la production de la revue.

A compter du 1er septembre 1992, la rédactrice-en-chef de la revue sera le Dr. Laurie Gottlieb, professeure associée de l'école des sciences infirmières à l'université McGill. Ses recherches se concentrent au développement fraternel et au développement des familles. Elle a publié plusieurs articles et elle a servi comme correctrice permanente pour la Revue canadienne de recherche en sciences infirmières. Je voudrais remercier le Dr. Gottlieb d'avoir accepté cette responsabilité et je suis confiante qu'elle fera preuve du leadership nécessaire pour assurer l'avenir de la revue.

Cette parution de la revue est consacrée à une série d'articles sur l'enseignement et la recherche; ils ne sont pas les résultats de recherches originales, mais nous croyons que ces articles intéresseront nos lecteurs. Nous recevons de nombreux articles chaque année qui ne correspondent pas exactement au mandat de la revue, mais qui sont considérés importants par les correctrices pour les membres des corps enseignants au Canada. La pu-

blication d'une revue spécialisée dans l'enseignement des sciences infirmières devrait être envisagée prochainement par les canadiens. Entretemps, nous ressentons la responsabilité de partager avec nos lecteurs des sujets que nos collègues considèrent importants.

Certains articles de cette parution peuvent être sujets à controverse. Après l'avoir lue, vous aurez peut-être l'intention d'écrire à la rédactrice concernant certains propos mentionnés. L'analyse critique est une façon d'échanger des idées qui nous permet aussi de réfléchir sur les lignes de pensées émanant de la discipline. Deux articles se rapportent à l'agrément de programmes universitaires au niveau du baccalauréat en sciences infirmières. Ceci est un sujet d'actualité pour les établissements d'enseignement canadiens, puisque de plus en plus d'écoles soumettent une demande d'agrément à l'Association canadienne des écoles universitaires en sciences infirmières (CAUSN). J'espère que nos lectrices trouveront ces articles utiles afin de comprendre la procédure d'agrément et de mieux préparer leur établissement à subir cet exercice.

J'aimerais une fois de plus, vous remercier tous pour votre appui durant la période où j'exerçais les fonctions de rédactrice-en- chef de la Revue canadienne de recherche en sciences infirmières. Je vous souhaite tous beaucoup de succès dans vos carrières et j'attends avec impatience de lire les articles que vous publierez dans cette revue.

Mary Ellen Jeans

THE COMING OF AGE OF FEMINIST RESEARCH IN CANADIAN NURSING

Barbara Keddy

The most significant issue facing nursing scholars and practitioners alike in the 1990s is related to feminist research, theory and epistemology. Schools of nursing and health care institutions are slowly beginning to embrace feminism, with all its diversity, appeal and promises of hope for a conflict-ridden profession. We are at the forefront of a movement in nursing that has been slow in coming; in fact, it has taken us over twenty years to align ourselves with the second wave women's movement. Nonetheless, we are slowly beginning to call ourselves feminists. Some schools are changing their curricula to reflect this new mood, while in others, individual faculty who have been feminists for many years and others who have newly arrived at feminist views are slowly beginning to bring about a courtship between nursing and feminism. Researchers are beginning to find that their old traditional methods are no longer acceptable means for investigating questions related to practice and the profession itself. Theorists have begun to question the relevance of the nursing theories that were developed without a feminist perspective to guide them. Many practitioners have been exposed to new ways of viewing the world and, like the theorists and researchers, will no longer be silent. As yet however, little is being written about this trend; instead the rumblings are just beginning to be heard softly like thunder in the distance.

What does all this mean to the profession? How will practice be changed forever? How are we to identify with both the theoretical and the practical issues that will emerge? The answers to these and other questions are merely speculative to this point, coming, as we have, to feminism at a point in history when schematic divisions have resulted in clashes in both feminist thought and action. Rather than attempt to cogitate about these issues, I

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choose instead to write about some of the more obvious changes that are "blowin' in the wind". The most significant of these are related to research methods and theory (rejecting the usual division between the two), and to praxis: "understand the world and then change it" (Stanley, 1990, p.12).

So, how to begin to discuss the research issue as feminists interpret it? First, let me say that one of the most liberating aspects of feminist scholarship is related to avoiding the term objectivity and embracing the term subjectivity. To that end, feminist research is not generally written in the third person. The use of I and me is an accepted first principle of feminist writing. As well, feminist scholarship is frequently either directly or indirectly about the researcher or theorist's own journey. The usual hierarchal relationship between the researcher and the researched is also avoided as much as possible. An integral component of feminist scholarship is the reduction of the power differential between the participants and the researcher. This is accomplished by involving the participants in the process as much as possible if they wish. Most importantly, feminist research usually allows the voices of the participants to be heard. Stanley and Wise (1990, p.23) have outlined the place of feminism in research in the following areas.

1. In the researcher-researched relationship.
2. In emotion as a research experience.
3. In the intellectual autobiography of researchers.
4. In how to manage the differing "realities" and understandings of researchers and researched.
5. In the complex question of power in research and writing.

I have come associate my own experiences with this journey. Trained in the traditional quantitative research methods in the 1970s, I was slow to observe that feminists were redefining science (Fox Keller, 1990, p.41-57). Issues related to reliability, validity, generalizability, objectivity were incorporated into my professional research jargon and practice. Concerning this issue of objectivity, the feminist Catherine MacKinnon has written the following.

Scientific epistemology defines itself in the stance of "objectivity", whose polar opposite is subjectivity. Socially, men are considered objective, women subjective. Objectivity as a stance toward the world erects two tests to which its method must conform: distance

and aperspectivity. To perceive reality accurately, one must be distant from what one is looking at and view it from no place and at no time in particular, hence from all places and times at once. (1989, p.97)

While I thought myself a feminist, twenty years ago, I too, (like most feminists) did not understand that objectivity meant the devaluing of the view from "the inside" and "within the moment" and the "perspective from the bottom of the social order" (MacKinnon, 1989, p.99). I too believed that subjectivity was biased and unreliable. Since that time I have come to value "the personal" and the "lived experience". It has, however, required shifts in thinking that as yet have not been totally accepted by many of my colleagues. It has been disheartening to hear them tell me cautiously that research from a feminist point of view is "interesting, but only one of many perspectives". However, I understand their concerns about changing their research approaches after years of using the mainstream traditional manner of doing research and finding it rewarding, especially in terms of tenure and promotion. As a skill, it has become comfortable. Changing approaches involves personal change. Liz Stanley (1990, p.13-14) has written, "I also doubt there are many who are willing to accept the risks associated with adopting such a position: the professional vulnerability it occasions, particularly that it becomes possible for other academics to dismiss it..."

However, there is a brighter side. Joyce McCarl Nielsen writes:

Note that many (usually younger and/or less traditional) researchers do not need to go through a conversion because the new view had become the received one during their professional lifetimes and was thus part of their professional training. They essentially "grew up" with the new view (1990, p.21).

The question begs to be asked. What is this "new view" or, in the words of Sandra Harding, "Is there a distinctive feminist method of inquiry?" (1987, p.1). To answer this question she describes method, methodology and epistemology. On method, she states: "A research method is a technique for (or way of proceeding in) gathering evidence" (p.2). Feminist researchers use the same methods that traditional androcentric researchers have used. The difference is how they use them. As has been previously mentioned, the new approach involves the participants and researcher in an entirely different

way than traditional research: that is, it is subjective, personal, experiential and non-hierarchical. "Attention to the affective components of inquiry represents an attempt among feminist scholars to restore the emotional dimension to the current conceptions of rationality," write Fonow and Cook (1991, p.11). This approach lends itself to the possibility of tremendous insights. It does not, however, remain in the realm of superficial descriptions. Rather, as Mies has written, "It denotes the sum of the processes which individuals or groups have gone through in the production of their lives; it denotes their reality, their history" (1991, p.66).

Sandra Harding defines the concept of methodology as "a theory and analysis of how research does or should proceed" (1987, p.3). This issue is particularly significant for nurse researchers, bogged down as we have been with nursing theories that evolved from the social sciences - many of them from symbolic interactionism. While symbolic interactionism can be a particularly useful theory for feminist research, it has been used in the past mainly to understand men's worlds. But nurses' worlds are primarily women's worlds that have not yet been thoroughly understood; nurses' work has traditionally been women's work and these linkages should be more fully described.

Finally, what is meant by epistemology? Fonow and Cook (1991, p.1) write, "By this we mean the study of assumptions about how to know the social and apprehend its meaning." As a theory of knowledge, what can be validated as nursing knowledge has been a difficult issue for nurse scholars to grapple with. My concluding point here is that methods, methodology and epistemology cannot be separated if we are to begin to answer the more difficult questions facing nursing to-day. Only through feminist research will we be able to redefine what we have already thought was knowledge. To this point we have much misinformation and half-truths, built upon male or medical models. We have modelled ourselves after the male "scientists" whose respect we fought for in order to achieve status, distinction and some degree of recognition.

It is becoming increasingly difficult to find female academics in the so-called "soft sciences" who are still intent upon duplicating traditional research. Those that do are primarily nurses and other health care professionals. Most however, will attempt to overcome this bias "by choosing the 'adding-on' approach" (Duelli Klein, 1983, p.90). By that is meant that

women are presumed to be similar to men and are evaluated against male standards. It is research on women, not for and with women.

Duelli Klein (1983) points out that feminist research should be written in plain, easy to read language that will allow it to be accessible to all women. She also discourages piling the methods of several disciplines upon each other. These kinds of accepted feminist principles are extremely liberating. For nurse researchers they allow the freedom to connect with educators, practitioners, patients and, I hope, male scholars who could be influenced to incorporate feminist research principles in their own research.

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HOW TO JUDGE A SUCCESSFUL RESEARCH CAREER

Barbara S. Kisilevsky

In the January 8th, 1990 issue of *McLean's* magazine (Burning, 1990, p.8), readers were informed that "Darryl Strawberry (a right fielder for the New York Mets) ... intends to renegotiate his terms of employment. Strawberry favours a four-year pact worth \$13.8 million ... that, or he will depart Shea Stadium at the earliest opportunity." During the 1990 baseball season, Darryl Strawberry's batting average was .277 (*The World Almanac and Book of Facts*, 1991). If we examine this average from a statistical perspective, we can see that he got a hit about two or three times out of every 10 that he got up to the plate (of course, this calculation ignores the times that he got onto base because of walks, etc.). This is a success rate of 20-30%. Alternatively, it represents a *failure* rate of 70-80%. Nevertheless, by baseball standards, this man is an achiever, commanding a salary that many of us will not make over our entire working careers. As a baseball fan, I know that any player who bats around .300 is going to have one of the highest, if not the highest, batting averages on his team and will command one of the largest salaries on the team. (*He* is used when referring to professional baseball players; 100% are male. *She* is used when referring to nurses; 97% are female).

However, when I started my research training, one of the things that I did not know was that an academic research career is judged by these same standards, i.e., a 20-30% success rate coupled with a 70-80% failure rate. These rates are clearly evident when one examines the statistics for the success of first time grant applications submitted to major funding bodies. For example, in November 1990 the Medical Research Council of Canada (MRC) reported a 30% success rate for its new applications (September 1989 competition) (Slotin & Hetenyi, 1990). This funding rate for new grants is not unique to Canada. During a recent invited symposium on U.S.

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federal funding for research on child development, the 1991 biennial meeting of the Society for Research in Child Development, it was reported that only 20% of NIH funds are awarded to first applications. Consequently, one of the most difficult but important changes for me when I began submitting grants and papers was to re-orient my standards of success to this criteria, not only to the 20-30% acceptance rate but especially to the 70-80% rejection rate.

This criterion for success was contrary to all of my academic training and clinical practice standards of evaluation. When I was a student, a letter grade of A was considered the standard of excellence and a marker of success. Whether in a diploma school of nursing, an American university where I obtained a Bachelor's and Master's in Nursing, or in a Canadian university where I did the equivalent of an honours B.A. and obtained a second M.A. and a Ph.D. in developmental and perceptual psychology, that A represented an 80-100%. The evaluation standards for nursing practice to which I have been conditioned are even higher. Nurses must strive for perfection in their practices. Any *one* negative incident can result in the College of Nurses of Ontario investigating a registered nurse member. All it takes is for *one* member of the public to file *one* written complaint about the nursing practice or conduct of that R.N. (*College of Nurses of Ontario College Communiqué*, 1991).

Clearly, neither formal academic training nor clinical practice prepared me for either the standards used to measure the success of a research career or the fierce competition which I would come up against in trying to establish a research program. The question remains then, "How did I learn these new standards?" The answer is, "from three sources". The first source was colleagues. Mentors and peers openly shared their experiences. The second source was information put out by the granting bodies, as noted above. Finally, the third source was from playing the game. In 1987-88 after finishing my Ph.D., I submitted three grants for career support (one national, one provincial, one university) and obtained one; a success rate of 33%. The next year, I submitted four operating grants. I received funding from the Natural Sciences and Engineering Research Council of Canada to establish a program of research examining fetal behaviour. This represents a 25% success rate. Over the next two years, I submitted a second grant in collaboration with Dr. J. A. Low to examine the use of fetal behavioural measures in the assessment of fetal well-being. It was submitted four times before it was

funded by the Hospital for Sick Children Foundation. This, again, represents a 25% success rate. Looking at articles submitted for publication to peer-reviewed journals, I saw the same rates. In the year that I submitted three grants for career support, I also submitted five articles for publication. One was accepted after revision; a 20% success rate. In the three years since their submission, three articles have been published (two were revised into one) and the fifth article is being revised for submission to a fourth journal. This represents ten submissions and six revisions for a total of three published articles for about a 19% success rate.

I am going to go back to the famous baseball player for one final comparison with the nurse researcher. We all know that, at one time or another during the season, our baseball hero is going to have a period known in baseball lingo as a "slump". Typically, no-one knows why (although the sports commentators do a great deal of speculating), he just will not be hitting the ball. During this time of "crisis" for the ballplayer, his owners, managers, coaches, and team-mates rally round to offer support and encouragement. He keeps on trying and eventually (after a shorter or longer period of time), his hitting prowess returns. Given that a new grant proposal takes the better part of a year to write, takes almost another year to go through the review process, and has about a 20-30% chance of being funded, "slumps" appear to be an inevitable part of a research career. Thus, the question for me, now that I have learned these new standards, is, "How do I survive when my batting average dips below .200?" For the present time, I seem to be protected. To maintain my Ontario Ministry of Health Career Scientist Award, I must hold an externally funded peer-reviewed grant-in-aid when I submit my annual report. If I do not, then I have another year to spend a minimum of 75% of my time in research-related activities and to continue to try to obtain an operating grant. In essence, because of my award, I am protected from increased University teaching and administrative responsibilities during a "slump." In two years when my award expires, I am still going to need this kind of protection. Is it there?

In summary, I have told the story of *How to Judge a Successful Research Career* because I think it is one of the most important lessons that a nurse must learn when she takes that path labelled "Research Lane". After being conditioned to an academic and clinical value system with much higher criteria for success, she has to re-orient her value system to know that she is a good researcher through a constant bombardment of rejections. I have

used the baseball analogy to demonstrate that these criteria for nurses are not different or special. The criteria in any arena depend upon the game being played.

As a caveat, I would like to point out that I may have made a "quantum" leap from the data when I assumed that nurse researchers, like other researchers, have a 20-30% success rate, especially for operating grants. In Canada, there is no national pot of money where a nurse may apply for funding for *Nursing* research. It may be, given that she must compete for someone else's pot, that the success rate is even lower.

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THE MYTH OF THE PROGRAMMATIC RESEARCH GRANT

Janice M. Morse

I have chosen to examine the mythical Programmatic Research Grant, which I refer to as mythical, not because we do not have research programs - I think we do - but because, to my knowledge, one has yet to be awarded to nursing in Canada, despite a competition created especially for this purpose.

The three most common types of research grants are career awards, designed to relieve the researcher from teaching responsibilities by paying the researcher's salary, thus giving the researcher time to conduct research; equipment grants that enable the researcher to purchase equipment to conduct research; and operating grants that provide for the costs of personnel to assist with the research and for supplies needed for day-to-day work. A grant must not be confused with a contract: contracts are awarded for the proposal exactly as presented and often prepared to meet the agencies specifications. Research grants are more flexible, and changes may be made by the investigator provided the funding agency and the ethical review committees are notified.

It is ironical that we have funding to support salaries but not operating costs. The scarcer resource in nursing is the researcher (with only a handful nationally); the product desperately needed is nursing research: thus, the lack of funding for nursing research must be corrected, urgently and instantly.

I do not know how to make a stronger statement than to show my own attempts at obtaining operating costs over the past decade. I know that fund-

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ing records vary from province to province according to the foundations available for residents of each particular province; I know that funding records vary with the relevance of the research program according to current national and provincial health care needs; and most importantly, I know that funding records vary tremendously with the "track record" of the investigator and that funding is based primarily on the grantsmanship skills and perceived abilities of the applicant to conduct the research. How I rank in the grantsmanship arena is beyond the purpose of this presentation; I wish merely to show you my attempts at obtaining funding to conduct nursing research and to show how difficult - or successful - this has been when giving it my "best shot". In an attempt to illustrate the real cost of the lack of programmatic funding for nursing research in Canada, I have "valued", both in dollars and time, the cost of having a proposal funded or rejected in the present funding system.

I will be talking about 9.5 years or 114 months. During the years 1982-1984, I was employed in a joint research position with the University of Alberta Hospitals; and since 1984 I have had 75% of my time designated for research as an NHRDP Research Scholar and, for the last two years, as an MRC/NHRDP scholar.

The grants that I have applied (and reapplied) for are on List 1. During this time, I planned 14 research projects. Two of these were funded on first application (one major [#10] and one minor[#1.1]); nine required multiple applications, either with the funding awarded being insufficient to conduct the research and multiple applications required for a single project, or the grant rejected and the applications resubmitted, sometimes up to eight times. Two projects remain unfunded (#6 and #9), one project was completed without funding, and three applications were for equipment grants. Patterns that are not evident in the way List 1 is organized are: early in my career I was very successful at obtaining small grants (very small); after that, I went through a few very difficult years attempting to obtain larger grants; and recently, a miracle occurred when I received a foreign award from the United States from the National Center for Nursing Research Grant (NIH). Importantly, from Canadian sources at all levels (i.e., federal, provincial and foundation), I have been required to make multiple applications for one project (either reject/resubmit) or have been awarded inadequate levels of funding which have resulted in several small grants accumulating for the same project, and which gave me the feeling that I spent a lot of time with my

"wheels spinning". Usually, these cumulative grants fall short of the amount required, with the investigator assuming all the tasks that could be "picked up" by lesser trained personnel if adequate funds were available. I call this situation the "little red hen" phenomenon, or "I'll do it myself."

List 1

Record of grant applications and outcomes (1982-1991)

1. Patient Falls

1.1) Phase I	AARN (\$2,500) (3/82)	Funded	\$ 2,500 (6/82)
1.2) Phase II	UAH (\$8,052)	Denied/ Appealed/Funded	\$ 8,085 (83)
1.3) Phase III	UAH (\$52,000) (7/85)	Denied/Appealed/ Funded (2/88)	\$52,620 (8/85)
1.4) Phase IV	GLENROSE (\$35,136)	Funded	\$32,000 (11/85)
	UAH	Funded	\$29,320 (9/85)

2. Restraints

MSI (1/86)	Denied	
UAH/FDN	Funded	\$23,300 (3/86)
UAH	Funded	\$ 5,000 (2/86)
Summer Empl	Funded	\$10,727 (5/86)

3. Breast Feeding/ Working Mothers

SSHRC (7/83)	Denied (6/84)	
NHRDP (12/83)	Denied (6/84)	
UA.CRF	Funded	\$ 4,755
MSI/FDN (6/86)	Denied (6/86)	
ROSS LABS	Denied	
AFAR	\$2,500-refused	
AFNR	Denied, Appealed/Funded	\$41,380 (2/86)

4. Gift-giving

\$34,205	NHRDP (11/87)	Denied(6/88)	
	AFNR	Denied	
	AFNR	Denied	
\$50,000	AFNR (10/88)	Funded	\$50,000 (3/89)

5. Painfulness of Childbirth

Funded internally

List 1 (Continued)

6. <i>Refugee Health</i>	NHRDP (12/86)	Denied (6/87)	
\$384,413	NHRDP (10/88)	Denied (6/89)	-
7. <i>Menarche</i>			
\$ 49,592	AFNR (2/87)	Denied (6/87)	
\$ 7,230	UAH.CRF (9/87)	Funded	\$ 5,000 (10/87)
8. <i>Lactation</i>	MSI (11/87)	Denied (2/88)	
		Appealed/Denied	
	UAH	Funded	\$ 3,000 (3/88)
	NHRDP (11/89)	Funded	\$15,000 (6/90)
9a. <i>Childbirth (op)</i>	NSERC	Denied (10/89)	
9b. <i>(Equipment)</i>	NSERC	Denied (10/89)	
	NHRDP/MRC	Denied (6/89)	
10. <i>Comfort</i>			
\$350,000	NCNR/NIH (12/88)	Funded	US \$315,000 (10/89)
		[CDN	\$362,250]
11. <i>PT-PT Communic</i>			
[\$ 15,000.00]	SNR CITIZ. (6/89)	Funded/Funding	
		reduced(2/90)	\$ 8,000
	UA.SF.	Funded	\$ 3,000 (6/90)
	UA.CRF (3/90)	Funded	\$ 4,000 (3/90)
	AFNR	Funded	\$14,128 (6/90)
12. <i>Equipment</i>	APPLE FDN (2/85)	Denied (12/85)	
\$ 40,403	AHFMR (10/86)	Denied (10/86)	
		Appealed/Funded	\$30,017 (12/86)
13. <i>More Equipment</i>	AHFMR (3/86)	Denied (7/88)	

* Includes proposals as PI ONLY (i.e., if co-investigator, then grant not included on this list)

** Research grants only - excluded career awards, conference grants, etc.

The grants that have made the most difference to my career were: (1) the equipment grant (i.e., #12), (2) the small grants received early in my career (e.g., #1a, #1b), and (3) the NCNR grant (# 10). The equipment grant was used to purchase six Macintosh computers, laser printer, scanner, and some

video equipment. Having this basic equipment available meant we could actually do research, quickly and almost efficiently. We each had a computer on which to write and to analyze data; in essence, we had a print shop for preparing manuscripts; we had equipment that enabled us to collect data. (But I describe this as *almost* efficiently, as we did not have funding for hard drives and software, and the scramble to acquire these essential items continued for four more years, and it continues today for we need to expand and upgrade as our needs change). The small grants were important as they allowed me to begin research and to establish a "track record." We did not have mentors in those days, and I did not have the opportunity to become a part of a research group or to become a part of an on-going research program of an established researcher. The NCNR grant was important as it made me realize what is possible when funded adequately and the extent of the ineffectiveness of the Canadian system for funding nursing research: I no longer find the *status quo* acceptable.

Gains

From the 12 funded research projects listed above, there have been some benefits. I have received support for a duration of 111 months of the 114 months in this period. However, this does not mean that I have been "doing" research almost continuously as many grants funded only a few hours of research time per week, and often, several grants were held concurrently. Frequently, there were "dry" periods without funding. During these inactive periods, I wrote proposals and methodological and theoretical articles.

The net gain from successful applications is shown below (see List 2) in both research dollars (operational, equipment costs, and career awards) and research and teaching productivity. Although it is not possible to evaluate the *significance* of the research and the impact of the publications, I think it represents a reasonable decade of effort.

In order to obtain a balanced perspective, the cost of the system requiring the researcher to prepare and submit a separate grant proposal for every project, no matter how minor the project and how modest the cost, must also be valued, even if the researcher appears somewhat successful. I have calculated the cost of a new proposal as three months of effort researching, conceptualizing, and writing, using a mean salary of \$50,000 for the ten-year period. As preparing a proposal also involves the time and salary of others

List 2

Net gain from research applications, 1982-1991

Funding

Operating costs (yield from operating applications)	\$666,065
Career awards (since 1984)	\$338,679
Other (conference grants, etc.)	\$ 46,578
Unfunded research	(2 projects)

Publications

Articles/chapters	106
Books	7
Patents	2
Scales/standardized questionnaires	2

Research contributions

Fall prevention, restraints
Minimal breastfeeding, breastfeeding patterns
Nursing models - illness/comfort, etc.
Some contribution to research methodology

Teaching/collaboration/mentorship

Courses taught	16
Students (Supervised)	25
(as committee member)	22
Collaborators: Post doc/Visiting prof	8
Conferences/workshops organized	5

in ethical review committees, in cooperating clinical agencies (for access and support), in secretarial help, and for help obtaining quotations for equipments, the preparation of the budget, and for copying supplies and postage, an additional \$5,000 per application is added, for a total of \$15,500 per proposal. Reapplications or resubmissions for equipment grants are based on 0.5 months (i.e., \$1,750 in investigator salary costs) plus \$500 for the salary time of others, supplies and incidental costs, for a total of \$2,250. Thus, in the period of 1982 to 1991, submission costs may be calculated as follows:

New applications	14 x \$15,500	\$217,000
Resubmissions and equipment grants	29 x \$ 2,250	<u>\$ 65,250</u>
	Total	\$282,250

Although it may be argued (and rightly so) that the preparation of proposals is a necessary insurance of quality for the granting agency, maximizing the chances that the work will be successfully completed and worthwhile, and that sponsors are entitled to "call the shots", granting agencies must recognize that slow mechanisms of approval impede the research process. Figure 1 shows the milestones in the grant review process, from submission to funding, with (a) representing *unproductive (waiting) time*, the time from proposal preparation to the first possible funding date; (b) representing *delay time*, the length of time from submission until each proposal was actually funded (including rejections and resubmission time); and (c) *postponement time*, or the time from the first possible funding date until the proposal was actually funded (i.e., the amount of time waiting for funding for proposals that have been resubmitted). In my case, approximate unproductive time totals 128 months, delay time 61 months, and postponement time 67 months.

In the present system, the delay caused from unproductive time is unavoidable because of the cumbersome - and costly - nature of the grant review process. It seems logical, therefore, to reduce this expenditure by giving established researchers programmatic research grants; that is, grants for larger amounts of funding to solve a particular problem in certain topic areas. By removing the administrative application procedures, this system

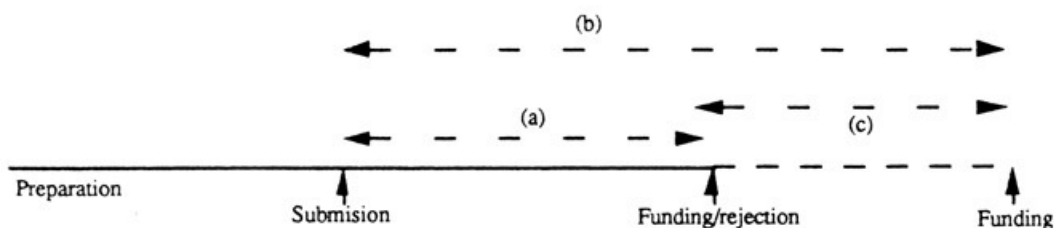


Figure 1

The Lag Time in Funding Research

would maximize investigator time for research. It would save investigator effort, reduce research costs overall, remove the need for agencies to conduct multiple minor reviews, and give the taxpayers more for their tax dollars.

In science, delay time has a cost to society as it retards the research product from reaching the consumer, perhaps for many years. Luckily, in nursing, we do not have to worry about being "scooped", of entering a race against other investigators, and the delay time does not seem to be of concern to agencies.

Postponement time, wasted time, is the one that causes ulcers in the investigator. Although I have to rewrite the proposals - and update them - I have yet been requested to make a helpful, constructive change to my research design by a granting agency. The "change" usually consists of clarifying, explaining, and teaching the agency about the research methods or the importance of the topic. Some of these "problems" may be attributed to the use of lesser known qualitative research methods. Still, the moral issue of inadequate reviews that penalize investigators must be discussed openly.

Inability to predict whether a proposal will or will not be funded is a problem for the investigator when projecting workload. Does an investigator take a holiday if a grant is denied? And if two grants are funded simultaneously, how does the investigator cope with the unexpected workload? Further, if a grant is not funded, project staff must be "released", and new staff hired when another grant is funded. This system results in little job security for research assistants, and the continual retraining of staff devours additional principal investigator time.

I often imagine what would happen if teaching was set on the same model, with professors bidding for courses, their teaching load determined by their success at writing proposals, and promotion and tenure decisions being contingent on the success of the proposal, following evaluation by non-nurses?

I have been advised that if I wish to receive funding from MRC (Medical Research Council), I am eligible to submit to the committee that reviews clinical trials. The recommendation that we couch our research in designs that are planned to answer questions of concern to medicine (focussed on cure and epidemiological designs - that which medicine understands and considers important) would bastardize the development of nursing research. The shift of focus necessary to meet the requirements to meet that funding strategy (for we cannot investigate *nursing questions* using inappropriate designs) leaves me dumbfounded. Three decades ago, we banished physicians from our lecture halls, insisting that nursing was a separate and a distinct profession from medicine and that physicians were not authorities - not qualified to teach nursing. Despite this, we are prepared to "sell out" nursing research - the supposedly "cutting edge" of the discipline - to relinquish the development of nursing knowledge to the techniques and the control of medicine. I have also been advised that the research councils cannot consider nursing a priority as they have not received the critical mass of applications required to demonstrate a need. How many proposals must be rejected before a "critical mass" is reached? Principles of zoology suggest that it is prudent to nurture endangered species.

Neither can we break nor loosen the tunnel vision of what medicine considers to be *research*. Several years ago, I naively thought that if I chose to research topics of mutual interest to nursing and medicine I would increase my chances of funding. It may be of interest to all nurses who have ever requested a medical order to apply restraints that the use of restraints is not a topic of interest for medical research. Even a study investigating lactation was considered "on the fringe of medical research" and received low priority. Maybe we can use such comments from medical funding agencies to clarify the differences between our professions, between our research methods and between our research purposes, in order to illustrate the complementary aspects of our two research endeavours and to clarify for the Federal and Provincial agencies the importance of funding nursing research. We can no longer afford to ignore nursing research nor to continue to

tolerate risking the health of Canadians by allowing the government to continue to refuse to fund research that will improve nursing care.

In 1989, I received a three-year grant from the US Public Health Service, National Center for Nursing Research, to delineate the concept of comfort. The grant has been the most freeing experience of my life, but it increased my awareness many-fold of the constraints and costs imposed by the present system. The present system in Canada of refusing to provide operating costs or equipment grants and forcing investigators to write multiple grants for few dollars handicaps researchers: *It absorbs the energy and time that should be used for conducting research.*

The career awards, without operating costs, make investigators feel like disadvantaged children who won a trip to Disneyland but had no money for a day pass. We watch others ride, while busily writing letters to all known relatives, trying, in the short time allowed, to gather enough coins for a single ride.

But the system of writing multiple small grants for a single project has another serious limitation. The system requires that each grant be fully developed, with the methods clearly explicated. Review committees tend to focus on the methods used in the grant, rather than evaluating the contribution the research will make to knowledge and the theoretical and clinical gains that will be achieved from the outcome. Thus, committees tend to reject grants on the basis of minor methodological flaws, rather than evaluating major issues, such as, the importance of the research topic or the contribution of the research question to nursing science. Paradoxically, research methods are highly subjective, and as any doctoral candidate with a committee of five will attest, they contain few rules that cannot be contradicted by one source or another. Yet, grants have continually been rejected for inappropriate reasons, such as, "poor development" of an unstructured, open-ended interview or such controversial issues as sample size. These rejections are extremely disturbing to researchers when they recognize that they, not the members of the review committees, have the most experience, preparation and skill to conduct the research and, as nurses, are better prepared than other social science colleagues to judge the research direction for the profession. A programmatic research grant, of long-term duration and adequate funding, would allow researchers to *investigate*, to move the frontiers of

nursing forward, to challenge the very foundations of nursing and to do research that will make a difference.

I am not asking nor suggesting that nursing be given "special treatment"; rather, we must have the support to allow our discipline to catch up to those that have always been supported in their research endeavours. We need equipment, resources, space and support personnel. We need to be left to set our own priorities, to set our own standards, and to select research methods that fit nursing phenomena. Most of all, we need the freedom and the funding to work productively and creatively for the improvement of patient care.

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CLIENT-ENVIRONMENT INTERACTION: CONTEXT FOR NURSING CARE

Jo Ann Neff and Sharon Summers

Person, environment, and health have been described as the essential constructs of the discipline of nursing - constructs that should guide both the phenomena selected for investigation as well as the diagnostic and therapeutic modalities employed in practice. A central feature of the role of the nurse is the management of the person-environment interface to improve and maintain the health of clients. Success in facilitating adaptive responses in health and illness depends upon understanding important contextual and dispositional factors that may influence human response.

The notion that human response is a function of both the person and the environment is not a new one. It dates back historically to the writings of Kantor (1924) and Lewin (1935) in the early twentieth century. These scientists established the foundation for further person-environment theories by Angyal (1941), Murray (1938), Murphy (1947), and Sullivan (1953). Of these early theorists, Kurt Lewin's work has had the most significant impact. His construct of the field or life space consisted of a sphere of existing facts surrounding the individual that could be divided into two classes: those facts that describe the person and those describing the environment. It was the relationship of all these facts that was thought to determine a person's response at any given time.

A major challenge for knowledge development in relation to the person-environment interaction is a fundamental philosophical view upon which science rests. All traditional forms of knowing rest on an idea about objectivity, where truth is thought to exist apart from, or outside of, the person who knows. A fundamental idea about reality from which traditional science

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developed was Cartesian dualism (1960), in which the rational mind and the "out there" reality of truth are viewed as separate.

The Cartesian view of separation of mind and body in the human person has proven to be ideal for supporting a technological model of health as well as physicians who are unable to recognize the part that environmental and social factors play in disease processes and human responses to illness experiences.

The quantum challenge

Developments in twentieth-century physics have questioned and transcended nearly every assumption of the Cartesian model. It is not that the mechanistic view of the universe is wrong, but that, as Thomas Kuhn (1972) suggests, as a dominant paradigm it has long since expanded to the limits of its methodologies and become no longer useful. Both the theory of relativity and the discoveries of quantum physics lead us towards an organic ecological view of reality which has much in common with the teachings of mystics throughout the ages. Einstein poked holes in the classical view of reality with his theory of relativity; he showed that mass and energy are one and space and time are inseparable, forming a four-dimensional continuum.

The new physics has also demonstrated that there is no way in which we can pull reality (or the human body) into its parts, study the parts and expect to know it. This is because reality is like a complicated tapestry of relationships between the complex parts of a unified whole. And woven deeply into this tapestry is something Descartes never imagined - the consciousness of the human observer studying it. So much is this now shown to be true that any "object or patient" the scientist observes can only be understood by taking into account the state of the observers' consciousness and expectations. In turn, the observer is not only needed to record the characteristics of the phenomena, but may actually help determine many of these characteristics.

We will never again be able to speak about the universe without speaking about ourselves. Matter is no longer static, made up of passive building blocks. It is made up of active bundles of energy continuously involved in dynamic processes. What scientists now observe is a continuous dance of

energy in which consciousness, far from being the result of material existence, plays a primary creative role and should be valued.

The Cartesian paradigm with which we and our ancestors have lived for generations depicts humans as biological machines driven by instinctual impulses - which are fundamentally destructive in nature and which need to be kept in check. The human has been seen as a creature driven by a "survival of the fittest" will. This old world-view has also encouraged us to look upon life as an ultimately futile process - an accidental occurrence within an endless struggle against death.

If order is not a static state against which we must struggle to live but instead a dynamic process of energy exchange between the living body and the world outside, and if consciousness plays an important part in both the creation of living organisms and the carrying out of living processes, the new view of man emerging from such findings is of a completely different order.

Order out of chaos

British biologist Rupert Sheldrake (1981) believes that living organisms are not simply complex biological machines. He has demonstrated that life cannot be reduced to a series of chemical reactions and has presented evidence that the form, development and behaviour of living organisms are shaped through "morphological fields." These formative energy fields appear to be the result of the actions of past members of the same species, via direct connections that span both time and space. As such, alterations in the consciousness or the behaviour of a few of a species appear able to change the behaviour of great numbers almost simultaneously. An excellent example of this is the anecdote reported by Lyall Watson (1979) in his book *Lifetides*. It is known as the "hundredth monkey phenomenon". Watson tells of how a female monkey living on the island of Koshima began washing raw sweet potatoes to remove the sand and grit. This behaviour was not only picked up by monkeys living close to her; it also suddenly appeared in monkeys on neighbouring islands until the number of animals using it reached a few dozen. Watson's findings have far-reaching implications not only for biology but also for nursing and psychology. If he is right, then much could be changed - from mentally induced healing of a sick body to heightening mental and spiritual awareness on a broad scale and through the creation of a kind of "morphic resonance" that makes such events possible. Meanwhile

Nobel laureate chemist Ilya Prigogine (1984) has even altered the meaning of the word "order". He has discovered the presence of so-called dissipative structures in chemical reactions and found that a new principle underlies them - a principle of "order through fluctuation". These dissipative structures also appear to be self-organizing and responsible for keeping life energy dynamically intact.

Holographics and beyond

David Bohm, a protege of Einstein in both quantum physics and the relativity theory, has made his own revision of the mechanistic world-view in the form of what is called his "holonomic theory of the universe". In his book, *Wholeness: The Implicate Order*, Bohm (1980) shows that the stuff we observe in this world when we are in our ordinary state of consciousness is but one side of reality - the explicate or unfolded order. Behind it lies another in the form of a generative matrix which is called the implicate, or enfolded order. This implicate order cannot be observed, except perhaps in exceptional states of consciousness such as deep meditation. Yet this implicate order, like Sheldrake's morphogenic fields, appear to be formative in nature. And there are now many forward thinking scientists who believe that gaining access to it through non-ordinary states of consciousness may make possible dramatic leaps in man's evolutionary progress. One day we may actually become conscious masters of our own destiny if we can learn to connect with it and allow it to unfold freely. One highly respected neurosurgeon who is numbered amongst them is Karl Pribram at Stanford University in California. Pribram (1982) has developed a new model of the brain that in many ways lends support to Bohm's theory of holomovement. Pribram has shown that as well as processing information and experience digitally, the brain also processes in a parallel manner that is holographic in nature. This means that specific memory does not have a location but is scattered throughout the brain. Pribram has also speculated that the real world may itself be holographic, and that there may be a matrix within the brain that doesn't objectify unless we do something to it. His work indicates that we may be the creators of the world we see before us: that is, each of us, may mathematically construct outer reality by interpreting from a dimension such as Bohm's implicate order, which transcends time and space. Our brains may well be holograms interpreting a holographic universe so that what happens within also happens without. Most important of all, Pribram believes that far from being the passive product of random evolution strug-

gling for survival, we, as human beings, have access to the primary realm of reality which determines our health and evolution.

The health connection

Fundamentally, what all of these paradigm shifts mean, in terms of health care for the future, is two things. First, because consciousness plays such an integral role in the creation of reality, individual responsibility for health is likely to be increasingly emphasized and healing approaches that make use of such techniques as autogenic training, hypnosis and meditation will be used more and more as tools for gaining access to the primary realm of reality that creates illness or wellness. Secondly, the new visions of reality create an absolute necessity, even for the individual who is willing to work hard personally to achieve a high level of wellbeing and energy, to recognize that none of us can remain healthy in isolation.

Imperative for Nursing

In the past, the majority of nursing investigations have studied selected person or environment variables in a static manner, often without attention to multi-directional and multi-causal elements, let alone the processes by which they may interact. This mode is changing as we understand the dangers in oversimplifying human response by assuming the existence of global rather than situation-specific effects, or by assuming no synergistic interface between person and environment.

The dominant paradigm we have used to guide our knowing has been useful in giving us a partial understanding of the client's environment. For example, we understand how bone tissue mends, how endocrines influence cardiovascular function and how human breast milk nourishes. But the model does not exhaust what we need to know to give nursing care. It does not tell nurses how to comfort a child whose fracture is due to an automobile accident that killed his mother, or how to revitalize a once-healthy self-concept that has been abruptly changed by facial burns, or what quality of life means to the chronically ill. These are complex human experiences moderated by an interactive environment-client relationship that nurses should know about. Too rarely is the interactive aspect of the individual and the environment addressed in the literature (Andercason, 1985; Nikiferuk, 1985; Porter et al., 1985). Too often nurses depict the environment as a local

circumscribed parameter in which the client acts. Often the family and the community are seen as the boundaries of the environment.

As well, the effect of the environment upon clients in public and private institutions should be of monumental concern to nurses. There are many client environments that cry out for the intervention of nurses: the often deplorable state of nursing homes, custodial rather than developmental child care facilities, poor housing and its contributions to illnesses and disabilities. Nurses deal with human responses to social disorder and deprivations. The environment is too often perceived in epidemiological terms; that is, as demographic data. A broader interpretation of the environment is needed that considers political, legislative, social and economic spheres that give rise to individuals' responses of malnutrition, noncompliance, alienation, hostility, joblessness, poverty and widespread social unrest. Where is the knowledge base of how the profession deals with the totality of the environment, the global influences that affect every aspect of clients' lives - the air they breathe, the water and food they ingest, their living arrangements, the politics, policies, crime, legislation and economics that determine quality of life, affect longevity and establish or impede wellness? Nightingale (1860, 1882, 1893) delineated the nurse's responsibility to protect a client's environment. Perhaps a rereading of her monumental works would set us upon a productive path for knowledge development.

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ACCREDITATION OF UNIVERSITY NURSING PROGRAMMES IN CANADA

**Barbara Thomas, Anne-Marie Arseneault, Jeannette Bouchard,
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Educational programmes for health professionals, including nurses, have been established in response to the need for health services in a particular society (French, 1978). Governments and professional groups have made considerable effort to ensure that educational programmes are preparing the appropriate number of well-qualified practitioners needed to address current and future health needs of Canadians effectively (CAUSN, 1984). Accreditation of educational programmes in university schools of nursing is seen as a mechanism of external regulation to ensure standards of nursing practice and promote programmes that are responsive to societal needs (CAUSN, 1984; French, 1978). Nursing education in Canada has evolved to the extent that accreditation of schools of nursing in universities is now regularly carried out. To appreciate the current level of activities, it is important to place the origins of nursing education in Canada in perspective.

Overview of Nursing Education in Canada

Nursing education in Canada began in 1874 with the establishment of the first nursing school at the General and Marine Hospital in St. Catharines,

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Ontario. By 1900, twenty training schools had been established in hospitals across Canada. The training schools did not generally offer a systematic programme of study and rarely employed a full-time instructor (Coburn, 1974). Apprenticeship training was the model used to teach nursing. Such personal qualities as dedication and womanly devotion were emphasized, rather than educational values such as knowledge acquisition and the development of critical thinking. The number of hospital training schools grew rapidly as hospitals realized the economic advantages of staffing their institutions with cheap labour provided by student nurses.

In 1914, the President of the University of Toronto headed a special committee on nursing education; it concluded that the hospital training programmes were unnecessarily arduous and recommended that nurses' training should take place within the educational system (Gibbon & Mathewson, 1947). The first university-based programme in nursing in Canada was started at the University of British Columbia in 1919, under the direction of Ethel Johns. This non-integrated degree programme became the prototype for the development of university nursing programmes over a number of years (King, 1970). It has been described as the "sandwich model" of nursing education, with the university providing the academic courses in the first and final years and the hospital school responsible for the nursing component in the middle years. Little, if any, coordination occurred between the two components of the nursing baccalaureate programme (Kergin, 1968; King, 1970). It was not until 1942 that the first four-year integrated nursing programme leading to a degree was begun at the University of Toronto. As Director of the programme, Miss Kathleen Russell required that all nursing courses meet university standards and that candidates for a degree in nursing meet admission requirements of the university. Four years later a second basic degree programme, under the direction of Miss Gladys Sharpe, was developed at McMaster University, in Hamilton (Kerr, 1988). University authority and responsibility for basic nursing education had been initiated.

It is interesting to note that the university schools of nursing formed a national association that was the predecessor to the Canadian Association of University Schools of Nursing (CAUSN) in 1942, despite the vast majority of basic nursing education continuing to be controlled by hospitals (CAUSN, 1984). Integration of nursing education into the general system of higher education had not occurred in any province and hospital schools functioned

as adjuncts to hospital nursing service (Hill & Kirkwood, 1991). Although Russell has been credited with providing early leadership in nursing education in Canada, baccalaureate nursing education spread slowly. Rovers and Bajnok (1988) suggest that on-going problems in the educational preparation of nurses led to Mussallem's review of nursing schools, which was sponsored by the Canadian Nurses' Association (CNA) in the late 1950s. This review recommended that a process of accreditation of nursing schools was necessary if standards were to be improved. Control of nursing schools by hospitals where the primary focus was service, not education, appeared to be the major cause of weaknesses found in nursing schools.

The Report of the Royal Commission on Health Services (Government of Canada, 1964) was critical of the existing system. It recommended the expansion of nursing education in universities, the transfer of diploma schools from hospitals to post-secondary institutions and movement away from non-integrated degree programmes for nurses. In Ontario, the provincial government announced the move to place all diploma schools under the Colleges of Applied Arts and Technology in 1973 (Rovers & Bajnok, 1988). A similar process occurred in Quebec from 1967 - 1972 with the closure of hospital schools and nursing programmes moving to the community colleges (CEGEPs), (Association of Nurses of the Province of Quebec, 1972). Other provinces followed this move, with nursing education being taught in a diversity of settings. The monitoring mechanism for these programmes was provincially regulated.

Baumgart and Kirkwood (1990) suggest that the admission of nursing to the university was not originally based on developing a unique body of scientific nursing knowledge, but rather was based on a need for public service. They also indicate that there was much disagreement about including nursing among the professional schools seeking university affiliation. In the male-dominated realm of university education and scholarship, nursing was considered marginal. The ratio of diploma to baccalaureate-prepared nurses has increased since 1965 to approximately one in ten nationally (Kerr, 1988). Enrolments in university schools are, however, still low in comparison to those in diploma programmes. Recent efforts at collaboration and articulation between universities and institutions offering diploma nursing programmes have sought to increase the accessibility of baccalaureate programmes and respond to the need for more highly educated nurses in the complex Canadian health care system.

Historical Perspectives on Accreditation

CAUSN, as the organized body speaking on behalf of university nursing education, had, in 1957, established *Desirable Standards for Canadian University Schools of Nursing* (CAUSN, 1984). These standards, which were revised in 1962, provided a guide for developing university schools of nursing and focused on such issues as preparation of faculty, administrative organization and resources. Other early work on the development of criteria for university nursing programmes included *Guidelines for Baccalaureate Programmes in Ontario* by the Ontario Region of CAUSN in 1970 and the McGill University document in 1971 entitled *Criteria for University Schools of Nursing*. Developments in health services and education and the interest of government in accreditation prompted CAUSN to establish an ad hoc committee on evaluation in 1971 (CAUSN, 1984). CAUSN appreciated the work of regional organizations in developing criteria for university nursing, but identified the need for a national approach to evaluation. In 1972, the ad hoc committee submitted a report entitled *Tentative Statement for Functions of the Baccalaureate Nurse - Evaluation of Baccalaureate Schools of Nursing*. This document cited the critical functions of the baccalaureate nurse and stated the criteria of relevance, accountability, relatedness and uniqueness for use in the evaluation of schools of nursing. At this stage, CAUSN recognized the need for evaluation of its educational programmes, and the value of developing a national accreditation process. In 1972, CAUSN was designated as the accrediting body for university nursing programmes in Canada and the CAUSN Committee on Accreditation was subsequently established to develop the accreditation programme (CAUSN, 1984; Curran, 1984). The first meeting of this Committee was held in 1974.

Accreditation of nursing programmes is a mechanism of external regulation used to promote the development of education programmes or services that are responsive to present and future health situations, to encourage individuality and diversity and to stimulate innovation and change (CAUSN, 1984). External regulation has evolved to ensure that the public's interests are protected. Nahm (1971) indicated that accreditation encouraged nursing schools to improve their programmes to obtain accreditation and helped in raising standards of the profession.

In developing a process of accreditation for Canadian university nursing programmes, the following assumptions (CAUSN, 1984) were made.

1. Nursing, as a profession, is accountable to the public and has a responsibility to ensure the quality of the educational preparation of its members.

2. Nursing has the major responsibility for establishing, developing and monitoring standards for educational programmes in nursing.

3. Essential qualities having attributes of change and development can be identified.

4. The qualities or criteria are amenable to measurement.

5. Standards can be developed that will promote change, innovation, diversity within and among programmes and responsiveness to societal needs now and in the future.

At the June 1974 CAUSN conference, Dr. Nahm, who had been actively involved in the American accreditation process for nursing education programmes, encouraged CAUSN to use criteria that were dynamic and would stimulate innovation in the development of programmes relevant to society (CAUSN, 1984). Later that year, the Committee on Accreditation was asked to proceed with assessing the criteria and developing methods to evaluate undergraduate programmes in nursing. The Committee was cognizant of the need to develop an accreditation system that would take into consideration the teaching of nursing as well as the practice and study of nursing within the overall administrative organization. The teaching of nursing emerged as a very complex component and was identified as the primary source of data relating to the criterion of accountability.

In June 1975, the Committee submitted a report to CAUSN Council outlining the indicators of the criteria, time frame and methods of data collection and analysis, for use in assessing baccalaureate nursing programmes: it recommended that the criteria of relevance, accountability, relatedness and uniqueness form the basis of this process (CAUSN, 1984).

As French (1978) indicated, the CAUSN accreditation programme was innovative in design as it focused on how students learn to nurse as the most important factor in predicting the future direction of nursing services. Assessment of budget, faculty and other resources that may form the basis of traditional approaches to accreditation would be judged in relation to the impact they have on the teaching of nursing in the CAUSN process. The criteria also addressed whether the programme was responding to society's changing needs and fostered the continued development and individuality of schools. Since its inception, the Committee on Accreditation has considered

many important issues (CAUSN, 1991). Much time was devoted to developing methods for data collection and analysis, identifying indicators of the various criteria and developing instruments to measure the teaching of nursing. Funding issues related to the costs of accreditation have also been discussed.

In 1981, a workshop on accreditation was held at the CAUSN conference to further understanding of the criteria and of the process of accreditation. Two baccalaureate programmes were visited to gather data for isolating significant indicators of the criteria and providing selective evidence of the indicators. The tools for data collection and analyses were subsequently refined.

Curran and Bouchard (1987) reported a number of important milestones. In 1983, CAUSN Council received the draft document *Accreditation: Criteria and Process for Baccalaureate Programmes in Nursing* which had been prepared by the CAUSN Accreditation Committee. The next year, CAUSN Council approved the establishment of a Board of Accreditation for Baccalaureate Programmes in Nursing to administer the CAUSN accreditation programme. It also approved the appointment of an Executive Secretary to assist the Board of Accreditation and the Committee on Accreditation. The development of a pool of nurse educators to serve on review teams was also approved. The Committee on Accreditation continued as a Standing Committee of CAUSN, having the responsibility of recommending to Council, on an on-going basis, policy, norms and standards for the programme of accreditation. In 1985, Council accepted the framework for the Accreditation process, which included the weighting of criteria, the use of a self-evaluation questionnaire and the philosophy of nursing education, as well as a numerical rating system for use in determining the accredited status of a programme. Procedures for new programmes to apply for candidacy status were included in the accreditation documents. In 1986 Council approved the Self-Evaluation Guide and the Nursing Education Data Base. CAUSN was designated to implement the Accreditation programme and charged with undertaking an on-going formal evaluation of the accreditation process. The evaluation task was delegated to the Committee on Accreditation, to be reported to Council following the first five years of implementation.

A meeting of the Accreditation Committee and the Executive was held in 1986 to discuss the implementation of the accreditation process. Issues dis-

cussed included the financial aspect of the process; the mandate of the Committee on Accreditation; selection and orientation of Review Teams; relationships with Provincial Associations; and, the arm's length relationship between the Council, the Board of Accreditation and the Committee on Accreditation. The Board of Accreditation met in Montreal to review and implement the process. The document Relationships, Checks and Balances was reviewed and recommendations were presented. Requests for review from two universities were accepted and the selection of review team members was initiated. Later that year, Council gave approval for the Dean/Director of the programme under review to be present at the discussion of the report by the Board prior to the decision on accreditation status. In May, 1987 the first review of an organizational unit was completed and the CAUSN accreditation process was launched. The accreditation process has now become well established, with ten programmes having been reviewed for accreditation and one programme having been admitted to the candidacy process for new programmes. As more programmes are reviewed and as review teams become increasingly representative of the various regions, the process has become more national in character.

Evaluation of the Accreditation Process

The task of evaluating the accreditation process was delegated to the Committee on Accreditation. It began in 1986 with a review of the literature and CAUSN accreditation documents. Five evaluation criteria were developed and reported to Council (Table 1). The Committee identified sources of data for each criterion, which included all documents and all bodies or groups involved in the process (Committee on Accreditation, June, 1987), and then developed and refined six evaluation tools. Evaluation tools were approved, translated and utilized to collect data from schools, review team members, members of the Board of Accreditation, members of the Committee on Accreditation and the Executive Director. The orientation programmes for the review teams were also evaluated.

Table 1

Criteria for Evaluation of the Accreditation Programme

1. Growth Promotion	the Accreditation process fosters self-development and innovation;
2. Internal Validity	the process provides for measurement of the quality of educational programmes; the process discriminates among programmes;
3. External Validity	the Accreditation status of educational programmes is credible in the nursing community, the university community and the public sector; the Accreditation criteria and measures are relevant to changing societal needs for educational programmes;
4. Reliability	the process provides for unbiased measurement; the process assures a balance of scope and depth in data collection that is representative of the educational programme; the checks and balances assure integrity in the system;
5. Feasibility	the structure facilitates the process (for example, preparation, timing, streamlining); the programme is financially feasible; benefits outweigh costs.

Evaluation Data

The evaluation data were summarized and presented by source (CAUSN, 1991).

Response from schools

Six schools that completed the evaluation tool indicated that the accreditation process fostered self-development in a positive manner and helped faculty see their programmes in the context of contemporary society and health services. The process reinforced and validated issues already known to faculty and increased their cohesion and solidarity. Recommendations from the accreditation report often became priorities for programme development and change. The self-study process was found to be very time consuming and redundancy of certain indicators was noted. It did, however, increase awareness and stimulate discussion about the programme among faculty and students. A need to have experienced reviewers with complementary backgrounds, including some with doctoral preparation, was particularly identified in relation to the site visit. The impact of the report on the schools varied; some found it was useful for reflection and planning improvements, while others indicated that it did not provide new insights or clear suggestions for change. In general, the report reflected the school's views on the quality of the programme. From the schools' perspectives, the unplanned effects of the process were overwhelmingly positive in increasing credibility and confidence in their programmes. Support from within the university and local professional groups was also noted.

Response from review team members

The feedback obtained from the members of the review teams indicated that an orientation programme for review teams was an important component of the accreditation process at this stage of development. The orientation kits and preparatory materials have been well received. The importance of having experienced team members was emphasized. Most team members found that time management was very important for an efficient site visit and repetitive experiences should be avoided. Validating each indicator from the school's self-evaluation was identified as being unnecessarily time consuming. This validation plus the fact that some indicators are unclear, repetitious

or difficult to ascertain took time that could be better used to write the summary report.

Teams composed of a mix of new and experienced members seemed to work well. A member with administrative experience, such as a dean or director, was considered desirable. The members of the review team generally agreed that the accreditation process fostered growth and development and it seemed to be as objective as possible. Preparatory materials had to be complete but kept to a manageable minimum. A French version of the tool was necessary. Time for orientation appeared to be sufficient. Some teams had to discuss how to resolve in-group differences. Site visit expectations of team members were generally similar, but some teams felt that the time frame (generally three days) did not allow for in-depth study of the programme. Most review team members felt that their summary report was written by consensus. Side effects experienced by review team members were generally positive but the process was found to be very intensive and onerous.

Response from members of the Committee on Accreditation

Responses gathered from the members of the Committee on Accreditation indicated that the linguistic and regional representation of the committee was effective and necessary, and that there should be some system to ensure at least one bilingual member. To date there has been a good mixture of experience among members and previous review team experience is valuable at the committee level. Members expressed concern about a lack of clarity with respect to roles and responsibilities of different groups i.e. Board and Council and Executive. The structure seems cumbersome with respect to these bodies as the Committee deals with policy in an advisory, not decision-making role. The Committee has monitored many aspects of the accreditation process for undergraduate programmes and developed policy for consideration by Council. Recently, committee activities have focused on analyzing the evaluation data and developing recommendations to improve the process as more experience is obtained.

Response from members of the Board of Accreditation

Board members noted the contributions of AUCC and community representatives to the Board activities. Linguistic and regional representation have

not been criteria for appointment, but were considered important and should be monitored. Board members observed that they require knowledge in the following areas: health care system, educational institutions, curriculum process and structure, conceptual models of nursing, clinical teaching approaches and the accreditation process. Communication skills and the ability to work in a group were also considered important as was the ability to read rapidly and synthesize large amounts of information. Concerning the composition of the review team, the Board members stated that they required more information about potential members' familiarity with the accreditation process. Academic preparation and qualifications for membership on review teams should be similar to those required for the Board of Accreditation. The availability of French language reviewers was considered important. The role of the Executive Director as a link for communications was seen as critical and positive at this time. No consensus exists on the usefulness of numerical ratings or on the appointment of deans or directors and board members to review teams.

Response from the Executive Director

The Executive Director functions in a key role in the accreditation process. Accreditation activities include providing on-going information on the process and organizing and coordinating the on site visits of the review teams, as well as providing the orientation for the review teams. The Executive Director also acts as resource person and secretary to both the Board and the Committee of Accreditation. Communication of current issues from the Executive to the Council is helpful in relaying current concerns and the latest policy and procedure changes.

Analysis and Discussion of Data

Using the five criteria for evaluation (Table 1), it was clear from the data received that the accreditation process fosters growth promotion and self-development (CAUSN, 1991). The feedback obtained from the review teams and the schools supported this view. It will be interesting to see if a subsequent accreditation review of the programmes will confirm these impressions. The fact that the Board of Accreditation can render a decision based on the data provided by the process and has allowed for different decisions is an indication that the process has internal validity and the capacity to discriminate among programmes. The evaluations by review team members

indicated that the accreditation process appears to be objective. The fact that there is unanimity about the redundancy of some indicators needs monitoring.

Although the evaluation process did not provide specific information on external validity, the indicators dealing with uniqueness and relevance allow for adaptation of programmes to accommodate changing societal needs. During its implementation there have been indications that the Accreditation programme has gained acceptance and credibility in the nursing community and support from the various universities. An increasing number of schools are seeking accreditation for the first time and several have expressed their intent for a second review. One school has been admitted to candidacy. Provincial nursing associations have inquired about the accreditation process. Educational institutions seeking membership in CAUSN have expressed interest in the accreditation service. The congruence noted between the schools' self-evaluations and the observation of the review teams, in several instances, is an indication of the reliability of the process. Data from schools and review teams indicate that there is a problem in the balancing of scope and depth in the accreditation process. Use of the 75 indicators provides a broad description of the programme, however, it requires review teams to validate each one may prevent an in-depth analysis of specific criteria. Two examples of checks and balances that assure integrity of the system are that three reviewers are selected by the Board and accepted by the school and that further clarification/validation is sought by the Board from the Dean/Director of the school and review team chair during the decision-making process. Two reviews have challenged the integrity of the system and have provided opportunities to test the capacity of the system to maintain its credibility.

Schools and review team members made suggestions to improve the feasibility of the process. The site visit was often considered unnecessarily arduous. The main criticisms related to tedious validation of each indicator, time management and preparation of the report to the Board. It is difficult at this time to evaluate the long term financial feasibility of the programme, given the variability in the number of programmes requesting reviews, particularly during times of budgetary constraint in post-secondary institutions. Financial viability must be monitored. The potential for multiple three-year reviews could affect the feasibility of the existing system.

Evolution of the Accreditation Process

As the accreditation process was implemented certain changes were made to facilitate the process. For example, at Council's request, the dean or director is now invited to meet with the Board of Accreditation when the programme is being discussed. This provides the dean or director with the opportunity to clarify factual details or speak about the accreditation process. Another modification relates to the orientations that were originally done either by a member of the Committee on Accreditation or a former review team member. They are now done by the Executive Director. The names of university programmes that are accredited and admitted to candidacy are published in the CAUSN *Newsletter*. Clarification of decisional options means that accreditation status can be granted for a seven- or a three-year period or can be denied. The evaluation report entitled *Evaluation of the Accreditation Process: The first five years of implementation 1986-1991* was received by Council in November 1991. Two recommendations from the report were approved by Council. These were: that Council immediately establish mechanisms to enlarge the review team pool with highly qualified, regionally representative members and that the Board of Accreditation communicate to Review Team members, through the Executive Director, the desirability of using sampling strategies during site visits to ensure the validation of the self-evaluation report within a reasonable time frame. The third recommendation, that Council delegate within the next two years, responsibility for the revision and refinement of the monograph entitled *Accreditation Program* (1987), was referred to the Executive for future action. Council also recommended that evaluation data continue to be collected from schools and review teams for the next three years in order to increase the data base.

The origins nursing education in Canada are based in service to hospitals. Since then it has evolved through several phases of development and has been monitored at various levels. Nursing education is now well established within the Canadian university system and can no longer be considered marginal.

In 1972, CAUSN began the development of a national accreditation programme that sought to ensure that the public's interests were protected through a process of external evaluation. The first accreditation of a nursing programme in Canada was completed in 1987. As more schools request

reviews, the process is gaining acceptance and credibility. To date, the accreditation of university nursing programmes has indicated that the process promotes growth in the schools and that the programs are relevant and responsive to changing societal needs. As well, the process values uniqueness and encourages schools to develop individuality within their own contexts. With only ten reviews completed, the process is still young and needs continued monitoring. The challenge for the future is to ensure that the CAUSN accreditation process remains sufficiently flexible to address the rapid changes occurring in our health and education systems while, at the same time, maintaining its integrity.

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RÉSUMÉ

L'agrément des programmes universitaires de formation infirmière au Canada

Le but de cet article est de tracer l'évolution du processus d'agrément des programmes universitaires de formation en soins infirmiers et de décrire l'évaluation du processus d'agrément. L'agrément des programmes de formation est situé par rapport au développement historique de la formation infirmière en tenant compte du contexte social, de la santé de la population et des exigences de formation pour assurer des soins de qualité. Les rôles de l'ACEUN et de son Comité d'agrément sont décrits en ce qui concerne le développement des critères et des instruments de collecte de données. Cinq ans après l'implantation du programme d'agrément, le Comité d'agrément a procédé à son évaluation. Les instruments utilisés par les divers groupes impliqués sont présentés. Finalement les résultats de l'évaluation du programme sont exposés selon les critères suivants: la promotion du développement du programme, la validité interne et externe, la fiabilité et la faisabilité. Des recommandations sont proposées afin d'améliorer divers aspects du programme d'agrément.

ORGANIZING YOUR SCHOOL FOR ACCREDITATION

Barbara Thomas and Anne-Marie Arseneault

Accreditation of baccalaureate nursing programs in Canada is a recent phenomenon. The Canadian Association of University Schools of Nursing (CAUSN) was designated as the accrediting body for university nursing programs in 1972, and the accreditation process was developed over a number of years by the CAUSN Committee on Accreditation (CAUSN, 1984, Curran, 1984). In 1987, the first program was reviewed (Curran & Bouchard, 1987) and by 1992, ten reviews had been completed.

Accreditation is a mechanism of external regulation that is used to promote the development of education programs that are responsive to societal needs and to ensure standards of nursing practice, encourage individuality and diversity, and stimulate innovation (CAUSN, 1984; French, 1978).

Undertaking accreditation to seek professional recognition for a university nursing program is an enormous task for faculty as it involves additional work and increased stress (Malarkey, 1981). As well, the impact of accreditation on academic programs and curricula is of concern to universities (Moore, 1992). This paper will provide an overview of the accreditation process and discuss some approaches that may be utilized or modified according to the educational philosophy and faculty experience in a school as it organizes for accreditation.

The Accreditation Process

In order to initiate the accreditation process in Canada, a school must file a written application with the CAUSN Board of Accreditation. Once an appli-

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cation for accreditation has been accepted, the school will be notified of the year in which the review will take place. Site visits are usually carried out in January or February, followed by meetings of the Board of Accreditation in the spring.

CAUSN has prepared a 72-page monograph entitled Accreditation Program (1987) that outlines the philosophy, criteria and process. The data collection tools are included in the monograph as are the policies and procedures for accreditation. It also provides the framework for the accreditation of baccalaureate nursing programs in Canada. The data collection section guides the school in collecting the appropriate information.

Hawken and Reed (1978) suggest that the first and perhaps hardest step in the accreditation process is the self-evaluation. This is the process by which the school collects data about its program as outlined in the Nursing Education Data Base (CAUSN, 1987). The school also measures itself against the four criteria of relevance, accountability, relatedness and uniqueness (Table 1) and prepares responses, which include a rating score of 1 (low) to 4 (high), and an example of behaviour supporting the rating, to each of the 75 indicators in the evaluation questionnaire. The accreditation program is process oriented; as such, the report must summarize how the school meets the criteria and identify areas of strength and areas needing improvement.

Following submission of the self-evaluation report, the school is visited by three reviewers who have been chosen by the Board of Accreditation and approved by the school. The purpose of the site visit is to clarify and validate the information in the self-evaluation report and to provide a global assessment of the program. The reviewers meet with faculty, students, and administrators. As well, they observe student activities in various clinical and university settings. They also usually meet with health agency personnel who are involved in hiring and working with graduates of the program. The reviewers then prepare a report that addresses the indicators, areas of achievement, areas requiring further development and summaries of the program in relation to each of the four criteria. Both the reviewers' report and the school's self-evaluation report are submitted to the Board of Accreditation for use in the decision-making process. The dean or director of the school under review is invited to meet with the Board for clarification of factual details at the time of the deliberations. Decision options available

to the Board include granting accreditation for seven years, granting accreditation for three years or denying accreditation.

Table 1

Four Criteria Used in CAUSN Accreditation

Criteria	Components
Relevance	The extent to which the purposes, goals and objectives of a program reflect a response to the major trends in society that impact on the health needs, present and future, of the larger community.
Accountability	The extent to which the program teaches the student that the primary responsibility in nursing is to the client, that is, community, group, family, person.
Relatedness	The extent to which the parts of a program support and build on other parts, thereby promoting or negating the achievements of goals. The parts are curriculum, the teaching of nursing, faculty practice and study of nursing and administration. This quality is a measure of internal consistency.
Uniqueness	The extent to which a program capitalizes on unique characteristics of its resources (includes faculty, community values, financial support, etc.) within its particular setting.

Getting Started

Getting an early start in the planning and preparation for the accreditation process is wise. Kauffmann & Burke (1989) suggest that four important and early decisions should be made by the school. These include when to begin collecting the data, what information is needed, method of presentation of the material and designation of the responsibility for preparation of the report. A time frame of 12 to 18 months before the expected date of the site visit is suggested (Hawken & Reed, 1978; Kauffmann & Burke, 1989). University schools of nursing vary in their stages of development from firmly established programs to relatively early stages of development (CAUSN, 1984). This along with other factors such as faculty availability and familiarity with the CAUSN accreditation process may influence the amount of preparation time required. The use of a flow chart (Hawken & Reed, 1978) is probably a good way to show faculty the magnitude and the scope of various aspects of the accreditation process.

The management strategies that are utilized in preparing for accreditation will have to be adapted to the individual school and administrative structure. Whether an individual or a steering committee is responsible for developing the accreditation report in a school, it is important that the faculty understand and support the process. If time and funds permit, it may be desirable to have a consultant meet with the faculty to review the goals of accreditation and to discuss the criteria and ways of approaching the data collection and report writing phases. Sufficient time must be allowed for the various components of accreditation, and some momentum needs to be maintained throughout the process. Some schools have been able to provide release time from regular teaching and academic duties for the individual or chair of the steering committee who is responsible for collecting data and putting the final report together. This has generally worked very well, and is recommended if resources permit. Having a skilled secretary who feels a commitment to the school and to the process is also helpful. The use of computer diskettes for the indicators saves time and allows for input from several sources. One can be prepared at the school or purchased from CAUSN. It is also helpful if one is made available to the review team for report writing during the site visit.

Data Collection and Report Writing

The task of collecting data and writing the self-evaluation report is usually delegated to an individual or a committee with the authority to obtain information from whatever sources are considered necessary. According to the CAUSN Accreditation Program (1987), data must be collected for the Nursing Education Data Base, the ratings and responses to the Evaluation Questionnaire, a summary of the program in relation to the criteria and an outline of the strengths and priority needs for further development. A description of the data collection process that identifies the scope and length of time of the self-study, the number of faculty involved, sources of data and procedures and resources utilized is also required. Data can be gathered for the Nursing Education Data Base at the same time as responses to the criteria and indicators are being prepared. The Nursing Education Data Base refers to the historical development of the program, administrative structure and information on faculty, students, curriculum and related learning resources. As such, it may be desirable to have one person with administrative experience on the steering committee prepare it. We strongly recommend that all full- and part-time faculty be introduced to the accreditation process, perhaps through a workshop, and be involved in developing the report. This allows for input from the grass roots, so to speak, and helps everyone share in the ownership of the process. Probably the best way to involve the faculty is to have members evaluate the program from their own perspectives, according to the accreditation criteria and indicators. This can be done by individual faculty members or by a small team. They should give examples of student behaviour and teaching-learning activities that demonstrate the process by which the criteria and indicators are met.

The students should also be oriented to the process, made aware of the benefits of accreditation and encouraged to give their input. This can be done by meeting with individual classes or student representatives. Hawken and Reed (1978) suggest that students should be given information about their roles and, prior to the site visit, they should have examples of the general types of questions they may be asked. They also suggest that students should be encouraged to be open and honest. The process should be seen as a review of the program, not a gripe session about a particular concern.

Data collection is an activity that often leads to in-depth discussion of the program and learning experiences; as such, it is important to allow

opportunity for discussions to take place at various levels to address these issues. Responding to the 75 indicators is the most difficult part of the report preparation. Evaluation has identified some redundancy in the indicators (CAUSN, 1991) and faculty may have difficulty identifying different student behaviours for each one. Occasionally it may be necessary to note that one behaviour refers to more than one indicator. If the steering committee receives responses for each indicator from several levels of the program, it helps to ensure that most aspects of the program are addressed in the report.

Establishing the numerical rating for each indicator and average for the criterion presents another challenge. It is probably wise to have input on this aspect from several sources. One way would be to have the steering committee members rate each indicator independently. The committee could then meet to discuss and compare their rationales for those ratings in which there was diversity of opinion.

At the time the report is finalized, it may be helpful to have the report reviewed for clarity and readability by a faculty member with particular expertise in writing. Copies of the report must be sent to the CAUSN office for circulation to the review team members at least six weeks before the scheduled site visit. Faculty members should each have a copy of the report and copies should also be sent to the president, vice-president academic or other university officials who will be meeting with the review team, for background information prior to the site visit.

The Site Visit

The site visit is a critical component of the accreditation process. It is the time when the school and the university presents its program and campus in a positive way to the external reviewers. In educational institutions, external appraisal is well accepted and valued as a method of evaluation (CAUSN, 1984). To prepare for the visit, several activities can be suggested. Hawken & Reed (1978) indicate that role-playing exercises, in which faculty are questioned about the various aspects of the curriculum, proved helpful in assisting faculty to think about the total program, increasing their familiarity with the self-study report and enabling them to speak more readily about the overall program. Colleagues in other disciplines who have had considerable experience with an external review process can be helpful resources to nursing faculty, and are usually willing to meet or offer useful suggestions. One

suggestion received in this manner was to have a room available for the review team during the day. This room could be the repository for important materials, provide access to a computer, and be available as a conference room between appointments. A good way to initiate the visit is for the dean or director to meet with review team members at the beginning of the site visit, to clarify or modify the schedule as necessary and to obtain general information on the program or school. The review team usually meets with the university president or academic vice-president. It is important that these appointments are scheduled early. Various members of the review team may meet with the librarian, computer centre staff or professors who provide service courses. It is wise to review the requirements of the nursing program in relation to each of these areas, so that the reviewers' questions can be addressed and the issues of particular concern to nursing can readily be discussed.

As the reviewers will want to observe students of different levels in various clinical settings as well as during clinical conferences, it is important to speak with the hospital personnel about the accreditation process and advise them of the planned schedule. Hospital and agency staff are usually very supportive and understanding of the stresses of accreditation.

The review team members will receive the self-evaluation report six weeks before the scheduled visit; the school may be requested to supply additional materials or information before the site visit. The schedule of the site visit should be circulated well in advance of the visit so that the review team can request changes if that is considered necessary. The schedule should be planned in detail to avoid delays and overloading and to be certain that the schedule is manageable. It is helpful if transportation can be arranged for review team members and considerable time can often be saved if an escort is available to take a reviewer to a particular location in the university or in a health care institution.

Accommodation for the review team should be located conveniently near the school and include a room to work in during the evening. It is generally considered desirable to have a computer, with diskettes that include the indicators and a printer available at this location for report writing after each day's visits. Evening activities should be avoided as this time is required for discussion of the data collected during the day and for planning the next day's visits. Compiling the data is an on-going process throughout the visit,

but the last evening following the visit and the final day should be reserved, by all the team members, for report writing. Review teams have also found it helpful to meet with the dean or director at the end of the visit for closure and, if necessary, to clarify certain aspects of the data. It may be helpful if the dean or director is available by telephone for verification of factual information.

The final draft of the report will be sent by the chair of the review team to the CAUSN Executive Director who will forward it to the dean or director for a final verification of factual data. The reports from the review teams have become more refined since they began in 1987. As on-going feedback is received from the Board, the review teams are able to make their reports more relevant to the needs of the Board. For example, the Board is encouraging more focus on the summary report of each criterion that reflects the overall quality of the program in the areas addressed. It is also recommending a sampling approach to the behaviours observed for each indicator.

When the Board of Accreditation meets to discuss the self-evaluation report and the review team report of the school, the dean or director is invited to meet with the Board to respond to any specific questions that the Board may have, and to discuss any comments about the accreditation process. Following the visit and receipt of the report of the Board of Accreditation, the school will be asked to complete an evaluation form addressing their experience with the Accreditation process. This is an essential component in the on-going evaluation of the Accreditation program.

Our experience to date indicates that a number of schools have successfully organized for the CAUSN accreditation process. Preparing the self-evaluation report is time consuming but also rewarding. It fosters self-development and frequently reinforced and validated issues already known to the school (CAUSN, 1991). Recommendations from the Board of Accreditation have become priorities for change. A complete and well-written self-evaluation report along with a well-organized site visit enable the reviewers and the Board to focus on the program under review and evaluate the extent to which it meets the criteria of relevance, accountability, relatedness and uniqueness.

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RÉSUMÉ

La planification pour le processus d'agrément

Le programme d'Agrément de l'Association canadienne des écoles universitaires de nursing a été finalisé en 1987 et à date, dix programmes d'étude ont été évalués. Le processus d'agrément exige une période de planification par tous les membres du corps professoral à partir de l'auto-évaluation selon les critères de pertinence, d'imputabilité, de cohérence et de spécificité jusqu'à la visite par l'équipe d'enquête. L'évaluation du programme d'Agrément indique que cette préparation, bien qu'elle peut être stressante, est enrichissante et favorise le développement du programme.

Le but de cet article est de présenter une séquence d'activités qui peuvent faciliter la planification des différentes étapes de la préparation de l'évaluation externe. Des suggestions pratiques sont faites afin de favoriser une collecte de données complète et d'assurer le déroulement efficace du processus aussi bien pour l'école que pour les membres de l'équipe d'enquête.

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