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SUMMER EDITORIAL

Family Nursing in Tertiary Care: History or the Promise of Things to Come?

In the past decade, nursing has been developing the necessary knowledge and expertise to move from nursing the patient-within-a family context to nursing the family. Just as family nursing is coming of age for the second time in this century (the turn of the century being the first), a revolutionary approach to health care services is sweeping the country, resulting in a radical restructuring of health services. In the imminent future, the tertiary care settings will house only the acutely ill, community health clinics, and extended care facilities. Whereas primary health care holds considerable promise for family nursing in the community, the same cannot be said with respect to tertiary care settings.

Despite the discipline's hard-won advances in establishing university education as the basis for nursing practice and family as the focus of care, there is clinical evidence of widespread reluctance to practise family nursing in tertiary care settings. It is argued that a family-oriented approach is more in keeping with the hospital's main mandate of treating acutely ill patients. Cost-cutting initiatives and a trend toward shorter lengths of stay in hospital appear to justify this line of reasoning. The question of who will truly benefit — the family or the administrative system — impels us to examine practice and administrative issues related to these two clinical perspectives.

Family nursing is embedded in a nursing legacy of community work, illness prevention, and health promotion. It is based on a premise that the "patient" is the family. Conversely, the community is thought to help shape the family's values and sense of connectedness with the "outside" world. Both family and community offer members a safe haven, and, sometimes, a stressful course. Although stressful situations may actually promote family development, they may result in family dysfunction and compromised levels of well-being, if improperly managed. In the past decade, the nursing profession has advanced its thinking about several family-related concepts through clinical research and clinical practice. And, unfettered by the constraints of traditional models of practice, yet consistent with government policies first articu-

lated by the Lalonde Report (1974), there is reason to believe that family nursing in the community will flourish.

Although family-oriented nursing acknowledges the family's need for "emotional support," medical information, and patient access, in practice there is very little nursing that involves any family perspective. This family-oriented approach has appeal precisely because it requires a minimal investment of the nurse's time, knowledge of family health, and clinical skills. Some nurse professionals argue that this is justifiable because the measurable benefits of family nursing *against cost* have yet to be determined. The intent to decrease the number of hospital beds and shorten length of stays also contributes to an impression that the nurse will have little time to develop family nursing. Rather than find alternative ways to realize our nursing obligation, which is to care for the patient and his or her family, we continue to yield to the powers that be. But what are the potential costs to family and their community?

There are at least two compelling reasons for supporting family nursing, rather than family-oriented nursing in tertiary care. First, there may be a greater need for family nursing due to the predicted increase in acuity levels of patients and the known stressful impact of hospitalization on the family as well as the patient. A hospitalization signifies, more and more, the human condition of suffering, pain, and potential loss for all family members. Shortened hospital stays do not reduce the meaning of the event for the patient and his or her family. An injury or illness may be of such consequence that sense of hope and purpose are altered forever. Consequently, a main goal of nursing in tertiary care is not just to facilitate the patient's physical recovery but to promote family strengths and coping skillfulness. Family nursing's unique contribution lies in its expert knowledge of the potential effects of transitional events on family functioning, learning, and, perhaps most essentially, the inner world of meanings, myths, and identity (Bruner, 1979). The potential benefits of family nursing may be discovered in families that have faced severe adversity yet are able to re-integrate successfully into the workplace and re-affirm their communal and familial relationships and responsibilities.

The second reason for supporting family nursing in tertiary care is based on knowledge that early detection and intervention facilitates the process of physical and psychological recovery. Expert theoretical and clinical knowledge of how families initially anticipate, respond to, and deal with stressful situations lies at the heart of helping families in crisis to make sense of traumatic events. A respectful clinical approach that does not include an exploration of patient and family feelings and

thoughts has little therapeutic value. More and more studies are demonstrating that physical recovery is a poor indicator of the individual's health status and that family health is a significant predictor of the patient's own recovery. What good is knowledge if we do not begin to use it to justify our clinical practice? In summary, a family-oriented approach not only perpetuates a traditional approach to health care but represents a failure of sorts to meet the expectations of the discipline for knowledge-driven practice.

The question then is how do we nurse families according to the expectations and requirements of our discipline in a medically driven setting. One possible response is to reconceptualize the *coordination and delivery* of family nursing, not the content of its clinical practice in these hospitals. One approach consistent with principles of prevention may be to integrate the nursing services of community and tertiary care. An obvious first step would be to strengthen family nursing expertise in the ambulatory services of hospitals. Ambulatory-based nurses could assess initial family concerns and help to identify those who would benefit from family nursing during a critical hospital stay. When the patient is ready for discharge, the ambulatory-based nurse could refer the family back to a community clinic or elect to follow the family who met a specific set of health-related criteria. Alternatively, family nurses from community clinics could follow their families throughout the hospitalization period. A strengthened professional collaboration between nurses from hospital units, ambulatory services, and community, around family assessment and clinical interventions, provides continuity of health service. Most importantly, we need to institute a family nursing service on hospital units that will ensure at a minimum that family concerns have been assessed and followed through in an appropriate manner. Perhaps we need to incorporate family support groups led by a clinical nurse specialist that are held at the families' convenience on the hospital unit.

In summary, exciting developments in health care pose several clinical challenges for the discipline — all of which, carefully considered, may provide just the impetus to fully realize family nursing on a broad scale. However, in the process of restructuring our tertiary care settings, we must be guided not only by the need to cut hospital costs but by the values and beliefs of our discipline. In addition, we must be faithful across all clinical situations to the principles of primary health care, alleged to be the principal force for change in Canadian health-care services.

Mary Grossman
Associate Editor

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ÉDITORIAL DE L'ÉTÉ

Les Sciences infirmières de la famille entrent-elles dans l'histoire des soins tertiaires ou sont-elles la promesse de l'avenir?

Dans la décennie passée, les sciences infirmières ont développé la connaissance et les compétences nécessaires pour passer des soins donnés au malade au sein de sa famille aux soins à la famille. Tout comme les sciences infirmières de la famille arrivent à maturité pour la deuxième fois dans ce siècle (la première fois étant au début du siècle), une méthode révolutionnaire appliquée aux services de santé conquiert le pays et entraîne une restructuration radicale des services de santé. Dans un futur proche, les établissements de soins tertiaires accueilleront seulement les malades pour de courts séjours; davantage d'argent sera alloué aux services ambulatoires, aux cliniques de services de santé communautaires et aux établissements de soins prolongés. Bien que les soins de santé primaires donnent de formidables espérances aux sciences infirmières de la famille dans la collectivité, on ne peut pas en dire autant des établissements de soins tertiaires.

En dépit des avancées durement acquises de la discipline dans l'élaboration d'un enseignement universitaires comme base pour la pratique des sciences infirmières et la famille comme point central des soins, il existe des preuves médicales d'une grande répugnance à pratiquer les sciences infirmières de la famille dans les établissements de soins tertiaires. On affirme qu'une méthode axée sur la famille s'accorde mieux avec la mission principale de l'hôpital concernant le traitement des personnes atteintes de maladies aiguës. Des initiatives pour la réduction des coûts et une tendance à des hospitalisations plus courtes semblent justifier ce type de raisonnement. La question de savoir qui bénéficiera vraiment, la famille ou le système administratif, nous oblige à examiner les questions de la pratique et de l'administration liées à ces deux perspectives médicales.

Les sciences infirmières de la famille font partie intégrante d'un héritage de sciences infirmières liées au travail communautaire, à la prévention de la maladie et à la promotion de la santé. Elles sont

fondées sur le postulat que le « malade » est la famille. Réciproquement, on estime que la collectivité aide à modeler les valeurs de la famille et le sens de connexion avec le monde extérieur. La famille de même que la collectivité offrent à leurs membres un havre de sécurité et parfois un cours stressant. Même si les situations stressantes peuvent parfois aider au développement de la famille, elles peuvent, lorsqu'elles sont mal gérées, rendre la famille dysfonctionnelle et nuire à son bien-être. Durant la décennie passée, notre profession, grâce à la recherche et à la pratique médicales, a avancé dans sa réflexion sur différents concepts liés à la famille. Pourtant, libérées des contraintes des modèles de pratique traditionnels et cependant respectueuses des politiques gouvernementales d'abord exprimées par le rapport Lalonde (1974), il y a tout lieu de croire que les sciences infirmières de la famille dans la collectivité vont s'épanouir.

Bien que les sciences infirmières axées sur la famille reconnaissent que la famille a besoin de soutien affectif, de renseignements médicaux et d'accès au malade, dans la pratique, très peu de soins infirmiers impliquent une perspective familiale. Cette méthode axée sur la famille est intéressante précisément parce qu'elle exige peu d'investissement pour ce qui a trait au temps de l'infirmière, à la connaissance de l'état de santé de la famille et aux compétences médicales. Certains de nos professionnels estiment que cela se justifie, étant donnée que les bénéfices mesurables des sciences infirmières de la famille *par opposition aux coûts* restent à déterminer. Le projet de diminuer le nombre de lits d'hôpital et d'abrèger la durée des hospitalisations a également contribué à donner l'impression que les infirmières auront peu de temps à consacrer au développement des sciences infirmières de la famille. Au lieu de trouver des alternatives aux moyens de remplir nos obligations, à savoir prendre soin du malade *et* de sa famille, nous continuons de nous en remettre aux pouvoirs établis. Quels peuvent en être les coûts pour la famille et la collectivité ?

Deux raisons impérieuses au moins nous obligent à soutenir les sciences infirmières de la famille plutôt que les sciences infirmières axées sur la famille au niveau des soins tertiaires. D'abord, il se peut qu'il y ait un besoin plus grand de soins infirmiers à la famille à cause de l'augmentation prévue des maladies aiguës et de l'impact connu du stress de l'hospitalisation sur la famille autant que sur le malade. L'hospitalisation représente de plus en plus la condition humaine de la souffrance, de la douleur et de la perte éventuelle pour tous les membres de la famille. Les séjours plus brefs en hôpital ne réduisent pas la signification de l'événement pour le malade et sa famille. Une

blessure ou une maladie peuvent entraîner des conséquences telles que l'espérance et la résolution sont altérées à tout jamais. En conséquence, un des objectifs principaux des sciences infirmières en soins tertiaires ne consiste pas à seulement faciliter la guérison physique du malade mais à mettre en avant les forces de la famille et son aptitude à s'adapter. La contribution unique des sciences infirmières de la famille tient dans sa connaissance experte des effets éventuels d'événements de transition sur le fonctionnement de la famille, l'apprentissage et, peut-être plus fondamentalement, le monde intérieur des significations, des mythes et de l'identité (Bruner, 1979). On peut voir les bénéfices éventuels des soins infirmières à la famille dans des familles qui ont dû faire face à de graves malheurs et qui ont pu néanmoins réintégrer avec succès leur milieu de travail et réaffirmer leurs liens et leurs responsabilités au sein de la famille et de la collectivité.

La seconde bonne raison que l'on a de soutenir les sciences infirmières de la famille en soins tertiaires est fondée sur le fait que l'orsqu'on détecte précocement la maladie et que l'on intervient rapidement, cela facilite le processus de guérison physique et psychologique. Le véritable savoir, théorique et clinique, de la façon dont les familles prévoient les situations stressantes, y réagissent et les règlent, est au cœur de l'aide aux familles en crise afin de comprendre les événement traumatisants. La méthode clinique respectueuse mais qui ne tient pas compte des sentiments et des réflexions du malade et de sa famille n'a que peu de valeur thérapeutique. De plus en plus d'études montrent que la guérison physique est un piètre indicateur de l'état de santé de la personne et que la santé de la famille est un facteur de prédiction significatif de la guérison du malade. À quoi sert la connaissance si nous ne l'utilisons pas pour justifier notre pratique médicale ? En résumé, une méthode axée sur la famille ne perpétue pas seulement une approche traditionnelle aux soins de santé mais représente en quelque sorte un échec face aux attentes de la discipline pour une pratique guidée par la connaissance.

La question est alors de savoir comment s'occuper des familles selon les attentes et les exigences de notre discipline dans un environnement guidé par le fait médical. Une réponse possible est de conceptualiser de nouveau la *coordination* et la *prestation* de soins infirmiers à la famille et non pas le contenu des pratiques médicales dans ces hôpitaux. Une méthode, compatible avec les principes de la prévention, consisterait à intégrer les services de soins infirmiers de la collectivité aux soins tertiaires. La première étape évidente serait de renforcer les compétences des sciences infirmières de la famille dans les services ambu-

latoires des hôpitaux. Les infirmières en service ambulatoire pourraient procéder à l'évaluation des difficultés de la famille et aider à reconnaître les personnes qui bénéficieraient le plus de soins infirmiers à la famille au cours d'une hospitalisation particulièrement grave. Lorsqu'un malade est prêt à sortir de l'hôpital, l'infirmière en service ambulatoire pourrait aiguiller la famille vers une clinique communautaire ou bien choisir de faire le suivi de la famille qui a rempli une série de critères liés à la santé. Une autre alternative serait que les infirmières familiales des cliniques communautaires suivent leurs familles tout au long de l'hospitalisation. Une collaboration professionnelle renforcée entre les infirmières des hôpitaux, les services ambulatoires et la collectivité pour ce qui concerne l'évaluation de la famille et les interventions médicales offre une continuité dans les services de santé. Ce qui est le plus important, c'est que nous mettions en place des services de soins infirmiers à la famille dans les hôpitaux et que cela assure au moins que les difficultés de la famille seront évaluées et qu'on en fera le suivi de façon appropriée. Peut-être devrions-nous intégrer des groupes de soutien à la famille dirigés par une infirmière clinicienne spécialisée, groupes qui se réuniraient à l'hôpital lorsque cela convient à la famille.

En résumé, les formidables progrès en soins de santé mettent au défi sur le plan médical notre discipline. Tout bien considéré, cela pourrait donner son élan à la réalisation totale des soins infirmiers à la famille à grande échelle. Néanmoins, au cours du processus de restructuration de nos établissements de soins tertiaires, il nous faut être guidés non seulement par la nécessité de réduire les coûts dans les hôpitaux mais également par les valeurs et les convictions de notre discipline. Enfin, dans toutes les situations médicales, nous devons rester fidèles aux principes de soins de santé primaires qui sont considérés comme la principale force de changement dans les services de santé canadiens.

Mary Grossman
Redactrice adjointe

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Focus: philosophy/theory

GUEST EDITORIAL

Moving Forward in Our Philosophizing and Theorizing in Nursing

A couple of years ago, when Dr. Laurie Gottlieb invited me to serve as the "Philosophy/Theory" section guest editor, I considered the usual things that one does in making a practical decision of importance. Among other things, I thought about the significance, for the development of the nursing discipline, of the *Canadian Journal of Nursing Research's* (CJNR's) decision to devote, for the first time, some space to philosophical thought and theory development in nursing. Related to that significance, I thought of the unique opportunity that I was being offered to contribute to the development of the *CJNR* and of the nursing discipline. However, the potential problem of too few papers being submitted in response to the planned call for manuscripts concerned me. I thought of the times that Dr. Peggy Chinn, as editor of *Advances in Nursing Science*, had remarked on how few papers had been submitted on a particular, specified topic. But, influenced by Dr. Gottlieb's infectious optimism, I thought I would cross that bridge when I came to it and decided to take up the challenge.

Much to my surprise and delight, the *CJNR* received a record number of submissions. Besides, they came from nurses around the world. My delight, however, was short-lived. Following internal and external peer reviews of the manuscripts, my concern about an insufficient number of submissions was soon replaced with that of not having enough publishable papers for the section. I am sufficiently dismayed by the reasons why a large number of submitted manuscripts were deemed not to be of publishable quality by reviewers to devote the first half of this guest editorial to that very matter.

My dismay has to do with the fact that papers had to be turned back for what seem to be preventable problems — preventable in the

sense that the problems that ailed the papers presumably could have been identified through collegial review and then dealt with, prior to manuscript submission. What commonly ailed the papers was lack of clarity of thought and expression, underdevelopment of ideas, and superficial treatment of topics. What makes all of this so unfortunate is that the papers focused on matters, and presented perspectives, of real import to the nursing discipline. With regard to the common problems, I found myself asking, "How preventable are they? How prepared are nurses to deal with them?" Myra Levine's discourse (to follow) on the need for study in the humanities in nursing would seem to indicate that the problems may be symptomatic of a larger one — one that can be overcome, albeit not readily, and has to do with how we go about "educating" nurses, leaving them ill-equipped to pursue scholarly endeavors of the sort being discussed here.

If the manuscripts we received are any indication of what is being submitted to other nursing journals in the areas of philosophical thought and theory development in nursing, I would say that the discipline is at a critical point. At a time when it is becoming increasingly vital to clarify and clearly communicate the philosophical underpinnings of our practices as nurse researchers, theorists, educators, clinicians, and administrators, we apparently are wanting in terms of the resources required to meet that challenge. It would seem that the time has come to reconsider the place of the liberal arts and of the humanities in the preparation of nurses. Maybe too the time has come for us to concentrate our efforts on helping one another become more disciplined in our thinking and in the expression of it. The latter, I realize, is easier to say than do. It would require each of us to be temperate, just, and courageous in examining our colleagues' work. Also, it would require that we be willing to subject our own work to criticism and to share that precious commodity — our time — which seems to just keep evaporating in this fast-paced world of ours. If we would do that much, we would be contributing to the release, through publications, of those ideas among our membership, which stand to advance the nursing discipline to new heights.

That said, what of the papers that were accepted for publication? What potential do they hold for contributing to the development of the nursing discipline? At the outset, I had hoped that we would be able to publish papers representative of the diversity of philosophical positions being held by nurses today, because it is difference that provokes thought. However, for the most part, authors tended to base their think-

ing in philosophies which were more or less similar. The end result is that the accepted papers by Gadow, Polifroni and Packard, and Wells are alike in that regard. That aside, the papers are sure to provoke discussion by virtue of the different solution each offers to some very serious epistemological problems presently facing the discipline.

What is particularly significant about the papers by Gadow and by Polifroni and Packard is that they reveal that nurses are attempting to deal with problems which have surfaced, of late, in conceiving of nursing as a human science rather than as a natural science. In conceiving of nursing as a human science and adopting all that is presupposed in such a conception (e.g., that reality conforms to the individual mind and that all knowledge is context-bound), it has become apparent that knowledge which is applicable beyond a particular situation or individual cannot be had. Solutions to this problem offered by Gadow and by Polifroni and Packard entail nontraditional conceptions of such notions as the general, the particular, generalizability, and theory.

Another matter of concern, yet to be resolved and considered by not only Gadow and by Polifroni and Packard but also by Bergum and James in their book review of *Interpretative Phenomenology. Embodiment, Caring, and Ethics in Health and Illness*, is the place of theory in nursing research and practice. Ought nursing research and practice to be guided by theory? Is theory development the aim of nursing research? If so, theory in what sense? If not, what is the aim of nursing research? In her paper, Wells makes a case for theory guiding research and demonstrates how a philosophical theory guided her research directed to improving nursing practice.

All of the contributors to the "Philosophy/Theory" section of this issue have taken courage in hand and exposed their thinking for critical examination. It is my hope that we will seize the opportunity that their contributions provide to engage in disciplined discussion of their ideas and of the serious problems facing the nursing discipline with which they have attempted to grapple.

I would indeed be remiss if I did not close this editorial with a note of thanks to all who contributed to making this "Philosophy/Theory" section a reality — to those who took the time to submit manuscripts, to our reviewers who so carefully reviewed those manuscripts, and to those who promptly made requested revisions. Finally, I would like to express my thanks and appreciation to Dr. Laurie Gottlieb and to

Guest Editorial

Ms. Jill Martis for all they did to make the experience of serving as guest editor very pleasant and worthwhile.

June F. Kikuchi
Guest Editor

June F. Kikuchi, R.N., Ph.D., Professor and Director, Institute for Philosophical Nursing Research, Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada.

Le point : philosophie/théorie

ÉDITORIAL INVITÉ

Sciences infirmières : Philosopher et théoriser davantage

Lorsque Dre Laurie Gottlieb m'a invitée il y a deux ans à être la rédactrice invitée de la partie « Philosophie/Théorie », j'ai réfléchi à ce que l'on doit faire habituellement quand on prend une décision pratique importante. Entre autres choses, j'ai pensé à l'importance, pour le développement de notre discipline, de la décision de la *Revue canadienne de recherche en sciences infirmières* de réserver, pour la première fois, de l'espace à la pensée philosophique et à l'élaboration théorique en sciences infirmières. Et cette importance m'a fait méditer sur l'occasion unique qui m'était offerte de participer au développement de la revue et de notre discipline. Ce qui m'inquiétait le plus était qu'éventuellement trop peu d'articles soient soumis, après les appels lancés pour obtenir des manuscrits. Je me suis rappelée les moments où la Dre Peggy Chinn, rédactrice en chef de *Advances in Nursing Science*, avait fait remarquer le peu d'articles envoyés sur un sujet particulier. Contaminée par l'optimisme de la Dre Gottlieb, je croyais que je n'aurais aucun mal à faire face à cette difficulté et je décidai donc de relever le défi.

À ma grande surprise et à mon grand plaisir, la revue reçut de nombreux articles. Ceux-ci parvenaient d'infirmières du monde entier. Ma joie cependant fut brève. Après que des pairs aient révisé les manuscrits, à l'interne et à l'extérieur, mon souci de recevoir trop peu d'articles fit bientôt place à celui de n'avoir pas assez d'articles publiables pour la partie « Philosophie/Théorie ». J'étais suffisamment consternée des raisons pour lesquelles les réviseurs considéraient qu'un grand nombre des articles ne présentaient pas une qualité suffisante pour être publiés que je décidais de consacrer la première partie du présent éditorial à ce problème.

Ma consternation tenait du fait que les articles devaient être renvoyés pour des problèmes qui semblaient pouvoir être évités, à savoir

que ceux-ci auraient pu être détectés par une révision collégiale puis être réglés avant que le manuscrit soit soumis. Les lacunes les plus communes étaient le manque de clarté dans la pensée et sa formulation, des idées insuffisamment développées et un traitement superficiel des sujets. Le plus grave est que les articles traitaient de sujets précis et offraient des perspectives d'importance réelle aux sciences infirmières. Pour ce qui concerne les difficultés ordinaires, je me suis demandé : Comment peut-on les prévenir ? Dans quelle mesure les infirmières sont-elles prêtes à y faire face ? Le traité de Levine (à suivre) sur la nécessité d'étudier les sciences humaines en sciences infirmières semble indiquer que les problèmes peuvent être symptomatiques d'un problème plus vaste qui peut être réglé, quoique pas immédiatement, et qui tient à la façon dont nous « éduquons » les infirmières, en ne leur donnant pas les moyens d'entreprendre des travaux érudits du niveau dont nous discutons présentement.

Si les manuscrits que nous recevons indiquent le type de manuscrits soumis aux autres revues en sciences infirmières dans les domaines de la pensée philosophique et de l'élaboration théorique en sciences infirmières, j'estime que notre discipline est dans une situation critique. À une époque où il est de plus en plus crucial de clarifier et de communiquer clairement les fondements philosophiques de notre pratique en tant que chercheurs, théoriciens, éducateurs, cliniciens et administrateurs en sciences infirmières, nous manquons apparemment des ressources nécessaires pour relever ce défi. Il semble qu'il faille maintenant réviser la place des arts libéraux et des sciences humaines dans la formation des infirmières. Le moment est peut-être également venu de nous entraider à structurer davantage notre pensée et notre façon de l'énoncer. J'admets qu'exprimer clairement sa pensée est plus facile à dire qu'à faire. Cela implique que chacun de nous soit modéré, juste et courageux dans l'examen du travail de nos collègues, que nous soyons prêts à voir notre travail critiqué et à partager cette denrée précieuse, notre temps, qui semble fondre comme neige au soleil dans notre monde trépidant. En faisant seulement cela, nous participerons à travers nos publications à la propagation des idées des membres de notre discipline et cela fera atteindre de nouveaux sommets aux sciences infirmières.

Ceci étant dit, parlons des articles parus. Qu'offrent-ils au développement de notre discipline ? Au début, j'espérais que nous pourrions publier des articles qui représenteraient les diverses positions philosophiques des infirmières à l'heure actuelle, étant donné que la dif-

férence engendre la réflexion. Dans la majorité des cas cependant, les auteurs ont eu tendance à fonder leur réflexion sur des philosophies plus ou moins semblables. Le résultat final est que les articles acceptés qui ont été rédigés par Gadow, Polifroni et Packard sont identiques de ce point de vue. Malgré cela, les articles entraîneront inévitablement la discussion en raison des différentes solutions que chacun propose à certains problèmes épistémologiques très graves auxquels est actuellement confrontée la discipline.

Les articles de Gadow, Polifroni et Packard révèlent le fait important que les infirmières essaient de régler les problèmes qui ont surgi récemment par rapport à la conception des sciences infirmières comme science humaine plutôt que comme science naturelle. En concevant les sciences infirmières comme science humaine et en acceptant tout ce que présuppose cette conception (à savoir que la réalité s'adapte à l'esprit de la personne et que toute connaissance est liée au contexte), il apparaît que la connaissance applicable au-delà d'une situation ou d'une personne particulière ne peut être acquise. Les solutions à ce problème qu'offrent Gadow, Polifroni et Packard exigent des conceptions révolutionnaires des notions telles que ce qui est général, particulier, la généralisabilité, et la théorie.

Une autre question importante, qui n'est pas encore résolue et qu'examinent non seulement Gadow, Polifroni et Packard mais également Bergum et James dans leur étude *Interpretative Phenomenology. Embodiment, Caring, and Ethics in Health and Illness*, est la place qu'occupe la théorie dans la recherche en sciences infirmières et sa pratique. La théorie devrait-elle guider la recherche en sciences infirmières et sa pratique? Le développement de la théorie est-il l'objectif de la recherche en sciences infirmières? Dans l'affirmative, la théorie dans quel sens? Dans la négative, quel est l'objectif de la recherche en sciences infirmières? Dans son article, madame Wells présente des arguments en faveur d'une théorie qui guide la recherche et montre comment une théorie philosophique a guidé sa recherche dont le but était d'améliorer la pratique des sciences infirmières.

Toutes les personnes qui ont participé à la partie « Philosophie/Théorie » du présent numéro ont pris leur courage à deux mains et ont exposé leur réflexion à la critique. J'espère que nous saisisons l'occasion que nous offre leur participation pour entamer une discussion rigoureuse sur leurs idées et sur les problèmes graves que rencontre notre discipline et auxquels elles ont essayé de répondre.

Je serais bien négligente de terminer cet éditorial sans remercier tous ceux qui ont participé à la mise en place de cette partie « Philosophie/Théorie », les personnes qui ont pris le temps d'envoyer des manuscrits, celles qui les ont révisés avant tant de soin et celles qui ont rapidement apporté les corrections nécessaires. En dernier lieu, je tiens à remercier chaleureusement D^{re} Laurie Gottlieb et madame Jill Martis pour tout ce qu'elles ont fait afin de rendre cette expérience de rédactrice invitée très agréable et intéressante.

June F. Kikuchi
Rédactrice invitée

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Discourse

On the Humanities in Nursing

Myra E. Levine

Nursing is a humanitarian enterprise. The emphasis placed on scientific and technical knowledge is indispensable to the development of the craft — but it is imperfectly achieved without the intellectual skills that are the special province of the humanities. The humanities invite both introspection and participation. Poet, novelist, essayist, storyteller — all provide the language of memory and anticipation, a sharing which belongs to each alone but speaks in a voice heard and understood by many. The written word is a lifeline to the historical past, and with it the rediscovery of reality as described and celebrated by the creative spokespersons of their times. Here is recorded how human beings have confronted their world, some of it intimate and familiar and some of it strange and foreign. Expressions of human experience are transmitted across generations to speak their mysteries again and again.

But these voices have been silent in the education of nurses. Racing through curricula which seek to be all-inclusive, there is seldom time for courses in philosophy or literature, or history or music. However efficient the education of nurses in disciplines of science, a large void remains. Nurses are adept in their practice, but do not have the language and reading and thinking skills that are the basis of a liberal education. This failure, a failure of literacy, not only deprives the individual of precious gifts, but it isolates nurses from other professional health colleagues, and ultimately limits the depth and meaning of the profession itself.

Nursing education skirted the humanities, using what was deemed essential in a superficial way. While ethics, nursing history and philosophy have had a foothold in the nursing curriculum, their impact has been meager and restrictive.

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“Ethics” has been a part of the curriculum ever since Nightingale regaled the probationers of St. Thomas with her homilies, a practice imitated in many schools of nursing afterwards. But ethics were really rules of etiquette — how proper young ladies behaved on the wards and in the halls of their residence. For years, pupil nurses were closely monitored by straight-laced house mothers who prowled the floors of the residence to be certain all was in order. The professional Code of Ethics was actually a code of etiquette. In 1968, the first of several revisions sought to eliminate the rules of etiquette and finally emphasize the ethical responsibilities of the nurse.

When an overwhelming technology transformed health care practice, the ethical issues that faced practitioners could not be ignored. Nurses were swept into the bioethics movement, following the lead of the ethicists at Georgetown University and directly into the philosophy of John Stuart Mill. The bioethics literature is a dialectic of dilemmas, and nurse authors adopted the dilemmas as a nursing ethic. But the issues of nursing ethics are *not* dilemmas. Dilemmas demand a choice, posing two equally unsatisfactory answers. The utilitarian doctrine advocates the “greatest happiness for the greatest number” — a doctrine in which, obviously, some will be excluded. In providing nursing care, exclusion is rarely permissible. Mill is not the only philosopher with a message for nurse ethicists. But the paucity of nursing experience in philosophy has limited the progress of nursing ethics.

Nursing history was taught, but never accorded much importance, either by the instructors or the students. A minor course that had little relevance to their daily experience, the history of nursing was a casual interlude for tired students. But even more disheartening, the history of nursing institutions was not valued. The official papers that recorded the meaning and the purpose and development of the organization were not viewed as archival materials but discarded — a history tossed away without a second thought. Efforts to recover the history of an organization was sometimes undertaken by alumnae associations, and, while the collections are valuable, they were undertaken by devoted alumnae not schooled in historiography. They were seldom catalogued in libraries and many were lost. When the Illinois Training School for Nurses¹ was closed, the remaining copies of its alumnae history were placed in the attic of a building at the University of Chicago, and upon request were sold for ten cents each by Professor Nellie X. Hawkinson.

Nurses cherish the icons of their beginnings and their past, and yet the wisdom and experience of great nurse leaders — Lavinia Dock, Isabel Stewart, Katherine Densford, Janet Geister, Katherine Faville, and indeed Nellie Hawkinson and many others — was imperfectly recorded for later generations. Lacking the historical record, the profession is poorly informed of nursing's actual role in the development of the health care system, in the creation and management of hospitals and public health agencies, and in defining the role of the professional nurse. Such a void in self-awareness critically affects the stature and growth of nursing as a vital, essential public service.

An increasing cadre of nurses have prepared themselves as historians, and their influence is gradually being felt. There are several academic centers which have established Nursing Archives as well as an international society for Nursing History and the publication of nursing history research that is increasingly sophisticated.

To American nurses a "philosophy" was the preamble to the curriculum required for accreditation by the National League for Nursing. Faculty committees anguished over the preparation of the "philosophy" and their labor invariably produced a mundane listing of "We believe..." Since few of the faculty ever studied philosophy, they had a vague notion of what a philosophy was. Those fortunate nurses whose parochial education required that they study theology, and sometimes philosophy as well, were outnumbered by the unschooled faculty bound to the traditional pattern that dictated the school's "philosophy.

Graduate nursing students choosing elective courses met considerable resistance, in registering for philosophy courses, from both the nursing and philosophy faculties. But some graduate nursing students succeeded in choosing a major or minor in philosophy, and some seized upon a single philosophical corpus and sought to make it into nursing dogma. Lacking a knowledgeable audience, efforts to "use" philosophy in nursing are subjected to few restraints, so that advocacy of "alternatives" such as transcendentalism or mysticism finds few nurses capable of rebuttal. Perhaps the influence of the Institute for Philosophical Nursing Research at the University of Alberta will create a more sober approach to philosophy in nursing.

The inadequacy of nursing's grasp of philosophy was especially clear in the impact of theory on nursing. Philosophy should drive theory, but it is rare that theorists make explicit the philosophy that

influenced their theory. More often, the philosophical roots are vague, the antecedents to identifiable philosophies barely recognizable. Instead, a "philosophy" is contrived — usually in a critique — from assumptions and propositions offered by the theorist. It is characteristic of nursing theory that the antecedents are not clearly identified, philosophical or otherwise. Nurses have always developed processes or procedures and a posteriori sought to explain their provenance. Unhappily, that has also been the pattern in the development of nursing theory.

Those few theorists who claim philosophy as the basis of their work, tend to choose generalizations rather than identify a specific author. Others select a philosopher, but limit the influence of — and in some instances misuse — the concepts they select. Seizing upon the idea of a "lived life," the phenomenologists have promoted their own science of nursing — a "human science" — and dismiss the scientific method as reductionist and mechanistic. They cite Heidegger, Sartre, Merleau-Ponty, Buber, Marcel, and others as if there were no differences between them. An informed audience might have objected, but as Stevens suggested, theorists may have benefited by "nurses who mistakenly assume that any theory must have merit if they cannot understand it."²

The nursing penchant to find a "practical" use for every area of learning seriously hampers the introduction of humanities into the curriculum. And yet, the gifts awaiting the student of humanities *are* practical beyond measure. The questions that the humanities ask insist on the cultivation of habits of analysis and reflection, introspection and self-examination — the uses of the mind that create a thinking person. It is no small task to confront Descartes, or Shakespeare, or John Donne, to identify new perspectives, to enter their thoughts and find personal meaning and direction. A liberal education is a consequence of acquaintance with the creative imagination of the writers, poets, artists and musicians who have celebrated their lives. And it enriches the life of the student, demanding discipline in reading critically and discovering the structure and style and beauty of the message of the artists. It develops a respect for language and what words mean, and how they are used appropriately. A liberal education enlarges the life space of the individual, offering horizons previously hidden and unexplored.

Must it be the price of a professional education to forswear a liberal education? The expectation that every subject must demonstrate its usefulness has excluded those that enlarge the intellectual and aesthetic

abilities of the individual. The nurse is witness. There should be no limits placed on the knowledge and sensitivity brought to the tasks of nursing. The humanities promise a tempering and a gentling of the relationships between patient and nurse.

Nursing education has finally established a firm foothold in Academia, and the resources for the broadening of nursing education to include studies in the humanities are readily available. A liberal education encourages the potential to become all that the individual wishes to be. It is, ultimately, a possession that cannot be compromised or lost. It is singularly personal, a selfish achievement with its own private dimensions. And therein lies the true wonder of a liberally educated nurse: that in experiencing the joy and exaltation of discovering the self, there is stored the compassion and wisdom that can be readily shared with others.

Footnotes

1. Shryver, Grace F. (1930). *A History of the Illinois Training School for Nurses*. Chicago: The Illinois Training School for Nurses.
2. Stevens, Barbara (Barnum) (1979). *Nursing Theory: Analysis, application, evaluation*. Boston: Little Brown and Company, p. 37.

Clinical Epistemology: A Dialectic of Nursing Assessment

Sally Gadow

L'évaluation clinique des soins infirmiers allie une connaissance générale basée sur la théorie à la recherche basée sur la connaissance particulière que l'on a d'un malade. On doit faire un compte rendu philosophique de cette synthèse pour élucider le paradoxe d'une connaissance à la fois générale et particulière. La méthode exposée dans le présent document est un modèle dialectique de connaissance clinique qui mène à une sécurité existentielle plutôt qu'à une certitude épistémique. Dans ce modèle, l'évaluation des soins infirmiers consiste à montrer comment l'on passe d'une vulnérabilité subjective à travers différents niveaux d'objectivité (désengagement, réduction, holisme) à une intersubjectivité par laquelle l'infirmière et le malade expriment ce qu'ils comprennent de la situation par un récit en relation mutuelle. L'article se termine par une réflexion sur le rôle de la théorie dans un récit clinique complet sur le plan de la dialectique.

Clinical assessment in nursing combines general knowledge from theory and research with particular knowledge about a client. A philosophical account of this synthesis is required to elucidate the paradox of knowledge that is both general and particular. The approach developed here is a dialectical model of clinical knowledge that culminates in existential safety rather than epistemic certainty. In the model, nursing assessment is the progression from subjective vulnerability through levels of objectivity (disengagement, reduction, holism) to an intersubjectivity in which nurse and client express their combined understanding in a relational narrative. The discussion concludes with reflection on the role of theory in a dialectically complete clinical narrative.

Advanced nursing practice is based on expert clinical assessment, combining knowledge from nursing theory and research with knowledge about a specific client. Clinical assessment, in short, creates a synthesis of general and particular knowledge. Underlying advanced practice is the epistemological question that nursing must address: *How* does clinical assessment unite general and particular knowledge?

The answer to that question will have important implications for nursing practice and theory. If nursing assessments are theoretical judgements, they cannot express the particularity of a client's situation, and they fall short of expert practice: "... there is no higher court than the expert's reading of a particular situation" (Benner, 1984, p. 177).

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On the other hand, if clinical knowledge expresses particularity it cannot be theoretical, even though it is theory-based: "... there is theory and the use of theory, but no theory of the use of theory" (Jonas 1982, p. 199).

If clinical assessment is indeed a synthesis, it somehow combines general and particular knowledge. Since these are mutually exclusive in most epistemological traditions, nursing assessment evidently represents an advance beyond the traditional dichotomy. What is the philosophical description of that advance? In the following discussion I employ dialectic as the framework for a philosophical account of nursing assessment. In the model I develop, clinical knowledge involves a process in which the very meanings of *general* and *particular* undergo a series of changes, culminating at a level at which knowledge is co-authored by client and nurse together in their relational narrative.

The dialectic framework is especially useful for illuminating a process such as clinical assessment in which the opposition between general and particular is overcome. The concept of dialectic used here is adapted from Hegel's philosophy (1967). For Hegel, the most advanced understanding of a situation is one that achieves completeness through a process wherein each level of understanding evolves as an overcoming of the specific limitation at the former level. The essential point in Hegel's model is that the overall process, not the outcome, of dialectical development is epistemologically complete. The conclusion, apart from the process, has neither truth nor value. Knowledge is complete when it represents a dialectic that incorporates — not omits — opposing elements in the overall progression.

To elaborate the model of clinical knowledge as dialectic, I will describe five levels of nursing assessment and illustrate the client's experience at each level with examples from Arthur Frank's (1992) autobiographical account of illness. Conceptualizing clinical knowledge as a series of levels is a heuristic device; it displays the logic of self-correction whereby knowledge moves from one type of understanding to another. Epistemologically, the dialectic reaches completion only when all of the levels have been opened — *and remain open* — to exploration, not when a series of stages has been followed to its end and earlier levels abandoned.

Vulnerability

Logically, the first level of a dialectic is the level of greatest immediacy. In a clinical situation, immediacy can be translated as urgency. Immediacy characterizes a client's distress when it is not mediated by explanation or intervention. Breathing difficulty, for example, can be an experience of terror when there is no interpretation within which it becomes intelligible. A corresponding immediacy is felt by a nurse who recognizes the person's terror and acts to alleviate the dyspnea without pausing to reflect on etiology.

The importance of this level is clear. Many conditions might be ignored unless urgent symptoms demand attention. Moreover, some symptoms may be so threatening that immediate measures are required before etiology can be addressed.

The limitation at this level is equally clear. Distress cannot always be relieved by mere symptomatic treatment and, even when it is relieved, can mysteriously return. Lacking explanation, illness becomes for the sick person a situation of limitless vulnerability. Frank (1992, p. 27) describes vulnerability as an overwhelming sense of unreality and danger when he was told he had cancer: "The future disappeared . . . I was walking through a nightmare . . . My body had become a kind of quicksand, and I was sinking into myself." A nurse's response to him at this level could take many forms, as immediate as his own experience, as simple as impulsively reaching for his hand.

Disengagement

The dialectic advances when assessment moves beyond immediacy to an interpretive level, by means of disengagement from subjectivity and vulnerability.

With the move to reflective disengagement, experience becomes meaningful for a new reason: not only because it is distressing, but because it refers or signifies. Breathing difficulty is not a problem in itself that demands attention only because of the discomfort it brings. It is a clue that must be investigated to identify an underlying pathology.

Pathologies are general categories. They are the opposite of subjective, particular experience. Disease entities, as abstract categories, transcend the persons who manifest them. Normal conditions, too, are

abstractions, defined objectively: the healthy family, the low-risk pregnancy. The extreme objectivism at this level is the same whether a situation is a case of disease or of health. Either can be translated into "a case of . . ." as a means of understanding it. In that objectification, the subjectivity of the first level is overturned and the client's experience is redescribed in general terms. Knowledge takes the form of the clinical gaze (Foucault, 1975) straining to glimpse the category that will explain, the category for which the case is merely an indicator.

Subjective experience — the basis for knowledge at the first level — is now an impediment to assessment. Understanding requires abstraction from contingencies that obscure the category. Both individuals, the client and the nurse, can be a source of distortion. Personal characteristics have to be ignored, because the focus of knowledge at this level is general, not particular. Disengagement from vulnerability produces knowledge that is entirely impersonal: ". . . *my* body becomes *the* body" (Frank, 1992, p. 12).

The categories seen by the clinical gaze of the nurse will be inaccessible to clients who cannot look beyond the urgency of their experience. For this reason the level of disengagement can involve not only opposition between client subjectivity and nursing objectivity, but conflict between client and nurse. The only reconciliation available at this level is achieved by a client adopting the same disengagement that the nurse uses to maintain a reflective distance from subjectivity. Client and nurse can collaborate in the translation of experience into categories. Frank (1992, p. 10) describes the negotiation: ". . . we talked about my heart as if we were consulting about some computer that was producing errors in the output Hearing this talk, I knew full well that I was being offered a deal. If my response was equally cool and professional, I would have at least a junior place on the management team. I knew that as a patient's choices go, it wasn't a bad deal."

Translating concrete experience into abstract categories provides a way for both client and nurse to escape the force of subjective immediacy. But in the move from experience to explanation, the person is erased: ". . . the individual must be *subtracted* to understand the disease" (Foucault, 1975, p.14). In disengagement the force of immediacy is countered by a new force, the power of objectification — a force so strong that experience itself can be objectified, reduced to its simplest parts.

Reduction

In conventional medical diagnosis, reductive knowledge is exemplified by the examination of tissue to explain symptoms (Baron, 1985; Foucault, 1975; Leder, 1984). Abstract categories are replaced by concrete phenomena as the basis for diagnostic certainty. Cells, not concepts, are the reality behind a client's condition. The previous level's esoteric essentialism gives way to its opposite, a straightforward positivism. The purest example of medical empiricism is postmortem dissection, the definitive reduction after subjectivity has disappeared altogether.

The fact that nurses typically do not practise reduction in the form of tissue analysis does not prevent them from relying on that reduction as a source of certainty to validate nursing assessments. Nurses as well as physicians may appeal to the pathology report as the authoritative verdict on a client's situation. More importantly, reductionist nursing diagnoses are not limited to physical findings. Other reductions include historical, economic, social, psychological, developmental, and environmental analyses. Clients' conditions can be explained in terms of childhood trauma, nutritional depletion, occupational exposure, etc. In all of its forms, reduction is the reliance upon a single, objectively identifiable element in a client's situation as the basis for diagnostic certainty.

Clients themselves can find reassurance in that certainty, as did Frank (1992, p. 18) during his angiogram: "After months of staring at the abstract cardiograms of my heartbeat, here at last was a chance to see the real thing in action." Reductionism can be defined in no clearer terms than the search for "the real thing" underlying the symptoms and the categories.

When more than one explanatory element is identified, however, certainty is eroded by ambiguity. And if an element is not objectively identifiable, certainty is further compromised. The problem with reduction as a basis for clinical knowledge is that more than one element is always available for interpreting a situation, and many elements may not be verifiable in positivist terms. Reduction, then, far from producing a convincing univocal basis for certainty, produces its opposite: a wealth of possible factors, some objective and others not.

Outside a dialectical model of knowledge, the outcome of reduction would be an impasse, an endless and futile search for the diagnostic touchstone. But viewed dialectically, reduction is not a dead-end.

It carries within it the means for its own correction. Instead of dissecting a situation into a single basic cause — genes, emotions, allergies — reduction reconstitutes the situation as myriad incommensurate causes, all vying for primacy. Originally a device for simplification, for locating the one “real thing,” reduction contradicts itself in generating the ingredients for greater complexity. That self-contradiction is the self-correction inherent in reduction, the basis for movement to the next level.

Holism

The level of assessment that emerges from the self-correcting tendency in reduction can be termed holism, the view that definitive knowledge about a situation incorporates knowledge of *all* of the concrete particularities in the situation.

How does the dialectical turn from reduction to holism occur? And why does the turn logically occur after reduction rather than after disengagement? Reduction, like disengagement, abstracts away from the concrete situation. Biopsies examine physical specimens that are as remote from a client’s experience as abstract disease categories are. But unlike disengagement, reduction focuses on the individual, looking for explanatory factors within the concrete situation. The biopsied tissue, the childhood trauma, belong to a particular person. The tendency of reduction to refocus inquiry on the individual, combined with its identification of many factors rather than one, is the tendency that leads assessment beyond reduction to holism.

At the level of holistic assessment, there are still persons with empirical lesions, but they are persons who also have families, anxieties, histories, and values (Kramer, 1990). All of the elements in an individual case — elements that reduction has identified — have equal significance initially. None is discounted; each may signal a recurring configuration that will be thematic for interpreting the situation. Holistic assessment can be as comprehensive as the diversity of data permits, encompassing particulars from as many realms of interpretation as can be analyzed in a given case.

Viewing the client’s situation as a field in which no single type of data is privileged provides a more comprehensive view than cell pathology, social history, or personality alone. Frank’s (1992, p. 112) repudiation of cancer personality theories is a call for a more holistic view: “. . . the genius of the cancer personality argument is that . . . the fault and the fear are safely contained, locked up inside the cancer

patient. Cigarette companies stay in business, polluters can pollute, advertisers can glorify sunbathing, and those who enjoy good health can believe they have earned it. Only the ill are left to feel guilty."

Holistic assessment allows a situation to emerge with more complexity than either reduction or disengagement allows. But like those levels, holism provides only objective knowledge of the person. The client emerges as an object assembled by data analysis, not as a subject encountered by another subject. The person is viewed not as a self-unifying whole but a set of frequencies, a field of elements without intrinsic unity (Callicott, 1986). Enlarging the field of data to include not only cells but emotions, pollutants, and politics corrects reductionism but does not correct objectivism.

In viewing the person as a field of data, the observer decides what constitutes "the whole," with no assurance that the image constructed corresponds to the client's own view. The whole that is described is not yet the client as *self*-interpreting. Holism assumes for the nurse the responsibility for deciding how to reconstruct the whole that reduction dissected. For that reason, holistic knowledge remains objective, and nurse and client remain disengaged. At its objectively most encompassing level, that of holism, clinical assessment must return to its origin — subjective experience — and engage the client as subject through relationship with the nurse as subject.

Engagement

Through engaging the client as author rather than object of the assessment, clinical knowledge moves beyond an objectively constructed image of the whole. Only the client can bring the image to life. Through engagement, the client becomes the person by whom the whole is constituted as meaningful. Meaning is not a final datum the client adds to the nurse's collection. Meaning is the internal coherence of all of the data when interpreted by the client.

Centrality of the client does not mean the dialectic is finished, the nurse dismissed, while a client completes the assessment in isolation. That is the difference between the subjectivity at the two levels of vulnerability and engagement. At the first level a client experiences an immersion in subjectivity. Clinical assessment by the nurse at the three levels of objectivity is the attempt to offer safe passage out of that isolation, into a new and now shared subjectivity at the level of engagement.

Engagement is the intersubjectivity whereby client and nurse become co-authors of a relational narrative (Gadow, 1994), reconstructing the situation as one in which meaning resides. A situation that is meaningful is the only one in which a person can reside. Through the narrative, a situation becomes unified, not objectively but existentially, as a *lived* situation. The assessment narrative that client and nurse together construct can interpret their situation in such a way that it becomes liveable. In Frank's (1992, p. 81) words, "we have to choose carefully which stories to live with, which to use to answer the question of what is happening to us." His own assessment, the "personal mythology of illness" in which he lived, included adventure, exile, medical colonization, admiring wonder toward his body, intimate ceremony around care of his central line, and a belief in "prevailing until the sun rose" (p. 82).

Nursing assessment culminates in participation with clients in revising a situation of vulnerability into one of safety, where it is possible to be at home. Regrettably, in Frank's situation, no nurse seems to have become engaged with him in crafting his personal mythology. No doubt, nurses were involved at other levels of assessment, but none continued through the dialectic to its culmination. It is not difficult to imagine the reason. Modern nursing emphasizes objectification as the means of alleviating vulnerability, and nursing ethics emphasizes autonomous self-determination of the client as individual. The dialectic proposed here includes yet transcends modern objectivism and its ethical corollary, individualism. The dialectic brings nursing beyond modern epistemology to a postmodern level at which subjectivity and relationality are central, and epistemic certainty is neither possible nor desirable.

Implications for Nursing Theory

Clinical assessment can be characterized as the struggle to understand what is happening, "the dialectical or layering process through which knowledge is created" (Lam, 1994, p. 884). Knowledge created in layers requires a continuing synthesis. The relational narrative illustrates the synthesis of layers that are general with those that are particular. A dialectically complete narrative will comprise all of the epistemic layers described above. Moreover, the narrative itself as the embodiment of clinical knowledge is both general and particular. The meaning expressed in the narrative is general in that it transcends the singularity of each author — nurse and client — at the same time that it remains particular to their situation. The narrative embodies their relationship

and thus extends beyond the particularity of either person alone, but it does not extend beyond their relationship. It is, so to speak, general without being generalizable. A relational narrative creates a new objectivity in the form of intersubjectivity, an advance beyond the subjectivity of vulnerability and the antisubjectivity of objectivism.

A new question arises with a dialectical model of clinical knowledge. If the general-particular dichotomy loses its force, what is the role of theory in nursing assessment?

Theory explains phenomena by reference to their general aspects; it abstracts from the particular existence of individuals. It relies, in short, on the force of the dichotomy between general and particular knowledge; it employs only the impersonal voice. Even the particular voice of the theorist as an individual is muted. "Theory speaks of the world as if the world itself were speaking" (Gouldner, 1978, p. 45).

As a form of certainty about the world, theory is a remedy for ambiguity, but it is limited to the layers of general knowledge in dialectical assessment. Thus only the levels of objectification — disengagement, reduction, and holism — lend themselves to theory. No theory of vulnerability can adequately render subjective urgency such as terror or hopelessness. Nor is a theory of engagement possible; the objective voice fades as the personal voices of client and nurse emerge. The clinical knowledge they create — their narrative — will incorporate elements of objectivity, just as a novelist uses words that have general meanings. But the narrative is not a logical derivation from those elements. It is a freely authored interpretation of them.

Freedom of interpretation is possible because more than one meaning for a situation will always be available. Some meanings may seem more compelling than others, but none is intrinsically privileged or correct. Hermeneutically, every situation is open rather than closed. Its meaning is ambiguous, but the ambiguity is not a defect: it is the possibility for freedom, the space in which choice among meanings can occur.

The paradox of dialectical assessment is not only that it culminates in ambiguity rather than certainty, but that in so doing it offers nurse and client a safer narrative in which to locate themselves, existentially, than could be found in objective certainty. That certainty would be bought at the cost of their particularity. Their reality as individuals would be jeopardized as much by the strict objectivity of theory as by

the quicksand of vulnerability. The aim of nursing assessment is to provide safe passage beyond both, through creation of an existential home, a place where client and nurse can belong, a narrative that encompasses the particular as well as the general nature of their situation together.

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Explanation in Nursing Science

E. Carol Polifroni and Sheila A. Packard

Est-il possible d'expliquer ce que nous faisons en sciences infirmières et dans la plupart des sciences humaines? Notre objectif est-il l'explication, la prédiction? Ne devrait-il pas plutôt être la compréhension et l'interprétation? Le but peut-il être en même temps la compréhension et l'explication? En tant que sciences humaines, les sciences infirmières mettent-elles l'accent sur l'individualité ou sur la généralisabilité? Le présent article traite du débat actuel pour ce qui concerne l'explication et la compréhension. On y examine la vue traditionnelle de l'explication de même que la vue dichotomique de la compréhension. On y présente une troisième vue sur l'explication et la compréhension, élaborée par Miller (1983); celle-ci est proposée comme terrain d'entente possible entre deux différentes vues et comme approche des sciences infirmières sous l'angle de sciences humaines.

Is it possible to explain that which we do in nursing and in most human sciences? Is explanation/prediction our goal? Instead, should the goal be understanding/interpretation? Might the goal be both understanding and explanation? Is nursing, as a human science, focused on individuality or generalizability? This paper explores the current debate in relation to explanation and understanding. The traditional view of explanation is addressed as is the dichotomous view of understanding. A third view on explanation and understanding, designed by Miller (1983), is offered as a possible middle ground between the two diverse views as an approach for nursing as a human science.

In recent years, much controversy has arisen within nursing with regard to appropriate and, therefore, fruitful methodological strategies. The frequently cited "methods debate," which purports an extant dichotomy between quantitative/empirical and qualitative/interpretive approaches, is a current example of this controversy. The most frequently posited solution to this schism is triangulated or blended methodology (Packard & Polifroni, 1991). Yet it may be contended that this response does not resolve the more fundamental problem of generalizability of findings, nor does it address basic questions regarding objectivity in scientific enterprises. Disagreement on the intentions or purposes of nursing science (in particular, whether or not to aim for explanation or understanding) is simply reflected in the use of eclectic methodological strategies, and debates about these strategies, throughout the discipline.

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A large part of the controversy over methods within nursing evolves from a fundamental conflict among scholars regarding the nature of scientific explanation in a human science, and whether explanation is even possible in such a science. At the same time, frustration on the part of nurse scientists in attempting to achieve overarching predictive theory, and a pressing need for intermediate-range theory, which may serve to guide practice, lend great urgency to a discussion of explanation in nursing science.

The purpose of this paper is to briefly present the two major opposing views concerning explanation that have, in the authors' opinion, fuelled the fires of controversy regarding the methodological development in nursing. In addition, an elaborated view of the nature of explanation based on the ideas of Miller (1983) will be offered as a means of reframing the debate at this crucial juncture in the evolution of nursing as a science.

Perspectives on Explanation

When is a particular statement or set of propositions an adequate explanation of why a specific phenomenon occurred? Simply stated, an adequate explanation should provide true descriptions of prior conditions. However, it may be argued that this requirement is not enough. The fact that a patient had a restless night is an accurate but insufficient explanation for his falling out of bed the next afternoon. The confusion as to what additional qualifications or characteristics comprise a valid explanation constitutes a fundamental and pervasive dispute in the philosophy of science for all sciences, physical and human. The ramifications of this dispute have led to a suggestion by some scholars that nursing science should aim for understanding rather than explanation/prediction (Benner, 1985). Conversely, other nurse scholars hold that "the ultimate goal of science is to be able to explain the empirical world and, thus, to have increased control over it" (Burns & Grove, 1987, p. 11). The diverse opinions of the aim of science are perhaps best framed as follows: "The real business of inquiry was explanation, whereas interpretive practices were confined to the special domain of the human sciences, the traditional *Geisteswissenschaften*" (Bohman, Hiley, & Shusterman, 1991, p. 2-3). For purposes of clarity, these two disparate perspectives, explanation and understanding/interpretation, will be briefly described in terms of the deductive-nomological and the hermeneutic views.

A Covering Law: The Deductive-Nomological View

Carl Hempel (1965), in *Aspects of Scientific Explanation*, identifies four models of covering law. They are deductive nomological, causal explanation, deductive statistical, and inductive statistical. Each model is intended to represent a single law that addresses all phenomena. The deductive nomological covering-law model answers a *why* question. "The kind of explanation whose logical structure is suggested by schema will be called the deductive-nomological explanation...; for it effects a deductive subsumption of the explanandum under principles that have the character of general laws" (Hempel, 1965, pp. 336-337).

Causal explanation, as a covering-law model, focuses on the underlying reason something happened as an effect. Deductive-statistical explanation and inductive-statistical explanation address explanation within the parameters of probability and the likelihood that a specific event will or will not occur. The two statistical models differ in terms of the method of probability determination: deductive or inductive.

Although Hempel addresses four models of covering law, in this century the more widely held analysis of explanation has come to be known as the deductive-nomological, or covering-law, view. For the remainder of this paper, the term *covering law* should be read as the deductive-nomological view of explanation.

Basically, this covering-law view makes explanation, whether in the human or natural sciences, a matter of subsumption under general laws. A valid explanation of an event ought to contain characteristics of the situation leading up to the event and general empirical laws indicating that when such characteristics are realized, an event of that particular kind always (or almost always) follows.

Hempel elaborates on the deductive-nomological covering law in great detail, postulating that explanation in any and all fields of science must meet the following specific conditions of adequacy: (a) the conclusion must be a logical consequence of the premises (it must be deducible from the information contained in the premises); (b) the premises must contain at least one general law, and this law must be required for derivation of the conclusion; (c) the premises must have empirical content, which is to say they must be capable (at least in principle) of test by experiment or observation; and (d) the sentences in the premises must be true.

Hempel (1965) summarizes the arguments put forth by skeptics regarding the application of this criteria to the non-physical sciences as: (a) the contention that the activities of human beings have a peculiar uniqueness and irrepeatability that makes them inaccessible to causal explanation; (b) the belief that the establishment of scientific generalizations for human behaviour is not possible because reactions of an individual are at least partially dependent on the individual's previous history; and (c) the supposition that purposive behaviour calls for reference to motives and thus necessitates teleological rather than causal explanation. As a counter to these arguments emanating from social science, Hempel states that events in physical science are no less unique than human activities. And phenomena studied in physical science also have a history, which must be taken into account in the generation of general regularities. In addition, he has submitted that motivations involved in human behaviour, while referring to the future, are actually situated prior to activity and, therefore, may be classified as among the antecedent conditions in a causal explanation.

Skeptics aside, the deductive-nomological covering law has dominated the practice of science, including that of non-physical fields (Miller, 1983). For example, major thinkers in sociology, such as Durkheim (1938) and Weber (cited in Gerth and Mills, 1946), regarded subsumption under general laws as the means for making the study of social life truly scientific. In much the way that nursing has struggled to take its place among the sciences, concern has centred to some extent on the formulation of causal explanations. Norbeck, in her 1987 article "In Defense of Empiricism," asserts that a reliance on systematically gathered objective data drawn from relatively large numbers of individuals will yield predictive models and causal explanation.

Gortner (1990) expresses the notion that meeting the requirements of the covering-law model will legitimize nursing as a science:

Explanatory power is proposed as another premise of philosophy of science in nursing. Human science activities cannot rest only with increased understanding; nor can understanding be taken as the sole criteria for explanation Human patterns and regularities and perhaps even "laws" characterize the human state and undergird the whole enterprise of society and human life . . . explanation in the sense that is being proposed here must suggest what might occur the next time the event or phenomenon occurs. Thus temporality and predictability are assumed in scientific explanations that are within the definition of explanatory power. (p. 104)

The Hermeneutic View

Most opponents of the deductive-nomological covering-law model in nursing espouse a perspective going back at least as far as Wilhelm Dilthey (1883-1911). To Dilthey (cited in Copleston, 1965), the natural and the human sciences are both empirical, but the former deals with the outer experience of nature, while the latter are based on inner, "lived" experience, which provides a direct awareness of human life. The difference in aims of the natural versus human sciences (as opposed to the stance taken by Gortner, 1990) is characterized as that between explanation and understanding. The natural sciences seek causal explanations of nature that connect representations of outer experience through generalizations and abstract laws. The human sciences aim at an understanding of the fundamental structures of life found in the lived experience. The human sciences thus place an equal value on understanding of both individuality *and* universality. In contrast, the natural sciences are thought to place value solely on ever more comprehensive generalizations without concern for or attention to the individual.

Habermas (1989) submits that the deductive-nomological covering law does describe the goal of natural science — a pursuit of general laws with an interest in instrumental control over the environment. However, Habermas and his followers contend that this deductive-nomological approach neglects to recognize the insights offered by other sources of knowledge more important to the human sciences, such as the recognition and inclusion of understanding and interpretation.

While Bohman, Hiley, and Shusterman (1991, p. 5) do not specifically address explanation as a topic, they do state: "The issue is further compounded, because the human sciences are 'doubly hermeneutic.' They do not give interpretations, they are interpretations of interpretations." In other words, the human sciences are not necessarily concerned with general laws, but rather their focus is on interpretation of human experience to achieve understanding about the individual without concern for generalizability. Additionally, the interpretation (and subsequent understanding) is coloured and shaped by the lived experience of the interpreter (doubly hermeneutic).

The emphasis in human science is on understanding instead of on explanation, and the understanding is based on the lived experience of interpretation. Nurse disciples of Dilthey-Habermas point to the failure

of the covering-law model to validate hermeneutic understanding. This understanding, felt to be the aim of a human science such as nursing, refers to the capacity to interpret the words, acts, and symbols of others in the interest of mutual understanding and self-reflection.

The opposing positions of the deductive-nomological covering law and the hermeneutic view regarding the aims of human sciences place nursing in a quandary as it moves into the 21st century. "The hermeneutic stress on the narrative features of... explanation aggravates rather than resolves the question of how such narrations influence behavior (on the assumption that they sometimes do)" (Roth, 1991, p. 183). This polarity of perspectives is alluded to by Moccia (1988, p. 6) in asking,

Is science intended to legitimize nursing as a scientific discipline by expanding and refining the ability to predict and prescribe human behavior? Or is it intended to be useful in helping the non-scientific population to understand and explain their experiences in the world? Is there a science to be developed that might combine these polarities?

A Middle Ground in the Explanation Debate

In light of Moccia's query, is it possible to construct a way of looking at explanation that will allow for the future expansion of nursing science? Miller (1983) proposes such an approach in considering the position of human sciences. Fundamentally, Miller's alternative theory of adequate explanation employs causal notions, not notions of regularity or of accessibility to hermeneutic faculty. Simply put, an adequate explanation is seen as a true description of underlying causal factors sufficient to bring about the phenomenon in question. Three important distinctions from the previously discussed perspectives on explanation (model of covering law and hermeneutics) are inherent in this explication of scientific explanation: (a) an explanation must describe causal factors sufficient to bring about the phenomenon in question under the circumstances at hand, (b) causal factors must possess sufficient depth, and (c) the explanation is appropriate for only this particular event within this context (the phenomenon in question). A discussion of each of these distinctions will convey the usefulness of Miller's theory of explanation.

When might causal factors be deemed sufficient to bring about the phenomenon in question? It is suggested that particular rules of causal sufficiency are inherent in theoretical frameworks, subject to empirical

debate. Value judgements may affect the assessment of explanatory adequacy, in as much as they affect the choice of research question. In other words, acceptance of sufficient explanation is inseparable from theory. Furthermore, explanation in nursing science is best viewed not from a single source, but rather from multiple sources within physical and human sciences, given that nursing science is multidimensional (Gortner, 1993).

In a pragmatic sense, an explanation must describe those factors that led to the phenomenon under study, bounded by the circumstances at hand — the context. For example, a sufficient explanation could indicate that lack of maternal experience in combination with fear of failure may lead to difficulties in establishing a breast-feeding regimen among a population of inner-city adolescents in the United States. However, to require a description of all the causally relevant factors, factors that taken together would produce the phenomenon in question no matter what the further circumstances, is to reimpose the covering-law model (Miller, 1983). In the example cited, the factors of lack of experience and fear of failure are meant to be considered causal only in the circumstances at hand. There is no statement of a general law in the explanation. Difficulties in establishing a breast-feeding regimen may arise from other factors, given other circumstances — a different group of mothers in terms of age and nationality, or a different point in time. The explanation offered may give clues pertaining to different circumstances but is not intended to serve as a universal explanation.

A causal description sufficient to bring about a phenomenon is not an explanation if the causal factors included are lacking in depth. The description may be inadequate because of two kinds of shallowness: The factors in the explanation may lack depth in that had they not been present something else would have occurred, filling in the causal role and thus producing the same effects (Miller, 1983). If it may be shown that the same sorts of difficulties in establishing a breast-feeding regimen could occur to the group of young mothers when there is a weak support system, then lack of experience and fear do not explain the phenomenon. It must be assumed that there exists a deeper underlying cause.

The second issue related to depth of factors depends on a sort of causal priority. There are frequently relationships among the concurrent factors producing a phenomenon. It may be that a particular factor is sufficient to bring about the phenomenon of concern only because of the other factor (Miller, 1983). With regard to the case in point, it may

be that fear of failure is in fact produced by maternal inexperience. Therefore, the shallower cause (fear of failure) is a means by which the deeper cause (lack of maternal experience) produces its effect.

In essence, then, any scientific explanation is intrinsically comparative. In accounting for how a phenomenon was produced, we must also deny that another, "deeper," causal process is involved. Appraisal of scientific explanation using such criteria provides an assurance that rigour prevails.

Van Fraassen (cited in Rubin, 1993, p. 287) summarizes this new view of explanation by simply stating, "An explanation is not the same as a proposition, or an argument, or list of propositions; it is an *answer*." The explanation is an answer to a question, which has been framed within the context of "why." Therefore, a theory of explanation may be viewed as a theory of why-questions.

Value to Nursing

While the above example is perhaps a simplistic representation of explanatory power in nursing, it serves to illustrate the value of a different approach to the issue. Several points may be made regarding the departure from the present polarity in viewing explanation.

The proposed theory moves away from the deductive-nomological perspective, which, Hempel's (1965) arguments to the contrary, has proven to be problematic for human sciences. Phenomena of concern to nursing often comprise numerous factors. In addition, it is hard to imagine situations that are not too idiosyncratic to be governed by universal laws. In reality, this is frequently the case in physical science as well. Explaining why there are topographical formations on earth in no way implies an identical process on Mars. The covering-law model has placed nursing science in a seemingly impossible situation. Gortner (1990) acknowledges the frustration involved in trying to accommodate the science of nursing to standards derived for physical science. She states that "perhaps concern with the mechanistic philosophy of science has prompted the reaction against explication of patterns" in nursing science (p. 104).

Furthermore, the proposed theory of explanation provides an avenue for scientific aims beyond that of hermeneutic interpretation. It is submitted that this alternative stance does not nullify or oppose the potential contribution of hermeneutic understanding, but rather allows

for the value placed on the identification of universal experience. Explanation appraised through empirical debate as opposed to rules of logic (as in the deductive-nomological view) anticipates diversity in theoretical grounding. Opportunity is provided for a variety of conceptual approaches in the recognition that all are not equally valid. The governing principle is simply that a theoretical approach is invalid if the science guided by it is an inferior source of further discoveries. It is assumed that over time the more relevant frameworks will be the more productive. When one is searching for an answer, the context of the phenomenon becomes the guiding principle and the answer is the explanation.

Perhaps the greatest benefit of a different notion of scientific explanation has to do with shifting the attention of the discipline away from debates on methodology. Focus may then be placed on the aims and the products of science in nursing.

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In Memoriam

Sheila Packard died peacefully, April 23, 1995, after a courageous battle with metastatic cancer. Sheila will be remembered for her keen intellect, her wit, her love of life and her pursuit of truth. She was a dedicated and committed nurse and educator who envisioned the nurse/professor as a healer engaged in a dialectic with those whom s/he served. Sheila will be deeply missed, but her legacy will last forever.

The Importance of Critical Theory to Nursing: A Description Using Research Concerning Discharge Decision-Making

Donna L. Wells

La théorie critique s'est révélée une direction de recherche cruciale pour les sciences infirmières. Elle ouvre des aires de questions pour la recherche qui sont nouvelles et plus larges, et elle offre le potentiel pour étendre la base de connaissances en sciences infirmières. Je décris dans le présent article quelques applications de la théorie critique de Jurgen Habermas (1984-1987) aux sciences infirmières en utilisant l'exemple de la recherche que j'ai effectuée pour mon doctorat que je viens de terminer (Wells, 1994). La théorie a été utilisée comme perspective large pour la recherche dans laquelle j'ai étudié le processus de prise de décision de sortie de l'hôpital de malades âgés. Après avoir analysé les données de trente et un dossiers de malades, il s'est avéré que le processus était largement déterminé par les forces systémiques. La théorie de monsieur Habermas était essentielle pour comprendre la structure du processus comme moyen pour arriver à ses fins ou comme instrument, et pour trouver des idées pour changer la conceptualisation du processus de prise de décision de sortie. La théorie critique peut faire avancer la connaissance en sciences infirmières par rapport à notre compréhension de l'organisation sociale de situations de la pratique quotidienne et la possibilité de leur réorganisation.

Critical theory has emerged as an important research orientation for nursing. It provides for new and broader research questions and offers the potential to extend the knowledge base of nursing. In this paper I describe some applications of Jurgen Habermas's critical theory (1984, 1987) to nursing, using the example of my recently completed doctoral research (Wells, 1994). The theory was employed as a broad perspective for the study in which I investigated the process of decision-making concerning the discharge of elderly patients from the hospital. When data from 31 patient cases were analyzed, the process was found to be determined largely by systemic forces. Habermas's theory was key in understanding the structure of the process as a means-ends, or instrumental one, and in generating ideas for change in the conceptualization of the process of discharge decision making. Critical theory can advance nursing's understanding of the social organization of everyday practice situations and whether and how they might be reorganized.

Critical theory can orient research to the kinds of questions that relate to prevailing social conditions and the organization of human activity, posed in ways that potentially are linked to practical interventions

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(Morrow, 1994). In the last decade, this perspective has emerged as an important research orientation for nursing (see, for example, Allen, 1987; Hiraki, 1992; McKeever, 1992; Stevens, 1989; Street, 1992; Wells, 1994). Stevens articulated that critical theory provides an archaeology of the sociopolitical and cultural environment, which shapes our practices, our relationships with persons in our care, and, as Hiraki pointed out, what is accepted as legitimate knowledge. Meleis (1992), in her discussion of nursing theory development, argued that understanding "how individuals experience and respond to health and illness ... includes making connections and achieving syntheses that go beyond the perception and knowledge of the client and the provider" (the latter focus is characteristic of the phenomenological perspective of some nursing theories) (p.113). Although admitting a bias toward biobehavioural processes as the central focus in the development of nursing theory, Gortner (1993) acknowledged the potential benefits of critical theory to nursing. Bent (1993) identified another contribution of critical theory to nursing: as a theoretical and research tradition, it can help to identify points from which to approach change in the discipline as well as in health care in general.

Critical theory usually refers to the series of ideas that emerged in the 1920s and 1930s in Germany at the University of Frankfurt's Institute of Social Research. But Bronner (1994) has made it clear that, in fact, it began with a number of unorthodox thinkers including Karl Korsch and George Lukacs, who preceded the formation of the Institute. Rabinow and Sullivan (1987) point out that "the great strength of ... critical theory has been continually to urge that the human sciences cannot be detached from the greater problems of living" (p. 15). Critical theory, throughout its tradition and as expounded by Habermas (its current leading representative), has involved analysis and exposure of the sociocultural and political-economic conditions of modern society that can restrict human activity. This knowledge, in turn, is meant to prompt change. The interest of critical theorists thus has been to conjoin theory and critique to achieve praxis, or moral-practical action (Thompson & Held, 1982).

In order to demonstrate how useful Habermas's (1984, 1987) critical theory could be to nursing, I shall describe some of its applications by using the example of my doctoral research (Wells, 1994) about the decision-making process regarding the discharge of elderly patients from hospital. Personal clinical experience and a literature review had suggested to me that conflicting and multiple influences on the process (of a clinical, social, and organizational nature) rendered it complex

and, many times, frustrating and adverse for those involved. However, I found no studies focusing directly on elaborating the actual decision-making process, its multiple influences, and the broader context in which the process materializes and unfolds. My research was intended to fill these gaps in knowledge.

The study used the ethnographic research method to (a) describe the process of decision-making regarding the discharge of elderly patients from hospital, (b) make visible the more local, or immediate, circumstances organizing and giving shape to the everyday process of discharge decision-making, and (c) identify the consequences of the process for the persons involved. The ethnography involved participant observation of the discharge decision-making activities of professionals in a purposively-selected sample of 31 cases of patients 65 or older. These activities of professionals were observed across eight units in a large university hospital and over the patients' total hospital stays, in order to construct an in-depth description and explanation of the process of discharge decision-making. As well, focused interviews were conducted with patients, families, and key professionals involved in the process, in order to test emergent study findings and to fill gaps in the data. Medical-record analysis provided data about patients selected for case study and their clinical trajectory — that is, the course of their disease and its management. This information was important to the analysis of the relationship of the clinical course to discharge decision-making. *The Ethnograph* (Seidel, Kjolseth, & Seymour, 1988) computer software program was used to organize the unstructured data for interpretation, which consisted of identifying themes and patterns and generating the core findings of the study.

Habermas's critical theory was used as the broad framework for the study because it makes possible a discovery of, in Forester's (1985) words, "the institutional contingencies of practical actions" (p. x), a theme consistent with my research interest. The relation between Habermas's theoretical notions of rationality and social action in modern society, in particular, and the formulation of the study purposes and research questions, is illustrated in the first part of this paper. In the second part, I discuss how Habermas's perspective was also used in the interpretation of the research findings, which revealed that the discharge decision-making process was influenced largely by systemic forces. Habermas's theory offered a way of understanding the structure of the process as a means-ends, or instrumental, one. But the significance of his theoretical ideas goes beyond the interpretation of the empirical findings. Practical insights into ways to achieve change were

also generated by way of the theory. An example of these insights is outlined.

The Relation between Habermas's Critical Theory and This Study

Selected elements of Habermas's recent critical theory of society, published in his two-volume *The Theory of Communicative Action* (1984, 1987), broadly oriented the study. His ideas helped to frame the study objectives, beyond a mere description of the process of discharge decision-making for elderly patients, to include a focus on the play of forces underlying the process and the consequences of the process for those involved. In his theory of modern society, Habermas cogently argues that social structure (e.g., the organization of the hospital) is inseparable from social action (e.g., the discharge decision-making activities of practitioners), and that structure can constrain action. As Manicas explains (1987) in his analysis of the concept of social structure, " 'structure enters simultaneously into the constitution of the agent and social practices, and exists in the generating moments of this constitution.' It is both medium and product, enabling as well as constraining" (p. 272).

A reading of Habermas's theory suggested that the discharge decision-making process may have come to be structured by a strategic or instrumental (means-ends) mode of reasoning and of human interaction that undergirds our social systems, including health care. Habermas describes a strategic form of social interaction as oriented to " 'success,' to the efficient achievement of ends" (Bernstein, 1985, p. 18). Success is measured by the extent to which one's actions actually bring about the intended state of affairs. The mode of rationality supporting strategic action is instrumental, directing the choice of means to given — usually material — ends. The modernization of society (e.g., with industrialization and the development of capitalism) and its continuing growth and increasing complexity have necessitated goal-directed action and an instrumental rationality.

One of Habermas's central arguments is that strategic rationality and human action directed to the efficient achievement of ends have come to displace communicative rationality and action. A communicative or discursive form of reasoning directs individuals to question and negotiate issues, to reach mutual understanding (including an understanding of conflict) concerning social needs, interests, and norms. Communicative reasoning works from background assumptions,

norms, and values, which represent “cultural resources (including language) usually employed for the organization of everyday life in communication” (Misgeld, 1985, p. 96). Both forms of reasoning have become available to us in modern society as economic and political systems — as well as ways of interpreting the meaning of everyday life events — have become separated from traditional practices, such as those around kinship, and sacred (e.g., religious) forms of authority.

Habermas argues that society’s failure to engage strategic and communicative rationality and action in a balanced way is related to systemic imperatives, such as the need for economic growth, administrative efficiency, and scientific and technological progress, which depend on the coordination of human activities using instrumental reasoning. However, what this means, as Misgeld (1985) articulates in his discussion of critical theory and education, is that communicative ways of understanding and interpreting the whys (reasons), wheretos (purposes, ends), and wherefroms (origins, motives) of various human activities are suppressed and not reflected upon. Using the example of the instructional-objectives movement, Misgeld elaborates on the consequences of an instrumental rationalizing attitude toward education:

One does not know when one reads the book [*Objectives for Instruction and Evaluation*] where these units come from or why they must be there other than that they are the best thing to have for the sake of accountability, of improving the efficiency of teaching and of providing guarantees for learning success. (p. 88)

The active reflection of participants (teachers and learners) on the meaning and significance of educational work is bypassed.

The embeddedness of a strategic form of rationality and action in administrative and clinical practices in the hospital may have similar effects. It would mean that patient-related goals are defined according to the exigencies of the organization in order to meet predetermined ends efficiently — for example, in relation to acute medical care and its administrative management, including discharge decision-making, and to education and research in the university hospital. Moreover, reflective kinds of questions concerning the meaning and implications of a means-ends approach — to discharge decision-making, for example — may not be communicatively considered.

Habermas calls the one-sidedness (thus, distortion) that has come to exist in our forms of reasoning and actions *lifeworld colonization*.

Associated with this idea is the phenomenon of *cultural impoverishment*, which, he argues, has further contributed to the distorted way of reasoning in modern society. Communicative competence, Habermas argues, has come to take the form only of a specialized discourse or argumentation by expert cultures. As a consequence, increasing distance has been created between these cultures and the broader public. Furthermore, those who are not considered experts may become dependent on those who are for various definitions and decisions about human problems and their solutions.

The phenomenon of growth of professional groups as expert cultures, which has rendered the opinions of nonprofessionals about their health care irrelevant, or at best less important, has been documented in the literature on sociology of medicine (see, e.g., Freidson, 1988). As well, a number of empirical studies have found instances of professional interactions (including those involving nurses) with patients approximating action oriented to success concerning technical interests and preventing the emergence of holistic interpretations (Barrett, 1988; Brown, 1986; Fisher, 1982, 1984a, 1984b; Mishler, 1984; Scambler, 1987; Street, 1992; Waitzkin, 1984, 1989; Waitzkin & Britt, 1989; West, 1983). What this suggests in terms of discharge decision-making for elderly patients is that any significant interaction of a communicative, consensual nature in the definition of their situations may be infrequent, if it occurs at all.

The idea of cultural impoverishment constitutes Habermas's notion of ideology in modern society; that is, with the rise of expert cultures, opportunities for open or critical discourse are veiled. Furthermore, Habermas proposes that professional expertise founded on formal (i.e., scientific and technological) knowledge legitimizes a power relationship of professionals over the public. An imbalance in power results because instrumental rationality systematically displaces communicative rationality. In other words, the goals established by those with power, which may be advanced as a representation of collectively desired goals, cannot be examined, endorsed, or repudiated in a discursive or communicative manner. This is because the institutionalization of scientific, technological, and organizational rationality as the basis for social action makes it increasingly difficult for individuals to distinguish between technical interests on the one hand and practical or moral interests on the other. The concealment of the difference "proves the ideological power of the scientific-technocratic consciousness," Habermas claims (1970, p. 107). As a consequence, the political character

of a means-ends or instrumental form of rationality may go unrecognized as a constraint on human activity.

Habermas's conclusion is that although mutual understanding underlies all human action, it does so within the premises of formally regulated or instrumental domains of action. It is not the developments in the economy, administrative systems, science and technology, and expert cultures, *per se*, that are at issue: it is the subordination of communicative rationality and interaction to instrumental forms of reasoning and action.

In terms of the discharge decision-making process, Habermas's claims remained to be explored because the process and related activities of participants, along with the multiple influences on the process, had not yet been well articulated. Hence, it was still uncertain how the imperatives of the hospital system and of the lifeworld (arriving at shared understandings) were actually interwoven and/or conflicted in this everyday clinical practice situation.

Nevertheless, Habermas's critical perspective was helpful in leading me to ask broad and comprehensive questions about the process of discharge decision-making. Specifically, it directed an inquiry into (a) its basic description (sequences of stages and related activities and discourses of participants), (b) the play of forces underlying the process (reasons, purposes, and ends), (c) the perceptions of those involved (motives, origins), and (d) the consequences of the process for the persons involved (its positive features and pathologies). These questions related to the social context or organization and prevailing conditions of the process. Also, the questions were linked potentially to practical interventions because they were intended to establish the conditions of the process and expose the nature and source of its limits. The study questions thus reflected both the critical and the practical intent of the research consistent with critical theory. As well, they built on personal clinical experience and the research of others.

Habermas's critical theory was more useful than other critical theories (e.g., political economy) because of his central focus on the systemic distortion of communicative action. As well, unlike feminist theory, his theory does not impose a gender constraint in terms of the population that is of research interest. In the hospital, elderly women and men were observed to experience similar problems related to discharge decision-making. Finally, his theory was more relevant than traditional social theories in broadly framing the study purposes and

questions. The theoretical schools of functionalism (e.g., structural functionalism) and interpretivism (e.g., phenomenology), for instance, are limited by their view of social reality. In these perspectives, social structure and social action are assumed to serve the purpose of maintaining and/or restoring social order and human action. Description and explanation revolve around "what is" society and "why and how" it tends to hold together. The related inquiry does not entail identification of inherent conflicts and contradictions in social systems and the actions that can constrain human activity. Consequently, there is a quietism about these perspectives; they lack political force. However, it is the explicit task of critical theory to unveil the conditions that limit the full and conscious participation of individuals in society. For nursing, critical theory thus offers a research perspective that may help to uncover the nature of enabling and/or restrictive practices, and thereby create a space for potential change and, ultimately, a better quality of care for patients.

Habermas's Critical Theory and the Findings of This Study

The overarching conclusion, that the decision-making process to discharge elderly patients from hospital was mediated largely by systemic forces, was derived from the three core study findings that emerged during data analysis. The first core result was that the patients' clinical trajectories were not, contrary to what might be expected, a key element in shaping the process. In the majority of cases, decision-making took place without detailed knowledge or understanding of the patients' disease experiences. Characteristically, the patients' clinical outcomes were not manifest until later in the hospitalization; yet, discharge decision-making was tackled early on. For example, in the case study of an 81-year-old woman, the discharge decision-making process presented the following picture:

Several different decisions were proposed over the course of her hospitalization. Each decision was not intricately linked to her clinical trajectory. Long before the outcome of her disease was known, both home with Home Care and the initiation of nursing home placement were contemplated, and the latter pursued. A Regional Geriatric Program (RGP) consultation was requested during active medical treatment. At the same time, arrangements for Home Care were requested, and plans continued to complete nursing home papers. Finally, the patient did return home with Home Care, but only after a 7-week course of rehabilitation with the RGP. (Wells, 1994, p. 167)

The second central finding explained, in part, why the discharge decision-making process did not follow directly upon the clinical trajectory. Specifically, in all cases studied, the process was shaped, in large part, by a variety of patient-related social factors and organizational or hospital-based parameters, many of which were assumed. The likelihood of discharging the patients was a major concern from the time of admission. The concerns of professionals, and their reasons for discharge decisions, related largely to patients' social situations (e.g., non-compliant health behaviour, social nature of the admission, inadequate social support) and to imperatives of the organization (e.g., fear of recidivism, avoidance of a delay in discharge). As well, the actions and discourses of professionals were oriented strategically, and not communicatively, to accomplish discharge. In the case of a 73-year-old man, (a) discharge decision-making was undertaken early and outside the context of an informed understanding of his actual clinical trajectory, (b) the concerns about and conditions of his discharge were based on various social and organizational factors, many of them unsubstantiated, and (c) the patient and family were approached only when decisions had already been taken at rounds.

The third core result further explained why the discharge decision-making process did not directly result from the patients' clinical trajectories. It was found that professional perceptions of the discharge decision-making process were functional or instrumental in orientation, as opposed to holistic: that is, they were biased toward administrative concerns and those of practitioners, such as bed turnover and the economic viability of the hospital.

In ethnographies, the theoretical approach underpinning a study can be used in the interpretation of the findings (Hammersley, 1992). In this study, Habermas's theory provided a way of understanding the structure of the discharge decision-making process as a means to particular ends (i.e., as strategic or instrumental action). It is systemic forces — mainly institutional imperatives, which are economic or resource related — that shape the discharge decision-making process. The process, accordingly, is characterized by an approach oriented to the successful or efficient achievement of institutional goals — namely, the prompt discharge of patients. The patients' actual clinical trajectories are superseded as a key factor.

Further, in Habermas's terms the discharge decision-making process is instrumentally, or one-sidedly, organized. Systematically distorted communication occurs because communicative action, which is discur-

sive and understanding-oriented, does not materialize in the process. As Habermas's theory indicates, communicative action does not arise, because it is colonized or displaced by a strategic orientation, which also allows professionals to control the process. Contrary to what his theory would suggest, however, the displacement of communicative action does not occur mainly by way of cultural impoverishment (i.e., by the subordination of patients' discourses to the specialized discourses of professionals). Rather, it happens as professionals coordinate the process in a manner oriented toward the prompt discharge of patients on the basis of institutional imperatives. It is the structure of the process that grants professionals decision-making control; this structure is ideological to the extent that it displaces opportunities for a communicative orientation to occur. In this process, ongoing discussions with patients and families were rendered superfluous, and a holistic understanding of patients' discharge situations was not reached.

Habermas argues that the institutionalization of instrumental rationality as the paramount basis of action in our social and political systems undermines communicative action. In so doing, the instrumental structure of action eliminates the evaluation (i.e., self- or critical reflection) of the validity of the instrumental approach itself. In my study, the strategic orientation of the discharge process was unquestioned. Yet, the other study results about the pragmatic and moral consequences of the process indicated that the strategic orientation to discharge decision-making was distressful to patients, families, and professionals. Moreover, too early decision making was, ironically, inefficient for the hospital. In other words, professional and family resources were not always rationally employed in discharge decision-making, there was no apparent effect on patients' length of stay, and the process was unnecessarily complex. Clearly, in terms of nursing knowledge and practice, critical theory can help to illuminate the social-structural basis of an everyday, established practice situation and expose its limitations.

Habermas's communicative-action idea may also represent an intervention strategy for a restructuring of the discharge decision-making process. (A discussion of the serious challenges of this idea of Habermas's is beyond the scope of this paper.) Communicative action, which is marked by a discursive, understanding-oriented attitude concerning social needs, interests, and norms, demands shared, equal participation in decision-making and consensual decision-making. Involvement of all participants in discharge-related issues may bring about a broader and more holistic understanding of patients' clinical

situations and discharge requirements, which would in turn foster greater accountability and lend legitimacy to the process. The process of questioning and negotiating may have the added benefit of participants reflecting on the adequacies and inadequacies of instrumentally oriented practices. Ultimately, a greater balance may be achieved between the legitimate demands of the system (discursively determined) and an acceptable discharge decision-making process. A restructured discharge decision-making process would be valuable to hospital administrators and nurses (as well as other practitioners) trying to meet conflicting goals concerning resource utilization and patient-centred care. Critical theory as a research and theoretical orientation can deepen our understanding of the mechanisms and values that influence our practice. It can be a point of departure from which to examine and restructure our practice in an emancipatory way.

Conclusions

Using the example of my recently completed doctoral research, I have indicated the important contribution that Habermas's critical theory can make to nursing. As White (1988) summarizes, it has been argued that critical theory as designed by Habermas allows for fruitful research concerning forms of social action and pathologies in modern society. It serves to connect practices, such as discharge decision-making, to issues of social organization beyond the perceptions of clients and providers, and thus fulfils a requirement that Meleis (1992) sets out for knowledge development in nursing. Similarly, Street (1992) concludes that knowledge useful to nurses must incorporate ideas about the relationships between practices, the structural elements of the health-care situation, and the larger society. This kind of knowledge can greatly contribute to our understanding of the actual clinical care of patients and to our vision regarding health-care programs and policy.

Habermas's critical theory offers a way in which to achieve change. In Bryan Green's words (1993), "I confess to sharing with critical theorists an intellectual conviction [and a practical commitment] that is political" (p. xiv). Habermas's communicative action model provides a practical vehicle for a restructuring of our everyday practices, which may offset the dominance of a strategic orientation. Hiraki (1992) explains the rationale behind this important theoretical notion of Habermas's: it may be "appropriate for instrumental rationality to inform technical actions that control our natural world. But when instrumental actions affect the social life of people, it exceeds its bound-

aries" (p. 9). Therefore, decisions about practical life must be made communicatively with the people affected.

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Identifying the Psychosocial Needs of Individuals with Cancer

Terry Bunston and Deborah Mings

Le diagnostic et le traitement du cancer engendrent des besoins psychosociaux que les malades ont souvent du mal à satisfaire. Étant donné que la plupart des évaluations de besoins ne dépassent pas l'énumération des besoins afin d'examiner les barrières à franchir, les soutiens sociaux actuels ou les préférences des malades par rapport aux services, nous avons entrepris de faire l'inventaire de l'évaluation des besoins afin d'atteindre ces objectifs. La première étape a consisté à établir les catégories de besoins, en utilisant une méthodologie qualitative. Les buts de la recherche présentés dans le présent article sont les suivants : (a) comparer la façon dont le malade et les soignants identifient les besoins psychosociaux du malade; (b) établir les catégories de besoins psychosociaux; (c) vérifier les catégories résultant de l'analyse des données. On a établi vingt-sept catégories de besoins. Il existait des disparités entre les malades et les soignants en hôpital, et entre les soignants des deux centres d'oncologie au niveau de la fréquence où les catégories de besoins étaient citées. Ces disparités soulignent combien il est important de recueillir des renseignements d'après diverses perspectives.

The diagnosis and treatment of cancer creates psychosocial needs that patients often find difficult to resolve. Because most need assessments do not reach beyond enumerating needs to examine barriers to needs resolution, existing social supports or patients' service preferences, we set out to develop a needs assessment inventory to meet these objectives. The first step was to identify need categories using a qualitative methodology. The aims of the research presented in this paper are to: (a) compare patients' and professional caregivers' identification of patients' psychosocial needs, (b) establish categories of psychosocial needs, and (c) verify the categories resulting from the analysis of the data. Twenty-seven need categories were identified. There was a lack of congruency between patients and hospital caregivers and between caregivers at the two cancer centres in the frequencies with which the need categories were cited. The incongruence underscores the importance of gathering information from more than one perspective.

The diagnosis and treatment of cancer creates psychosocial needs that patients often find difficult to cope with and resolve. These needs range from the concrete to the existential. For example, Mor, Allen, Siegel, and Houts (1992) documented the daily living needs of individuals with cancer, while Ganz, Schag, Lee, and Sim (1992) documented their rehabilitation needs.

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The identification of psychosocial needs over the illness trajectory is clinically relevant for a number of reasons. Needs arising from the psychological and social difficulties patients experience are predictive of later affective illness (Haddad & Maguire, 1994), psychiatric morbidity (Parle, Jones, & Maguire, 1994), decreased adherence to therapy (Ali, Khalil, & Yousef, 1993; Dragone, 1990; Mor et al., 1992), coping strategies (Ali et al., 1993), quality of life (Ali et al., 1993; Schag, Heinrich, Aadland, & Ganz, 1990), the ability to seek benefits from the health-care system (Mechanic, 1983; Saunders & Baum, 1992; Waligora-Serafin, McMahon, Pruitt, & Davenport, 1992; Wiggers, O'Donovan, Redman, & Sanson-Fisher, 1990; Wool, Guadagnoli, Thomas, & Mor, 1989), and the outcome of medical care (Gustafson, Taylor, Thompson, & Chesney, 1993; Kiecott-Glaser & Glaser, 1987; Mor, Guadagnoli, & Rosenstein, 1991; Mor, Masterson-Allen, Houts, & Siegel, 1992; Spiegel, Bloom, Kraemer, & Gottheil, 1989).

While it is recognized that individuals with cancer, and their families, can be helped by psychosocial care, it is also recognized that the delivery of this care could be improved (Ballatori et al., 1993; Greer, 1994; Hill, Kellener, & Schumaker, 1992; Siegel, Mesagno, Karus, & Christ, 1992; Spiegel, 1994; Till, 1994; Tope, Ahles, & Silberfarb, 1993). To do so it is important to not only identify the psychosocial needs, but to also understand why needs remain unmet, evaluate current care, and determine preferences for future care. Standardized instruments often lack the specificity required to identify cancer-related problems (Holland, 1984). As well, patients frequently find it difficult to voice their concerns (Frank, 1991; Holland, 1984; Lochman, 1983; Mitchell & Glicksman, 1977; Wool et al., 1989) and busy outpatient and inpatient settings are not conducive to talking about problems (Friedman, Lehane, Weinberg, & Cooper, 1993; Saunders & Baum, 1992). Patients' perceptions of their needs often do not correspond with those of the professional caregivers (Ballatori et al., 1993; Camp & O'Sullivan, 1987; Fernsler, 1986; Lilley, 1987; Longman, Atwood, Sherman, & Benedict, 1992; Mullan & Stross, 1990; Sung, 1989; van Angthoven & Plomp, 1989), and thus services are not used to capacity (Buttram, 1990; Wool et al., 1989). A needs-assessment inventory can help patients articulate their needs.

A search of the available needs-assessment instruments did not locate an ideal tool. We therefore set out to develop an inventory that would not only enumerate patients' psychosocial needs, but also identify the existing sources of social support, barriers to the resolution of needs, and service preferences of patients. This paper will describe the

first stage of our research: the development of a set of psychosocial needs categories.

Purpose

We undertook a two-phase project: a qualitative study designed to establish categories of need, and a quantitative study designed to develop and verify the reliability and validity of an inventory of needs based on cancer patients' problems, concerns, and worries. The development of the needs categories is the focus of this paper. The objectives of Phase I were to: (a) compare psychosocial needs as identified by patients and professional caregivers, (b) establish categories of psychosocial needs, and (c) verify the categories resulting from analysis of the data.

Literature Review

Needs assessment is an obvious, straightforward, and commonsense approach to planning supportive care. Despite the diversity in methods and in the cancer populations studied, commonly cited concerns and problems include: pain, side effects, psychological needs, activities of daily living, self-care concerns, fear of recurrence and death, ability to cope, social interaction, finances and employment, resuming one's personal life, and sexual functioning (Canadian Cancer Society, 1990, 1992; Christ & Siegel, 1990; Friedman et al., 1993; Ganz, Schag, Polinsky, Heinrich, & Flack, 1987; Greer, 1994; Guadagnoli & Mor, 1991; Gustafson et al., 1993; Houts, Yasko, Kahn, Schelzel, & Marconi, 1986; Longman et al., 1992; Pistrang & Barker, 1992; Rapoport, Kreitler, Chaitchik, Algor, & Weissler, 1993; Schag & Heinrich, 1990; Vachon, Lancee, Conway, & Adair, 1990; Waligora-Serafin et al., 1992).

Although a number of needs assessments are available, we were unable to find a tool that (a) was developed for an adult cancer population, (b) elicits needs directly from the patients, (c) differentiates the method of resolving need from the need itself, (d) is comprehensive in its coverage of needs, (e) is valid and reliable and built upon patient-generated definitions, (f) has a manageable number of needs categories and differentiated levels of need, and (g) when possible, identifies barriers to needs resolution and service preferences.

A subset of the instruments developed for an adult cancer population relied on key informants, social indicators, community surveys, and professional judgements (Licitra et al., 1994; Maguire, Faulkner, &

Regnard, 1993; McDonald & Natarajan, 1989; Rust & Kloppenborg, 1990; Wellisch, Fawzy, Landsverk, Pasnau, & Wolcott, 1983). Other tools, while eliciting needs directly from patients, did not differentiate the method of resolving need from the need itself; this includes assessments of both information needs and service needs (Campbell-Forsyth, 1990; Galloway, Bubela, McKibbin, McCay, & Ross, 1993; Gustafson et al., 1993; Harrison-Woermke & Graydon, 1993; Jones, 1992; Mor, Guadagnoli, & Wool, 1987; Volker, 1991; Wolcott, Fawzy, Landsverk, & McCombs, 1986). Relatively few assessments were comprehensive in their coverage of needs; many studies examined subsets of needs such as nutritional, spiritual, self-care, and daily living needs (Bryan, Greger, Miller, Weinberger, & Loehrer, 1991; Chernoff & Ropka, 1988; Clifford & Gruca, 1987; Longman et al., 1992; Mor et al., 1992; Robinson & Posner, 1992; Siegel et al., 1992). In addition, few needs assessments had adequate validity and reliability testing or used samples of sufficient size (Wingate & Lackey, 1989).

Few quality-of-life (QOL) measures (Padilla, Ferrell, Grant, & Rhiner, 1990) and needs assessments are inductively developed from either cancer patients' or caregivers' reports of needs. Although patients are the best source of information, they have trouble expressing their concerns and asking questions. The patient and the caregiver each brings a unique perspective to the evaluation of needs. Without patient input, we work only from our own experience and assumptions, which, research shows, does not always reflect the patient's experience. Padilla and Kirshner (1991) point out, with respect to QOL domains, that it is impossible, without patient-generated definitions, to determine whether available instruments have overlooked critical aspects of care. Health caregivers, from years of experience with a variety of patients, can provide insight into the diversity of needs, and how they change over time, as well as identify needs that patients leave unexpressed. Osoba, Aaronson, and Till (1991) maintain that if a QOL questionnaire is to truly reflect the concerns of patients it must be a cooperative effort between caregivers and patients.

Method

This research used a qualitative design that relied on focus groups of patients and hospital caregivers to elicit information on psychosocial needs. This approach is particularly appropriate when the phenomenon under consideration has not been adequately identified or defined, or when a fresh perspective on a familiar problem is required (Stern,

1980). It allows patients and caregivers to relate their own experiences without having a conceptual framework imposed upon their interpretations.

Gathering the Data: The Nominal Group Technique

Among the several techniques available for collecting information from groups, the nominal group technique (NGT) appeared to be the one best suited to our needs. The NGT, developed by Delbecq and Van de Ven (1971), is a structured group meeting that begins with each individual recording his or her responses to a limited number of open-ended questions. At the end of five to 10 minutes, a structured sharing takes place, involving clarification, discussion, and voting. It has the advantage of being both (a) applicable in situations where individual judgements need to be tapped and combined in an efficient yet effective manner, and (b) sufficiently structured to focus on the generation of needs while minimizing conceptual or methodological biases.

The NGT is an expedient and efficient process for the creative generation of ideas, particularly when a large number of individuals is involved. In addition, the technique encourages maximum feasible participation, and participants are given equal opportunity to contribute to the group discussion. The NGT also involves a search process that assures independent generation of individual ideas unhampered by the reactive process that often confounds interactive groups. The influence of group opinion and dominant personalities can inhibit individual input. However, group discussion based on ideas generated independently of the group can serve to clarify and evaluate a person's ideas and allow the group to precipitate and stimulate ideas. This preserves the balance between task accomplishment and interpersonal social maintenance functions. Nominal groups have been found to be superior to interacting groups in generating information relevant to problem-solving (Delbecq, Van de Ven, & Gustafson, 1986).

Modifying the NGT somewhat, individuals were first asked to respond in writing, without interaction, to a set of open-ended questions. The questions differed slightly for the patient and the caregiver groups. Patients were asked the following two questions:

1. What do you think are the most difficult things about having cancer?
2. What are your concerns?

Hospital caregivers were asked the following questions:

1. What do you think patients find most difficult about having cancer?
2. What are patients' concerns?

The second step was a round-robin recording of the responses to the above questions. Each person was asked for several ideas that were recorded on a flip chart. Group members were allowed to ask only questions to gain additional information or to clarify an idea. After the first round, group participants were asked again, in the same manner, whether they had anything to add. The third step consisted of a serial discussion of the needs listed on the flip chart.

The sessions were conducted in a standardized way. Care was taken to introduce and describe the procedure uniformly to each group. The importance of each person's input was always emphasized. The group leader remained as neutral as possible, offering only points of clarification regarding the process and ensuring that no one participant dominated the discussion; she did not express her own ideas or knowingly offer positive or negative evaluations of the ideas presented. The entire procedure took approximately an hour and a half.

Description of the Groups

The patient groups consisted of outpatients at the Princess Margaret Hospital (PMH) who were staying at the Lodge, an alternative-care facility, situated adjacent to the hospital, for out-of-town ambulatory patients and their immediate families. The Lodge has an 80-bed capacity and the average occupation rate is 85%.

Participation was voluntary and individual written responses were anonymous. Thirty-six patients and one spouse participated — 20 women (including the spouse) and 16 men — in five groups. One individual did not indicate his or her gender. The mean age, for the women, was 57 years, ranging from 36 to 72 years; for the men, 59.5 years, ranging from 31 to 80 years. A variety of cancer sites and types was represented: for the women, bone, brain, colon, breast, stomach, melanoma, leukaemia, head and neck, and gynaecological system; for the men, bone, lung, thyroid, prostate, melanoma, pituitary, and head and neck. For the women, the time elapsed since diagnosis ranged from one month to five years, with a mean of 1.2 years; for the men, from four months to 10 years, with a mean of 2.4 years.

All PMH caregivers who had direct clinical responsibilities or direct contact with patients were invited to participate. The PMH is a cancer centre for both inpatient and ambulatory care. Approximately 5500 new patients are referred for medical and radiation treatment each year. Again, participation was voluntary and the individual written responses were anonymous. Group sessions were conducted with nurses (38.0%), imaging and radiation technicians (12.0%), dental, pharmacy, physiotherapy, respiratory, and nuclear medicine technicians (9.3%), social work and chaplaincy personnel (9.2%), support staff in the departments of medicine and radiation (7.7%), unit coordinators (7.0%), dietitians (4.2%), housekeeping and security personnel (3.5%), and volunteers (3.5%). Twenty-seven groups were formed. Eight physicians (5.6%), from medicine, radiation, and diagnostic imaging, were interviewed individually. Altogether, 142 hospital caregivers participated in this stage of the questionnaire construction.

Data were also collected by means of face-to-face interviews with 51 staff nurses at the Toronto Bayview Regional Cancer Centre (TBRCC), an outpatient referral facility that provides chemotherapy and radiation treatment for approximately 4200 new patients a year. Nurses' oncology experience ranged from two to 15 years. Nurses representing every disease site were interviewed. The question that elicited these data was: "What do you see as the primary problems your patients have to face?"

Analyzing the Data

Content analysis was chosen because it consists of a set of analytical procedures aimed at furthering the understanding of a phenomenon by measuring the frequency, order, or intensity of occurrences of words, phrases, or sentences (Krippendorff, 1980; McLaughlin & Marascuilo, 1990; Weber, 1985). The analysis was carried out using a procedure similar to the one described by Waltz, Strickland, and Lenz (1984) and involved seven steps:

1. The content universe was defined as all the individual responses to the questions and the round-robin group discussion, as recorded on the flip charts. Each word or phrase, written on a questionnaire or recorded on a flip chart, that reflected a patient's concern or problem represented a unit of analysis.

2. All the words or phrases were entered on individual index cards. Separate sets of cards were kept for the questionnaires and the group discussions as recorded on the flip chart. When responses were identical, the frequency was recorded. Responses that were similar, but not identical, were recorded separately. For example, the phrases "fear of death" and "fear of dying" were recorded on separate cards.
3. To address the issue of interrater reliability, the investigators independently categorized the words or phrases recorded from the questionnaires and the flip charts and from the interviews with the TBRCC nurses. Some responses were excluded because they were too general or vague to be classified, or because they did not represent a patients' need but were either a hospital caregivers' need or a barrier to need resolution. Separate analyses were undertaken for patients and each set of hospital caregivers.
4. Based on this initial sorting of the data and a review of the literature, the principal investigators defined the need categories,* then reviewed and resorted the results of the previous step. When consensus could not be achieved, a third party was asked to make a final decision on categorization.
5. Patients' and hospital caregivers' need categories were compared.
6. A set of need categories resulted from the previous steps.
7. Ten health-care professionals were asked to review the need categories and indicate, using a three-point scale, the importance of each need to patients. This group included two nurses, a chaplain, a dietitian, a volunteer, a social worker, a radiation oncologist, a patient education specialist, and the vice-president of patient-care services. The panel members were chosen to reflect the multidisciplinary nature of the supportive care available to patients. All the professional caregivers had extensive clinical oncology experience; none of them had been part of the groups and none of them had been interviewed previously.

This method, as with any method, has its limitations. The lack of random selection of the participants, as well as the difficulty and effort involved in recruiting reasonably large numbers of participants, limits

*Coding list and definitions available from the authors upon request

the generalizability of the findings to the larger populations. The open-ended nature of the responses makes summarization and interpretation difficult. In addition, error can be built in because of bias generated through group interaction and introduced by the group leader, who can unknowingly provide cues as to the desired responses. However, we believe that the NGT, when combined with careful analysis, minimizes error and produces a set of needs categories reflective of patients' psychosocial concerns and problems.

Results

Patient Perspective on Psychosocial Need

Individual patients' descriptions of their psychosocial needs were broken down into 21 categories of needs. The *most* frequently cited needs were: fear of recurrence, fear of the unknown, concerns around treatment efficacy and side effects, cure, fear of death, and acceptance of the illness. The *least* frequently cited were pain, information needs, anger, return to a normal lifestyle, family welfare, and separation from the home and family. Group discussion concurred with the individual responses and also recognized recurrence, fear of the unknown, and treatment as primary patient concerns. A 56-year-old man with head and neck cancer related some of these concerns:

Dealing with the fact. Concerns about it reoccurring. Although I'm told that it is gone and it is five years since the operation, there is a vulnerability of its coming back. Dealing with the post operation and treatment situation seems to be the most bothersome — a lifestyle change. [I] felt my body had let me down.

When asked what was most difficult about having cancer, an elderly man with bone cancer expressed in these few words the courage and isolation that cancer engenders: "Keeping a smile on your face!"

Although concerns over one's emotional reactions to the illness and interactions with the health-care system were described only infrequently by individual patients, they were regarded as important matters in the group discussions. Interactions with the health-care system, in fact, became a heated topic in every group. Many patients were dissatisfied with aspects of their care, particularly at the time of diagnosis. A woman with head and neck cancer recounted her problems around diagnosis: "My dentist did not come back after I complained about the symptoms. A second opinion gave the diagnosis.

It took two years to make the diagnosis." A 36-year-old mother with leukaemia voiced her concerns:

People don't understand what you are going through. You have to go through it alone — "inside." Not being able to do the things you used to do for yourself and having to ask all the time for help and not being able to get help or not getting enough help. Having the people at the community cancer society or any other agency try to solve the problems you are having [and] not leave it on your lap but to do the "leg work" for you in trying to solve any problems and not stopping until it is solved.

Not everyone, however, was negative. While the wife of a patient with prostate and bone cancer related some of her difficulties coping,

Immediate family are in a form of denial and think I am superwoman. They are having a hard time to accept [the cancer] and I, wife of a cancer patient, am trying to understand and sort it out,

she also made positive mention of the health-care system:

[We] have had a lot of stress, frustrations and run around. It is a great inspiration from the Princess Margaret Hospital to want to help. I would like to help other people who don't know what is available to them just from what my husband and I experienced.

Caregiver Perspective on Psychosocial Need

The caregiver perspective comes from two cancer centres, the PMH and the TBRCC. Caregivers at the PMH most frequently identified the following as patients' needs: finances and employment, treatment concerns, fear of the unknown, and family adjustment. They infrequently mentioned cure, return to a normal life, existential concerns, social roles, anger, nutrition, and hope.

A physician offered an eloquent description of patients' fears: "The primary problem a cancer patient faces is the initial confrontation with one's own death and later the confrontation with physical disability and the desperate attempt to put life in order." His voice was echoed by a nurse: "Although life is uncertain, uncertainty becomes more realistic and this then spells disaster for them."

Identifying the Psychosocial Needs of Individuals with Cancer

Group discussion of caregivers' individual perspectives on patient need resulted in a different ordering of patient needs. Although both individual responses and group discussion frequently recognized finances and employment, fear of the unknown, and family adjustment as patient concerns, group discussion placed greater emphasis on family welfare, information needs, change in body image, stigma, and fear of death than did the individual caregiver responses. Many caregivers were acutely aware of patients' concerns for their families, as expressed by these comments:

Providing for/caring for a loved one in spite of illness or impending death.

Explaining to the family and having them accept the implications of the disease.

The whole family is upside down. In some cultures, family do not want to talk about the cancer with the patient.

Nurses at the TBRCC most frequently cited information needs, emotional responses, and treatment concerns as patient needs. One nurse remarked, "Patients need information about what they can hope for." Another commented, "They have no information to work with. They can't even formulate the questions when they get here." Other nurses discussed the emotional consequences of cancer:

Confusion. The patient is faced with so many things and they have to make a decision. Emotions can interfere with making a decision. It is hard to concentrate, to make a decision.

The big thing is they have to learn to live with the chronic aspects of it — take medication for the rest of their lives.

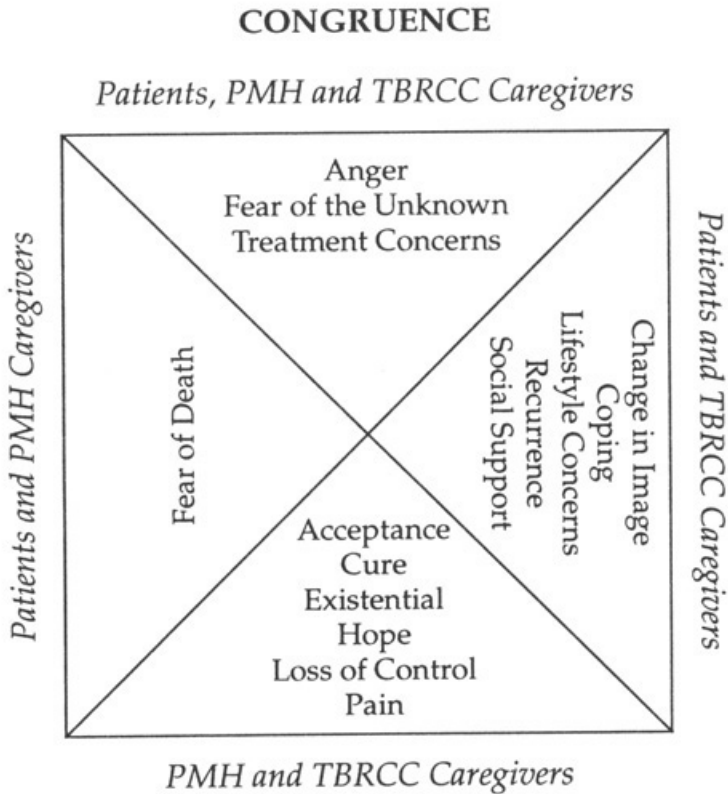
Facing the day-to-day reality [and] seeing others, children, can really hit rock bottom.

Patient-Hospital Caregiver Congruence

Comparison of the individual responses of patients, PMH caregivers, and TBRCC caregivers indicates that when patient needs are compared according to their ranking in the top, middle, or lower third of the order, there was little congruence of all three groups (Figure 1).

Figure 1:

Patient-Hospital Caregiver Congruence in Ranking of Need Categories



INCONGRUENCE

Finances and Employment
 Family Adjustment
 Family Welfare
 Interaction with the Health Care System
 Stigma
 Information Needs
 Sexuality
 Separation from Home
 Return to a Normal Life
 Social Roles
 Nutrition

Patients and caregivers from the two cancer centres ranked anger, fear of the unknown, and treatment concerns similarly. There was greater congruence between patients and TBRCC nurses, with similar rankings assigned to change in image, coping, lifestyle concerns, recurrence, and social support. Caregivers at the two facilities agreed in their rankings of acceptance, cure, existential concerns, hope, loss of control, and pain. In 12 of the 27 need categories, the rankings were dissimilar.

Comparison of the group discussions for patients and PMH caregivers provides a slightly different picture. Although congruence on fear of the unknown and treatment concerns echoes the individual responses, the group discussions also display congruence on social support, health-care system, stigma, information needs, and separation from the family. For example, a physician provided this insight into the barriers that physicians place between themselves and patients — thereby obstructing the pathway to wellness, particularly in relation to psychosocial concerns:

We are not sensitive enough to the patient. If not voiced, we may only know by happenstance. We do not take the time to talk to the patient. Some patients feel uncomfortable talking about these issues.

Caregivers from both cancer centres identified concerns that patients did not express, or emphasized those that patients brought up only infrequently, such as pain, hope, existential concerns, sexuality, and nutrition.

Content Validity

The content validity of the need categories was judged by having a panel of 10 hospital caregivers, including volunteers, rate the importance of each category to patients. As shown in Table 1, at least 80% of the panel judged each need category to be *very important* or *somewhat important*. Ten of the need categories were judged by at least 70% of the panel as *very important* and another six categories were judged by at least 50% of the panel as *very important*. The following needs were estimated by 50-80% of the panel to be *somewhat important*: social roles, change in body image, information needs, nutrition concerns, interaction with the health-care system, return to a normal lifestyle, separation from family or home, and sexuality.

Table 1

Importance Rating I by a Multidisciplinary Panel of Professional Health Caregivers (Including Volunteers) N = 10

	Very Important %	Somewhat Important %	Not at All Important %
Ability to Cope	100.0	0.0	0.0
Acceptance of Diagnosis and Prognosis*	44.4	55.6	0.0
Anger	50.0	40.0	10.0
Changes in Lifestyle	70.0	30.0	0.0
Changes in Social Roles	40.0	60.0	0.0
Cure	50.0	40.0	10.0
Emotional Concerns	70.0	30.0	0.0
Existential Concerns	40.0	50.0	10.0
Family Adjustment	70.0	30.0	0.0
Family Welfare	70.0	30.0	0.0
Fear of Death	80.0	20.0	0.0
Fear of Recurrence*	44.4	44.4	11.1
Fear of the Unknown	80.0	20.0	0.0
Financial Concerns	50.0	40.0	10.0
Hope	70.0	30.0	0.0
Image Concerns	20.0	80.0	0.0
Information*	44.4	55.6	0.0
Loss of Control	80.0	20.0	0.0
Nutritional Concerns	20.0	80.0	0.0
Pain	90.0	10.0	0.0
Problems with the Health Care System	20.0	60.0	20.0
Return to a Normal Lifestyle	50.0	50.0	0.0
Separation from Family or Home	50.0	50.0	0.0
Sexual Concerns	40.0	50.0	10.0
Social Support	60.0	40.0	0.0
Stigma	20.0	80.0	0.0
Treatment Concerns	70.0	30.0	0.0

* n = 9

Discussion

Before summarizing the results of our attempt to identify and categorize needs, we offer a few words of caution: handle with care. Several limitations, imposed by the method and by the organization in which the data were collected, can compromise the conclusions. The number of staff was greater than that of patients. Inclusion of a large number of participants is time-consuming in both recruiting members and conducting the research.

The non-random sampling of the populations also imposes a limitation. We gathered information from outpatients staying at the Lodge. It is quite possible that we did not adequately identify the needs of inpatients or of patients within commuting distance of the hospital. Also, because the Lodge staff makes an extraordinary effort to meet the needs of patients and encourages patients to bring a family member with them, a number of needs, such as family adjustment, may have been either given low priority or not expressed. This underscores the importance of interaction between the organizational environment and method of analysis. Although all the words, phrases, and sentences used by the participants were included in the analysis, the non-random selection of participants is an issue that must be taken into consideration since external validity is a goal of content analysis.

Difficulties in responding to open-ended questions, particularly on the part of the patients, may also compromise the process of identifying needs. For example, sexual concerns were never identified as needs by the patients. Another methodological caution is that the item generation is only as good as the open-ended questions. Nonetheless, our systematic research approach gives us confidence in our findings as a basis for identifying and classifying the psychosocial needs of patients, and using these categories to construct a needs-assessment inventory.

The two most striking findings create something of a paradox. On the one hand, when the frequency with which a need is cited is ignored, the majority of need categories (21 out of 27) were reported by all three groups. Of the six need categories not identified by all three groups, only nutrition and social roles were reported as patient needs by one group — the PMH caregivers. On the other hand, there was the lack of congruence between patients and hospital caregivers and between caregivers at the two cancer centres in the frequencies with which need categories were cited. We do not see this as cause for concern; the incongruence underscores the need to gather information from more than one perspective.

The difference in the need categories mapped out by each group indicates that none of the categories should be eliminated at this point. The hospital caregivers' perspective identifies the needs patients either feel reluctant to talk about, such as sexuality, or leave unexpressed, such as hope or the existential meaning of the illness. Frank (1991) points out that it takes time for an ill person to understand her or his needs and that it is difficult for a patient to give a coherent reply to the seemingly simple question "What do you need?" In the beginning, patients are

often trying to grasp the meaning and enormity of the diagnosis, and, as they continue along the illness path, their needs change continually. A nurse at the TBRCC summarized this succinctly: "The total impact of cancer. It affects the entire life... like a pebble in a pond... it has an impact that is tangible and intangible."

There were a number of unanticipated benefits to having conducted this study. Some staff members, particularly those in support functions, such as secretaries, technicians, and housekeeping personnel, appeared to feel empowered by the opportunity to discuss patients' needs. We hope that the process served to facilitate a better understanding of the psychosocial dimensions of illness. Lastly, and most important, the fact that someone was not only interested in what they had to say, but sought their participation, appeared to be therapeutic for many patients. Quite often, patients remained after the group session was over to keep the discussion going.

Identifying need domains is the first step in developing "need maps" as clinical and research tools. A needs-assessment inventory can help nurses address patients' cancer-related problems and thus help to enhance their quality of life. With an inventory based on patients' needs, derived from the perspectives of both patients and hospital caregivers, it will be possible to accurately identify the changing needs of patients over the illness trajectory. It is our hope that the PMH Needs Assessment Inventory will enable nurses to reach beyond people's ostensible invulnerability and numbness to not only help patients cope with expressed needs but also help them face their private pain, fears, and vulnerabilities.

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Nurses' Reactions to Physical Assault by Their Patients

Karen Croker and Anne L. Cummings

À l'aide du questionnaire sur les réactions par rapport à l'agression (Lanza, 1988a), on a étudié les réactions des points de vue social, affectif et biophysique de trente cinq infirmières non psychiatriques agressées par leurs malades. On a également demandé aux infirmières de décrire leur agression, de noter les causes et les stratégies qu'elles ont adoptées pour y faire face, et ce qui les a empêchées de rapporter l'agression. Les conclusions ont montré qu'étant donné que les infirmières font davantage face à des agressions au cours de leur carrière, leurs réactions sont plus intenses des points de vue affectif, biophysique et social. Les infirmières s'adaptent en apprenant; elles changent leur comportement, et le plus souvent, énumèrent comme causes de l'agression des variables provenant du malade, contrairement au blâme qu'elles portaient sur elles-mêmes dans des recherches précédentes.

Using the Assault Response Questionnaire (Lanza, 1988a), the emotional, biophysiological, and social reactions of 35 female non-psychiatric nurses who had been assaulted by their patients were investigated. These nurses were also asked to describe their assault experience, and to identify causes, their coping strategies, and the barriers preventing them from reporting assault. Results showed that as nurses reported more assaults, they experienced more intense emotional, biophysiological, and social reactions. They coped by learning to change their behaviours and they most often cited patient variables as causes for the assault — a finding that runs contrary to the pattern of self-blame reported in earlier studies.

Violence against nurses by patients is a topic that is discreetly kept from the public and consumers of health services. It is not a new phenomenon, however. The assault of nurses by patients has always occurred, and nurses have tended to adopt the attitude that assault is part of their job (Ryan & Poster, 1989). Concern about this tolerance has focused recent attention on the study of nurse assault.

The impetus for this study lies in the lack of knowledge about the reaction of female nurses to assault by their patients. If more is known about how female nurses react, broader, more comprehensive intervention strategies may be formulated and implemented. Most of the reviews concerning staff assault have focused on the area of psychiatry.

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The present study has attempted to fill this gap in the research by focusing on assault of medical and surgical nurses in a hospital setting.

Literature Review

The perspective of nurses' reactions following an assault has been studied in only a small number of cases (Lanza, 1985; Ryan & Poster, 1989; Roberts, 1989). When patients physically assault nurses, there is a strong tendency for nurses to deny or minimize the experience (Lanza, 1983; Murray & Snyder, 1991; Roberts, 1989). Rationalization occurs in many forms. Nurses report feeling blamed and ostracized for provoking the assault (Lanza, 1985; Ryan & Poster, 1989). Under-reporting of assault episodes is a cause of some concern for nurse researchers, who have been unable to collect accurate statistics.

A number of factors may have contributed to these reactions. Much of the literature on nurse assault has highlighted intervention and management strategies in dealing with a violent patient (Cahill, Stuart, Laraia, & Arana, 1991; Carmel & Hunter, 1990; Stevenson, 1991; Thackrey & Bobbitt, 1990; Wright, 1989). Management support of assaulted nurses, mainly to the extent of sanctioning education in how to deal with aggressive behaviour, is not comprehensive enough. This approach may be seen as an implicit form of victim blaming, because it places responsibility for patient assault with the nurse, suggesting that improvement in nurses' behaviour, attitude, and skills will prevent assault (Kinross, 1992). The system or the hospital, thus helps to perpetuate violence against nurses as an accepted part of the job; the nurse, in turn, may not feel supported.

One of the first descriptive studies to explore nurses' reactions to physical assault, conducted by Lanza (1983), evaluated their social, cognitive, behavioural, and emotional reactions. Surprisingly, 50% of the nurses indicated "no response" to a majority of the questions on emotional, social, and behavioral response. Those who indicated reactions to the assault reported that the effects lasted up to one year.

In a followup study, Lanza (1985) compared the responses of the same nurses to a simulated assault situation and to an actual assault. Over 70% of the nurses who watched the simulation of a nurse being hit by a patient felt that the nurse would suffer fairly severe to very severe emotional and physical effects. These same nurses rated the effects of their own assault as either slight or non-existent. The author speculated that the nurses may have suppressed their reactions or

rationalized them, as their way of dealing with the anxiety and helplessness caused by the assault. The tendency to minimize and deny the effects of an assaultive experience has been documented elsewhere in the nurse assault literature (Lanza, 1983; Murray & Snyder, 1991; Roberts, 1989, 1991). This tendency to minimize and deny can also be found in the family violence literature (Gage, 1991; Moss & Taylor, 1991).

Lanza (1988b) reported various emotional and behavioural reactions to an assault, including shock, anger (at the patient and others), fear, depression, loss of trust, compulsive behaviour, returning to work too soon, concentration difficulties, strained family relations, and denial. The nurses' reactions included needing to keep control, absenteeism, fear, disbelief, and wanting to avoid the paperwork involved in reporting the incident. Only 50% of nurses reported the assault. Reasons for failing to report included the belief that only severe assaults should be reported — that assaults are too common to be reported each time, the opinion that patients are not responsible for their behaviour, the feeling that aggression against nurses is part of the job, there was not enough time, and peer pressure not to report.

Prior to the 1980's, studies concerning the assault of nurses were conducted and reported on by non-nurses. More recently, nurse generated research has added important descriptive information, primarily in psychiatry and geriatrics. Very little is known about general medical and surgical areas of the hospital, where assault is anticipated to a lesser extent.

The first goal of the present study was to extend the descriptive research done on assault in psychiatric settings to assault in general surgical, medical and specialty units of a hospital. More specifically, this study addressed the following question: What is the relationship between demographic variables (e.g., age, education, experience, number of times assaulted) and nurses' reactions to assault (emotional, biophysiological, social)?

The second goal of the study was to enrich the quantitative data with qualitative data, to gain a better understanding of various factors involved in nurse abuse. Four areas were investigated using a self-report survey: causes, nurses' opinions of why the assault occurred, coping strategies, and barriers to reporting assault. While there are limitations to using retrospective self-reports, they have the potential to provide helpful information about nurses' experiences that cannot be obtained through purely quantitative measures.

Method

Study Population

Questionnaires were sent to female nursing staff in all non-psychiatric units of a rural general hospital in Central Ontario. Of the 515 questionnaires sent, 160 were returned to the first author (a nurse consultant in the hospital), representing a return rate of 31%. (A one-third return rate is normal for mail survey research. In a meta-analysis of mail survey research, Yammarino, Skinner, and Childers [1991] found a consistent response rate of 20-40%.) Of the 160 returned questionnaires, 35 nurses — or 22% (24 registered nurses and 11 registered nursing assistants) reported being assaulted.

The age of the participants ranged from 26 to 61 years ($M = 39$ years). The number of years of experience in nursing ranged from four to 38 years ($M = 17$ years), the length of employment ranging from two months to 26 years. The registered nurses and assistants were employed as staff nurses on all units throughout the hospital except psychiatry. Participants were contacted through the hospital mail system. Each participant received a letter explaining the purpose of the study, and was asked to complete the Assault Response Questionnaire and the Personal Assault Experience Questionnaire on a voluntary basis. The letter of information sent to all participants defined assault as "occurring when any patient has knowingly physically touched you with the intent to harm (e.g., a punch, pinch, strike, kick)." All responses were anonymous.

Instruments

Assault Response Questionnaire — ARQ (Lanza, 1988a). The ARQ was developed to measure or quantify the intensity, for the nurse, of patient assault. It is composed of basic demographic data about the victim and the patient. The instrument contains three scales: emotional, biophysiological, and social. The emotional scale has 19 items, which measure the intensity of feeling after an assault (e.g., "shame," "withdrawal"). The biophysiological scale contains 15 items, which measure the intensity of physical reactions after an assault (e.g., "headaches," "nausea"). The social scale contains ten items, which measure changes in behaviour and/or relationships with others after an assault (e.g., "fear of other patients," "difficulty returning to work"). The individual is asked to rate each item on a Likert scale ranging from 1 to 5, with 1 indicating no reaction and 5 indicating severe reaction.

Lanza (1988a) obtained split-half reliability of .95 for the emotional scale, .89 for the biophysiological scale, and .93 for the social scale. Cronbach's alpha for these three scales in our study were .91, .84, and .91, respectively. Item analysis correlations among scales ranged from .84 to .86 (Lanza, 1988a). The ARQ has been used in other research studies (Lanza, 1983; Mahoney, 1991).

Personal Assault Experience Questionnaire — PAEQ. The questions in this portion of the written survey were developed by the first author and were intended to tap the nurses' experiences of assault in a qualitative manner. The questionnaire contained eight questions, but for the purposes of this study only the following four questions were used: (a) Describe an incident of assault that happened to you. (b) How have you explained to yourself why this incident happened? (c) How have you dealt with it since it happened? (d) Did you report the assault? If yes, what was the response you received? If no, what prevented you from reporting the assault?

Results

Thirty-five non-psychiatric nurses had been physically assaulted by patients in the past five years. The number of assaults during their careers ranged from one to many. Fifty-one percent of the nurses indicated the number of assaults as "many," "daily," "frequently," or "numerous". When asked whether they reported the assaults to the hospital administration, 34% responded "no," and 66% responded "yes." Sixty-nine percent of the patients who assaulted nurses were males.

In order to determine the relationships among the demographic data of all the nurses and their scores on the ARQ, Pearson product-moment correlations were calculated among all of the independent variables (age, height, weight, education, years of experience, patient's age, patient's sex, number of assaults, severity of assault, and coping behaviours) and the dependent variables (emotional reaction, biophysiological reaction, social reaction, and whether the assault was reported). These correlations are provided in Table 1. The number of previous assaults correlated significantly with emotional reaction, biophysiological reaction, and social reaction. As nurses experienced more assaults, their emotional, biophysiological, and social reactions intensified. The sex of the patient correlated significantly with the intensity of biophysiological reactions: more intense physical reactions were associated with assault by female patients.

Table 1
Correlations Between Demographic Data and Assault Response Questionnaire Scales

	Experience	Patient Age	Patient Sex	Number of Assaults	Emotional Reaction	Biophysiological Reaction	Social Reaction
Patient Age	.07						
Patient Sex	-.18	.15					
Number of Assaults	.12	-.02	.24				
Emotional Reaction	-.09	-.02	.28	.48**			
Biophysiological	-.06	.07	.32*	.49**	.92**		
Social Reaction	-.12	.02	.13	.34*	.90**	.88**	
Reported	-.31	.13	.16	.17	-.11	-.06	-.03
N = 35 ** $p < .01$ * $p < .05$							

All answers to the PAEQ were analyzed and categorized separately. The first item asked nurses to describe their assault experience. The requested information included the activity in which the nurse was engaged at the time of the assault, type of assault, and possible reason for assault. All of the reported assaults were preceded by close patient-nurse contact. Positioning and turning patients or assisting patients in returning to their rooms resulted in the most assaults (29%). Other tasks included bathing (20%), close-contact nursing treatment such as checking intravenous lines, dressings, monitors (17%), restraining (14%), toileting (11%), and unmentioned (9%). In 37% of the cases, the assault occurred after the patient had refused treatment, and ingestion of alcohol was involved in 14% of additional cases. Twenty-three percent of the nurses reported having received injury severe enough to require treatment.

The nurses' perceptions of why the assault occurred was divided into "patient reasons," "nurse reasons," and "other reasons." (Table 2). Patient reasons included confusion related to post-operative effects of anaesthesia, disease-related effects, medication-induced behaviour, alcohol-induced behaviour, or dementia, fear, anger, or manipulative behaviour. Nurse reasons included self-blame. Other reasons included anger at doctors and the administration.

Table 2

Causes Given by Nurses to Explain Patient Assault

Variable	Frequency	Percent
<i>Patient Reasons</i>		
Confusion	14	33
Fear	7	17
Anger	6	14
Alcohol	6	14
Manipulating	2	5
<i>Nurse Reasons</i>		
Self-Blame	2	5
<i>Other Reasons</i>		
Doctor	2	5
Administration	3	7
Total	42	
<i>Note: Some incidents fit into more than one category.</i>		

Nurses dealt with assault in a variety of ways, such as learning from the experience and changing their nursing practice so that the incident would not occur again. Some nurses coped by forgetting about it or accepting it as a job risk, seeking support, becoming generally wary, becoming angry, or quitting the job (Table 3).

Table 3

How Nurses Dealt with Assault by Their Patients

Variable	Frequency	Percent
Learn and change	14	31
Forget	7	16
Responded affirmatively	7	16
Accepted job risk	5	11
Perceived support	4	9
Generalized wariness	4	9
Anger	3	6
Left job	1	2
Total	45	
<i>Note: Some responses occurred in more than one category.</i>		

Of the nurses who had been assaulted, 66% reported the incidents and 34% did not. Of those who reported, 38% received support from the administration and their coworkers, 25% felt they had effected change as a consequence of their reporting, 29% reported no response, and 8% felt blamed. Fifty percent of the nurses who did not report the assault believed they would not be justified in reporting it because they perceived it was part of the job and no injury was sustained. The other 50% of the nurses who did not report tended to deny and minimize the assault, and fear blame from administration and their peers.

Discussion

The first goal of the study was to extend the descriptive research on assault in psychiatric settings to surgical and medical units of a hospital. In this study, 22% of the participants who returned the questionnaires indicated that they had been physically assaulted by their patients within the preceding five years. This low rate of reporting assault is consistent with the assault research of the past 12 years, which suggests that nurses tend to deny, rationalize, and minimize assault

by their patients (Brooks, 1967; Kalogerakis, 1971; Lanza, 1983; Lion, Snyder, & Merrill, 1981). The data differ, however, from a recent survey. The Registered Nurses Association of Ontario (1991) provincial survey found that 59% of 808 nurses reported being physically assaulted by patients during their careers. Although that study was carried out earlier than ours, these statistics clearly reflect a higher incidence of assault reporting.

Anecdotally, many nurses wrote that they did not feel they had been *assaulted* by a patient, even though they admitted that they had been hit, pushed, or punched. They did not consider these actions assaultive, for a variety of reasons. Some nurses felt that because patients were confused or unfamiliar with their surroundings, their behaviour was understandable, excusable, and not assaultive. Others thought that only severe events of hitting or punching should be considered assaultive.

This pattern of minimizing or excusing patient behaviours could be one of the reasons for the low response rate in the current study. Our definition of assault required a perceptual interpretation because it included the phrase "with intent to harm." Because nurses tend to believe that patients do not mean harm, they may not consider an incident assaultive when it happens.

In addition, hospital downsizing strategies taking place at the time the study was carried out could have affected the mood of the nurses.

Another reason for the low rate of reporting assault may be placement of blame on the nurse. Lanza (1987) found that women were blamed more than men for an assault. Perhaps the fear that they would be blamed for precipitating or provoking the assault caused the nurses to disclaim their assault experience.

We found that the more assaults experienced during a nurse's career, the more intense her emotional, biophysiological, and social reactions. It appears that, for these nurses, repeated assaults had a cumulative effect. This finding suggests that hospital administrations should provide support for nurses who are at high risk for repeated assaults, rather than deny or minimize the problem of assault within institutions.

A surprising correlation was that the nurses had more intense biophysiological reactions to being assaulted by female patients than by

male patients, perhaps because of the cognitive dissonance that may have resulted. In our society, it is much more stereotypically common for men to assault women (Freedman, 1985; Gage, 1991; Sinclair, 1985). Women have been socialized to be nurturers and caretakers, so when this internalized concept has been violated, the reaction may be more intense. It is interesting to note that only biophysiological reactions are intensified. Perhaps the nurses found it appropriate to react in a manner that was *least* threatening to others, and *most* internally self-focused. No previous research has correlated these variables; thus, it is not clear the degree to which this finding could be generalized to apply to other hospital settings.

The second goal of the study was to better understand nurses' view of the assault, coping strategies, and barriers to reporting the assault experience. It is interesting to note that 91% of the assaults occurred when it was necessary for the nurse to touch the patient's body. In 64% of the cases, the nurses' perception of why the assault occurred involved patient confusion, fear, and anger. It is possible that those who were confused, afraid, or angry struck out at the nurse when she was touching the patient for therapeutic reasons. These patients may have felt their personal body space was being violated. Few other professions are responsible for such intimate physical contact. Nurses approach patients with treatments that they perceive as harmless and routine; however, patients who are confused for a variety of reasons might not perceive the intervention as innocent and routine. Nurses need to be cognizant of the importance of explaining each procedure carefully before touching the patient.

The nurses' most frequent method of coping with assault was to learn from the experience and change their nursing practice by telling patients what to expect before proceeding with a treatment, maintaining a distance from angry patients, and communicating with other nurses by preparing a care plan. Seeking support from colleagues and the hospital administration was another strategy used by nurses in our study. These positive coping strategies may signify that the nurse is gradually taking more responsibility for her environment and refusing to accept working conditions as they have always been. Negative coping patterns such as accepting assault as part of the job, forgetting the incident, becoming angry or wary, and quitting the job were also evident in the present study. By failing to resolve the assault situation, these nurses may develop problems in the future. Negative coping styles are evident in other nursing studies (Lanza, 1988b; Ryan & Poster,

1989). These varied reactions to assault suggest that effective intervention for assaulted nurses could be multifaceted.

Underreporting of assault has been a serious problem in the past, because denial, rationalization, and minimization have been used as coping strategies (Casseem, 1984; Jones, 1985; Lion et al., 1981). Two thirds of the participants in our study reported the assault to the hospital administration. These nurses reported that they felt supported by the administration and their coworkers and felt that their actions had created a positive change in management's view of the abusive situation. Previous studies (Lanza, 1987, 1988b) have indicated that only a small percentage of nurses report assault, because of fear of reprisal from their peers, doctors, and the administration. The higher percentage of reporting found in our study may represent a shift away from an attitude of blaming, on the part of hospital personnel, toward one of openness in dealing with assault when it occurs.

A survey by the Registered Nurses Association of Ontario (1991) suggested numerous strategies for placing the onus on the institution to support the staff member and also for placing responsibility with the patient. Ways of empowering nurses include police protection for nurses, ensuring more input by nurses in decision-making treatment of patients who are violent, and charging patients through the legal system.

Intervention has been developed to help nurses deal with their reactions to an assault. Newer modalities of treatment available to the nurse include nursing support groups (Roberts, 1989) and nursing consultation support services (Murray & Snyder, 1991), which provide counselling and debriefing following assault. Hospital administrations could initiate, sponsor, and sanction programmes to deal effectively with the increasing problem of nurse assault (Kinross, 1992).

Certainly, a number of limitations to the current study affected the generalizability of the results. The PAEQ was used for the first time in research. As a self-report questionnaire, it may have been limited by difficulties common to such instruments (e.g., biased questions, answering in a socially desirable way, and inconsistency of responses). Interviews might have elicited richer, clearer, and more detailed data. The small sample size also makes generalizing the findings difficult. Finally, its definition of assault may not have fit some nurses' perceptions of their experiences.

Given these caveats, however, this study enhances the reliability of the ARQ (Lanza, 1988a). It also shows that the more assaults experienced, the more intense the nurses' emotional, biophysiological, and social reactions. Nurses who are at high risk will likely need specific supportive interventions so that their reactions are dealt with, and their trauma is resolved, at the time of the assault. Future research in the area of nurse assault is of paramount importance. Understanding the experiences of nurses prior to and following an assault is key to ensuring that comprehensive institutional policies will be developed. Research that focuses on testing and implementing various hospital support programs to identify which would be most beneficial for nurses is particularly needed.

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Book Review

Interpretative Phenomenology. Embodiment, Caring, and Ethics in Health and Illness.

Patricia Benner (Ed.). Thousand Oaks: Sage Publications, 1994. 349 pp.
ISBN 0-8039-4460-8 (cloth)/0-9039-6723-8 (paper).

Reviewed by Vangie Bergum and Susan James

Phenomenology and hermeneutics, philosophical approaches in research, are aimed at understanding human experience as it is lived, that is "understanding human concerns, meanings, experiential learning, and practical everyday skilful comportment" (p.xv). In this book, these philosophical traditions are explored from the perspective of research in nursing. The editor, Patricia Benner, states three aims of the book: (a) to offer a philosophical introduction to interpretive phenomenology, (b) to guide understanding of the strategies and processes of this approach, and (c) to provide a wide range of high-quality interpretative studies that show the central premises of interpretative enquiry within a variety of phenomena under investigation. The philosophical grounding of this book is focused on (and limited to) the work of Martin Heidegger, with Hubert Dreyfus and Charles Taylor offering extensions of Heidegger's thought.

In the first section of the book (chapters 1-7) authors explore theoretical and philosophical foundations as well as methodological criteria for accomplishing interpretive research (including beginning work on a computer program to assist in analysis of data). In chapter 3, Victoria Leonard skilfully demonstrates how the Heideggerian view opens up understanding of the person as always situated in the world, for whom things have significance, and as self-interpreting, embodied, and temporal. These views challenge the root of Cartesian thinking with which we have become comfortable. As with any approach that invites different ways of thinking, new words (e.g., thrownness, clearing, ready-to-hand, etc.) are difficult to grasp. Leonard and Karen Plager (chapter 4)

Vangie Bergum, Ph.D., is Professor in the Faculty of Nursing and Susan James is a doctoral candidate in the Faculty of Nursing at the University of Alberta, in Edmonton, Alberta.

effectively lead us to increased understanding through their use of examples. Leonard, Plager, and Benner (chapter 5) demonstrate why and how interpretive phenomenology methodology needs different standards (for evaluating rigour, for methods of data collection, and for analysis) than used in natural science research. Benner's chapter on method is abstract with a tendency to prescription and leaves us with a number of questions: Is engaged reasoning merely a form of comparison to uncover differences and similarities as in natural science? How can one understand sample size chosen to accommodate the researchers? How does one locate the paradigm case? Are themes the same as categories? What are the implications of mixing methods such as (clinical) ethnography and hermeneutic phenomenology.

The second half of the book (chapters 8-15) achieves the third aim of presenting a wide range of interpretative studies about embodiment, caring and ethics. Lee Smith Battle's study of teenage motherhood and Nancy Doolittle's study of stroke recovery are good examples of use of differing methods that accomplish enlarged understanding of the phenomena under investigation. Smith Battle, especially, shows the strength of narrative, which focuses on immediate experiences of the mothering experience of young women, rather than on gaps or deficits that others might identify. Attuning to their experience will increase understanding and encourage health professionals to rethink how to encourage and support the mothering abilities of these young women rather than to judge them. After all, as she says, it is the baby that calls out the moral claim of a changed life (p. 160). Doolittle describes the experience of the physical and social body following a stroke and the meaning of recovery as functioning in self-chosen activities. This level of understanding challenges nurses to go beyond an approach of coping with physical impairment to incorporating the experience of impairment into the personal concerns and meanings of that person (p. 223). The inclusion of discrete and sometimes quantified categories reported in some of the studies may result in confusion about the distinctions between the interpretive method and the empirical traditions in natural science. However, the various approaches to interpretive phenomenology and the attention to practice implications in the studies suggest a range of possible applications of the method in nursing practice and research.

There is a tension in this book that is somewhat troubling. On one hand, a desire for theory building is evident (chapters 1 and 2); and, on the other, there is a need to push off theory in order to reveal meanings, skills, and practices, the practical knowledge so hidden in traditional empirical research. In our view, hermeneutic phenomenology must

return us to practice (to human experience) rather than to theory (about experience). In this book the role of theory is not resolved.

Nursing practice and research will benefit from this timely and comprehensive book. To further the development of knowledge in nursing, outcome style research reflecting explanation or prediction through causal laws and formal theoretical propositions needs to be balanced with an understanding of how people experience health and illness. Interpretive inquiry encourages nurses to listen to people's experience in their particularity (personal narratives), attend to the language used in a thoughtful life deepening way, create meaning with participants in research (not just report it), and continue to learn about and enhance respect for our common human experience.

Call for Papers

Acute Care

Winter 1995 (vol.27, no.4)

Topics such as the individual's and families' responses to illness, new approaches to care, the impact of new technology, and interdisciplinary approaches are welcome. Priority will be given to research reports. However, review articles will also be considered.

Editors: Dr. Mary Grossman and Dr. Laurie Gottlieb

Submission Deadline: October 15, 1995

Culture & Gender

Spring 1996 (vol.28, no.1)

Papers are invited that address the theoretical and methodological issues in conducting cross-cultural research. We are especially interested in receiving articles from a feminist perspective, that attempt to examine the intersection of gender, race and class in the conduct of nursing research, and that outline strategies for the utilization of research findings.

Guest Editor: Dr. Joan Anderson

Submission Deadline: November 15, 1995

Symptom Management

Summer 1996 (vol.28, no.2)

Manuscripts are invited that address management of symptoms. Symptoms may include, but are not limited to, pain, discomfort, nausea, anxiety, depression, and confusion. We seek a wide range of patient populations, symptoms, and management strategies. Preference will be given to completed research reports.

Guest Editor: Dr. Celeste Johnston

Submission Deadline: December 15, 1995

Please send manuscripts to:

The Editor,

Canadian Journal of Nursing Research,
McGill University School of Nursing
3506 University Ave., Montreal, Qc H3A 2A7

Articles à publier

Soins aigus

publication: hiver 1995 (vol.27, no.4)

Vous êtes invités à nous soumettre des articles portant sur les soins aigus. Les sujets peuvent concerner, entre autres, l'existence de nouvelles approches de soins, l'impact de nouvelles technologies, les réactions à la maladie, l'implication du malade et de la famille et la collaboration interdisciplinaire. Les rapports de recherche auront la priorité. Cependant, les articles critiques seront également pris en considération.

Rédactrices : Dre Mary Grossman et Dre Laurie Gottlieb

Date limite pour les soumissions : le 15 octobre 1995

La culture et le sexe

publication : printemps 1996 (vol.28, no.1)

Les articles porteront sur les questions théoriques et méthodologiques dans la recherche interculturelle. Nous aimerions surtout des articles rédigés dans une optique féministe, qui tenteront d'examiner le croisement du sexe, de la race et de la classe sociale dans la recherche en sciences infirmières, et qui mentionneront des stratégies pour l'utilisation des résultats de la recherche.

Rédactrice invitée : Dre Joan Anderson

Date limite pour les soumissions : le 15 novembre 1995

La gestion des symptômes

publication : été 1996 (vol.28, no.2)

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Rédactrice invitée : Dre Celeste Johnston

Date limite pour les soumissions : le 15 décembre 1995

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For further information, please contact
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The University of Victoria School of Nursing

The School of Nursing offers a baccalaureate program, both generic and post-R.N., through on campus and distance formats. In partnership with nine nursing programs in British Columbia, the School is involved in implementing an innovative undergraduate curriculum with a health promotion and caring focus. The School participates in a multidisciplinary masters program and is exploring the possibility of developing further graduate programs at the masters level. The School of Nursing values the director working collectively with the faculty, staff, students and community to promote the vision and direction of the School.

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Journal of Family Nursing

The Journal of Family Nursing is a new journal (first issue was February 1995) owned by Sage Publications, Inc. and published in cooperation with the Faculty of Nursing, The University of Calgary. Janice M. Bell, R.N., Ph.D., Associate Professor of Nursing and Research Coordinator, Family Nursing Unit is the first editor of this journal.

The Journal of Family Nursing is a peer-reviewed journal that publishes original scholarly work on nursing research, practice, education and policy issues related to families in health and illness. In addition, appropriate articles of empirical and theoretical analyses on the subject of family health will be published. Both "family as context" and "family as unit" are represented. Additionally, there is a strong mandate to represent cultural diversity and families across the life cycle. Interdisciplinary and collaborative perspectives are encouraged, as are international contributions.

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Authors wishing to submit their work to the *Journal of Family Nursing* should send five copies of the manuscript to: Janice M. Bell, R.N., Ph.D., Editor, *Journal of Family Nursing*, Faculty of Nursing, The University of Calgary, 2500 University Dr. NW, Calgary, Alberta, Canada T2N 1N4.

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Information for Authors

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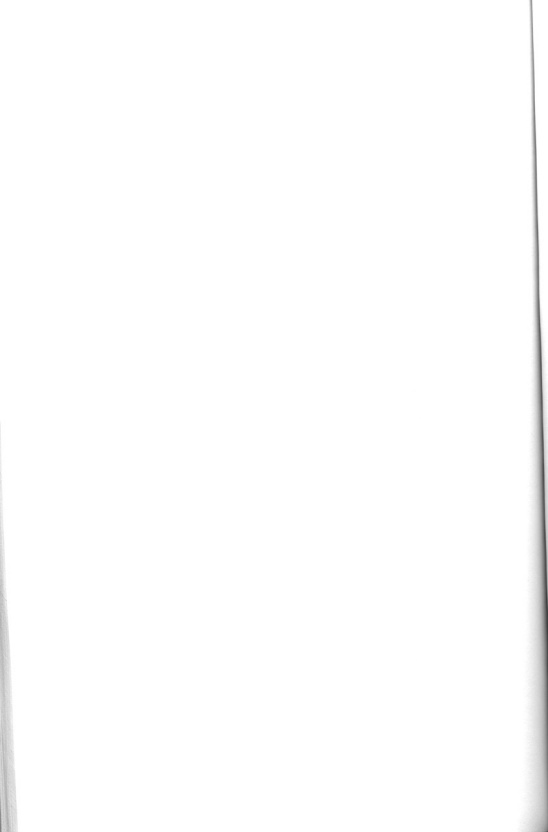
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