Discourse

The Practice of Family Nursing Care: Still a Challenge!

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Undeniably, the family is an essential part of nursing care. The incidence of chronic illness is increasing and early discharge of patients from hospitals, as a result of health care reform, require families to assume more responsibilities for the care of their members. These families find themselves in need of the assistance and expertise provided by nurses.

Family nursing is becoming a flourishing domain. Over the last seven years, three international family nursing conferences have been held, the *Journal of Family Nursing* was born, and the study of families has been incorporated into many educational curricula (Wright & Bell, 1989).

Theoretical concepts of family nursing are indeed rapidly developing under the influence of various family-focused disciplines. Despite the noticeable progress in theory and research, as a clinician, educator and researcher, I am struck by the absence of family nursing within the practice arena. The implementation of the theoretical concepts in clinical practice is lagging behind. In too many clinical settings family nursing is almost nonexistent or developing very slowly. Several questions come to mind: Do nurses recognize the importance of the family in health and illness? Do nurses know how to acquire a better understanding of families' experiences and how to deal with them? How are nurses taught to provide family nursing? Do nurses provide the families with the appropriate care? Is it effective? How is it measured? In this discourse I examine some of the factors that may explain why family nursing care is not being reflected in practice.

Family Nursing Practice

There is an increasing number of nurses who are interested in the family's experience in health and illness and who are sensitized to the importance of family care. In many clinical settings such as perinatal, pediatric, and commu-

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nity health care, the family has traditionally been an integral part of nursing practice. Families have been considered the target of nursing and have been a valued partner in all aspects of nursing care.

However, the involvement of families has been slow to extend to other clinical areas. Sadly, in these areas, families remain invisible or still worse are considered a burden. All too frequently the solution to dealing with families has been to avoid them or refer their concerns and complaints to the head nurse or clinical nurse specialist.

Lack of time, knowledge and skills, are cited as the major factors impeding the quality of family nursing care. If these can be considered valid reasons, what are the implications for the educational preparation of nurses, nursing administration, and research?

Educational Preparation

In recent years, we have made much progress in the development of family nursing models. Different theories from the fields of family science and family studies (e.g., Systems Theory, Developmental Theory, Role and Family Stress Theories) and Family Therapy have served as the foundational base for family assessment and intervention models in family nursing (Friedman, 1992; Gottlieb & Rowat,1987; Wright & Leahey, 1994). These family nursing models are continuously being updated. Scholars propel the theoretical component of family care ahead but at a pace that is rapidly surpassing implementation in actual nursing practice.

Yet despite the existing knowledge, as an educator involved in graduate nursing education and in various educational activities in the clinical setting, I have observed that nurses lack the theoretical and clinical preparation to effectively practise family nursing. Why is this so? Do educational curricula offer adequate preparation for the practice of family nursing? It would appear the emphasis of nursing education at the college level is focused on the individual and to a lesser extent on the family. Thus, it is not surprising that these nurses have limited skills in how to nurse families. In a survey of Canadian University Schools of Nursing, Wright and Bell (1989) found that family nursing content was well incorporated in undergraduate programs. Yet, there was a dearth of content dealing with family assessment, intervention, and interviewing skills. Wright and Bell hypothesized that the difficulties of implementing family nursing care could be traced to the absence of these competencies. Thus, we need to ask ourselves whether our existing educational system lacks the appropriate teaching resources or skills to ensure the practice of this essential component of nursing care.

For family nursing to become a reality, the first step is that educational programs need to adopt family nursing as an essential part of the curriculum rather than as a "luxury". A case in point is at McGill University School of Nursing, where family care is an essential component of the McGill Nursing Model (Gottlieb & Rowat, 1987) and consequently is integrated throughout the undergraduate and graduate curricula. Thus, throughout the McGill affiliated clinical settings, a more family-oriented nursing practice can be observed compared to other non-affiliated clinical settings.

An alternative model to developing family nursing is that found at the University of Calgary and Université de Montréal where family care is considered a domain of nursing in which one can specialize and develop advanced practice at the graduate level. Family systems nursing is practised when the "family system" is the unit of care; the relationship between the family dynamics and the health issue is assessed and considered the focus of intervention. A family nursing unit has been created to teach family systems nursing. Faculty members demonstrate family interviewing skills and provide on-site supervision (Wright, Watson & Bell, 1990). In so doing, graduate students are more inclined to promote family nursing.

Administration

Most nursing administrators recognize the significance of family nursing but only a minority ensure its practice. Priority is given to physical nursing care often citing economic restraints and nursing workload as the rationale. What often is not recognized, however, even in terms of these very practical considerations, is the inherent potential within a family-centred approach for the saving of time and effort. Unfortunately there are few mentors, within the clinical setting, who have the knowledge and skills of working with families.

Without the support of nursing administrators in clinical settings the implementation process is near to impossible. Nurse administrators need to support nurses in their practice of family nursing by providing educational resources (mentors and inservice education).

Research

To what extent can the relative absence of family nursing care be attributed to the nature of our research? Does the nurse view the results of such research as irrelevant to his/her practice? Family nursing research in the main has consisted of descriptive studies of families` experiences in health and illness, with a focus primarily on single family members or dyads. Very few studies have looked at family interactions or the interplay of family dynamics and health/illness. Limited also are those studies that evaluate the effect of selected nursing interventions on family health (Bell & Wright, 1995).

One possible approach to reducing the distance between practice and research may be to increase the dialogue between clinicians, researchers, and families. Systemic and "post-positivist" thinking demand new strategies to foster the concept of partnership between the nurse and the family not only in theory and practice but in research endeavours. A shift from individual to interactional data in family research is needed and the adoption of a perspective which enhances the dimension of "belief systems","interactions", and "relationships" between family members themselves and between the nurse and the family.

We need to refocus our thinking in family nursing research from a linear perspective (one which perceives nursing intervention as doing something to the client), towards a circular perspective (one which views nursing interventions as occurring within the context of a therapeutic conversation with the client/family). Within such an orientation, the nurse and the client/family co-construct interventions through their interactions. The nurse and the client/family are both influencing and being influenced by the interventions they co-construct.

If the constructivist paradigm (Watzlawick, 1984) is embraced as a useful way for conceptualizing reality, then it invites a new mode of research and a new type of researcher. Different research methodologies are needed to address the notion that one's world results from social co-constructions (Furth, 1987) and the principle of mutual connectedness of the observer and the observed (Varela, 1979). We need to consider research strategies such as participative or "co-operative inquiry" in order to be more congruent with the new emerging philosophy in the nursing of families. If embraced, families, nurse-clinicians, and researchers would jointly participate as co-researchers and co-subjects in the development and evaluation of family nursing interventions. Could this joint venture in research promote partnership in nursing care? Could it empower the family in its responsibilities and decision making regarding health and caring for its members? Could it facilitate the practice of family nursing?

Conclusion

To promote the practice of family nursing we must reevaluate our educational, administrative and research strategies. We must demonstrate flexibility towards new paradigms of inquiry that are more congruent with complex human and social phenomena and develop new practices that evolve out of practice-based research and research-based practice. The effervescence in this very promising field of nursing will be ever more useful and powerful!

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