

Canadian
Journal of
Nursing
Research

Revue
canadienne
de recherche
en sciences
infirmières

Spring/Printemps 1997 Volume 29 No. 1

Canadian Journal of Nursing Research
Revue canadienne de recherche en sciences infirmières

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SPRING EDITORIAL

"Co-opetition": A Model for Multidisciplinary Practice

Across the country, turf wars are being fought as health-care professionals jockey for position in the wake of the reorganization of health-care services. Nursing finds itself at the centre of many of these wars because it is multi-focused and has large numbers of practitioners. Of all the health-care professions, nursing has the most to win and the most to lose. The outcome of the wars will determine whether nursing emerges as a major player in the new health-care order or is fatally wounded – its roles carved up among other health-care professions, its skills reduced to technical tasks distributed among unskilled workers. At the moment both scenarios are being tried as possible solutions to the health-care crisis. Clearly, the strategies that nursing as a profession adopts *now* will determine which of the two scenarios will become dominant.

The last few months have seen the publication of a number of books and articles outlining strategies that professions might adopt to ensure their survival. These strategies can be grouped under three models – the Competitive-Replacement Model, the Diffusion Model, and the "Co-opetition" Model.

The Competitive-Replacement model is best illustrated by Ralph Sutherland's book *Will nurses call the shots?* In this model, nursing expands its role into medicine and competes with medicine for the same health-care dollar. With some retraining, nurses could fulfil many medical functions at a fraction of current costs. A number of assumptions underlie this model: (a) health care and medical care are synonymous; (b) governments are interested in financing only medical care; (c) the "fluffy stuff" (to quote Dr. Sutherland) involved in "traditional" nursing requires no specialized knowledge, skills, or training and could be delivered equally well by any "caring" health professional; (d) the "fluffy," or soft, aspects of caring have little or no effect on health outcomes; and (e) nursing is an extension of medicine, with no independent identity.

Under the Diffusion Model, in contrast, nursing will transcend its professional boundaries and lose its identity. The differences among

professions and disciplines become obscured and traditional boundaries blurred. The roles of the new health professional derive not from respective disciplines but from the context of practice. Nursing will cease to exist as a profession or a discipline, the term *nursing* merely describing a set of tasks.

The third model, developed for business, takes features from both cooperation and competition to create a new entity. The "Co-opetition" Model (Brandenburger & Nalebuff, 1996), when applied to the health-care system, defines professional relationships as both complementary and competitive. Under this model, all professions are equal, and each makes a unique and valuable contribution. On the other hand, each profession shares overlapping functions, skills, and roles that creates some tension and gives rise to competition.

Both the Competitive-Replacement Model and the Diffusion Model fail to recognize the uniqueness of nursing. The Competitive-Replacement Model sees little or no value in nursing beyond its purely medical contribution. The Diffusion Model calls for a blurring of roles and functions so that any one profession can be replaced by another. The inherent danger of this model is that nursing would lose control of its own direction and development and eventually cease to exist as an entity.

The "Co-opetition" Model offers the best solution for the survival of nursing. If nursing were to adopt this model, we would retain our unique identity while complementing the various functions of other health professions. The competition that would result from the overlapping of functions could be an advantage, in that competition tends to produce excellence. In fact, evolutionary theory informs us that the co-existence of complementarity and competition is critical to the survival of any organism. Organisms that carve out a niche because their skills are unique are the organisms that are most likely to survive. At the same time, however, they must be flexible enough to adapt to changing conditions. These two features, uniqueness and flexibility, characterize nursing.

The challenge for nursing in adopting the "Co-opetition" Model is to discover the right mix of complementarity and competition, for different populations, under different conditions, in different contexts. If nursing can demonstrate, through research, that it is able to deliver quality service at the most reasonable cost, it will undoubtedly play a central role in the new health-care system.

Laurie N. Gottlieb
Editor

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ÉDITORIAL DU PRINTEMPS

La « Coocurrence » : Un modèle pour une pratique multidisciplinaire

Partout au Canada, une forte concurrence s'est établie entre les professionnels de la santé, qui se rivalisent pour une place de choix dans le contexte de la réorganisation des services de santé. La profession infirmière se retrouve au cœur de plusieurs de ces luttes, à cause de sa nature multidimensionnelle et du nombre élevé de praticiennes. Parmi toutes les professions des soins de santé, celle-ci est susceptible de réaliser les plus grands gains ou subir les plus grandes pertes. L'aboutissement de ces luttes déterminera la place qu'elle occupera dans le nouvel ordre des soins de santé. Ou bien elle sera considérée comme étant un acteur des plus importants, ou bien elle subira un mortel recul et verra ses rôles disparaître parmi ceux des autres professions de la santé, et ses compétences réduites à des tâches techniques, exécutées par des travailleuses non qualifiées. Il est de plus en plus évident que les deux scénarios sont tout à fait plausibles. Nulle doute que les stratégies qui seront adoptées *dans le présent* par la profession infirmière, en tant que telle, détermineront lequel des scénarios se concrétisera.

Au cours des derniers mois, plusieurs livres et articles ont été publiés sur la question. Ils offrent des ébauches de stratégies pouvant être adoptées par les professions voulant assurer leur survie. Ces stratégies peuvent être regroupées selon trois modèles : le modèle de Compétition-Substitution, le modèle de Diffusion et le modèle de « Coocurrence ».

Le modèle de Compétition-Substitution est très bien illustré dans le livre de Ralph Sutherland, *Will nurses call the shots?* Selon ce modèle, la profession infirmière étend l'exercice de son rôle et entre dans le domaine de la médecine, avec laquelle elle rivalise pour les mêmes « dollars-santé ». À la suite d'une formation de perfectionnement, les infirmières pourraient exécuter plusieurs tâches d'ordre médical, pour une fraction des coûts actuels. Ce modèle présuppose un certain nombre d'hypothèses : a) les notions de soins de santé et de soins médicaux sont des notions synonymes ; b) les gouvernements ne veulent

financer que les soins médicaux ; c) l'attitude de « maternage » (pour citer le Dr Sutherland) qu'on retrouve dans la profession infirmière ne nécessite aucune connaissance, compétence ou formation spécialisées et pourrait être aussi bien véhiculée par n'importe quelle professionnelle de la santé possédant des qualités de compassion ; d) la dimension « maternage » ou « douceur » pouvant être contenue dans l'administration de soins n'a presque aucun effet, sinon aucun, sur le processus de santé ; e) la profession infirmière est une extension de la médecine et ne possède aucune identité propre.

Contrairement au modèle précédent, la profession infirmière, selon le modèle de Diffusion, transcendera ses limites professionnelles et perdra son identité. Les différences entre les professions et les disciplines sont nébuleuses et les limites traditionnelles, floues. Les rôles de la nouvelle professionnelle de la santé ne sont pas déterminés par des disciplines distinctes mais plutôt par le contexte de la pratique. La profession infirmière disparaîtra en tant que profession ou discipline, et le terme *soins infirmiers* ne décrira qu'un ensemble de tâches.

Le troisième modèle, élaboré pour le cadre de l'entreprise, puise des éléments des notions de coopération et de concurrence, afin de créer une nouvelle entité. Le modèle de « Coocurrence » (Brandenburger et Nalebuff, 1996), lorsqu'il est appliqué au système de santé, définit les relations professionnelles comme étant à la fois complémentaires et concurrentielles. Selon ce modèle, toutes les professions sont égales, et chacune d'elles apporte une contribution unique et précieuse. Toutefois, chaque profession, dans ses fonctions, ses compétences et ses rôles, recoupe d'autres professions, ce qui engendre des tensions et un climat de concurrence.

Le modèle de Compétition-Substitution et celui de Diffusion sont tous deux des modèles qui négligent de reconnaître l'unicité de la profession infirmière. Le premier attribue peu de valeur, sinon aucune, à la profession, au-delà de sa contribution d'ordre purement médical. Le deuxième préconise l'embrouillage des rôles et des fonctions pour faire en sorte que toute profession puisse exécuter les fonctions d'une autre. Le danger inhérent à ce modèle réside dans le fait que la profession infirmière pourrait perdre la maîtrise de sa direction et de son développement, et éventuellement cesser d'exister en tant que telle.

Le modèle de Coocurrence représente la meilleure solution qui permettrait d'assurer la survie de la profession infirmière. Si la profession choisit ce modèle, nous pourrions conserver notre identité tout en offrant un complément aux différentes fonctions exercées par d'autres professions de la santé. La concurrence issue du recoupement des fonc-

tions pourrait s'avérer avantageuse, puisqu'elle tend à générer l'excellence. En fait, la théorie de l'évolution nous indique que la coexistence de la complémentarité et de la concurrence est un facteur critique dans le processus de survie de tout organisme. Les organismes qui « font leur place » grâce à leurs habiletés uniques sont ceux qui sont les plus aptes à survivre. Toutefois, ils doivent démontrer assez de souplesse pour s'adapter aux conditions changeantes. Ces deux éléments, soit l'unicité et la souplesse, caractérisent la profession.

Le défi que doit relever la profession infirmière, si elle adopte le modèle « Coocurrence », c'est de trouver le bon dosage de complémentarité et de concurrence, dans le cadre de son travail avec des populations variées, selon des conditions et des contextes différents. Si la profession peut démontrer, par le biais de la recherche, qu'elle peut offrir un service de qualité à un coût raisonnable, le rôle qu'elle jouera dans le nouveau système de santé sera, sans aucun doute, un rôle des plus importants.

Laurie N. Gottlieb
Rédactrice en chef

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Le point : *La promotion de la santé*

ÉDITORIAL INVITÉ

Promotion de la santé : Pour un élargissement de notre perspective

Denise Paul

Depuis fort longtemps, la profession infirmière se réclame d'être orientée vers la promotion de la santé. Ce qui semble une évidence au sein de la profession est pourtant presque ignoré dans le mouvement multidisciplinaire de la promotion de la santé (Gottlieb, 1992, Meleis, 1990). En réponse à notre invitation de prendre en charge la section discours de ce numéro axé sur la promotion de la santé, le sociologue Michel O'Neill nous invite à réfléchir sur certaines causes de ce paradoxe, dont notamment la faible participation des infirmières aux grands débats de société, traitant des questions de santé, de même que la vision individualiste sous-jacente aux pratiques des infirmières dans le domaine de la promotion de la santé. Cette vision se traduit par la relative absence, dans la pratique infirmière, d'une perspective plus politique et environnementale, telle qu'endossée par les penseurs d'origine pluridisciplinaire qui définissent les orientations actuelles en promotion de la santé.

L'article *The social determinants of practice? A critical analysis of the discourse of health promotion*, de Purkis, dans le présent numéro, illustre cette préoccupation qui existe au sein de la profession, soit celle d'un élargissement de notre perspective de l'intervention en promotion de la santé, de façon à tenir compte, dans l'analyse critique de nos pratiques, de l'influence de certaines conditions sociales, lors des interactions infirmières-clients. En cela, l'auteur affronte un défi majeur, celui d'ouvrir des pistes de réflexion visant à combler le fossé entre le discours

théorique et son application complexe dans des situations concrètes de pratique en promotion de la santé.

Suite à certaines constatations émergeant de l'analyse des retombées d'un programme de recherche, l'article de Brunt, Lindsey et Hopkinson fait ressortir la possibilité de biais ethnocentriques dans nos approches en promotion de la santé. Ces auteurs présentent une vision critique de l'application généralisée d'un concept central au domaine de la promotion de la santé, soit celui de l'*empowerment*, en identifiant les contradictions entre les valeurs de la communauté Huttérite et les valeurs à la base du processus d'*empowerment*. Ce point de vue à la fois fort pertinent et original est de nature à stimuler la réflexion face à un concept qui, jusqu'à maintenant, avait suscité très peu de controverse parmi les professionnels théoriciens, chercheurs ou praticiens travaillant en promotion de la santé.

Dans un tout autre ordre d'idées, Angela Gillis nous présente une démarche classique et rigoureuse ayant conduit à l'élaboration et à la validation d'un questionnaire portant sur les habitudes de vie liées à la santé des adolescents. Elle comble ainsi un vide créé par l'absence d'un tel instrument adapté à cette population spécifique qui, en raison de ses caractéristiques particulières (âge, facteurs de risque...) constitue une cible de choix pour les programmes de promotion et de protection de la santé.

Comme on pourra le constater à la lecture de ces articles, la discipline des sciences infirmières contribue, de manière unique, à l'évolution du champ des connaissances multidisciplinaires en promotion de la santé. À cause de leur rôle important dans la pratique, les infirmières occupent une position de choix qui permet d'influencer le mouvement de promotion de la santé, le menant dans une direction qui conduit du discours à une application concrète dans cette même pratique. À cet égard, je vous invite à présenter ce numéro tant aux praticiennes infirmières qu'aux collègues d'autres disciplines oeuvrant en promotion de la santé.

Je tiens à remercier Laurie Gottlieb de m'avoir donné l'occasion d'agir à titre de rédactrice invitée pour ce numéro. Je suis également reconnaissante pour l'importante contribution des auteurs qui ont soumis des articles de fort calibre et à la fine pointe des connaissances dans le domaine. Les critiques nuancées et articulées de ces articles m'ont fait goûter à la fertilité du dialogue dont le but est de raffiner l'expression de la pensée. Tout ce processus a été grandement facilité par la présence de Jill Martis qui me semble être l'incarnation de la compétence et du respect.

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Focus: *Health Promotion*

GUEST EDITORIAL

Health Promotion: Enlarging Our Scope of Vision

Denise Paul

For years, nursing has claimed to focus on health promotion. What may seem obvious from within the profession, however, is being all but ignored by the wider, multidisciplinary health promotion movement (Gottlieb, 1992; Meleis, 1990). In his Discourse, "Health Promotion: Issues for the year 2000," sociologist Michel O'Neill invites us to reflect on some of the causes of this paradox. He sees these causes as the lack of involvement by nurses in the broad social debates around health issues, and the underlying individualistic view of nursing intervention in health promotion. This view is evidenced by the relative absence, in nursing practice, of political and environmental perspectives endorsed by multidisciplinary thinkers in health promotion discourse.

The article by Mary Ellen Purkis, entitled "The 'social determinants' of practice? A critical analysis of the discourse of health promotion," underscores the imperative in nursing to broaden our perspective on intervention in health promotion. A broadened perspective could take into account the influence of specific social conditions on nurse-client interactions and integrate these notions into a critical analysis of our practices. At this level, the author takes up the significant challenge of bridging the gulf between discourse and application within the practice of health promotion via various avenues of reflection.

Brunt, Lindsey, and Hopkinson raise the possibility, based on observations emerging from the impact analysis of a research program, of ethnocentric bias in our approaches to health promotion. They present a critical view of the generalized application of a concept that is

central to the field of health promotion – that of empowerment. By way of illustration, they identify the contradictions between the values of the Hutterite community and the values that underlie the empowerment process. This timely and original analysis is sure to stimulate further reflection on a concept that has remained largely unchallenged by theoreticians, researchers, and practitioners in health promotion.

In quite another vein, Angela Gillis presents us with classic and rigorous research that resulted in the design and validation of a questionnaire to measure health lifestyle in adolescents. This questionnaire fulfils the need for an instrument adapted for youth populations, who, because of such distinguishing characteristics as age and risk factors, constitute a target for health promotion and protection programs.

These articles make it apparent that nursing as a discipline has a unique contribution to make in the development of multidisciplinary knowledge within health promotion. Nurses can use their influential position as practitioners to encourage the health promotion movement to translate discourse into application. By the same token, I would urge you to share this issue with fellow nursing practitioners, as well as with colleagues from other disciplines involved in health promotion.

I am grateful to Laurie Gottlieb for giving me the opportunity to guest edit this issue. I am greatly indebted to our authors for contributing high-calibre articles containing cutting-edge information on health promotion. The subtle and articulate analyses of the review team allowed me to engage in the dialogue necessary to have the authors hone their expression of the concepts presented in the articles. Last but not least, my job was greatly facilitated by Jill Martis, who assisted me throughout the process and who remains, in my mind, the epitome of competence and sensitivity.

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Health Promotion in the Hutterite Community and the Ethnocentricity of Empowerment

**J. Howard Brunt, Elizabeth Lindsey,
and Jennifer Hopkinson**

L'optique transformatrice et émancipatrice du pédagogue révolutionnaire Paulo Freire ainsi qu'une théorie sociale critique ont influencé le concept d'appropriation, l'une des pierres angulaires de la promotion de la santé. Le processus d'appropriation est conçu comme une libération de l'oppression, de l'impuissance et de l'ignorance; les notions essentielles qui le caractérisent sont le militantisme de base et le rejet du statu quo. L'article examine de façon critique les difficultés auxquelles sont confrontés les praticiens et les chercheurs promoteurs de la santé qui essaient d'oeuvrer de manière émancipatrice avec un groupe de culture différente, à savoir les hutterites. La vision qu'ont du monde les hutterites, leurs valeurs qui comprennent la primauté de la communauté, le respect des prises de décisions hiérarchiques et une adhésion totale au code traditionnel de conduite, aux valeurs et aux croyances, fournissent l'occasion de critiquer l'ethnocentrisme du processus d'appropriation.

Empowerment, one of the cornerstones of health promotion, has been influenced by the transformative and emancipatory perspectives of the revolutionary educator Paulo Freire and critical social theory. The empowerment process is conceived as one of liberation from oppression, powerlessness, and ignorance, and at its core are notions of grassroots activism and rejection of the status quo. This paper critically examines the challenges faced by health-promotion practitioners and researchers who seek to work in an empowering way with a culturally distinct group, the Hutterites. The Hutterian world-view, which values (a) communalism, (b) respect for hierarchical decision-making, and (c) strict adherence to a traditional code of conduct, values, and beliefs, provides an opportunity to critique the ethnocentricity of the empowerment process.

If the end of the millennium health-care reform rhetoric is to be believed, in the 21st century the principles and practices of health promotion will take on greater significance in nursing practice, education, and research. Similarly, as Canada and many other first world nations become more culturally heterogeneous, through economic globalization and changing patterns of immigration, principles of transcultural health care will become increasingly important.

The authors are all associated with the University of Victoria's School of Nursing. Dr. Howard Brunt is a Professor of Nursing and the Coordinator of the Nursing Research Unit, Dr. Elizabeth Lindsey is an Associate Professor of Nursing, and Jennifer Hopkinson is the Research Coordinator for the Nursing Research Unit.

Culturally diverse nursing care requires a variety of approaches that respect a diversity of values, beliefs, norms, and practices (Leininger, 1985). There is little argument among nurses and other health-care professionals that health promotion should be conducted in a culturally sensitive way; in practice, however, such an approach poses a plethora of challenges. These challenges stem, in part, from a radical paradigm shift in health promotion, from the traditional "expert" biomedical perspective to one that embraces the concept of empowerment and the primacy of individuals, families, and communities in setting the health agenda. For nurses in the field of health promotion, the combination of cultural diversity – with its array of health-related expectations, beliefs, and practices – and this transformation of professional roles presents additional challenges.

The purpose of this article is to illustrate how one of the core principles of health promotion, empowerment, can be problematic when applied to a specific Canadian ethnic group – the Hutterian Brethren. Our examination points out the ethnocentricity of empowerment and it challenges nurses to ask whether they are practising in a way that respects cultural differences.

Background

Origins of the Problematic

Almost a decade ago, one of us (Brunt) began a program of research based on the epidemiology of cardiovascular disease (CVD) in the Hutterite community. While the initial interest in this area was investigator driven, the research questions strongly resonated with a widespread concern in the Hutterite community about a perceived high risk for CVD. The epidemiologic studies did indeed reveal a prevalence of CVD risk factors, including hypertension, hyperlipidemia, and obesity (Brunt & Love, 1992a; Brunt, Reeder, Stephenson, Love, & Chen, 1994), influenced by the Hutterian high-fat, high-salt diet and sedentary lifestyle. A series of related studies with the Hutterites established the critical role of genetics in their development of hypertension, hyperlipidemias, and coronary-prone obesity patterns (Hegele, Brunt, & Connelly, 1994, 1995, in press). Evaluations have helped document our work with the community and provide evidence that our use of a relatively low-impact screening and educational approach has increased the interest of Hutterites in adopting a more "heart healthy" lifestyle (Brunt & Love, 1992b; Brunt & Shields, 1996).

Once the results of these studies were shared with the Hutterites, the obvious question "What can be done?" emerged from the community. It became apparent during discussions with community leaders that they supported the development of a heart-health program. It also became apparent that the investigators, before proceeding further, had to develop an understanding of the cultural meaning of health and health promotion for the Hutterites. Thus a series of multidisciplinary studies was designed to provide information about possible approaches to developing heart-health programming that would be relevant for Hutterian culture.

An ethnographic investigation into Hutterite concepts of health was followed by a review of the theological underpinnings of the themes that had emerged, including literature surveys and field studies: community meetings, key informant interviews, and participant observation. The field studies focused on how heart-health promotion should or could proceed, from the perspective of the Hutterite community. However, as our collaborative program of research and planning evolved we were plagued by a nagging sense that our approach was fundamentally flawed. Our greatest area of concern was the dilemma posed when the world-views of one culture are juxtaposed with those of another. We were concerned that in our efforts to help the Hutterian Brethren improve their heart health we would unwittingly undermine their values and beliefs.

We will outline the nature of our dilemma by examining the theoretical and conceptual meanings of "empowerment." We will illustrate that these meanings represent ethnocentricity and that they come into direct conflict with the Hutterian world-view.

Empowerment

Many researchers, scholars, and community activists concede that a central tenet of health promotion is empowerment (Gibson, 1991; Labonte, 1994; Rissel, 1994; Robertson & Minkler, 1994; Rodwell, 1995). Etymological investigation reveals that empowerment is derived from *power*, which comes from the Latin *potere* or *potent*, to be able to choose or to be powerful (Rodwell). Empowerment is perhaps better understood by its absence: powerlessness, helplessness, hopelessness, subordination, oppression, dependency (Hegar & Hunzeker, 1988; Kieffer, 1984; Rappaport, 1984; Wallerstein & Bernstein, 1988). Because of the issues of power and oppression, empowerment has its roots in community psychology (Rappaport, 1987), feminist theory (Gutierrez, 1990), and social activism (Alinsky, 1972).

Although there is considerable debate about the definition of empowerment, there is agreement that it is both a process and an outcome (Bernstein et al., 1994; Gibson, 1991; Labonte, 1994). Labonte stresses the importance of differentiating between individual and collective empowerment in the development of an empowerment holosphere. This holosphere takes into account personal care, group development, community organization, coalition advocacy, and political action. Furthermore, according to Labonte, one cannot empower another, but one can participate in a process of which empowerment is the outcome. The process can be described as the *how* of empowerment, the outcome as the *what*. Gibson's definition captures the process and outcome of both individual and collective empowerment: "a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (p. 359). Central to these outcomes is a grassroots, bottom-up, emancipatory process rooted in a revolutionary paradigm, rather than an evolutionary one.

The process (the *how*) of empowerment is best described in the literature on community organizing (Minkler, 1990), community development (Labonte, 1994), and health education (Wallerstein & Bernstein, 1988). In these disciplines the thesis is that empowerment is a participatory process of critical consciousness-raising that, through grassroots organizing, promotes emancipation/transformation from oppression and the status quo. The empowerment movement has been greatly influenced by the work of the emancipatory educator Paulo Freire (1973), the critical theorist Jürgen Habermas (1972), and the political activist Saul Alinsky (1972) – through his contention that conflict is a necessary component of critical reflection and social change. Freire's central premise is that education is never neutral, but has a context. Education can be used to either socialize or challenge the status quo. Emancipatory education is the process of critical consciousness-raising through examination of the social structures that lead to oppression and that strengthen the status quo. Freire proposes a dialogical approach to helping people move beyond powerlessness and gain control of their lives: everyone in the educative encounter participates as an equal, as a co-learner, in the creation of social knowledge. The emphasis is on collective knowledge, as members of the group share experiences and come to an understanding of the social forces that influence people's lives.

Freire's methodology for emancipatory education comprises three stages. The first, listening to the experiences of the community, includes

story-telling and the exchange of experiences, issues, and problems. The second stage includes problem-posing dialogue: issues are raised and questions are posed as part of a process of consciousness-raising. The third stage involves envisioning action that leads to positive change; as action is taken, the people reflect on it, and the cycle of emancipatory education continues (praxis). These stages may occur slowly, with change evolving over extended periods of time. Wallerstein and Bernstein (1988) have adapted Freire's emancipatory educative model to elucidate the empowerment process of health education leading to effective change.

Thus the process (the *how*) of empowerment involves members of the community as equal partners and co-learners. Together they explore the issues at hand, engaging in grassroots dialogue, which leads to critical consciousness-raising and awareness, which, in turn, leads to envisioning action and positive change. Thus the *what* (or the outcome) of empowerment is a result of the process of conscientization (Freire, 1973), by enhancing the ability of the community to effect relevant change. Again, central to this understanding of empowerment in community-focused health promotion is openness to a bottom-up approach that questions the hegemony and the hierarchical structures that engender the determinants of health.

Characteristics of the Hutterite Community

The Hutterites constitute the largest single rural ethnic group in Canada. Approximately 30,000 Hutterites reside in some 300 colonies in North America, most of which are located in the Canadian prairie provinces and bordering American states (Evans, 1985). The Hutterites are subdivided into three groups (*leute*): the Dariusleut, Lehrerleut, and Schmiedeleut. Our research has been limited to the Dariusleut and Lehrerleut groups, the only two *leute* resident in Alberta. While the lifestyles and religious practices are virtually identical among the three *leute*, each is endogamous (featuring little or no intermarriage) and has a unique genetic lineage (Hostetler, 1985). The Hutterian Brethren are theologically related to both the Mennonites and the Amish, and they share many Christian beliefs with these two sects, most notably pacifism, adult baptism (anabaptism), and a strict biblical interpretation of human conduct.

Perhaps the three most distinguishing features of Hutterite life are an agrarian communal lifestyle, a simple, uniform dress code, and a dictum that all things are held in common. This translates into extended family units of between 60 and 150 people per farm colony, each

member sharing both the work and the bounty of the farm. Personal and family property are minimal, and most goods and services are fairly divided among colony members. The social order and individual lives are strictly governed by a series of principles that have changed little over the Hutterites' 500-year history. The elders of the colony – all baptized males – are charged with the responsibility of ensuring that the Hutterian vision of a proper spiritual and secular life is upheld. There is well ordered and prescribed hierarchy in the colony, the minister and the farm manager having the greatest responsibility. Those in positions of authority are not seen as "powerful"; rather, they are considered the "servants" of the colony, and thus as carrying the greatest burden.

Unlike the Amish and the Old Order Mennonites, the Hutterites employ up-to-date farming technology and have proven themselves to be highly successful in the competitive world of agribusiness. When it comes to the formal health-care system, they make use of the available allopathic and "alternative" services and their access is limited only by their relative geographic isolation.

Empowerment and the Hutterian World-View

The Hutterite world-view and religious beliefs are inculcated in early childhood, and deviations from the norm are corrected by parents, elders, and other baptized colony members. This is not to say that expressions of individual preference do not exist; however, in terms of beliefs, daily routines, work assignments, dress, and diet, there is a high degree of homogeneity, both within and among colonies. The purpose of social control and a rigid structure is maintenance of the status quo and the spiritual health of the colony. "Status quo," in the Hutterite context, means adherence to values and beliefs, and the term is not used here in a pejorative way.

Based on our work with the Hutterites, we have identified a number of aspects of their lives that, taken together, challenge the utility for the Hutterite community of the notion of empowerment in health promotion. These aspects relate to the Hutterites' hierarchical social organization, which is based on the tenets of communalism and maintenance of spiritual health.

The structure of the Hutterite colony is based on the system developed in the 1500s for the original *Bruderhofes* (Hutterite colonies). All decisions that affect colony life, both sacred and secular, are ultimately the responsibility of the elders. The elders comprise the ministers

(typically two), the farm manager, and several other men in positions of authority. The work of the colony is conducted along gender lines, the men assuming responsibility for farming and business activities, the women for communal child-rearing, housekeeping, and cooking. While each colony is autonomous, a conference of ministers is held at least once a year to deal with issues of common concern.

Changes in colony life usually begin with the introduction of a new idea or technique by a few members in a single colony. As other colonies or individuals begin to adopt the change it will come to the attention of the elders and be raised for discussion at meetings. Eventually, the innovation will be sanctioned or forbidden, depending on its perceived effect on the spiritual health of the colony. A recent example was conveyed to us while we were conducting our fieldwork. One colony found that two-way radios facilitated communication among the various work groups and the managers. This change was reviewed by a council of ministers and, ultimately, banned as too worldly.

The shunning of worldly temptations is a central practice. For a Hutterite, life is a constant struggle against the forces of evil and temptation: between the spirit, the infinite and perfect universe of Heaven, and the flesh, the impermanent and imperfect universe of life (Stephenson, 1991). This world-view is manifested throughout colony life in matters of dress, language, diet, and exercise, as well as in the isolation of colonies from "worldly" towns. Efforts to introduce change related to heart health must take into consideration the way in which Hutterite culture deals with decision-making and control. While individuals and colonies may adopt "heart healthy" changes, at some point these changes require a more general sanction at the level of the council of ministers.

There are prohibitions against a number of secular practices such as smoking, watching television, listening to radio, and engaging in many forms of recreational exercise. While children are permitted to play games and sports such as baseball and volleyball, once Hutterites become baptized adults they are expected to refrain from any exercise that might take them away from work or that could interfere with their spiritual life (e.g., taking part in "childish" activities for reasons of vanity or competitiveness). Each Hutterite is expected to struggle against worldliness and to exercise judgement when confronted with temptation. Choices must be made within the context of communal life, and, for the most part, "correct" and prescribed choices are expected to be made.

Central to an understanding of the Hutterite world-view is the following passage from Acts 2:44: "And all that believed were together, and had all things common; and they sold their possessions and goods and distributed them to all, as any had need." Communalism has persisted, despite periods of forced relocation and persecution, for 500 years. Key to the success of Hutterian communalism is a shared belief in the ideal of *gelassenheit* – to live a life based on selflessness, "giving-up-ness," and sharing. Stephenson (1991, p. 26) describes the experience of *gelassenheit* as a bit of heaven on earth marked by calmness, resigned composure, and deliberate patience.

The commitment to communalism is carefully monitored and controlled by the ministers and elders, and it is upheld by all baptized adults – who serve as guardians of the spiritual and secular welfare of the colony. Thus any change, if it is to have the approval of the elders, must support *gelassenheit*. *Gelassenheit* demands that attention be paid to the process, as well as the goal, of change. For example, a request for different foods for some members of a colony could be seen as running counter to the principles of "all things common" and thus destructive to the spiritual health of the community.

Not surprisingly, the Hutterian concept of health is largely understood in spiritual terms and is closely aligned with the concept of *gelassenheit*. Good physical, mental, and emotional health are considered gifts from God. Ill health is not considered a punishment, but, rather, a burden that one must bear, partly as a test of faith as expressed in Romans 5:3–5: "We rejoice in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope." Thus Hutterites do not consider it appropriate to pray for good health; instead, they pray for the wisdom to know how to either live a healthy life or bear their suffering without complaint. Hutterian beliefs about death and disability do not provide the negative motivating factors that are often used in health education. Next to baptism, death is considered the most important moment in a Hutterite's life, as it marks entry into eternal life in Heaven. It is a key event in the social life of a colony. Thus death per se is an unlikely stimulus for risk modification. However, the sudden disability of a member in the prime of life has a largely negative impact on the colony, requiring replacement of the affected individual in the workforce and, in some cases, provision of care. Health promotion and education strategies can be designed for the Hutterite world-view; however, empowerment strategies may not be appropriate for a Hutterite community.

Methods of fostering community participation have been greatly influenced by the value placed on empowerment as both a process and an outcome in health promotion. We have therefore been challenged by the prospect of working with a culture in which an emancipatory, grass-roots approach runs counter to community norms, expectations, and desires. For example, the approach of holding forums open to all members of a community is consistent with the process of empowerment found in the literature. However, the results of forums for all colony members to discuss their vision for improved heart health yielded unexpected results. Our first discovery was that having men and women participate in the same meeting runs counter to colony norms. Also, one or two male elders or senior women (usually the head cook or the wife of the minister or colony manager) did most of the talking. This deference to hierarchy rendered the grassroots approach, which is ideally predicated on widespread community participation, largely ineffective.

During individual interviews, colony members had many ideas about how health promotion could proceed. However, these ideas largely fell into two categories: (1) the need to work with elders to convince them that changes (i.e., to diet) could take place, and, (2) individuals could make changes as long as they did not interfere with normal colony life. For example, some members owned exercise equipment such as treadmills and stationary bicycles; this was generally tolerated as long as they used it on their own time and did not make an issue of it. Other respondents were concerned that if a large number of people had exercise equipment it could become an issue for the elders to deal with. Such ownership could ultimately be forbidden, if it is seen as a threat to communal integrity and *gelassenheit*.

For a Hutterite, questioning authority and choosing to be different are antithetical to the pursuit of *gelassenheit*. Individual choice is important, but only if it coincides with community expectations. While the philosophical underpinnings of empowerment are based on emancipation, questioning authority, and making individual choices, *gelassenheit* is predicated on surrendering to the wishes of the community as interpreted by the elders. There is an intrinsic conservatism built into colony decision-making that is rooted in both pragmatism and Hutterian spirituality. Researchers and health-promotion professionals interested in working with this population must take into account the hierarchical and communal aspects of Hutterite life.

By using a bottom-up and emancipatory process consistent with the notion of empowerment, we may unwittingly undermine Hutterite

cultural and spiritual values, and thus cause more harm than good (e.g., "The operation was a success but the patient died"). Ultimately, it is the Hutterites who must set the standard for judging the success of health promotion in their communities. It is entirely possible that over the next decade the risk of CVD in the Hutterite community will decrease. However, this improvement will be successful only to the extent that it meets the test of *gelassenheit*.

Based on the results of our research, we have modified our approach with the colonies in accordance with their vision of health and health promotion (*gelassenheit*). We must work with the elders rather than adhere to a grassroots approach, and we must respect the Hutterian system of evolutionary change that attends to communal needs rather than the individual needs of its members.

Conclusion

The construct of health promotion has undergone a radical transformation over the past decades. Health professionals' understanding of the processes (*how*) and outcomes (*what*) of health promotion is continually evolving. The prevailing definition of health promotion, "a process of enabling people to increase control over and to improve their health... a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health" (World Health Organization, 1984), has been closely aligned with the concept of empowerment. However, empowerment – to the extent that its process is framed in terms of undermining hegemony through collective, grassroots action – is not necessarily appropriate for all cultures. The Hutterites, with their emphasis on respect for hierarchy, for the common good, offer us an opportunity to question the ethnocentricity of empowerment with regard to health promotion.

Has the concept of empowerment become the prevailing hegemony? We must not let our understanding of the principles and practices of health promotion go unquestioned. We must critically examine our practices, to fully realize our potential as caring researchers and practitioners. In our program with the Hutterites, we have now adopted an approach that philosophically aligns more with the concept of *gelassenheit* than that of empowerment. This shift represents our attempt to respect the values, beliefs, and practices of the Hutterian Brethren.

Through our experiences with the Hutterites and through self-critique, we have expanded our understanding and practice of health promotion to include a cultural dimension that was lacking in our work.

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Acknowledgements

The researchers acknowledge the support of Health Canada (National Health Research and Development Program), the Social Sciences and Humanities Research Council, and the Centre for Studies in Religion and Society, University of Victoria.

Date accepted: March 1997

The Adolescent Lifestyle Questionnaire: Development and Psychometric Testing

Angela J. Gillis

L'article décrit l'élaboration et la mise à l'épreuve psychométrique d'un instrument destiné à mesurer un style de vie sain chez l'adolescent. On a remis le questionnaire à 292 adolescents vivant à l'est du Canada. On a testé ce questionnaire en utilisant une analyse d'items, une analyse factorielle et des mesures de fiabilité. L'analyse factorielle a isolé sept dimensions pour un style de vie sain chez l'adolescent; cela représentait 56 % de variance dans la mesure des 43 énoncés. Les sept facteurs comprenaient : la conscience de son identité, la nutrition, l'activité physique, la sécurité, la conscience de sa santé, le soutien social et la gestion du stress. Le coefficient Alpha de fidélité sur l'échelle totale est de 0,91; les coefficients Alpha pour ce qui a trait aux sous-échelles varient entre 0,60 et 0,88. Cet instrument justifie d'autres tests et une élaboration plus poussée auprès d'autres populations adolescentes. Il permettra aux chercheurs d'étudier les types de style de vie chez les adolescents et d'évaluer l'effet des interventions sur les changements dans le style de vie de cette population.

This paper describes the development and psychometric testing of an instrument designed to measure healthy lifestyle in adolescents. The Adolescent Lifestyle Questionnaire (ALQ) was tested on 292 adolescents residing in eastern Canada using item analysis, factor analysis, and reliability measures. Factor analysis isolated seven dimensions to a healthy lifestyle in adolescents, which accounted for 56.0% of the variance in the 43-item measure. The seven factors were: identity awareness, nutrition, physical participation, safety, health awareness, social support, and stress management. The alpha reliability coefficient for the total scale is .91; alpha coefficients for the subscales range from .60 to .88. The instrument warrants further testing and development with different adolescent populations. The instrument will enable researchers to investigate lifestyle patterns in adolescents and to assess the impact of interventions on lifestyle change in this population.

In recent years the concept of healthy lifestyle has emerged as a major variable in the nursing and health-related literature. One needs only to examine the major causes of morbidity and mortality to know that lifestyle factors are major contributors to many of today's leading health problems. This is particularly true for adolescents. If one examines the major sources of mortality during adolescence one will see that injuries, homicide, and suicide account for 75% of all deaths (Rice, 1996). Major sources of morbidity are injury and disability associated with the use of motor and recreational vehicles, sexual activity, and substance use or

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abuse (Millstein, Petersen, & Nightingale, 1993). If we limit our view of health to the absence of physical illness, adolescents might score quite high; however, if we expand the parameters of the health construct to include social, psychological, and environmental health, many deficits emerge for this group. The results of a number of studies of Canadian youth provide ample evidence that all is not well with our adolescent population (Canadian Institute of Child Health, 1989, 1994). It is alarming that adolescents are the only age group in North America for which morbidity and mortality patterns have shown no improvement in the past 30 years (Rice; Vernon, 1991). Youth are exhibiting health behaviours that place them at risk for motor accidents, suicide, unplanned pregnancies, sexually transmitted diseases, mental disorders, school dropout, and long-term health problems. These trends indicate a need for an emphasis on promoting healthy lifestyles in adolescents.

Health promotion, which attempts to both enhance wellness and diminish threats to health, is perhaps one of the most important areas for nursing to explore with adolescents (Pender, 1996; Tanner, 1991). It is important that we foster informed and positive health-related choices in youth, because attitudes and health behaviours developed in adolescence, related to diet, exercise, safety habits, and sexual practices, may have health consequences throughout adulthood and greatly influence present and future morbidity and mortality patterns (Gillis, 1994; Rosen, Xiangdong, & Blum, 1990). Nurses are in a position to encourage health promotion by assessing lifestyle patterns among youth. This is particularly true for school health nurses, community health nurses, and nurse practitioners in primary health-care settings. The assessment data could be used in helping adolescents make healthy lifestyle choices, in planning behaviour-modification interventions, and in using inner resources to enhance health status. It is in the area of aggregate-focused nursing among well populations such as adolescents that the full potential of nursing can best be demonstrated in ways consistent with contemporary health-promotion culture (Pender, Barkauskas, Hayman, Rice, & Anderson, 1992). Nursing's understanding of adolescent development and transition, and the integration of such knowledge into appropriate interventions, is central to the unique contribution of nursing in promoting health among youth.

The development of valid and reliable measures of lifestyle is an essential step in investigating and developing interventions to promote healthy lifestyles among adolescents. Few attempts have been made to develop instruments for measuring healthy lifestyle in adolescents, which is surprising given the importance of this concept for both health

promotion and disease prevention. Existing instruments tend to be excessively long, focus on health risk or hazards, lack testing for validity and reliability, or report weak psychometric properties. The purpose of this paper is to describe the development and psychometric evaluation of the Adolescent Lifestyle Questionnaire (ALQ), an instrument designed to measure the extent to which adolescents have healthy lifestyles. Healthy lifestyle is defined as a multidimensional pattern of discretionary activities and perceptions that are a part of an adolescent's daily approach to living and that significantly affect health status in a positive manner (Pender, 1996; Wiley & Comacho, 1980). The subjective reasons or motives for the behaviour are not included in the definition.

Literature Review

Several investigators have measured health behaviours and lifestyle patterns in adult populations (Ardell, 1986; Duffy, 1993; Harris & Guten, 1979; Kulbok, 1985; Pender, 1996; Walker, Sechrist, & Pender, 1987; Wingard, Berkman, & Brand, 1982), but few have studied lifestyle patterns in adolescents from the perspective of the adolescents themselves. In the adult studies, support was provided to varying extents for the lifestyle components of social relationships, good health habits related to sleep, nutrition, physical activity, and avoidance of harmful substances. According to Tanner (1991), lifestyle assessment ought to include target areas of health promotion, including nutrition, physical activity, stress management, and family planning, as well as areas of health protection, including prevention of smoking, alcohol and chemical substance abuse, exposure to environmental hazards and injury, and the spread of sexually transmitted diseases. Others have supported the contribution of these components to a healthy lifestyle (Mechanic & Cleary, 1980; Palank, 1991).

Healthy lifestyle as a construct is often divided into two categories: health-promoting and health-protecting behaviours or risk-reducing behaviours. Suggesting that health-protecting and health-promoting behaviours ought to be viewed as theoretically different, complementary components of a healthy lifestyle, Pender (1996) developed the Health Promotion Model as a paradigm for explaining health-promoting behaviour. Pender defines health-protecting behaviour as actions directed toward decreasing the likelihood of illness, health-promoting behaviour as a positive approach to living and a means of increasing well-being and self-actualization. Others define healthy lifestyle as all those behaviours over which one exercises control, including actions

that influence health risks (Ardell, 1986). Taylor (1986) defines health behaviour simply as behaviour designed to enhance or maintain health. This definition is consistent with a broad view of health and includes lifestyle choices with both proximal and distal effects on physical, mental, and social well-being. Included in this concept of health behaviour are such lifestyle choices as safe sex, proper diet, and regular exercise. It is this author's opinion that classification of a lifestyle behaviour as health promoting or health protecting depends on the state of the art of health-related knowledge and research, and is certainly subject to lack of consensus and changes in status.

For Pender (1996), the major distinction between health-promoting and health-protecting behaviour is underlying motivation. The use of motivation to distinguish between the two is a strong argument for considering both behaviours when designing an instrument to measure healthy lifestyle in adolescents. Adolescence is a period of vitality and sense of well-being when the threat of illness is almost non-existent. The motivation for adolescent health behaviour (both health-promoting and health-protecting) is the pleasure derived from them and their effects on physical attractiveness (Gillis, 1993; Mechanic & Cleary, 1980). This contrasts with the motivation for adult health behaviour; among this group the possibility of illness is real and the motivations for the two health behaviours are likely to coexist. Nursing should avoid a fragmented view of healthy lifestyle and embrace the integration of health-promoting and health-protecting behaviours in designing instruments to measure adolescent lifestyles. An integrated approach increases the scope of interventions and is a step in the direction of a holistic approach to health promotion among adolescents.

Research on adolescent lifestyle has been less extensive than that on adult lifestyle, as it is hindered by a lack of empirical measurement instruments. The several instruments that have been developed to measure adolescent health behaviours have been limited to behaviours and risk factors related to stress (Anderson, 1985), religiosity (Carson, Winkelstein, Soeken, & Brunins, 1986), and symptoms of illness (Woods, 1981), and they have focused on risk reduction rather than healthy lifestyle patterns (Donovan, Jessor, & Costa, 1991).

The literature includes reports of only three instruments for examining healthy lifestyle behaviours. Among these is the Health-Promoting Lifestyle Profile II (HPLP-II) (Walker, Sechrist, & Pender, 1987, 1995), which is a revision of the HPLP-I. It is a 52-item, six-sub-scale instrument designed to measure the following major components

of a health-promoting lifestyle: health responsibility, physical activity, nutrition, interpersonal relations, spiritual growth, and stress management. Mean scores can be derived for each subscale and for the total instrument as a measure of overall health-promoting lifestyle. Pender (1996) notes that the instrument was developed for and tested on adult populations and identifies a need for additional lifestyle assessment tools, appropriate for children and adolescents.

Muhlenkamp and Brown (1983) developed the Personal Lifestyle Questionnaire (PLQ) to measure the extent to which individuals engage in health-promoting activities. The 24-item instrument, which was developed and tested on a range of adult populations (Muhlenkamp & Sayles, 1986), has six subscales: exercise, substance use, nutrition, relaxation, safety, and general health promotion. The total score represents the sum of the subscales. Test-retest reliability analysis resulted in coefficients of .78 and .88 over four-week and three-week periods, respectively. Cronbach's alpha coefficients were calculated on two samples of adults and reported as .74 and .76. A factor analysis of the responses on 380 subjects confirmed the six subscales. While the PLQ appears to be a useful short instrument for measuring health practices in adults, some items are not appropriate for adolescents, and other, overt, adolescent behaviours are not included in the questionnaire. The investigators note that at this time they have more confidence in the total score than in the subscale scores.

The Lifestyle Questionnaire (LQ) (VanAntwerp & Spaniola, 1991) is a 30-item instrument, the content of which is based on childhood mortality and morbidity statistics and items from the University of Wisconsin-Stevens Point Foundation (1978) Lifestyle Assessment Questionnaire for adults. The LQ focuses on health promotion (11 items), injury prevention (14 items), and feelings (five items). It uses a four-category Likert-type response format. The LQ was intended to be used with school-aged children as a screening tool rather than a research instrument. It has not been used with adolescents and the authors caution that its reliability and validity have not been established (VanAntwerp, 1995).

In summary, there is a dearth of reliable and valid instruments to measure healthy lifestyle behaviour in adolescents. No lifestyle instrument has been developed for and tested with an adolescent population. A research instrument developed with adolescents as primary informants will prove invaluable in assessing lifestyle patterns and identifying health education and counselling needs for this age group.

Adolescent Lifestyle Questionnaire (ALQ)

Qualities

Qualities sought in developing the ALQ were that it (1) not be excessively long or complex, which would limit its usefulness in adolescents, (2) use a consistent response mode, to enhance simplicity and reduce potential for subject fatigue, (3) contain age-appropriate items reflective of the activities of adolescents aged 12–19, (4) focus on healthy lifestyle practices, both health-promoting and health-protecting, and (5) be based on a health-enhancement rather than a risk-reduction model.

Development and Testing

Items for the ALQ were developed from a qualitative research study using the inductive approach with a convenience sample of 30 adolescents attending a large junior/senior high school in eastern Canada. There were two broad interview questions: (1) "What does it mean to you as a teen to live a healthy lifestyle?" and (2) "What kinds of activities do teens your age do on a regular basis to keep healthy?" Interviews were audiotaped and transcribed verbatim to preserve the richness and completeness of the data. The face-to-face interviews were conducted at the school and ranged from 35 to 55 minutes. The adolescents seemed pleased to participate in the study, referring other teens to be interviewed, volunteering information, and expanding freely on the research questions.

Among the large number of statements made by the teens, factors were selected that a priori were congruent with the definition of lifestyle, including health-promoting and health-protecting activities, and were sufficiently general to apply to large numbers of adolescents. Although the conceptual definition of healthy lifestyle that guided the development of this study was not shared with the adolescents, their responses to the open-ended interview questions supported the definition. Items were developed for the ALQ guided by analysis of the qualitative interviews and a review of the adolescent and adult health-promotion literature cited above. The pilot form of the ALQ comprised 66 items in seven categories: physical participation, nutrition, safety, social support, health awareness, stress management, and identity awareness. The seven categories were considered dimensions of a healthy lifestyle in adolescents. The instrument used a five-point response format – 1 "never"; 2 "rarely"; 3 "sometimes"; 4 "often"; and 5 "almost always" – to obtain an ordinal measure of frequency of reported behaviours.

The pilot form of the instrument was tested for reliability, item clarity, and response variance. Stability and internal consistency were tested on a sample of 73 school-based adolescents over a three-week period. Results yielded a reliability coefficient of .76 for the total instrument, indicating stability. Cronbach's alpha was calculated as a measure of internal consistency. The alpha coefficient was .93 for the total instrument, indicating high internal consistency. The subscale coefficients ranged from .60 to .87. Examination of frequency distributions indicated that the full range of responses was used for the majority of items. Some items were deleted and others were edited because of student confusion over meaning and terminology. The instrument as a whole appeared to have sufficient reliability to warrant further development.

Content validity of the pilot instrument was assessed by eight nurses who had engaged in advanced study of adolescent health promotion. Four nurses were asked to rate each item using four criteria: readability, cultural relevance, age appropriateness of behaviours, and conceptual congruence of the items with the concept of healthy lifestyle. An instrument developed by the researcher employing a five-point Likert format was used for this purpose. The remaining four nurses were asked to place the items in the seven categories according to definitions provided by the researcher. Items required 75% or greater agreement – that is, three of the four had to place the items in the correct category. Items were added, deleted, and modified based on the input received from the panel of nurse experts and the adolescents in the pilot study. The resulting instrument contained 56 items.

Empirical Validation

Empirical validation of the ALQ followed the process suggested by Nunnally (1978). This included item analysis of the pool of 56 items to determine which contributed most to the internal consistency of the measure, factor analysis to define the factorial composition of the refined item pool, and reliability measures to estimate the internal consistency of the final version of the ALQ.

Sample. A stratified sampling frame was used to select a convenience sample of ($n = 350$) Grade 7 through Grade 12 students, on the basis of school and grade attended, from a large rural school district in eastern Canada. The ALQ was completed by 300 adolescents, for an overall response rate of 85%. Of the 300 questionnaires, eight (3%) were discarded because of missing data or evidence that the respondents had not taken the questionnaire seriously. Subject ages ranged from 12 to 19 years with a mean age of 15.6. Of the 292 subjects, 149 (51%) were

females and 143 (49%) were males. The majority, 275 (94.8%), were Caucasian, although other ethnic groups were represented. The sample was primarily middle class. Educational level of fathers ranged from Grade 8 to completion of post-graduate study, with the median at "some college or specialized training." Annual family income ranged from less than \$10,000 to greater than \$70,000, with the median and mode income in the \$30,000–39,000 category. Twenty-two adolescents did not respond to this item. A comparison of demographic characteristics for the school population indicated that this sample reflected the school population.

Procedure. After permission had been received from the appropriate school authorities, the study was explained to students in each grade during class. A cover letter and parent/adolescent consent form were distributed to interested students. They were asked to return the signed forms to the school office within the following 48 hours. Assurance of confidentiality of information was provided and students were told that completing or not completing the questionnaire would in no way affect their grades. The ALQ was distributed the following week, during a regular class period, to those who had consented to participate and returned the signed consent forms.

Data Analysis. The SPSS statistical package subprograms Reliability and Factor were used for item analysis, factor analysis, and reliability estimates. The frequency and distribution of all relevant variables was determined and descriptive statistics provided a profile of the sample characteristics.

Results

Item Analysis

Corrected item-total correlations were calculated both for the total scale and for each of the seven subscales in a series of analyses. At each step, items that depressed the reliability as measured by coefficient alpha of either the total scale or the subscale to which they were assigned were deleted from the item pool for that scale and the item-total correlations of the revised set were calculated. This approach was considered more useful than eliminating only those items that did not meet the criterion for observed item-total correlations. Five items were eliminated from the 56-item instrument on the basis of evaluation of the results of the item analysis. Of the remaining 51 items, 47 had item-total correlations of .25 or higher and four had correlations of between .21 and .24, levels considered acceptable by Nunnally (1978). The inter-item correlation

matrix was examined to identify items that were possibly redundant and therefore could be eliminated to shorten the instrument. No correlations above .70 were found; hence the 51 items were retained.

Factor Analysis

The remaining 51 items were subjected to factor analysis. The factor analysis was exploratory in nature, as this was the initial assessment of the construct validity of the ALQ; however, it was guided by the hypothesis that seven subscales did exist. A stepwise solution employing the principal axis factoring (PAF) extraction method followed by oblique rotation was used. PAF extraction is a form of common factor analysis which assumes that measurement error involves both a random component and a systematic component that is not unique to individual items. Consequently only common factor variance is factor analyzed in this method; error and unique variance are excluded (Ferketich & Muller, 1990; Polit, 1996). PAF was used to determine the number of independent hypothetical factors underlying the observed data. It is the most popular of the common factor extraction methods and has been used by other researchers to identify lifestyle patterns (Walker et al., 1987). Oblique rotation, which does not impose the restriction that factors be orthogonal, was used because the subscales were conceptualized as interrelated dimensions of a healthy lifestyle.

Applying Kaiser's criterion of using all unrotated factors that have eigenvalues greater than 1.00 for subsequent rotation, 10 factors were extracted and rotated. This solution explained 64.5% of the variance in the measure. Child (1970) and Walker et al. (1987) note that using Kaiser's criterion when more than 50 variables are involved may lead to the extraction of too many factors. The criterion of interpretability proved more useful in creating a meaningful factor solution. Three of the 10 factors extracted had two items and lacked sufficient reliability to serve as a subscale. Intuitively it appeared the 10 factors could be combined into seven conceptually valid subscales as hypothesized.

To define more efficiently the composition of the seven factors, eight items that did not load strongly (a loading of .45 or greater on the factor) or cleanly on a single factor were eliminated and the remaining 43 items were entered into a factor analysis with PAF extraction and oblique rotation. All items loaded on expected factors at a level of .45 or higher; two of the 43 items also loaded at the same or a slightly higher level on a factor other than the one expected. The loadings and the factor structure of the items with abbreviated item content are shown in Table 1. The seven-factor solution explained 56% of the variance of

the revised 43-item ALQ and appeared to be the most logically consistent alternative. The eigenvalues and the percentage of variance explained by each factor are presented in Table 2.

Table 1 *Factor Loadings and Factor Structure for the Adolescent Lifestyle Questionnaire (N=292)*

Items	Factors ¹						
	1	2	3	4	5	6	7
Like who I am	.65						
Know my strengths and weaknesses	.45						
Happy and content	.72						
Look forward to the future	.64						
Set goals for myself	.55						
Examine my beliefs	.46						
My life has purpose	.75						
Try to do my best	.59						
Confident about my beliefs	.71						
Read food labels		.46					
Follow a healthy diet		.46					
Limit foods high in fat		.81					
Limit foods high in salt		.76					
Limit foods high in sugar		.84					
Choose healthy snacks		.47					
Limit junk food		.60					
Choose foods without additives		.47					
Run, take long walks, dance, or swim 3–4 times weekly			.71				
Participate in sports at school			.69				
Exercise vigorously for 30 min. x 3 weekly			.68				
Play sports 3 times a week			.81				
Wear seatbelts in automobile				.47			
Avoid doing drugs				.60			
Refuse a drive if the driver is drinking				.47			
Avoid tobacco products				.60			
Avoid alcohol				.66			
Make informed choices re sexual relationships				.45			
Use protection if sexually active				.47			

(continued on next page)

Table 1 *Factor Loadings and Factor Structure
(cont'd) for the Adolescent Lifestyle Questionnaire (N=292)*

Items	Factors ¹						
	1	2	3	4	5	6	7
Report unusual body changes					.58		
Talk to teacher or nurse							
re ways to improve my health					.67		
Read magazines about health topics					.67		
Discuss health issues with others					.67		
Discuss problems with people close to me							.65
Enjoy spending time with my friends							.72
Express my concerns to others							.68
Have good friendships with girls and guys my age							.61
If I had a problem, I would have people to turn to							.65
Can express my feelings to others							.60
If I needed help, I could turn to family, friends, teachers, coaches						.65	.63
Exercise to control my stress							.45
Use helpful strategies to deal with stress							.64
Use spiritual beliefs to deal with stress							.49
Talk to my friends about my stress						.57	.57

¹ Factors are: 1, Identity Awareness; 2, Nutrition; 3, Physical Participation; 4, Safety; 5, Health Awareness; 6, Social Support; 7, Stress Management

Table 2 *Variance Explained by Seven Factors on the
Adolescent Lifestyle Questionnaire (N = 292)*

Factors	Eigenvalue	Percent of Variance	Cumulative Percentage
1. Identity Awareness	8.24	21.1	21.1
2. Nutrition	4.38	11.2	32.4
3. Physical Participation	2.71	6.9	39.3
4. Safety	2.02	5.2	44.5
5. Health Awareness	1.66	4.2	48.7
6. Social Support	1.56	4.0	52.7
7. Stress Management	1.30	3.3	56.0

Factor 1, Identity Awareness, is the strongest factor, explaining the greatest percentage of variance of the ALQ measure. Identity is the central developmental task of adolescence (Rice, 1996) and is formed as the adolescent chooses values, beliefs, and goals in life. The task of identity formation is one of making choices by exploring alternatives and committing to roles. Identity awareness in adolescence is an ongoing process of self-reflection and change as one moves through life. Its significance as a factor in the ALQ appears congruent with the definition of healthy lifestyle used in developing the instrument. The process of identity awareness involves re-evaluating, searching, and considering alternatives, including discretionary lifestyle activities that affect health status. Factor 1 includes items concerned with reflecting and choosing values, beliefs, goals, and commitments.

Factor 2, Nutrition, includes items related to food choices and eating patterns. The development of proper eating habits during adolescence is extremely important to health status. Factor 3, Physical Participation, incorporates items related to active participation in sports, exercise, or physical activity of some kind. Factor 4, Safety, is concerned with items that relate to protecting health status by making informed choices such as wearing seatbelts, practising safe sex, and avoiding alcohol and harmful substances. This factor is increasingly important as a lifestyle factor: motor accidents represent a pernicious threat to youth, and adolescents are the only age group in North America that have shown no improvement in health status over the past 30 years, because of accident morbidity.

Factor 5, Health Awareness, includes a limited set of items related to increasing awareness of health status and promoting and maintaining health through education and consultation. Factor 6, Social Support, incorporates items concerned with affirming friendships and functional sources of support. Factor 7, Stress Management, includes items related to specific strategies for dealing with stress. The cross-loading of one item from Factor 7 on Factor 6 (I talk to my friends about my stress) and one item from Factor 6 on Factor 7 (If I needed help I would have someone to turn to such as family, friends, coaches, teachers) is understandable given that social support from family and friends may overlap with the idea of stress management, as adolescents often manage stress by turning to these familiar sources of support.

The correlations among the seven factors on the measure are presented in Table 3. The low to moderate magnitude of the correlations suggests that each factor represents a distinct dimension related to other dimensions of healthy lifestyle, without being redundant.

Table 3 *Correlations among Factors on the Adolescent Lifestyle Questionnaire (N = 292)*

Factors	Factors ¹					
	2	3	4	5	6	7
1. Identity Awareness	.24	.04	.30	.39	.57	.44
2. Nutrition		.27	.22	.35	.16	.43
3. Physical Participation			.02	.21	.09	.23
4. Safety				.07	.12	.21
5. Health Awareness					.45	.43
6. Social Support						.32

¹ Factor 7 = Stress Management

Table 4 *Internal Consistency of the Adolescent Lifestyle Questionnaire and Its Subscales (N = 292)*

Subscales	Number of Items	Alpha
Identity Awareness	9	.84
Nutrition	8	.88
Physical Participation	4	.82
Safety	7	.74
Health Awareness	4	.71
Social Support	7	.80
Stress Management	4	.60
Adolescent Lifestyle Questionnaire Total	43	.91

Reliability

The final structure of the 43-item ALQ is shown in Table 4. Internal consistencies of the total instrument and of items within each subscale were examined using Cronbach's alpha. The total instrument was found to have high internal consistency, with an alpha coefficient of .91. Alpha coefficients for the seven subscales ranged from .60 to .88. According to Nunnally (1978) and Jackson (1995), modest reliability (.70 or higher) is

acceptable in the early stages of research. Although the alpha coefficient of .60 for the stress-management subscale was lower than desired, the mean inter-item correlation for this four-item scale was .27, which is considered acceptable for a scale of this length. A Spearman-Brown correction to eight items produced an alpha coefficient of .77 for the stress-management subscale. Test-retest reliability was again examined by administering the ALQ to 65 school-based adolescents at an interval of two weeks. The adolescents ranged in age from 12 to 19 with a mean age of 15.9 years. Pearson r was .88 for the total score and ranged from .80 to .88 for the subscales.

Discussion

The goal of this research was to develop an instrument to measure healthy lifestyle practices in adolescents. The ALQ appears to be a potentially useful instrument. It was hypothesized from the qualitative interview data that a healthy lifestyle profile from the perspective of adolescents would comprise seven distinct but related components. Factor analysis and reliability supported the seven components. Reliability of the ALQ, shown by a test-retest reliability coefficient after two weeks and by internal consistencies within the subscales of the instrument, is high, indicating that the instrument is stable and that the items in each dimension are measuring related but distinct concepts. The cross-loadings of items on factors 6 and 7 indicate that stress management and social support are not as independent as other combinations of dimensions. Further study of these two dimensions in an adolescent population will help explicate their relationship.

Several of the seven ALQ dimensions are similar to three of the five high-level wellness dimensions described by Ardell (1986). Ardell's dimensions of nutritional awareness, physical fitness, and stress management are similar to three dimensions identified in the current study. Similarly, this study provides support for three additional dimensions identified by Walker et al. (1987) in the HPLP-I. The dimension of self-actualization in the latter study is similar but not parallel to identity awareness in the ALQ. The interpersonal-support factor is comparable to the social-support dimension in the current investigation, and the health-awareness factor is consistent with the health-responsibility dimension described by Walker et al. (1987).

Support was provided for a seventh dimension – safety – not described by Ardell (1986) nor Walker et al. (1987). The emergence of safety as a factor is consistent with the conceptualization of healthy lifestyle as a broader construct than that of a health-promoting lifestyle.

A healthy lifestyle, as defined for this investigation, includes both health-promoting and health-protecting behaviours. It appears that safety as a component of healthy lifestyle is an important dimension to promote among adolescents. Accidents and injuries affect young people disproportionately and are the primary cause of death for those aged 1–37 (Rice, 1996). It is well documented that major sources of adolescent morbidity include injury and disability associated with motor accidents and the consequences of substance abuse and sexual activity (Millstein et al., 1993). Hence it appears there is both intuitive and empirical support for including safety as a component of healthy lifestyle in adolescents.

Previous studies addressing the issue of interrelationships of health behaviours show that such behaviours are intercorrelated, yet no consensus has emerged regarding the number and nature of underlying dimensions (Aaro, Laberg, & Wold, 1995; Hansell & Mechanic, 1990; Mechanic, 1979). Some researchers suggest that behaviours related to avoidance of undesirable health practices (health protection) form a set of behaviours different from those related to health-enhancing behaviours (health promotion) and therefore should not be included in a measure of healthy lifestyles (Walker et al., 1987). This author suggests that personal beliefs shape our definition of the healthy adolescent and generate great divergence of opinion about what is considered a healthy lifestyle. For example, ideological differences influence whether one considers sexual abstinence part of a healthy lifestyle or whether one focuses on having teens use protection to reduce the consequences of sexual activity. Personal beliefs play a role in less controversial areas as well. These multiple overlapping perspectives of healthy lifestyle make consensus difficult to reach and point to the need for consultation with youths when lifestyle measures are being developed, to ensure that the adolescent perspective is indeed represented. Inclusion of this perspective through qualitative interviews in the initial stages of development of the ALQ is clearly a strength of the instrument.

The ALQ appears to have sufficient validity and reliability for assessing healthy lifestyle in an adolescent population. It may also be useful for exploring determinants of a healthy lifestyle in adolescents and measuring lifestyle change as a result of interventions. This use is particularly relevant given the importance of health-promotion interventions among adolescents in introducing, reinforcing, and establishing healthy lifestyle patterns, and well as in prevention. The components of a healthy adolescent lifestyle must be understood and appropriately measured if relevant research and practice interventions

are to be advanced. The ALQ has the potential to make a contribution in this area.

Development and further testing of the ALQ appear warranted. Studies with adolescents representing various socio-economic levels and cultural backgrounds, and with adolescents in urban settings, would further evaluate construct validity and establish norms. Also, street youth who are school dropouts and who will likely have different perspectives and lifestyles must be studied if we are to fully understand a healthy lifestyle in this age group. The convergent and discriminant validity of the ALQ should be tested by using it with appropriate instruments with established reliability and validity in the same study. Additional items should be developed to strengthen the stress-management subscale.

In conclusion, the ALQ, a new instrument, was designed to measure the concept of healthy lifestyle in adolescents. We have observed high levels of validity and reliability with healthy, rural, middle-class adolescents. This instrument now requires further testing with a broader range of adolescent populations.

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Acknowledgements

Financial assistance for this research was provided by the St. Francis Xavier University Council on Research and the Canadian Nurses Foundation. The author acknowledges the assistance of Winston Jackson, Ph.D., with data analysis and statistical consultation.

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Date accepted: March 1997

The "Social Determinants" of Practice? A Critical Analysis of the Discourse of Health Promotion

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L'évolution de la pratique de la promotion de la santé s'est toujours concentrée sur ce que les clients apportent comme bagage contextuel lors de leurs rencontres avec des professionnels. Ce changement dans la relation professionnel/client marque une orientation très différente des modèles de pratique qui reposaient sur le fait que le professionnel, en tant qu'expert, donnait au client des indications de santé. La documentation qui essaie d'éclairer ces relations plus contemporaines avec les clients a tendance à ne pas tenir compte de ce que le praticien apporte à la rencontre promouvant la santé et, de façon significative, des conditions sociales sous-tendant la rencontre. L'article se base sur des résultats obtenus au cours d'une étude ethnographique sur la pratique dans une clinique publique et analyse de façon critique la promotion de la santé afin de mettre au défi les chercheurs, les enseignants et les praticiens pour ce qui concerne les possibilités de promouvoir la santé dans les milieux où l'on pratique actuellement.

Developments in the practice of health promotion have centred on considerations of what clients bring to their encounters with professionals. This change in the provider-client relationship marks a significant departure from practice models that relied on the professional giving the client expert health instructions. The literature that seeks to illuminate these more contemporary relationships with clients tends to ignore what practitioners bring to the health promotion encounter and, significantly, the social conditions that underlie the encounter. This paper, drawing on research gathered during an ethnographic study of practice in a public health clinic, critically analyzes health promotion with a view to challenging researchers, educators, and practitioners concerning the health-promoting possibilities in existing practice settings.

Introduction

The concept of "social determinants of health" has entered everyday discussion about health-care delivery. It signals a progressive, contemporary approach to health promotion, one concerned with acquiring knowledge beyond people's habits and their genetic endowment, to those features of their daily lives that affect their ability to make healthy choices. For instance, a low monthly income might force a person to live in a dangerous neighbourhood, thus limiting his or her opportunities

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to socialize in the evening, or even to engage in some light exercise as a way of relaxing after a hard day's work.

The concept of "social determinants of health" means that practitioners, in assessing and approaching the task of health promotion, must include factors that influence a person's relative position in society. Education, social status, income, employment and working conditions, social support networks, housing and living conditions, individual abilities and skills, natural environment, and use of health services all come under the rubric of social determinants (Office of the Provincial Health Officer, 1995). These refined definitions have undoubtedly sensitized health practitioners and educators to the need for broader considerations when approaching groups identified by these "determinants" as socially challenged. Once it is known that hidden factors may influence a client's ability to engage in health-promoting activity, the provider-client relationship is altered. In a setting where social determinants form the basis of practice, practitioners can no longer exclude such assessments from their work with clients. In other words, health professionals must now consider the client's social circumstances. We have moved away from a behavioural setting, wherein everyone is treated equally, to one in which differences can be treated differently.

Treating differences differently is not as new as the language of a transformed nursing practice might suggest. Even where "the social" was deliberately stripped away, in earlier forms of research on health and health promotion, a close reading of these texts reveals that differences were attended to (Field, 1989; Purkis, 1994a). What is new is that documents emanating from government offices and provincial nursing associations provide us with the technology to define *what counts* as a social determinant of health, and therefore what is to be *accounted* for in doing health-promotion work. These documents instruct us to focus our eyes and ears on particular aspects of a client's story – that is, to adjust our helping gaze. But have we, as practitioners and educators, considered the possibility that we make such adjustments to our gaze from a particular position? Before we came to the realization that health-promoting practice must consider our clients' social circumstances, we were practising from a particular position – one defined by our understanding of health and of nursing as formed by our nursing education and subsequent practice in a variety of settings. To what extent have we tried to analyze and alter our positions, in light of our work with clients? In fact, are there social determinants of health-promoting practice that might condition – limit as well as foster certain

kinds of practice – any practice that emerges from a disciplined position of nursing?

I shall be drawing on Foucault's (1973, 1979) notion of "disciplinary practices" in analyzing observational and interview data collected for an ethnographic study of health promotion in nursing (Purkis, 1993). Foucault's work is particularly important in this area, because he is concerned with the exercise of power accomplished through practices of surveillance. The aim of analysis is to excavate "regimes of truth" corresponding to surveillance practices that favour certain types of knowledge over others.

I shall then explore the effects of "disciplinary practices" by offering examples. The significance of this theoretical position warrants explication. If we think about the arrangement of people and knowledge in a health-promoting encounter, we will see that within a practice setting few if any of the "social determinants" of health are visible to the practitioner. The conditions of a client's everyday life of poverty, for example, are not obvious to a nurse when the client enters a health clinic. Rather, a plan of action is said to be "mutually" agreed after the client presents his or her circumstances and the nurse makes a disciplined, professional reading of these. Knowledge about the client's social circumstances and the extent to which these affect the plan of action represents a complex mediation of symbolic meanings. Understandings of work "worth" doing are influenced as much by the nurse's working conditions, especially the lines of accountability in her place of employment, and its position in society, as they are by the client's circumstances (Allen, 1995; Armstrong, 1983; Campbell & Jackson, 1992; Cheek & Rudge, 1994; Hiraki, 1992; Latimer, 1995; May, 1992a, 1992b). It is at this juncture of the client's presentation of the "everyday" and the nurse's reading of the "everyday" that disciplined practices organize action. Nurses are informed, through their education and day-to-day health-promoting work, about strategies considered by others (typically co-workers and managers) as "good." These strategies in a practice setting are disciplined, in the sense intended by Foucault, in that one's actions are constrained but also facilitated by collective understandings of what counts as "good" practice.

This paper has two aims: to question the present reliance on conceptual supports for improved health promotion – that is, the production of assessment forms framed by a new language of health promotion to broaden the nurse's helping gaze; and to suggest that a more productive way of exploring the effectiveness of health promotion might be to critically examine complex, sophisticated, everyday

encounters between health professionals and their clients. An example of such an examination will be presented, based on an ethnographic study of nursing practice.

Methodology: Social Practice and Ethnography

The study was undertaken in a public health clinic, a typical location for engaging in health promotion in Canada. Fieldwork was carried out over a four-month period in 1990 during which interactions between nurses and parents attending the clinic with their children were observed and audiotaped. Immediately following each interaction the researcher conducted an audiotaped interview with the nurse in the clinic. Arrangements were made for the researcher to carry out a follow-up interview with each of the parents who had been observed in interaction with a clinic nurse. This interview, which was also audiotaped, was held in the parent's home approximately one week after the clinic visit.

Analysis of these texts was undertaken using a critical hermeneutic approach (Allen, 1995). Patterns in discourse were excavated by noting the effects of particular language strategies employed by both parents and nurses in the construction of a clinic visit. Movement by either party towards the position of the other was taken as an effect of disciplinary practice (Fernandez, 1986; Lyotard, 1984). These methods have been explicated in greater detail elsewhere (Purkis, 1994a, 1994b). Examples of such an analytic position are offered below.

Setting Up for Health-Promoting Practice

An important feature of health promotion (as distinct from prevention, health education, and patient teaching) is a questioning of the role of "expert knowledge." Increasingly, clients, patients, and communities are seen as repositories of resources (Gillis, 1994; Hall, Stevens, & Meleis, 1994; MacLeod & Stewart, 1994; Morse, Miles, Clark, & Doberneck, 1994; Pender, 1987). The literature informs us it is essential for the health-care practitioner to uncover these resources before engaging in health promotion. Clients are understood to be experts on themselves. Before simply telling patients how to take care of themselves, health professionals must seek at least some information from their clients, and this information must have the appearance of information about the "self" – it must say something about the person or community that distinguishes this client from others. Once the practitioner has formed an idea of the resources brought to the encounter by the client, those

resources must find their way into the "intervention," in order for it to be counted as a health-promotion intervention. In this way, the practitioner can enter an account of practice intended to be understood as "client driven."

The foregoing is a brief and, some might say, stylized rendering of the health-promoting relationship; it is the "style" of such an encounter that the ethnographic study analyzes. It seeks to draw out features of health-promotion encounters that nurses struggled to describe in their interviews. Most nurses were quick to characterize their practice as health-promoting, but when asked to elaborate they had considerable difficulty describing their everyday work. For example, when asked how her work in the clinic differed from her previous work, one nurse (Kay) provided the following account:

This is quite, quite different. The only similarity really is that you're going into people's homes. Well, with VON nursing and home-care nursing you were doing a fair amount of teaching as well, but this public health-type nursing is... I can hardly even compare the two [laughs], especially when I think what I did originally. And yet... having progressed this far with it and learned new ideas, new theories about what we're doing and the types of nursing theories that we should all become familiar with [laughs]...to see how it applies not just to an individual but to a community, and that's what's making it kind of interesting right now, is thinking of the client as a community, be it a school community or a community of a district or a community of [sighs] a cultural group or something like that, so it's sort of taking nursing theory and applying it to a much broader perspective than just one single individual or the single individual's family. It's interesting to see how the different systems fit together and overlap.

Kay, an experienced public health nurse, came to her work in the clinic with a background in intensive care, outpost nursing, and finally home care. She sees her work in clients' homes as a continuation of her other "community" nursing positions, but her work in the clinic as "quite different." Kay presents her health-promoting work in the clinic as a "progression" of her earlier forms of work, which picks up on themes in the health-promotion literature yet interestingly contradicts claims in the literature that it emanates from a non-hierarchical ontology.

For Kay, practice within a health-promotion context also represents progress in her discipline. Her account suggests a helping gaze comparable to Foucault's medical gaze:

I wanted to find out how the medical gaze was institutionalised, how it was effectively inscribed in social space, how the new form of the

hospital was at once the effect and the support of a new type of gaze.
(Gordon, 1980, p. 146)

Foucault treats as intertwined the establishment of hospitals and the establishment of medical expertise starting in the 18th century in France. Hospitals were strategically designed to support and create medical knowledge. Kay's account reflects similar ideas. As a nurse, she has been trained in knowledge of the physical body. Now, to support her understanding of a broader sense of "health," she must look beyond the surface of the body of the client, to "the community." Kay inscribes a variety of forms of community: now, whole communities are to be treated as clients; schools might be understood as a community within the larger community; identifiable cultural groups, widely dispersed within the geographic community, might also be thought of as a community. Such configurations of community as a locus of practice stand in contrast to what might traditionally be thought of as fields of work: "just one single individual or the single individual's family."

The clinic nurses realized they were being asked to nurse differently. They referred to a shift in focus from individuals and groups to aspects of the physical community. Here is Diane's account:

All the public health stuff you get, it's always health promotion... preventing disease on a sort of major scale...not like on the one-to-one level, which I feel I'm stronger at...in a group situation...that's what I think health promotion is. You know, like teaching things about health to groups to prevent...illness and disabilities. That's what I've always felt health promotion is. And it sounds awfully cold and it doesn't fit into my nature at all. That's what makes me wonder if I'm in the right position. I know that I'm doing health promotion by just...even if I tell a mother in a clinic that she shouldn't be giving her two-month-old two percent because...the kidneys aren't fit for that kind of, you know...filtration problems they could have. So in that way I'm doing some health promotion, but it's not really the major stuff, I think, what all the literature's talking about. And like in the environment and the community where I think the real health promotion maybe should be happening...where you're getting other groups to do...where you're sort of mobilizing other people, I mean community people, not necessarily health people, just community types, to get going and doing different things for health. Whether it's everybody having their compost bin or whether it's sharing a garden or something like that, or getting better transportation for a community...that to me is what health promotion...how it is to me... Or maybe lobbying that clinic, or city hall...to have five or six free parking stalls just for mothers that come into clinic so they don't have to pay 25 cents an hour...that type of stuff, more global and universal than the one-to-one...

Diane is referring to the literature that on a daily basis instructs her (or "disciplines" her) to think about health promotion as something beyond the "one to one" she believes she is good at. Her knowledge of the body, her ability to map out the moral geography of the body (that is, what is "good" for the body and what is "bad"), is being displaced, in the literature, by the notion of working with "community types" to "get going and doing different things for health."

Diane's comments reflect the problematic character of health-promotion work. To her, it is indirect work: "you're sort of mobilizing other people." Rather than recognizing and acting on dangerous or difficult situations such as mothers having to walk through a busy commercial parking lot with small children because the clinic provides only staff parking, the nurses must somehow get the mothers themselves to recognize the problem and "mobilize" to eliminate it.

Nurses' understandings of such instruction or discipline cannot be treated as solely theoretical: the move towards a different form of practice is an *empirical* one. The problem nurses face is having to demonstrate to managers that their practice has changed. Language drawn from journals, newsletters, and organizational directives is one resource they can use. But attending to my claim that shifting sites of practice entails an empirical move, it must be recognized that the *context* of nursing practice offers many resources for nurses to accomplish a new form of practice. In the following sections I will set out some of these resources as I came to understand their influence on the work of nurses and as that work came to have effects on clients attending the clinic.

Institutionalized Forms of Surveillance

The above accounts of health-promoting practice demonstrate the ability of clinic nurses to discursively construct their work as health promotion work. Foucault's notion of discourse urges us to extend analysis beyond the nurses' verbal comments. For Foucault, discourse is more than merely the utterance of words; it is practice. The significance of this position is reflected in his argument that the emergence of hospitals in France in the late 1700s revealed "the effect and the support of a new type of gaze" (Gordon, 1980, p. 146): the new medical discourse, reflecting a new knowledge of the body and equipped with a disciplined and disciplining gaze, affected the hospitals empirically. Similarly, nursing practice in the clinic reflects a new knowledge of "health promotion." These discursive practices are equipped with a disciplined and disciplining gaze whose effects are discernible. It is important that such effects be demonstrated, because all too often health pro-

motion is treated as positive simply because clients are doing for themselves rather than being done to by "experts" (Anderson & Tomlinson, 1992; Brehaut, 1988; Duffy, 1988; Pender, 1990).

Some authors (Minkler, 1989; Morse, 1991; Wright & Levac, 1992) treat as problematic the talk of "expert skill" in the context of health promotion. This literature sees community-based health promotion as a *progressive* move for health-care practitioners. This is to suggest that a move out of buildings such as hospitals may be sufficient for practitioners to avoid the "problems" of hierarchy.

It is simplistic to think a structure could be so easily set aside. The structures enabling practice are so powerful that a nurse – without identifying herself as such or explaining what she is doing – could approach a mother, remove her child from her arms, undress the child, and proceed to rotate its hips. Where such actions are supported as "typical," there exist structures such as frames of meaning and versions of "expertise" that legitimize actions as appropriate. Rather than *clouding* the lens through which the nurse "sees" the client, structural properties such as those supporting hierarchical understandings of expertise (e.g., measurements to determine whether a baby is gaining weight or growing sufficiently, whether its hips are strong enough to bear its weight, or whether it is being adequately "cared" for by its parents) and legitimate modes for representing knowledge inherent to the realm of expertise serve to *focus* the lens through which clients are "seen" and thus "known." Knowledge is discursively constructed; it is socially constructed and clients participate in the construction and legitimation of this knowledge. Assessment activities such as those relied on by nurses in a setting such as a public health clinic make *knowing about clients* possible.

As nurses are increasingly encouraged to bring the community into their interactions with clients in order to engage in health promotion, traces of "the community" may be drawn in and transformed in the process; that is, nurses watch and listen for instances of "community" in their interactions with parents and use those "resources" in their instructions, thus *moving* the parent into the nurse's construction of community.

We will now explore the effects of health-promoting discourse on community members attending the public health clinic. The argument I will advance in the following section contrasts with instructions given to practitioners to assess the "social determinants of health," which I read as premised on an expectation that the organizational context of practice can be transcended. The position advanced through this analy-

sis is, rather, that any adjustments made by nurses to attend to the client's lifeworld (that which influences his or her opportunities for health) are made from the nurse's position *within* the hierarchical, discursive location of the clinic.

Rehearsing "Good" Parenting

When parents arrived at the clinic, they were greeted by one of the staff nurses. Once the child's weight and height were recorded, nurse, parent, and child entered a private office where the parent was encouraged to talk about the child. At the end of a series of observed encounters, nurses reported their perceptions of the quality of the encounters. Quality was often linked with the degree of ease with which the parent entered into conversation with the nurse.

Material resources were available to nurses and parents in the clinic, and these clearly influenced the organization of work. Kay refers to "nursing theories" in her account of her work as a community health nurse. The reader might read this as an attempt to identify nursing as a legitimate profession. However, it also serves as an organizing resource available to nurses in the not uncommon circumstances that parents claim to have "no concerns" about their children. In the absence of "concerns," nurses turn to an assessment form to facilitate talk about the child. It is from within such accounts of parental observations that nurses' work of promoting health derive.

Consider again the "stylized" description of health-promoting practice: there is surely a link between the apparent significance of getting parents to talk about their child and the production of "information" that can be used to individualize a health-promotion intervention. In significant spaces of the clinic, parents came to know "when to talk" and to a considerable extent "what to talk." Drawing on clinic resources (assessment forms, health-promotion discourse, nursing theories, measurements of children's bodies and souls), nurses provided parents with "cues" about what would transpire in the clinic.

The intricate relationship between being in a position to have a parent provide an account of her child's "development" and being in a position of having to provide such an account points to the importance of considering the conditions supporting a nurse as s/he approaches a health-promoting encounter. In the analysis reported here, interestingly, reports of "good parenting" contributed to organizing day-to-day work regimens involving nurse and client. Following are some close readings of an exchange between a nurse and a client: how might agency (in a

form consistent with the rhetoric of health promotion) be apprehended within such an encounter? Who is guiding whom?

Evidence of "Good" Parenting: Disciplined Accounts of "Change"

The following example, which is presented in two sections, might help us explore the health-promoting work of a clinic nurse. In the first section, the nurse, Fran, assesses "change." In addition to using weigh-scales and tape measures, Fran seeks the parent's verbal renderings of the child's development. Erica, mother of four-month-old Loraine, provides an account of Loraine's "developmental" changes since the previous visit:

Fran: O.K., and what sort of things do you notice her doing now, developmentally, that she wasn't...when you were in here at two months? [looks briefly at the nursing record on the desk in front of her, then back at Erica]

Erica: She's talking a lot...she's quite vocal sometimes...she's not too vocal today [laughs]. She seems to be grabbing things a little bit. She learned how to pinch real good! She's pinched me...and...I've given her some toys to play with, and she's really fascinated by those.

Fran: Is she pick...is it the toys that she's picking up, or more that she's watching?

Erica: She's got a thingamajiggy [points at the ceiling]...a mobile! And she really likes that, and I've given her a mirror to look in, so...the play school thing has a mobile on it, she loves that. She rolls it and she looks at herself and talks and... [laughs]

Fran: O.K. Is she rolling yet?

Erica: She's trying to. She's really trying to turn her back and her hips, but she can't quite get the leverage to push herself over.

Fran: O.K. Well, she probably will surprise you /

Erica: / she rolled over, actually.

Fran: Oh, really!

Erica: A month ago, like from a...from front to back, but she doesn't know how to do it back to front.

Fran: O.K.

Erica: But she only did it once for me. She hasn't done it since, so I think she maybe had a little spurt of energy that day or something! [laughs]

Fran provides Erica with a clear instruction at the outset. She seeks an account from Erica of what Loraine is doing now, "developmentally," that she was not doing at the previous clinic visit. Inherent in her instruction is that Erica, as the mother, should have noticed Loraine's development, marked it, and recorded it, and should be able to reproduce it verbally in this setting. Thus baby Loraine is marked as a "resource" for health-promotion work, and as such is drawn into the discourse of parental accounts at the clinic. A primary function of parenting (as it is understood and expressed by nurses in the clinic) is cued: as a mother, you ought to monitor your child's "development," *in particular ways*.

In the ensuing exchange, Erica provides information on several of Loraine's "abilities." She mentions Loraine's verbal abilities, her fine motor skills, and, with some prompting from the nurse, her gross motor skills. Fran's initial request represents a "disciplined instruction": it assumes knowledge about the ostensible relationship between "development" and "parenting." Fran's question swiftly positions all three parties to the exchange in relation to one another: Fran as the legitimate questioner, Erica as the legitimate responder to the question, and Loraine as the legitimate referent of the question. Fran disciplines Erica by positioning her in such a way that Erica must return a particular type of message – one constrained within (or defined by) a "developmental" discourse. Constrained by institutional boundaries, Erica's response defers other, alternative responses. Erica is disciplined against talk of objects (toys and mobiles) and her daughter's response to these (fascinations, things she "loves") in favour of talk of visible action (rolling and picking up toys). The discipline provides an important signal for Erica regarding "what to talk about" in the clinic encounter.

The "successful" elicitation of a response to Fran's request relies, then, on Erica's ability to lock into and generate an account resonant with a particular discursive form. Erica is assisted in producing such an account by Fran's occasional prompts: "is it the toys that she's picking up, or more that she's watching?" and "Is she rolling yet?" Fran's guidance disciplines Erica: her prompts tell Erica what sorts of "developmental" change Fran wants to hear about. Erica's ability to draw on the developmental discourse is thus guided and shaped.

Erica shows an ability to report on several topics organized around the category of "childhood development." Fran's verbal prompt, seeking particular information on the baby's ability to roll, extends Erica's demonstrated knowledge of topics within the category of devel-

opment. Fran's prompt "instructs" Erica by refining the category even further.

Childhood development is constructed within this meshing of parental demonstrations of accounts, which are, significantly, already disciplined. It is significant that Erica already knows her account must be organized around an assessment of her child's movements, verbal skills, and fine motor skills. Discipline, the effect of intricate forms of surveillance, operates well beyond the boundaries of the clinic. These have already influenced how Erica "sees" her child. Such self-discipline is another resource tapped into by nurses in the clinic.

Enlisting Parents' Self-Discipline

The interaction between mother and nurse continues. Information obtained earlier in the encounter is inserted by Fran several minutes later in the form of an "intervention." In this part of the encounter Fran formulates a specific instruction based on Erica's disciplined rendering of how Loraine has changed since the previous visit. Note how this part of the conversation reflects the "stylized" health-promotion encounter discussed earlier, in that Fran draws upon material offered by Erica in constructing her "intervention":

Fran: O.K. [looks at forms, then back at Erica]. And she's sleeping through the night still?

Erica: Oh, yeah /

Fran: / Good /

Erica: / no problem.

Fran: She seems to have a really nice disposition, doesn't she?

Erica: Yeah, so far! [laughs] So far.

Fran: O.K., and have you started to think about house-proofing your house?

Erica: Yeah, yeah. I've got everything up – up in the cupboards and stuff like that. I have to get some locks for the cupboards still.

Fran: Yeah, cause she's going to be mobile fairly soon, so that's why...just be aware with rolling, that even if they're not rolling they can grab onto the edge of something and pull them, you know. If she's on the couch by herself /

Erica: / yeah! /

Fran: / she could really grab on and then pull herself to the edge and then /

Erica: / Oh, yeah, that's true. She could get leverage that way. I never thought about that /

Fran: / yeah /

Erica: / She's got a playpen downstairs, so I'll put her in that.

Having discovered earlier that the child is not yet rolling but is able to grab clothing and furniture, Fran inserts that individualized message into her instruction to Erica (the child can pull herself to the edge of the couch). It is interesting that the real danger – of the child falling from the couch and injuring herself – never gets mentioned. It is as though it is more effective to leave the dangers open.

The encounter is "successful." Erica has been "mobilized" to act in the community to prevent injury to her daughter. This example could stand as an instance of health promotion as nurses in the clinic have come to define it. What remains unexamined within these locally defined "standards" of practice, however, is a critical exploration of how such effects have been achieved. Although the preventive step of placing Loraine in the playpen must be taken by Erica herself – in her home, in the community – traces of the clinic and Fran are surely an integral part of this health-promoting action. Yet the rhetoric of health promotion, including concerns with accounting for the "social determinants of health," seeks to displace this participation of the health-care provider. The ensuing blindness to how health effects are achieved is, in my view, highly problematic.

Health Promotion as Position and Positioning

The challenge arising out of an analysis of practice such as that generated here may be of interest to practitioners, educators, and researchers. The challenge arises primarily out of a critical analysis of those factors that condition the *approach* of nurses within health-promoting encounters and the *effects* of that approach on the nurses' clients. The "will to instruct" is strong when administrative structures drive practitioners to show productivity in terms of monitoring clients' adherence to such behavioural norms as quality parenting. In the preceding example, the nurse successfully relayed to the mother her professional interest in preventing injury. Is the relay of professional surveillance consistent with contemporary understandings of the objects of health promotion? Has the radical shift in the relationship between client and provider really been completed within the context of such an encounter? Or has it been subverted in response to egalitarian demands embedded in the health-promotion literature, only to resurface as a more traditional,

expert-driven model of practice? This model is all the more difficult to recognize as powerful because power is now exercised, just as Foucault claims, through parents' monitoring of both themselves and the "developing" selves of their children.

This ethnographic study offers opportunities for researchers and practitioners to confront grounded examples of how educational rhetoric about practising nursing are put into play within contextualized settings. Such examples of practice must be taken seriously. The nurses whose work was observed as part of the study were serious in their engagements with clients. They were practising in ways they understood to be sanctioned by their managers. But these sorts of understandings do not flow directly from managers to practitioners. Understandings are mediated by situated appreciation of the resources available. Research that seeks to strip away the context of practice because it introduces "bias" or "complexity" into the findings also seeks to remove the highly sophisticated knowledge of "the social" used effectively by nurses and their clients. A perspective that seeks to surface concerns about "social" factors influencing opportunities for taking up health-promoting messages cannot avoid the positioned and positioning effect of the health provider by suggesting that the client's situation is somehow separate from that of the practitioner. Those who imagine the power of the provider's position can be displaced by separating the social conditions of client-hood from those that achieve a space within which practitioners can operate may well be practising a form of "mobilization" on readers.

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Date accepted: March 1997

Discours

Promotion de la santé : Enjeux pour l'an 2000

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Quelques éléments de contexte

Les origines de la promotion de la santé

La promotion de la santé, même si elle remonte à la Grèce antique, provient, principalement de deux courants récents, reliés aux interventions professionnelles et gouvernementales en santé publique : un dominant, celui de l'éducation pour la santé, et un plus marginal, celui de l'intervention sur les politiques publiques (Green et Kreuter, 1991 ; Bunton et Macdonald, 1992 ; Badgley, 1994 ; O'Neill et Pederson, 1994).

L'éducation pour la santé s'est développée surtout après la seconde guerre mondiale, principalement sous l'influence de la psychologie sociale et des États-Unis. Elle vise à modifier, de manière volontaire, les comportements individuels ayant un effet sur la santé (Godin, 1991 ; Green et Kreuter, 1991). L'approche de l'intervention (principalement gouvernementale) sur les politiques publiques a été mise de l'avant par l'Organisation mondiale de la santé (OMS) et diverses instances canadiennes, à partir de la fin des années 70 (Kickbusch, 1986 ; 1989 ; 1994). Cette approche vise à créer des environnements physiques et socio-économiques qui facilitent l'adoption et le maintien d'habitudes individuelles favorables à la santé (Milio, 1986).

Le milieu des années 80, en particulier l'année 1986, a été le moment historique où ces deux courants, qui évoluaient en parallèle ou même en opposition, se sont fusionnés pour produire le champ de la promotion de la santé, tel qu'on le connaît aujourd'hui sur la scène internationale (O'Neill et Pederson, 1994).

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Vers une définition de la promotion de la santé

Les deux définitions de la promotion de la santé les plus largement utilisées à l'échelle de la planète sont, sans doute, celle de la Charte d'Ottawa pour la promotion de la santé : « un processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci » (Charte, 1986 :5), et celle de l'incontournable ouvrage de Green et Kreuter : « toute combinaison d'actions planifiées de type éducatif, politique, législatif ou organisationnel appuyant des habitudes de vie et des conditions de vie favorables à la santé d'individus, de groupes ou de collectivités (1991 : 432, traduction libre) ».

La juxtaposition de ces deux définitions permet d'énoncer un problème conceptuel majeur. En effet, on utilise encore aujourd'hui l'expression « promotion de la santé » pour désigner deux éléments fort distincts. Il s'agit d'une part d'une *idéologie*, qui n'est finalement rien d'autre que la philosophie traditionnelle de la santé publique désignée au fil des ans, au Canada, sous les appellations : hygiène publique, santé publique, santé communautaire et plus récemment santé des populations (Lalonde, 1974 ; Evans, Barer et Marmor, 1994). D'autre part, il s'agit d'abord et surtout un ensemble de *pratiques spécifiques* visant le changement planifié d'habitudes et de conditions de vie ayant un rapport avec la santé, à l'aide de stratégies d'interventions, telles l'éducation sanitaire, le marketing social, la communication persuasive, l'action politique, l'organisation communautaire et le développement organisationnel (O'Neill et Cardinal, 1994). Cesser d'utiliser le mot « promotion de la santé » pour désigner la dimension idéologique et ne le réserver que pour désigner les pratiques spécifiques mentionnées ici aiderait sans doute à clarifier le concept, mais cette proposition (O'Neill et Cardinal, 1994) ne fait pas encore totalement l'objet d'un consensus (Rootman et Goodstadt, 1996).

Les enjeux en promotion de la santé autour de l'an 2000

Au Canada comme ailleurs, cerner le contenu conceptuel de la promotion de la santé demeure donc l'enjeu majeur car cela a des effets directs sur son financement, son enseignement, sa pratique et la recherche faite à son propos. D'autres enjeux existent aussi.

Sur la scène internationale

Le plus important des autres enjeux, c'est sans doute la manière dont l'économie politique mondiale évolue. Les valeurs et l'idéologie

de la promotion de la santé sont nées à l'époque de l'État providence. Les changements dans l'économie politique mondiale, au cours des derniers vingt ans, ont toutefois entraîné, dans les anciens états providences des pays du Nord (Europe de l'Ouest, É.-U., Canada, Australie, Nouvelle-Zélande), la situation que nous connaissons aujourd'hui : démantèlement des services publics pour réduire les déficits gouvernementaux, chômage chronique, exportation des emplois vers l'étranger, etc. La promotion de la santé évolue ainsi dans un environnement international qui utilise à l'occasion son discours. Toutefois, cet environnement, de manière générale, favorise la mise en œuvre de politiques qui, loin de promouvoir la santé, ont comme conséquences d'exacerber les iniquités et d'augmenter les problèmes de santé et de bien-être plutôt que de les réduire (Hancock et Labonté, 1997).

L'OMS continue malgré tout de proposer aux gouvernements des pays qui en sont membres des orientations conformes à la Charte d'Ottawa. La Quatrième conférence internationale sur la promotion de la santé aura lieu en juillet 1997, à Djakarta, en Indonésie. Son titre, « De nouveaux joueurs pour une nouvelle époque », traduit bien les changements planétaires où nous sommes plongés et propose de les voir autant comme des opportunités que comme des contraintes (WHO, 1997). De son côté, le principal ONG à caractère mondial dans le domaine de la promotion de la santé, l'Union internationale pour la promotion de la santé et l'éducation pour la santé, a modifié ses programmes, son image et même son nom au cours des dernières années, témoignant lui aussi des bouleversements majeurs qui se produisent à l'échelle planétaire.

Sur la scène canadienne

Les grands enjeux internationaux se reflètent aussi au Canada. On peut, en effet, retenir les éléments qui suivent. Premièrement, le Canada continue, mais de manière différente, à jouer un rôle de leader international dans le domaine. Deuxièmement, l'important leadership du gouvernement fédéral est en voie de se transformer radicalement, sinon de disparaître, suite notamment à l'apparition du « nouveau » discours sur la santé des populations et aux coupures draconiennes qu'il impose. Troisièmement, il y a une grande variabilité dans la vitesse d'adoption et dans les stratégies d'utilisation du discours de la promotion de la santé, selon les provinces et territoires. Quatrièmement, cette utilisation se fait partout dans le contexte de réformes importantes apportées au

système de santé. Cinquièmement, aux acteurs plus habituels viennent se greffer de nouveaux acteurs importants : le secteur privé, les hôpitaux, les gouvernements municipaux et le Consortium canadien de recherche en promotion de la santé. Sixièmement, l'ambiguïté du discours de promotion de la santé fait qu'il peut être repris à la fois pour des objectifs politiques de gauche ou de droite, à des fins individualisantes ou collectivisantes, servant ainsi une pléiade d'agendas politiques. Septièmement, le champ de la promotion de la santé a de la difficulté à faire la preuve de son utilité dans des termes recevables (science positiviste, coûts-bénéfices, etc.) par les décideurs politiques actuels et est souvent perçu comme peu scientifique et trop idéologique (O'Neill, Rootman et Pederson, 1994 ; Rootman et Goodstadt, 1996 ; O'Neill, 1996 ; Hancock et Labonté, 1997).

Qu'advient-il des infirmières dans ce contexte ?

La place des infirmières dans le cadre de ces enjeux

Le paradoxe infirmier

Au Canada comme ailleurs, les infirmières sont au coeur de la *pratique* en promotion de la santé ; elles sont les principales dispensatrices de programmes et d'activités dans ce domaine, et la dimension éducative de leur rôle est fondamentale (Hagan et Proulx, 1996). Un premier élément du paradoxe infirmier en promotion de la santé concerne donc les interventions éducatives. Malgré l'importance qualitative et quantitative énorme de ces interventions, on est forcé de constater le peu de formation offerte aux infirmières, face à leurs pratiques éducatives. De plus, on note la relative faiblesse de la base scientifique sur laquelle elles s'appuient (Hagan, O'Neill et Dallaire, 1995), même si, dans ce domaine, la sophistication de la recherche s'est accrue rapidement au cours des trois ou quatre dernières années (Stewart, 1995 ; Bottroff, Johnson, Ratner et Hayduck, 1996).

Le second élément du paradoxe concerne la dimension *idéologique* de la promotion de la santé. Malgré leur importance centrale comme praticiennes, les infirmières ont été peu présentes dans l'évolution plus générale du champ (Gottlieb, 1992). De plus, malgré de notables exceptions (Milio, 1971 ; Dallaire, 1991 ; Flynn, 1996) et une lente évolution (Stewart, 1995), les infirmières ont eu tendance à ne pas consacrer beaucoup d'attention aux dimensions plus politiques et environnementales du travail en promotion de la santé pour se concentrer sur les aspects plus individuels (Stevens, 1989 ; Williams, 1989).

Les causes du paradoxe

Pourquoi les infirmières n'occupent-elles pas plus de place dans la définition d'un champ où, par ailleurs, elles sont les principales praticiennes ? Une première réponse a trait aux efforts majeurs déployés, principalement depuis une vingtaine d'années, à l'élaboration du corpus de connaissances requis pour conférer, aux soins infirmiers, le statut de Science. Construire son propre champ sur des bases épistémologiques et théoriques solides mène parfois à se centrer sur soi-même et à négliger un peu le reste. Pour une personne non-infirmière, il est toujours intrigant de voir que même dans un champ aussi interdisciplinaire que la promotion de la santé, les auteur-es cité-es en référence dans les recherches infirmières (incluant celles de haut niveau) sont presque exclusivement des infirmières. Toutefois, les théories ou les méthodes que ces infirmières évoquent (souvent de manière non critique) ont généralement été développées dans le cadre d'autres disciplines, notamment dans les diverses sciences sociales.

Le paradoxe est aussi explicable par le fait que prendre des positions politiques sur des sujets d'envergure nationale, intervenir politiquement auprès de collectivités ou encore participer de plein droit à développer des champs de savoirs multidisciplinaires, comme celui de la promotion de la santé, est encore loin de l'image que la majorité d'entre elles se font de leur activité professionnelle « normale ». Finalement, l'image et la position sociales de la profession ne favorisent pas non plus un engagement important dans le processus de définition des orientations de la société, du système de santé ou du champ de la promotion de la santé. Encore trop souvent perçue comme totalement dépendante de la profession médicale, la profession infirmière éprouve une grande difficulté à se défaire du poids des « cinq D » qui l'affligent par les temps qui courent : division, désertion, difficulté des conditions de travail, déqualification et démotivation (Dallaire, O'Neill et Lessard, 1994).

Y a-t-il un avenir en promotion de la santé pour les infirmières ?

Bien sûr que oui ! En ce qui a trait aux *pratiques*, les acquis de la recherche (infirmière et autre) doivent cependant trouver davantage écho dans les interventions quotidiennes. Cela est important notamment pour les interventions éducatives qui demeureront le champ d'action privilégié des infirmières, où qu'elles soient déployées, attendu les changements importants des lieux et modes de pratiques qui se produisent présentement. De plus, une plus grande attention devra être portée aux dimensions collectives, politiques et environnementales des

interventions et ces dimensions doivent être maintenant perçues comme des aspects normaux et légitimes du rôle de l'infirmière, même si elles ne sont mises en oeuvre que par une minorité de praticiennes; autrement, elles seront condamnées à voir le contenu de leur pratique dicté par d'autres instances (médecins, gouvernements, autres professionnels de la santé).

Finalement, en ce qui a trait à la dimension *idéologique*, la vision et les valeurs de la promotion de la santé sont très proches de celles véhiculées traditionnellement par les infirmières. Il est donc important qu'elles acceptent de devenir, bien davantage, des intervenantes majeures dans les débats de société autour des questions de santé ainsi que des participantes très significatives à la construction de champs interdisciplinaires comme celui de la promotion de la santé.

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Discourse

Health Promotion: Issues for the Year 2000

Michel O'Neill

Background

The Origins of Health Promotion

Although it can be traced back to ancient Greece, health promotion as we know it today is generally seen as originating from professional and governmental involvement in public health, which has produced two schools of thought: health education (the predominant school) and intervention in public policy (Badgley, 1994; Bunton & Macdonald, 1992; Green & Kreuter, 1991; O'Neill & Pederson, 1994).

The development of health education occurred primarily in the post-World War II period, strongly influenced by social psychology in the United States and focusing on personal, voluntary, health-related behaviour modification (Godin, 1991; Green & Kreuter, 1991). The approach to intervention in public policy, mainly on the part of government, was proposed by the World Health Organization (WHO) and various Canadian agencies in the late 1970s (Kickbusch, 1986, 1989, 1994), with a view to creating physical and socio-economic environments conducive to adopting and maintaining a healthful personal lifestyle (Milio, 1986).

The mid-1980s, specifically the year 1986, represent a historic juncture: the two schools of thought, having grown parallel and occasionally in opposition to each other, joined to produce the field of health promotion as it is universally known today (O'Neill & Pederson, 1994).

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Towards a Definition of Health Promotion

The two definitions of health promotion most widely used around the world are that of *The Ottawa Charter for the Promotion of Health*: "Health promotion is the process of enabling people to increase control over, and to improve, their health" (*Ottawa Charter*, 1986, p. 5), and that of Green and Kreuter in their most important work: "Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities" (1991, p. 432).

The juxtaposition of these two definitions highlights a major conceptual problem. To this day we use the term *health promotion* in two very distinct senses. On the one hand, it is an *ideology* – the traditional philosophy of public health developed over the years in Canada under the categories of public health, community health, and, more recently, population health (Evans, Barer, & Marmor, 1994; Lalonde, 1974). On the other hand, it is a set of *specific practices* designed to effect change in health-related lifestyle and living conditions through health education, social marketing, persuasive communication, political action, community organization, and organizational development (O'Neill & Cardinal, 1994). The concept of health promotion would be clearer if it were used only to designate the specific practices just mentioned, and not the ideology of public health. However, such a proposal (O'Neill & Cardinal) has yet to be universally accepted (Rootman & Goodstadt, 1996).

Issues in Health Promotion for the Year 2000

In Canada and elsewhere, the main issue at hand is to agree on a definition of the concept of health promotion, as this has a direct impact on related research, funding, teaching, and practice. Other issues are also noteworthy.

The International Scene

There is no doubt that the most important issue for health promotion is the evolution of the world political economy. The ideology and values of health promotion were born in the era of the welfare state. However, the political and economic changes in the last two decades in the former welfare states of Western Europe, the United States, Canada, Australia, and New Zealand have been manifested in the dismantling of public services – to reduce government deficits – chronic unemployment, the export of jobs, and so on. Health promotion is thus being developed in

an international climate in which it is occasionally part of the discourse but which generally favours the implementation of policies that, instead of promoting health, serve to exacerbate inequities and health and welfare problems (Hancock & Labonté, 1997).

Despite these trends, however, the WHO continues to promote the tenets of the *Ottawa Charter* (1986). The Fourth International Conference on Health Promotion will take place in July 1997 in Djakarta, Indonesia. Its theme, "New Players for a New Era," is a poignant reflection of the changes we are experiencing worldwide – by proposing that we view the changes as both opportunities and limitations (WHO, 1997). For its part, the International Union for Health Promotion and Health Education, the main NGO working in the area of health promotion on an international level, has in recent years changed its programs, its image, and even its name, in order to keep up with the profound changes occurring around the world.

The Canadian Scene

Major international issues are reflected on the Canadian scene as well. In this regard, the following facts should be kept in mind:

- In its own way, Canada continues to be a leader in the field of health promotion.
- The vital leadership taken by the federal government has changed radically, if not disappeared altogether, with the advent of the "new" discourse on population health and the drastic cuts this government has made in health expenditures.
- The time lapse between adoption and implementation of health promotion strategies varies greatly with province and territory.
- Health promotion discourse is exploited everywhere in the context of major reforms to the health-care system.
- The usual players in the field of health promotion are being joined by new ones: the private sector, hospitals, municipal governments, and the Canadian Consortium for Health Promotion.
- The ambiguity of the discourse in health promotion is such that it may be used to meet the objectives of either right-wing or left-wing policies, or for individualistic or collective ends, and thus to serve a host of political agendas.

- The proponents of health promotion have difficulty proving its usefulness in terms (positivist science, costs-benefits, etc.) that are acceptable to current political decision-makers; health promotion is often perceived as lacking scientific rigour and indulging in pointless ideology (Hancock & Labonté, 1997; O'Neill, 1996; O'Neill, Rootman, & Pederson, 1994; Rootman & Goodstadt, 1996).

Where do nurses fit into all of this?

The Role of Nurses in the Current Issues

The Nursing Paradox

In Canada, as elsewhere, nurses are at the heart of the *practice* of health promotion; they are the main providers in health promotion programs and the educational dimension of their role is a fundamental one (Hagan & Proulx, 1996). Thus the first element of the nursing paradox in health promotion concerns educational interventions. Although these are enormously important, both qualitatively and quantitatively, there is an apparent paucity of training available to nurses for their educational role, and the scientific basis upon which they rely is relatively weak (Hagan, O'Neill, & Dallaire, 1995), despite increasingly more sophisticated research in health promotion over the past three or four years (Bottroff, Johnson, Ratner, & Hayduck, 1996; Stewart, 1995).

The second element in the nursing paradox concerns the *ideological* dimension of health promotion. In spite of their central role as practitioners, nurses have not, by and large, participated in the general development of the field (Gottlieb, 1992). Moreover, with few notable exceptions (Dallaire, 1991; Flynn, 1996; Milio, 1971; Stewart, 1995), nurses have tended to pay little attention to the political and environmental dimensions of their profession, concentrating instead on the more individual aspects of their work (Stevens, 1989; Williams, 1989).

Causes of the Paradox

Why aren't nurses playing a more significant role in defining a field in which they are, in fact, the main practitioners? The first answer has to do with the major effort made, primarily in the last 20 years, in building a corpus of knowledge to elevate nursing to the status of a science. Constructing a distinctive field on solid epistemological and theoretical bases has sometimes led to a neglect of what is happening outside

of nursing. It is intriguing for a non-nurse to observe that, in a field as interdisciplinary as health promotion, the authors cited by even the top nursing researchers are frequently almost exclusively nurses, whereas the theories or methods they utilize – often uncritically – have generally been developed in other disciplines, particularly the social sciences.

The nursing paradox can also be explained by the fact that such conduct as taking a political stand on national issues, taking group action, or participating in the development of multidisciplinary fields of knowledge like health promotion is far from nurses' image of "normal" professional behaviour. In addition, the social image of the profession is not conducive to heavy involvement in defining orientations in our society, our health system, or the field of health promotion. Nursing, which is all too often seen as totally dependent on the medical profession, is struggling to rid itself of the burden of the "five Ds" that describe its current situation: divided, deserted, disqualified, regrouping demotivated professionals working in difficult conditions (Dallaire, O'Neill, & Lessard, 1994).

Is There a Future for Nurses in Health Promotion?

Of course there is a future for nurses in health promotion. With regard to *practice*, however, it is imperative that gains made in research (research conducted by nurses as well as that conducted by other professionals) be reflected in day-to-day interventions. This consideration is particularly important in educational interventions, which remain within the purview of nursing – wherever nurses may be assigned, given the considerable changes in venue and approach that currently prevail. Furthermore, it is crucial that more attention be paid to the collective, political, and environmental dimensions of their role, and that these aspects be regarded as a legitimate part of nursing, even if only a minority of nurses choose to focus on them. If these aspects of nursing are not integrated into the profession, nurses will be forced to follow the dictates of governments, physicians, and other health professionals regarding their practice.

The *ideological* dimension, the vision, and the values of health promotion correspond closely to concepts that nurses have traditionally promoted. It is therefore vital that nurses play a key role in the debates surrounding health issues, while at the same time making a significant contribution to the development of interdisciplinary fields such as health promotion.

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Development and Testing of the Primary Health Care Questionnaire (PHCQ): Results with Students and Faculty in Diploma and Degree Nursing Programs

Karen I. Chalmers, Ina J. Bramadat, and Jeffrey Sloan

Les soins de santé primaires (SSP) sont perçus comme stratégie essentielle pour l'amélioration de la santé de la collectivité et les infirmières sont reconnues comme étant les professionnels de soins de santé essentiels pour atteindre ce but. Pour que les infirmières mettent en place les diverses politiques de SSP, il faut d'abord qu'elles aient connaissance de cette méthode de soins de santé et qu'elles y adhèrent. L'objectif sous-jacent de la présente étude était d'élaborer une façon de mesurer les connaissances, les attitudes et les pratiques concernant les SSP ainsi que d'évaluer la fidélité et la validité de la mesure auprès d'un échantillon d'étudiantes-infirmières et du corps enseignant des programmes au niveau du baccalauréat et au niveaux collégial. Le questionnaire sur les soins de santé primaires (QSSP) est un instrument d'auto-évaluation en trois volets; il fournit des données quantitatives sur les connaissances et les attitudes ainsi que des données qualitatives sur les pratiques concernant les SSP. L'instrument a été élaboré à partir d'une étude rigoureuse de la documentation et de la rétroinformation systématique de deux comités (au niveau local et national) spécialisés en SSP. Des données ont été recueillies dans une province de l'Ouest canadien, à partir d'un échantillon de 457 étudiantes et membres du corps enseignant dans le cadre d'un programme de 4 ans menant à un baccalauréat (trois sites), d'un programme post-collégial pour le baccalauréat et de trois programmes d'études collégiales. Les estimations quant à la fidélité par rapport à la cohérence interne, d'après le coefficient Alpha de Cronbach, étaient de 0,76 (pour ce qui a trait aux connaissances) et de 0,85 (pour ce qui a trait aux attitudes). La fiabilité de mesure test-retest après deux semaines était de $r = 0,67$ (pour ce qui a trait aux connaissances) et de 0,76 (pour ce qui a trait aux attitudes). La validité du contenu était rehaussée grâce à une révision systématique de l'instrument par un comité de spécialistes en deux temps, au niveau local et au niveau national. Les résultats ont montré de plus grandes connaissances et des attitudes plus positives parmi les étudiants en fin de scolarité par rapport aux étudiants en début de scolarité, parmi les étudiants au baccalauréat par rapport aux étudiants au niveau collégial, et parmi le corps enseignant par rapport aux étudiantes. Ces résultats corroborent la validité de la mesure. Les données qualitatives ont montré que les occasions d'apprendre liées aux SSP étaient fournies autant dans les programmes d'études collégiales que dans ceux du baccalauréat grâce à l'enseignement en cours, la pratique clinique et les travaux écrits.

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Primary health care (PHC) has been proposed as a key strategy for improving the health of the world community, and nurses are acknowledged as key health-care professionals in meeting this goal. Efforts to have nurses implement PHC policies presuppose that they are knowledgeable about this approach to health care and have positive attitudes. The underlying aim of this study was to develop a measure of knowledge, attitudes, and practices in PHC and to assess the reliability and validity of the measure with a sample of student nurses and faculty in degree and diploma programs. The Primary Health Care Questionnaire (PHCQ) is a three-part self-report measure that provides quantitative data on knowledge and attitudes and qualitative data on practices of PHC. The instrument was developed from a rigorous review of the literature and systematic feedback from two panels (local and national) expert in PHC. Data were collected from 457 students and faculty in one four-year degree program (three sites), one post-diploma degree program, and three diploma programs, in a western Canadian province. Internal consistency reliability estimates using Cronbach's alpha were .76 (knowledge) and .85 (attitudes). Test-retest reliability at two weeks was $r = .67$ (knowledge) and .76 (attitudes). Content validity was enhanced through a systematic review of the instrument by a two-phase local and a national expert panel. Findings indicated greater knowledge and more positive attitudes among senior compared to junior students, degree compared to diploma students, and faculty compared to students. These findings lend support to the validity of the measure. The qualitative data revealed that learning opportunities related to PHC were built into both the diploma and the degree program through classroom teaching, clinical practice, and written assignments.

Introduction

Primary health care (PHC) has been proposed as a key strategy for improving the health of the world community (Pan American Health Organization, 1988; World Health Organization [WHO], 1978, 1981, 1986, 1992). Nurses are acknowledged as key professionals in meeting this goal (Mahler, 1978, 1985), and nursing associations worldwide advocate the development of PHC as the basis for national health-care systems. Efforts to have nurses carry out PHC work presuppose that nurses are knowledgeable about this approach and that their attitudes to PHC are positive ones. However, little empirical evidence is available regarding nurses' understanding, acceptance, or practice of PHC, or regarding PHC content in current nursing programs.

Education programs play a key role in socializing nursing students and often are perceived as introducing new ideas and ideals. The World Health Organization (WHO) has pointed out that if PHC is to become "the central function and main focus" of a country's health-care system (WHO, 1978) it is imperative that it becomes central to the nursing curricula. For many nursing programs, this will require "a major shift... from a cure orientation based on hospital medicine to a prevention orientation based on the practice of primary health care in the community" (WHO/ICN, 1989, p. 4). Diploma/community college programs have a long history of effectively preparing staff for acute-care institu-

tions. Although the vast majority of teachers in these programs are baccalaureate or master's prepared, the extent to which they continue to espouse the values of community-based PHC practice is not known. Even within university schools, the focus is on the ill individual, and elective courses often are selected from disciplines in which the focus is on the individual. Concepts related to the community form a comparatively small portion of the nursing curriculum (Chalmers & Kristjanson, 1989). A recent study of Canadian baccalaureate schools of nursing (Tenn & Niskala, 1994) found that all schools acknowledged PHC in their course content; however, only 60% of schools had, to a "reasonable" degree, integrated PHC into their curriculum.

One of the difficulties in measuring diffusion of PHC concepts and practice has been the lack of instruments available to obtain this information. The purpose of this study was to develop a psychometrically sound questionnaire to assess knowledge, attitudes, and practice of PHC, and then to use the instrument to measure these variables among faculty and students in nursing programs.

Method

Instrument Development

The Primary Health Care Questionnaire (PHCQ) was developed from a review of the theoretical and empirical literature on PHC. The WHO definition of PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology and made universally accessible to individuals and families in the community through their full participation and at a cost they can afford" (WHO, 1978, p. 34) provided the conceptual underpinning for development of the instrument.

Items in Part A of the questionnaire (Knowledge) were developed with nominal response options in which respondents assessed whether they considered the statements to be "true" or "not true" of PHC. Correctly answered items were totalled to produce a knowledge score. Part B (Attitudes) used a four-point Likert-type response format. Each item was rated from "strongly agree" to "strongly disagree." Items from parts A and B are listed in Table 1. The third part of the questionnaire addressed PHC practices using an open-ended response format. Respondents were asked to list PHC practices experienced (students), or offered to students (faculty), in their program. Demographic and work-experience items also were included in the questionnaire.

Table 1 *Items from PHCQ. Part A: Knowledge; Part B: Attitudes*

Part A: Knowledge items from PHCQ (True/Not true)

1. Accessibility to health care is a basic concept of primary health care.
2. The World Health Organization considers primary health care to be the best way to achieve "Health for All."
3. The WHO considers that primary health care is equally important for both industrialized and developing countries.
4. The key approach to achieving primary health care is technology.
5. Provincial health economists should be the key planners in any primary health-care project.
6. One major emphasis of primary health care is disease prevention.
7. Within a primary health-care system, safe adequate drinking water is considered as important as professional health services.
8. A statement of commitment to primary health care was ratified at the International Conference held at Alma Ata in 1978.
9. In a primary health-care system, lay health-care personnel replace most health professionals.
10. Primary health care emphasizes the importance of a biomedical approach to health care.
11. An increase in physicians is needed in Canada to fully implement primary health care.
12. The Canadian Nurses Association supports the goals of primary health care.
13. The primary health-care movement began under the auspices of the International Council of Nurses.
14. Many governmental departments, such as Agriculture and Municipal Planning, are important for the implementation of the goals of primary health care.
15. Within a primary health-care framework, the health-care system is considered to be the key determinant of the population's health.
16. Supporters of primary health care consider that the most effective way to improve the mental health of the community is to increase the number of psychiatrists.
17. In a primary health-care system, nurses have an increased role in prevention and promotion.

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18. A primary health-care system centralizes the planning and implementation of health care.
19. A primary health-care system is based on the belief that if enough effort is spent developing health-care technology systems, quality of life is enhanced.
20. Primary health care involves, among other activities, working on underlying problems that affect social and emotional health.
21. An example of a primary health-care strategy to improve the health of the community is to increase the number of cardiac specialists.
22. Rehabilitative services are part of primary health care.
23. Improved health education is a key concept in primary health care.
24. Cooperation between governments and voluntary organizations is a key concept in primary health care.
25. The primary health-care movement was initiated at the International Health Promotion Conference in 1988.
26. Primary health-care approaches take into consideration ways to provide culturally appropriate care.
27. Community participation is central to an effective primary health-care system.
28. Within the primary health-care perspective, many functions that lay health-care workers currently perform are the responsibility of health-care professionals.
29. Acute care services are not considered part of a primary health-care system.
30. In a primary health-care system, efforts are made to use the least expensive technology and personnel to achieve positive health outcomes.
31. Primary health care focuses on setting targets and plans of action to meet national health goals.
32. One of the five key principles of primary health care is the provision of high-quality, episodic medical care.
33. Primary health-care services do not include curative or palliative care.
34. Our current provincial health-care system is based on a primary health-care model.
35. A coalition of seniors, police, and local merchants working to improve neighbourhood safety is an appropriate primary health-care strategy.

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Part B: Attitude items from PHCQ

1. More health-care dollars should go towards developing technological equipment to diagnose disease.
2. Increased medical specialization is needed to improve the community's health.
3. All people in a country should have access to basic health care even if it means that some people would receive fewer services than they currently receive.
4. Nurses could provide many health-care services that physicians currently provide.
5. Most children need "well child" care from a pediatrician rather than from a general practitioner (i.e., family doctor).
6. Fee for service as a method of payment for physicians should be discontinued and another payment system substituted.
7. Access to good health care is a fundamental right of all people.
8. More money needs to be spent on health promotion and disease prevention even if this means less money is available for highly specialized treatment and acute care.
9. Volunteers and lay personnel could provide many services that are currently provided by health-care professionals.
10. The physician is the best person to keep people well.
11. Community members should have input into how health-care dollars are spent in their communities.
12. Many tasks that physicians currently perform could be carried out equally well by nurses.
13. Helping people learn to stay well is an important role for nurses.
14. Doctors and nurses should spend more time providing information to people about their health situations.
15. Childbearing women should have an increased role in decision-making regarding procedures used during their labour and delivery.
16. More effort should be taken by health-care professionals to discourage traditional healers from providing health care.
17. More money needs to be spent on accident prevention for children and adolescents, even if this means longer waits for elective surgery for some patients.

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18. The health-care system should take increased responsibility for developing programs to address problems such as family violence.
19. The way to solve the problem of high death rates from heart disease is to screen children for high lipid levels.
20. Each person has a responsibility to maintain his/her health.
21. Trained midwives should be accessible for women who choose to use the services of this health professional.
22. As much emphasis should be placed on assisting people to cope with their health problems as is placed on diagnosing and treating them.
23. Getting consumers involved in decisions about how health-care dollars are spent would result in lower-quality health care.
24. People should have liberal access to health information from doctors and nurses so they can participate fully in decisions affecting their health.
25. Provincial governments need to assume more responsibility to ensure that people in all areas of the province have access to needed medical services, even if this means controlling where some physicians can practise.
26. Individuals are capable of taking primary responsibility for their own health.
27. If individuals can afford to pay user fees for services, they should be expected to do so.
28. Primary health care is a useful approach for developing countries but has little relevance for industrialized countries.
29. Currently used health indicators (morbidity and mortality) are useful but limited ways of determining the effectiveness of primary health care.
30. Primary health care is appropriate only for low-income groups and communities.
31. Cultural variations in health-care practices are over-emphasized.
32. Community participation is a deterrent in implementing primary health-care programs.
33. No matter where our health-care dollars are spent, we will never be able to reduce the incidence of disease in Canada.
34. All health-care professionals have a role in primary health care.

The initial instrument was reviewed by a panel of senior nurses who were knowledgeable about PHC ($n = 4$). The panel assessed items for relevance to PHC and provided additional areas that they considered lacking in the questionnaire. Based on this feedback, and on input from an expert in psychometrics, the instrument was revised and then re-assessed by a panel of six national experts in PHC.

Using Imle and Atwood's (1988) model for instrument development, the experts systematically assessed items for clarity, apparent internal consistency, and content validity. Retained were items that exceeded 70% agreement among panel members, the minimum percentage set as acceptable for retention in beginning scales (Topf, 1986). Based on this assessment, one item considered ambiguous was deleted and four items were added to more adequately assess the intersectoral cooperation component of PHC. The instrument was then pilot-tested with subjects deemed similar to the study population.

The final PHCQ comprised 35 knowledge items, 34 attitude items, and three open-ended items addressing experiences in the classroom, with clinical practice, and with assignments. The instrument was designed so that minor changes to the instructions in the practice section and the demographic data sheet would adapt it for use with practising nurses, other health-care practitioners, or members of the community. Completion time was approximately 20 minutes.

Sample

The population from which participants were drawn were faculty and students from diploma and undergraduate degree programs in the study province. Students were recruited from each year of basic programs and from both years of a two-year post-diploma program for registered nurses. The intention was to determine whether the instrument was sensitive enough to detect anticipated differences in knowledge and attitudes between faculty and students, among programs, and across years within programs.

Students. The student sample was drawn from a four-year baccalaureate program (delivered at three sites); a two-year baccalaureate program for registered nurses (BPRN); and three diploma programs. The potential student population included more than 95% of nursing students in the province.

A convenience sample of students attending selected classes on the designated data-collection days were recruited into the study. The response rates for each site and class (based on the total population of

students listed on the academic rolls) ranged from 25 to 53% with an overall response rate of 39%. Because of their timetables, many students were unavailable for recruitment. Thus the response rate for students who were present on recruitment days was considerably higher – that is, in excess of 70%. Of the 394 students who returned questionnaires at first testing, 172 completed the questionnaire two weeks later (44% response rate) for the purpose of test-retest reliability assessment.

The mean and median age of the student sample was 23.1 years ($SD = 11.60$) with a range from 17 to 53 years. Most of the respondents were full-time students ($n = 336$, 85%). Almost half ($n = 193$, 49%) reported having earned previous degrees or certificates.

Faculty. Of the 130 educators who participated, 75 were with the degree programs and 55 were with the three diploma programs. Response rates ranged from 43 to 56% across study sites. Sixty-three of the 130 questionnaires (48.5%) were returned at the first testing and 21 (33%) were completed at the second testing.

The majority of the faculty taught full-time ($n = 50$, 79%), addressing all the major substantive areas offered in the curriculum, including acute and chronic care, health promotion and disease prevention, and palliative care. Faculty respondents were experienced teachers and nurses. Their work experience ranged from five to 35 years ($M = 21.0$, $SD = 6.9$, $Mdn = 19.5$); teaching experience ranged from less than one year to 28 years ($M = 10.4$, $SD = 6.9$, $Mdn = 12.1$). The ages of the faculty reflected their years of professional work (range 30 to 58 years, $M = 44$, $SD = 6.9$, $Mdn = 44$).

Procedure

Following approval by the Ethical Review Committee and access approval from the six study sites, a research assistant recruited students (degree and diploma) through a short oral presentation in a scheduled class. Written information also was provided. Those interested in participating completed the PHCQ and returned it to a box in the classroom. Registered nurse students were recruited at the end of their classes. Due to time constraints, these participants completed their questionnaires at home and returned them by mail. Faculty were recruited by distributing an explanatory letter and questionnaire in their mailboxes at their place of work. Those wishing to participate either returned their envelopes to a sealed box in their workplace or mailed their questionnaire to the researchers. All participants who completed the questionnaire were invited to complete a second administra-

tion of parts A and B of the questionnaire two weeks later (to assess the stability of the instrument).

Analysis

One questionnaire was eliminated because several pages of data were missing. Less than 10% of the data were missing on the remainder of the questionnaires, resulting in 457 questionnaires available for analysis. A comparisonwise type I error rate of 5% was used for all analyses. Instrument reliability was assessed using Cronbach's alpha coefficient and test-retest correlation coefficients. Cross-tabulation of items identified as detracting from the test-retest reliability was examined using Fisher's exact test. Variability of the knowledge items was examined by simple percentage correct responses; variability of attitudinal items was examined using frequency distributions.

Normality testing (Shapiro-Wilks) indicated that the data for the knowledge scale were not normally distributed. The distribution was unimodal and relatively bell-shaped (by histogram), with some extremely low scores ($n = 4$). These outliers were likely responsible for the lack of normality. Attitude scores were normally distributed (Shapiro-Wilks). Parametric and non-parametric tests were conducted as appropriate to distribution of the data. Correlation matrices were calculated to carry out an item analysis. The correlation matrices were examined to assess items with low correlation and item redundancy.

Comparison of knowledge and attitudinal differences across respondent educational level was carried out using both parametric and non-parametric procedures. Use of both approaches allows for cross-validation of results relative to the robustness of procedural assumptions. The use of multiple testing procedures ensures that the uniformly most powerful procedures are included in the analysis, regardless of distributional eccentricities.

Qualitative data from the open-ended questions (Part C) were coded and analyzed using manifest content analysis procedures (Field & Morse, 1991; Fox, 1982). Categories were developed for each portion of Part C (classroom, clinical, assignments).

Results

Performance of the PHCQ

Reliability and Validity. An alpha of .70 was pre-set as an adequate indication of internal consistency for a beginning instrument (Nunnally,

1978). The instrument met this standard, with internal consistency reliability estimates (Cronbach's alpha) of .76 for the 35 knowledge items and .85 for the 34 items on the attitude scale. The test re-test reliability for the knowledge scores was .67 (Spearman's) and for the attitude scores .76 (Spearman's). As suggested by Bland and Altman (1995), examining the difference between scores, as well as the correlation between scores, provides valuable insights into the comparability of any two scores. Differences in knowledge and attitude scores over time were consistent regardless of whether the score value was high or low ($p = .11$ and $.27$, respectively). There was a statistically significant increase in knowledge scores, of 2% on average ($p = .002$), which was indicative of a learning effect of one out of three people responding correctly to one more item on average. The average difference in attitude scores over time of 0.7% was not statistically significant ($p = .25$).

Correlations of $r = .40$ to $.60$ (item-to-scale correlation) and $r = .30$ to $.70$ (item-to-item correlation) are typically accepted for item retention when developing new scales (Nunnally, 1978). For Part A (Knowledge), eight items (23%) were within the accepted range, suggesting that they contributed to the measurement of the construct of knowledge. Several ($n = 7$, 20%) also approached the .40 standard. No items exceeded .70, which suggested that none were redundant. For Part B (Attitudes), 14 items (41%) were within the accepted range and an additional nine (26%) approached $r = .40$. Inter-item correlation assessment of the knowledge items (Part A) indicated that 17 items (49%) achieved an inter-item correlation of between .30 and .70. In one instance, inter-item correlation of .91 between two items (#17 and #23) suggested redundancy. For Part B, 21 items (62%) met the criterion. Although some items did not meet the accepted criteria, we considered it premature to delete those items with low correlation prior to further testing. A follow-up study is planned; item deletion was deferred until the performance of all items, using both samples, is evaluated.

Knowledge and Attitudes

Total sample. Scores on the knowledge and attitude items were converted to percentages for ease of interpretation and comparison across scales, giving a range of potential scores from 0 to 100. Knowledge scores for the total sample of faculty and students ($n = 434$) ranged from 23.5 to 100. Measures of central tendency for knowledge scores were mean 77.89; standard deviation 11.53; median 77.43; and mode 77.14 ($n = 434$). Respondents with "low" scores ($n = 15$) were evenly distributed between degree ($n = 8$) and diploma ($n = 7$) programs, in the earlier

years of their programs. Attitude scores ranged, in the upper end of the scale, from 53.9 (less positive attitude) to 99.0 (more positive attitude), with a mean score of 74.56, standard deviation 8.65 ($Mdn = 73.52$; mode = 70.58). Mean, median, and standard deviations of knowledge and attitude scores are summarized in Table 2.

Table 2 <i>Mean, Median, and Standard Deviations of Knowledge and Attitude Scores</i>						
Variables	N	X	SD	Mdn	Min	Max
Knowledge Time 1	434	77.89	11.53	77.14	23.53	100.00
Attitude Time 1	445	74.42	8.80	74.51	48.49	99.02

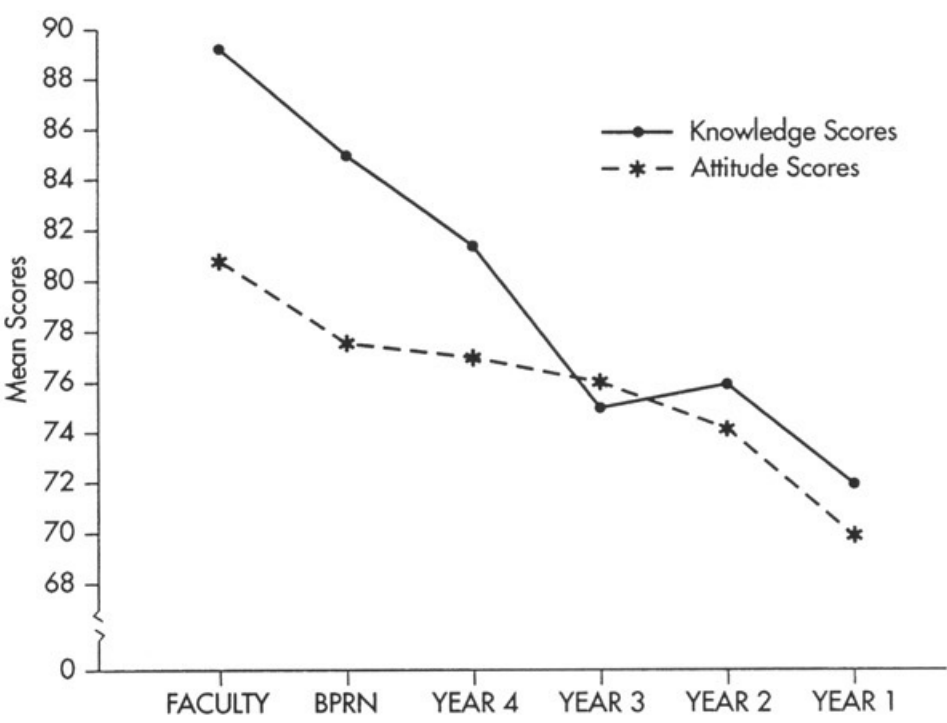
Group comparison was carried out via ANOVA and Kruskal-Wallis procedures, with comparable results. For the sake of brevity, only the ANOVA results are reported here. Mean knowledge and attitude scores for faculty, BPRN students, and diploma/degree students across years are summarized in Figure 1.

Faculty versus students. Mean scores for faculty were significantly higher than scores for students, for both knowledge (89.17 vs. 76.05, $p = .0001$, $n = 434$) and attitudes (80.81 vs. 73.3, $p = .0001$, $n = 457$).

Degree versus diploma programs. Significant differences also were found between the mean scores for degree students and those for diploma students ($n = 394$) on knowledge items (78.24 vs. 72.99, $p = .05$) and on attitude items (76.59 vs. 71.94, $p = .0001$). Likewise, when mean scores were compared between faculty teaching in the degree programs and faculty teaching in diploma programs ($n = 63$) significant differences were found for both knowledge (89.92 vs. 88.36, $p = .026$) and attitudes (82.52 vs. 79.04, $p = .012$).

Program year versus post-RN versus faculty. Analysis of variance was calculated on knowledge scores for students (years 1–4 across sites, BPRN) and for faculty. Mean scores ranged from 72.15 to 89.18. Mean scores increased from year 1 through year 4 to BPRN students and faculty, with the exception of the reversal of scores for students in years 2 and 3. Significant differences were found among the six groups ($p = .0001$, $n = 434$).

Figure 1 Mean Knowledge and Attitude Scores for Faculty, BPRN Students, and Diploma/Degree Students



Mean *knowledge* scores were compared using ANOVA and Kruskal-Wallis procedures (seven student groups and one faculty group). Significant differences were found among the eight groups ($p = .0001$, $n = 434$). First-year students had lower mean scores in both the diploma program and the degree program than did second-year students, and degree students had higher scores than diploma students in both first year and second year.

Similar comparisons were made for attitude scores across years. Analysis of variance was conducted on attitude scores and the year in the program across sites (years 1, 2, 3, 4, and BPRN). Faculty scores were again included as a sixth category for analysis purposes. Mean scores ranged from 69.31 to 80.81. Mean attitude scores increased from year 1 through year 4 to BPRN students and faculty. Significant differences were found among the six groups ($p = .0001$, $n = 445$).

Mean *attitude* scores of diploma and degree students by year and of faculty also were compared using ANOVA procedures (seven student groups plus faculty, to form eight groups). Significant differences were

found among the eight groups ($p = .0001$, $n = 445$). First-year students had lower mean scores in both the diploma program and the degree program than did second-year students, and degree students had higher scores than diploma students in both first and second year. Senior students had higher mean scores than junior students, and faculty had the highest mean scores.

In summary, both knowledge and favourable attitudes toward PHC increased with each additional year in a nursing program (for both degree and diploma students). The only exception was the modest but significant reversal of the mean knowledge scores between second year and third year. Degree students had higher knowledge and attitude scores than diploma students, and faculty scored higher on both measures compared to students.

Practice of PHC

Faculty and students described their practice of PHC in response to the three open-ended questions in Part C of the instrument.

Students. Students described their PHC experiences and classified these as classroom, clinical, or assignment experiences. Approximately two thirds of the students completed all or part of this section of the questionnaire.

Diploma nursing students described fairly extensive classroom exposure to PHC concepts: lecture content focusing on the key concept of prevention, including aspects of safety, pollution, fire prevention, STD prevention, nutrition, and self-care; nurses' role in prevention through patient education, identification of risk factors, hygiene, and asepsis. Degree nursing students similarly identified prevention as the key concept in primary health care. Degree students perceived that they received a paucity of information on PHC, and stated that the dominant client model was medically based; however, their responses suggested that their lecture content included more PHC concepts than that of diploma students.

For diploma students, clinical practice activities related to PHC included a focus on patient teaching. Subjects for teaching included identification of risk factors, need for lifestyle changes, and information about community resources. Degree students also identified patient teaching and prevention activities among their clinical experiences. In addition, they frequently mentioned health-education work in the community, with both individuals and families in the home (e.g., families

with a newborn) as well as group education (e.g., health education sessions with schoolchildren and adolescents).

For diploma students, PHC assignments centred around client teaching. Degree students described assignments related to PHC concepts directly, including papers differentiating between health promotion and disease prevention and contrasting the theory and practice of PHC. One assignment involved wellness self-assessment in which students identified areas of concern and described the experience of implementing behaviour modification related to that area. Patient-education plans were by far the most common PHC-related assignment for the degree students, with content similar to that of the diploma students.

Some variation was noted between content described by diploma students and that described by degree students. Degree students identified more community-health issues than did diploma students, who were more focused on the health problems of individuals. Both groups noted that prevention was a key concept of PHC, and their value of client education reflected this perspective. A few students in each program indicated that they were not very familiar with PHC concepts, and some of their answers reflected this lack of knowledge.

Faculty. Responses of faculty members paralleled those of the students. In general, diploma and degree faculty used similar strategies in classroom teaching, clinical experience, and evaluation of their students. Faculty described student assignments only minimally in the questionnaire: because many faculty noted that PHC concepts were taught indirectly, perhaps they evaluated them indirectly as well.

The qualitative data provided information that learning opportunities related to PHC were built into both diploma and degree programs though classroom teaching, clinical practice, and written assignments. However, learning opportunities for degree students exceeded those of diploma students in both number and scope.

Discussion

The findings of this study indicate that the PHCQ shows promise as an instrument for studying the dissemination of PHC concepts and practice. The psychometric properties of the instrument, with the exception of the test re-test reliability of the knowledge scores ($\rho = .67$), appear adequate for a beginning instrument. The test re-test reliability of the attitude scores exceeded the minimum accepted standard ($r = .70$). Internal consistency and reliability estimates for both the knowledge and the attitude scores were adequate (alphas of .76 and .85).

Confidence in the content validity of the measure was enhanced by thorough review of the PHC literature and the systematic feedback from the local and expert panel. Validity of the instrument was further demonstrated by distribution of the mean scores. Generally, the students in the senior years and in the post-diploma program had higher knowledge scores and higher attitude scores (indicating more positive attitudes) than students in the lower years, and faculty had the highest scores. It would be expected that understanding of PHC and increasingly positive attitudes would develop over time with exposure to learning opportunities about PHC. That students' scores increased across the years and that faculty had more knowledge and more positive attitudes provides support for the validity of the PHCQ and for its ability to discriminate among groups. The higher knowledge scores and more positive attitudes of degree students compared to diploma students also suggests that the instrument is effective in measuring the relevant constructs. Students in the degree program had more opportunities, including clinical practice, to learn about PHC, particularly as it relates to community-health settings.

The qualitative data indicated that PHC learning opportunities were built into both diploma and degree programs, through classroom teaching, clinical practice, and written assignments. Students in the degree program generally had a wider range and a greater number of learning opportunities than students in diploma programs; however, this was partly a result of the increased time (four years) for learning to occur. Students in both types of programs commented on the importance of disease prevention and health promotion; this appears to indicate an acceptance of the key underpinnings of PHC.

Much of the content reported in Part C (Practices) addressed some aspect of health promotion and disease prevention, including the promotion of self-care with a view to prevention. Little classroom and assignment content and clinical practice related to principles other than prevention (e.g., intersectoral cooperation, accessibility, public participation, appropriate technology). While these topics were likely addressed when content related to PHC was introduced in lectures, the integration of these principles into other content areas was not evident. It was difficult to determine from the data whether PHC was used as an overarching framework for discussion of nursing care of client groups.

Use of the PHCQ

This study began the process of developing and refining the PHCQ. The instrument is being refined further in a comparative study of stu-

dents in nursing programs in the United Kingdom. In Canada, it currently is being used to evaluate development of PHC across four years of a baccalaureate nursing program designed within a PHC framework. We anticipate that the instrument also will be useful as a teaching tool in the classroom or in workshops to initiate and frame discussion of PHC. To date, the PHCQ has been tested in academic settings. However, with minor changes to the instructions in Part C (Practices) and the demographic data sheet, the instrument can also be used with community populations to assess their understanding and acceptance of PHC. This would entail omitting the two questions addressing classroom learning and assignments and retaining the item addressing clinical practice.

Diffusion theory acknowledges that a key factor affecting the adoption rate of any new idea or trend is its compatibility with the knowledge, beliefs, and experiences of the target population (Rogers, 1983). Currently, health-care systems are undergoing reform, and the benefits of PHC strategies are finally being recognized by provincial health-care systems. The PHCQ can be used to assess progress toward implementation of a health-care system based on primary health principles.

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Acknowledgement

This research was funded by a Dorothy Kergin Primary Health Care Award, administered through the Canadian Nurses Foundation, Ottawa.

Date accepted: November 1996

Clarifying the Nature of Conceptualizations about Nursing

June F. Kikuchi

Les sciences infirmières, en tant que discipline, sont à un point crucial de leur évolution. La conceptualisation des sciences infirmières est élaborée et testée sans que l'on ait une conception claire de leur essence. Ainsi, la documentation sur le sujet a tendance à embrouiller plutôt qu'à clarifier la pensée. L'objectif du présent traité philosophique est de montrer qu'on pourrait obtenir une plus grande clarté en reconnaissant que les questions posées sur les diverses conceptions des sciences infirmières sont par essence philosophiques. On critique l'influence de Jacqueline Fawcett dans la mesure où la façon de reconnaître et d'agir en fonction du fait ci-haut mentionné permettrait de préciser la réflexion sur la question.

The discipline of nursing is at a crucial point in its development. Conceptualizations about nursing are being developed and tested without benefit of a clear conception as to their nature. Consequently, the nursing literature on the topic tends to confuse rather than clarify thought. The purpose of this philosophic treatise is to show that greater clarity could be achieved by acknowledging the fact that questions addressed in conceptions about nursing are philosophic in nature. The influential thought of Jacqueline Fawcett is critiqued with reference to how acknowledging and acting in terms of this fact would also lend parsimony to thought on the matter.

Introduction

During the past several decades, a dozen or more conceptualizations about nursing have been developed by nurse scholars such as Orem, Parse, and Henderson to guide nursing endeavours. It is clear, from various historical accounts (e.g., Chinn & Kramer, 1995; Meleis, 1991; Peplau, 1987; Whall, 1989), that the evolution of contemporary conceptualizations about nursing was precipitated by the pressing need to answer the question What is nursing? Nurse leaders correctly surmised that the development of nursing, as a discipline in its own right, awaited an answer to that question. The identification of *nursing* curricula, practice, and research was dependent on it; the circumstantial need to define the nature of nursing was intensified by the growing concern that nursing, as a science, was not developing theories of its own – that it could afford to neither continue to borrow theories from other sciences nor accumulate bits and pieces of unrelated information.

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In the 1970s and 1980s, nurse scholars' conceptualizations about nursing, and guidelines for analyzing and evaluating the conceptions, began to flood the nursing book market. Graduate nursing students began to earnestly study this literature and debate aspects of it. One debate has centred directly on the nature of conceptualizations about nursing. In Meleis's (1991) view, the distinctions that some nurse theorists have made among metaparadigm, conceptual model and framework, and theory, in deciding what to call conceptualizations about nursing, are "hair-splitting, unclear, and confusing at worst" (p.16). Being of the view that these distinctions are not worth debating, Meleis takes the position – as do Chinn and Kramer (1995) – that conceptions about nursing are theories, pure and simple. But Fawcett (1993, 1995) continues to insist on the importance of making these distinctions, and of distinguishing between those conceptions that are conceptual models or frameworks and those that are theories, in terms of level of abstractness. However, Uys (1987) correctly points out that theories can be just as abstract as conceptual models.

Given all that has transpired, it is amazing that the nursing literature on the nature of conceptions about nursing remains unclear and confusing. This philosophic treatise attempts to lend clarity to the matter. The thesis, simply put, is that our present confusion stems from a failure to recognize that the conceptions are philosophic in nature. It is defended, first, by revealing that conceptions about nursing have been generally and erroneously assumed by nurse scholars to be scientific in nature. Then taken up is the notion that they are philosophic in nature – more specifically that they are formal philosophies of nursing (i.e., philosophies of nursing having the form of a philosophic nursing theory). Finally, Fawcett's (1995) conception of the "structural hierarchy of contemporary nursing knowledge" (p. 6) is examined to demonstrate how tangled we have become in our attempts to clarify the nature of conceptions about nursing, and to show how we might extricate ourselves by properly conceiving of them as philosophic in nature.

Assumptions

The argument put forward in this treatise is grounded in, and is to be interpreted in light of, the commonsense philosophic position of *moderate* realism, which holds that reality exists outside and independent of the mind and is knowable. In its conception of modes of inquiry (as put forward by such moderate realist philosophers as Adler [1965], Maritain [1959], and Wallace [1983]), moderate realism reasonably makes a place for philosophy as a mode of inquiry capable of produc-

ing theories of the calibre that science, history, and mathematics do in terms of truth value.

Conceptualizations about Nursing as Scientific

There is ample evidence that nurse scholars have generally assumed that conceptions about nursing are scientific in nature. Consider the following examples from the nursing literature. Fitzpatrick and Whall (1989) speak of *indirectly* testing conceptualizations about nursing through investigative hypothesis-testing and using operational definitions – methods characteristic of science as a mode of inquiry. Fawcett (1993, 1995) does so as well with regard to conceptions that she deems to be models or grand theories, but she takes such thinking even further. She refers to the *direct* testing of conceptions about nursing (having, in her view, the form of a middle-range theory) through measurement and statistical procedures. Also, when Parse (1987), Meleis (1991), Barnum (1994), and Chinn and Kramer (1995) address conceptions about nursing as theories, they use terms characteristic of science – such as description, explanation, prediction, and phenomena. The assumption that conceptions about nursing are scientific in nature is also apparent in the numerous references, in the nursing literature, to these conceptions vis-à-vis sociology's notion of scientific grand and middle-range theories (e.g., Chinn & Kramer; Fawcett, 1993, 1995; Fitzpatrick & Whall; Kim, 1983, 1989; Meleis; Melia & Fawcett, 1986; Moody, 1990; Smith, 1992).

The problem in conceiving of conceptions about nursing as scientific is evident in the nature, scope, and object of science as opposed to philosophy as a mode of inquiry. In its inquiry, *science* seeks scientific theories, having the form of probable truth, about what is and happens in the world, grounding its inquiry in (and testing the results against) *special* experience – special in that the experience results from deliberate effort, conducting an investigation to observe phenomena (Adler, 1965). Thus description, explanation, and prediction of the phenomenal (i.e., that which is material and directly or indirectly observable) lie within the purview of science (Maritain, 1930, 1959; Wallace, 1983), giving science the power to attain know-that knowledge about the phenomenal as well as know-how knowledge – or knowledge of how to control phenomena to reach desired outcomes (Adler).

The nature of nursing per se (in the essential sense portrayed in nurse scholars' conceptions about nursing as what distinguishes nursing from other entities) is nonphenomenal (i.e., immaterial and nonobservable). As such, it is not amenable to study through science.

The question What is the essential nature of nursing? is a philosophic nursing question, not a scientific one (Kikuchi, 1992). It is to philosophic inquiry that we must turn for an answer to that question, the outcome of which would be (contrary to the thinking of Salsberry [1994]) a philosophy of nursing having the form of a philosophic nursing theory (Kikuchi & Simmons, 1994). What, then, is a philosophic nursing theory, and how is it attained? The answer, let it be kept in mind, is based in the moderate realist's conception of philosophy as a mode of inquiry.

Conceptualizations about Nursing as Philosophic

Maritain (1959) and Wallace (1983) distinguish between scientific, mathematic, and philosophic modes of inquiry, and their respective concepts, in terms of Aristotle's three degrees of abstraction from matter. Science, dealing with the material and directly or indirectly observable aspects of entities, operates at the first degree of abstraction, the closest, of the three, to matter and therefore the most concrete and least abstract. Philosophy, dealing with the immaterial and nonobservable aspects of entities, operates at the third degree, the furthest removed from matter and therefore the most abstract. Mathematics operates at the second degree. In other words, as the mind moves from the first to the third degree of abstraction, it sheds more and more of the material aspects of the entity under study until, at the level of philosophic thought, only the immaterial aspects remain to be considered. Thus a theory at the philosophic level of thought consists of a compendious set of concepts and propositions that are more abstract and general in nature than those found in a scientific theory.

Also, at the level of philosophic thought, theories are developed using methods appropriate to it. Unlike science, which collects and then analyzes observational data at the first degree of abstraction, *philosophy* engages in armchair thinking at the third degree of abstraction. This thinking consists of reflection upon, and discursive analysis of, commonsense knowledge gained through *common* experience (as opposed to the *special* experience in which science is grounded). Commonsense knowledge and common experience are the basic knowledge and experience that all humans have by virtue of simply living and acting day to day, without making a deliberate effort to investigate anything (Adler, 1965). Further, in its inquiry, philosophy, like science, seeks theories, having the form of probable truth, about what is and happens in the world. Unlike science, however, it seeks knowledge of the immaterial or nonobservable aspects of that which exists in the world, and knowledge of what we ought to do and seek in human life. Thus it does not

concern itself, as science does, with prediction or control of phenomena. Yet it alone has the power to provide us with the fundamental theoretical and practical knowledge to guide our human endeavours (Adler; Maritain, 1930, 1959; Wallace, 1983) – for example, knowledge of the essential nature of human beings and of moral standards.

From the foregoing explanation of the development of philosophic theories per se, it is clear that armchair thinking would be required to develop a philosophy of nursing having the form of a philosophic nursing theory. This thinking would consist of reflection upon, and discursive analysis of, that commonsense knowledge of nursing which nurses come to possess, not from engaging in extraordinary nursing activity but simply from engaging in everyday practice (i.e., that knowledge of nursing which comes from ordinary or common nursing experience). In other words, through reflection upon this knowledge, answers to philosophic nursing questions would be proposed and analyzed in a discursive manner to develop a philosophy of nursing having the form of a philosophic nursing theory. The established philosophy would consist of a compendious set of concepts and propositions that address philosophic nursing questions concerning the nature, scope, and object of nursing and of nursing knowledge; and of what ought to be done and sought in nursing – questions that nursing as a discipline is responsible for answering (Kikuchi, 1992; Schlotfeldt, 1992). Needless to say, the nursing philosophy so established would be a derived philosophy (Kreyche, 1959) – derived from the philosophic theories of the various branches of the discipline of philosophy (e.g., metaphysics; epistemology; philosophy of mind; philosophy of religion, ethics, and politics) developed in response to questions of a more basic nature that those branches are responsible for answering. Following is an example of how inquiry along these lines might proceed.

Suppose that the question *What is the end-goal of nursing?* were to be asked and that “quality of life,” conceived as “a life befitting human beings,” were proposed as a possible end-goal. Reflection on this answer might lead to the question *What does such a life entail?* Proposed answers would likely spawn other questions, such as: *What conditions are required for quality of life, so defined, to exist? What are the consequences of it existing or not existing? How is it different from, or similar to, other things like it?* If the inquiry were to be conducted properly, increasingly more penetrating questions would be asked in response to the ongoing analysis of proposed answers to questions already posed (Phenix, 1964). With this kind of cyclical asking and answering of questions, deeper penetration into the true nature of things – in this instance, into the end-goal of nursing – becomes possible.

Having considered the nature of a philosophic theory and of a philosophic nursing theory, and how they are attained, let us now see how greater clarity and parsimony of nursing thought could be achieved by properly conceiving of conceptions about nursing as philosophic in nature. Fawcett's (1993, 1995) conception of the structural hierarchy of contemporary nursing knowledge will be used to establish this point, because Fawcett has described it in sufficient detail to permit such an endeavour.

Fawcett's Structural Hierarchy of Nursing Knowledge

First, a synopsis of Fawcett's (1993, 1995) description of her conception of the structural hierarchy of contemporary nursing knowledge will be presented. The analysis will focus only on those aspects of Fawcett's work that are problematic in that they contain seeds of confusion regarding the nature of conceptions about nursing – seeds sown, it would seem, by virtue of the failure to see that the conceptions are philosophic, rather than scientific in nature and the eclectic amalgamation of ideas. Direct quotations will be used, rather than paraphrasing, wherever it is crucial that Fawcett's ideas, and those of others that she uses, be conveyed accurately.

According to Fawcett (1993, 1995), the structural hierarchy of contemporary nursing knowledge has several components: a metaparadigm, philosophies, conceptual models, theories, and empirical indicators. The hierarchy descends from the metaparadigm (the most abstract) to the empirical indicators (the most concrete).

Metaparadigm

Fawcett (1995) states that the functions of a metaparadigm include that of summarizing a discipline's intellectual and social missions and placing a boundary on that discipline's subject matter. These functions are said to be reflected in the following four requirements of a metaparadigm: (1) it must identify a discipline's domain such that it is distinct from those of other disciplines, (2) it must parsimoniously encompass all phenomena of interest to a discipline, (3) it must be neutral in perspective, and (4) it must be international in scope and substance.

Fawcett (1995) identifies the central concepts of the nursing metaparadigm (the phenomena of interest to nursing) as person, environment, health, and nursing, based on four concepts induced from the conceptual frameworks of baccalaureate programs accredited by the National League for Nursing (NLN). The relationships among the

metaparadigm concepts, which Fawcett enunciates in four propositions, are based mainly on the work of Donaldson and Crowley (1978). Finally, Fawcett states that the metaparadigm cannot be tested empirically because there is no direct connection between it and empirical indicators but that it "should be defensible on the basis of dialogue and debate" (p. 30).

Philosophies

The second component of the structural hierarchy Fawcett (1993, 1995) identifies as "philosophies," describing the relationship of philosophies to the metaparadigm and conceptual models thus:

Philosophies do not follow directly in line from the metaparadigm of the discipline, and they do not directly precede conceptual models. Rather, the metaparadigm of a discipline identifies the phenomena about which philosophical claims are made. The unique focus and content of each conceptual model then reflect the philosophical claims. (1995, p. 24)

Fawcett offers an example of that relationship: a philosophy's claim that all people are equal would be reflected in a conceptual model as nurse and patient being equal partners in health care. Fawcett (1993) outlines the substantive content of philosophies:

Philosophies encompass ontological claims about the nature of human beings and the goal of the discipline, epistemic claims regarding how knowledge is developed, and ethical claims about what the members of a discipline should do (Salsberry, 1991). Different philosophies (world views) lead to different conceptualizations of the central concepts of a discipline and to different statements about the nature of the relationships among those concepts (Altman & Rogoff, 1987). (p. 8)

According to Fawcett (1995), one cannot empirically test philosophies, directly or indirectly, because there is no direct connection between philosophies and empirical indicators and because philosophies are statements of beliefs and values. They "should, however, be defensible on the basis of logic or through dialogue (Salsberry, 1991)" (p. 30).

In her guidelines for analyzing conceptual models of nursing, Fawcett (1995) suggests the following question be asked in relation to the philosophy component: "On what philosophical beliefs and values about nursing is the conceptual model based?" (p. 53). She proposes a similar question with regard to analyzing nursing theories (Fawcett, 1993, p. 36). Additionally, in describing how the components of the structural hierarchy of nursing knowledge might be "translated" in a

particular practice setting, she translates *philosophies* into *philosophy of nursing department* and *conceptual models* into *professional nursing perspective* (1995, p. 521).

Conceptual Models of Nursing

Fawcett (1995) refers to the third component of the structural hierarchy, conceptual models of nursing, as the "formal presentations of some nurses' private images of nursing" (p. 5) and as paradigmatic views of the metaparadigm concepts (pp. 12–13). The term *conceptual model* she takes to be synonymous with *conceptual framework* (p. 2). Conceptualizations of nursing that Fawcett identifies as conceptual models include those of Johnson, King, Levine, Neuman, Orem, Rogers, and Roy. To clarify the purpose of conceptual models, Fawcett (1995) calls upon Dorothy Johnson.

Johnson (1987) explained, "Conceptual models specify for nurses and society the mission and boundaries of the profession. They clarify the realm of nursing responsibility and accountability, and they allow the practitioner and/or the profession to document services and outcomes" (pp. 196–197). (p. 4)

Fawcett (1995) suggests that in analyzing a particular model, one should determine, among other things, how the metaparadigm concepts are defined and/or described and what is stated as the goal of nursing (p. 53).

According to Fawcett (1995), "conceptual models evolve from the empirical observations and intuitive insights of scholars and/or from deductions that creatively combine ideas from several fields of inquiry" (p. 3). Also, the concepts of a conceptual model are not directly observable "nor limited to any particular individual, group, situation, or event" (p. 2), because of their sheer abstractness and generality. Further, the conceptual model is empirically untestable, because there is no direct connection between a conceptual model and empirical indicators, but its credibility can be established indirectly (indirectly tested) by empirically testing middle-range theories derived from the model – theories whose concepts can be defined in measurable terms and from whose propositions empirically testable hypotheses of observable relationships can be derived (pp. 28–30).

Theories

Theories, the fourth component of the structural hierarchy, Fawcett (1993, 1995) believes are different from conceptual models in that they

are less abstract and comprehensive. She posits two kinds of theories: grand theories and middle-range theories. Grand theories are more abstract and comprehensive and, like conceptual models, empirically untestable except indirectly through the empirical testing of middle-range theories derived from them. According to Fawcett (1995), "grand theories are developed through thoughtful and insightful appraisal of existing ideas or creative intellectual leaps beyond existing knowledge" (pp. 24–25). Leininger's, Newman's, and Parse's conceptualizations of nursing Fawcett identifies as grand theories in nursing; those of Orlando, Peplau, and Watson she identifies as middle-range theories in nursing.

Empirical Indicators

The last component of the structural hierarchy Fawcett (1993, 1995) refers to as empirical indicators. "They are the actual instruments, experimental conditions, and procedures that are used to observe or measure the concepts of a middle-range theory" (1995, p. 29).

With the foregoing synopsis of Fawcett's (1993, 1995) conception of the structural hierarchy of contemporary nursing knowledge in mind, let us now see where the seeds of confusion lie and how they could be eliminated through properly conceiving of conceptions about nursing as philosophic in nature.

Fawcett's Conception: Eliminating the Seeds of Confusion

The confusion inherent in Fawcett's conception become apparent when one tries to distinguish between and among the components of her structural hierarchy, on the basis of her descriptions of them. Let us begin by considering the second component, philosophies, because the key to eliminating the seeds of confusion lies here. From Fawcett's (1993, 1995) description of what she refers to as philosophies, it is hard to get a handle on how, exactly, she conceives of this second component. At times it is portrayed as consisting of general philosophies – world views about basic matters; at other times as consisting of philosophies (views) of nursing (philosophic beliefs and values about nursing); at still other times it seems to consist of both general philosophies and philosophies of nursing. This ambiguity is complicated by the lack of clarity in how the beliefs and values about nursing contained in this component differ from those contained in the components that she refers to as conceptual models and theories.

When Fawcett asserts that (a) philosophies inform us of beliefs and values about nursing, its goal, and what its practitioners should do, and (b) conceptual models of nursing tell us of the mission and boundaries of the profession, its realm of responsibility and accountability, and its goal, then philosophies and conceptual models appear to be similar notions. Both seem to provide a nursing perspective. The water becomes murkier when one considers that conceptualizations deemed theories are also said to inform us of those matters seen as falling within the scope of philosophies and conceptual models. Further, Fawcett's (1995) description of how grand theories and conceptual models are developed reminds one of how philosophies are in fact developed.

Finally, the essential difference between philosophies and the metaparadigm becomes further obscured when one reflects on Fawcett's (1995) claim that (a) the metaparadigm identifies the domain of nursing; (b) philosophies are empirically untestable because there is no direct connection between them and empirical indicators and because they are statements of beliefs and values, but they should be defensible by means of dialogue and logic; and (c) the metaparadigm is empirically untestable because there is no direct connection between it and empirical indicators but it should be defensible through dialogue and debate. Now, philosophies and the metaparadigm appear to be similar notions.

Fawcett could argue that philosophies and the metaparadigm are not alike because philosophies are *not* perspective-neutral (i.e., they are perspective-oriented) in that they are world views (Fawcett, 1993) and the metaparadigm is perspective-neutral (1995). But it is hard to see how the metaparadigm can possibly be perspective-neutral if philosophies are perspective-oriented. Given that there can be no presuppositionless conceptions (Martin, 1964), must the metaparadigm concepts and propositions (not to mention the conception of the metaparadigm qua metaparadigm) be grounded in and driven by some philosophy? If so, and if philosophies are perspective-oriented, then would there not be multiple perspective-oriented metaparadigms (and multiple perspective-oriented conceptions of the metaparadigm per se)? Further, it might be asked: how would it be possible to defend philosophies and the metaparadigm(s) in dialogue and on the basis of logic, as Fawcett (1995) prescribes, given that, in her conception, philosophies (being world views) would define truth in different ways, with some rejecting the principle of noncontradiction altogether?

That the preceding questions need to be addressed becomes readily apparent when one examines Fawcett's (1995) analysis of nurse scholars' revisions to her metaparadigm of nursing. Fawcett fails to provide

an adequate defence of her selection of the metaparadigm concepts and propositions and of her claim that the metaparadigm is perspective-neutral and international in scope and substance. In fact, what explanation she does provide (e.g., that the metaparadigm concepts are based on those induced from the conceptual frameworks of baccalaureate NLN-accredited programs), and an examination of the metaparadigm, would support the notion that her metaparadigm is *not* perspective-neutral. It contains a mixture of notions (e.g., "labeling," "intervention," "laws," "patterning," and "wholeness" [p. 7]), which are reflective of specific philosophies and conceptual models or theories of nursing.

Given the seeds of confusion contained in Fawcett's conception of the structural hierarchy of contemporary nursing knowledge, how can we better realize the potential of that structure, to benefit the discipline of nursing? Greater clarity, not to mention parsimony, of thought might be possible by properly conceiving of conceptions about nursing as philosophic in nature, making possible, in turn, the replacement of what Fawcett calls the metaparadigm of nursing, philosophies, and conceptual models and theories of nursing with philosophies of nursing having the form of a philosophic nursing theory. Such a proposal makes sense given that little, if anything, distinguishes the metaparadigm of nursing, philosophies, and conceptual models and theories of nursing in terms of a difference in kind. The distinction that Fawcett (1993, 1995) makes, in terms of levels of abstractness (and all that flows from it), is one of degree rather than of kind. Further, and most importantly, Fawcett attributes to each of them what is in fact a philosophic function: in one way or another, they all address nursing's philosophic questions – questions concerning the nature, scope, and object of nursing and of nursing knowledge, and of what ought to be done and sought in nursing.

With the proposed change, the structural hierarchy of nursing knowledge would consist of components of nursing knowledge (e.g., the science of nursing – scientific nursing theories about nursing phenomena developed using the scientific mode of inquiry and, where appropriate, what Fawcett [1993, 1995] refers to as empirical indicators – the art of nursing, and the history of nursing), all grounded in the basic component, the philosophy of nursing. It should be noted that this change would require that philosophy be released from the domain of mere speculation or opinion and the confines of the nonempirical analytic realm of what Adler (1965) refers to as second-order philosophic questions – analytical questions about what has been put forward as knowledge by the various disciplines. Stated positively, this means we would need to acknowledge that (a) philosophic inquiry can also

provide us with answers to first-order philosophic questions about what is and happens in the world, and of what we ought to do and seek in human life; and (b) its answers are not only logically but empirically testable against common experience (Adler). Acting upon this acknowledgement would make possible the settling of important philosophic nursing issues, such as the nature of nursing, by empirical and logical means, and guard against treating philosophies of nursing as ideologies. In other words, philosophies of nursing in the form of a philosophic nursing theory would be testable against common nursing experience to determine their truth value.

Conclusion

The discipline of nursing is without a doubt at a crucial point in its development. Conceptualizations about nursing are being developed and tested without benefit of a clear conception as to their nature. Despite the ongoing remarkable efforts of such nurse scholars as Fawcett, the nursing literature still serves to confuse rather than clarify thought on this matter. Greater clarity could be achieved by recognizing that questions addressed in conceptions about nursing are philosophic nursing questions to which tenable answers in the form of a formal philosophy of nursing (a philosophic nursing theory) can be attained using the philosophic mode of inquiry (Kikuchi & Simmons, 1994). At a time when it is becoming increasingly important that we define the nature of nursing in a manner that is satisfactory not only to members of our own discipline but to those of other disciplines and to the public, surely it behooves us to clarify the nature of conceptions about nursing. Without such clarification we may continue to struggle in vain to define nursing and, in the process, lose all that we have come to cherish about nursing and seek to retain through definition.

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Acknowledgement

The author gratefully acknowledges the helpful comments made by Dr. Helen Simmons in her reading of drafts of this paper.

Date accepted: June 1996

The Ethical Theory of Existential Authenticity: The Lived Experience of the Art of Caring in Nursing Administration

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Le but de la présente recherche était de procéder à une étude sur l'art de soigner, en tant qu'expérience vécue dans le contexte de gestion en soins infirmiers. Grâce à une méthode autant phénoménologique que herméneutique, on a mis à jour et analysé les expériences de soins qu'ont eues six infirmières-gestionnaires. La description de leurs expériences a fait ressortir des thèmes essentiels. L'interprétation des données sert de lentille à travers laquelle les expressions de l'art de soigner établissaient un rapport avec les philosophies archétypes de l'art : forme vivante, imitation et expression. On a découvert une théorie éthique, l'authenticité existentielle, comme étant l'unité significatif de la gestion en context de soins infirmiers. Cette unité de sens exprimait l'art de gouverner que Platon qualifiait comme la forme la plus élevée de l'art. On présente les diverses implications pour la transformation de la pratique de la gestion en soins infirmiers comme une entreprise éthique de soins où l'on fait appel à l'art de gouverner.

The purpose of this research was to conduct a study of the art of caring in nursing administration. By means of a phenomenologic-hermeneutic approach, the caring experiences of six nurse administrators were revealed and analyzed. Essential themes emerged from their descriptions of their experiences. Interpretation of the data served as the lens through which the expressions of the art of caring related to archetypal philosophies of art: living form, imitation, and expression. An ethical theory, Existential Authenticity, was uncovered as the unity of meaning of nursing administrative caring art. This unity of meaning embodied statespersonship, which was viewed by Plato as the highest form of art. Implications for the transformation of nursing administrative practice as an ethical caring enterprise by the manifestation of statespersonship are presented.

Introduction

Nursing is regarded as an art and a science. Whereas much study has focused on the science of nursing throughout its modern history, the art of nursing has received little attention (Johnson, 1996). Throughout history, art has been distinguished by three major philosophies: form, imitation, and expression (Rader, 1979). Typically, art is viewed as creating harmony and beauty. Within nursing, it is viewed as both a

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rational nursing process and a holistic interpretation of the patient situation (Johnson). Appleton (1993) portrays nursing art as a gift of self. Watson (1985) characterizes it as the reciprocal harmony of body, mind, and spirit.

Enhancing aesthetic knowledge, or the art of nursing as caring, is a necessary pedagogical endeavour in nursing (Appleton, 1993; Brown, 1991; Chinn & Watson, 1994; Smith, 1992). Despite the current foci of nursing as structural, competitive, and driven by outcomes (Barnum & Kerfoot, 1995; Blancett & Flarey, 1995), it is critical that study of the meaning of caring through aesthetic knowing be continued, because it is nursing's most dynamic and visible sign (Ray, 1994; Silva, Sorrell, & Sorrell, 1995).

The purpose of this article is twofold: to explore the meaning of the art of caring in nursing administrative practice, and to illustrate the interconnection among practice, research, philosophy, and theory, by illuminating a theory generated from a phenomenologic-hermeneutic method. In this study, Existential Authenticity characterizes the theory of nursing administrative caring art. Implications for transforming nursing administrative practice as an ethical caring enterprise will be presented.

Significance of the Art of Caring and the Concept of Art

The Art of Caring

The idea of the art of caring can be traced to ancient thought. Gravesite offerings left with human remains by prehistoric survivors more than forty thousand years ago can be interpreted as symbolic of caring. With regard to these offerings, the archeologist Solecki (cited in Constable, 1973, p. 7) stated, "If there is anything that can be labeled as of paramount importance in human development, aside from the brain itself, it is the appearance of caring." Historically, the art of caring was linked to the concept of love, or charity, which evolved through religious organizations and professional nursing into the care of the sick through works of mercy (Donahue, 1985; Nightingale, 1860/1992). A growing body of literature on caring in nursing administration has identified caring as multidimensional and grounded in organizational cultures (Jones & Alexander, 1993; Ray, 1989). Caring in nursing administration has been examined by Brown, 1991; Dunham, 1989; Jacques, 1993; Jones and Alexander, 1993; Miller, 1987; Nyberg, 1989, 1990a, 1990b, 1993; and Ray, 1989. Caring for the caregiver and fostering the integration of

caring into bureaucratic goals has been documented. Caring overall has been defined as the protection and enhancement of human dignity and nurturing wholeness through advocacy and knowledge. Caring has also been viewed as the key component of quality health care (Farley & Nyberg, 1990). Today, within the utilitarian and business philosophy of re-engineering health care (Barnum & Kerfoot, 1995; Blancett & Flarey, 1995), there is a call for a strengthening of human caring in the nursing workplace.

The Concept of Art

Visibility of the ideal in the real is interpreted as the ontology of the beautiful and is recognized as the foundation of fine art (Gadamer, 1986). The expression of beauty connects the visibility of sense, feeling, imagination, and communication presented by the art with the meaning that our understanding senses in the art (Gadamer; Kant, cited in Rader, 1979). Plato (cited in Rader) declared that the highest art is inspired by a direct vision of the pure eternal forms of goodness, truth, and love – unchanging forms, the archetypes that create beauty. Furthermore, he proclaimed statesmanship (referred to in this paper as statespersonship), rather than visual art, as the highest form of art. Statespersonship is “the art of herding [nurturing] human beings by the human caretaker exercising the art of voluntary care voluntarily accepted” (Plato, cited in Klein, 1977, p. 162). A central goal of this study was to find meanings of the art of caring in experiences of nurse administrators, for the purposes of description, interpretation, and the advancement of nursing administrative knowledge.

Method

A phenomenologic-hermeneutic qualitative method of inquiry (van Manen, 1991; Ray, 1991) was chosen for this study of the art of caring in nursing administration. The focus of phenomenology is the meaning of experience; the nexus of life wherein all that we know and do in the world is secured in the intentional consciousness or awareness of the individual, and is self-evident (Husserl, 1970; Levinas, 1988; Solomon, 1988; Wagner, 1983). Phenomenologic research is the descriptive approach to the meaning of experience. Hermeneutics is the theory and practice of interpretation. Its aim is to disclose for the purposes of understanding the meanings of experience, which exist in every human motivation (Solomon). The practice of interpretation is to capture the meaning of the inner dynamics and spirit of a text (subject, situation, or

transcript) within an historical-cultural context (Outhwaite, 1985; Solomon). For the researcher, both the phenomenologic approach and the hermeneutic approach are important. The phenomenologic approach facilitates description of how the consciousness of persons in the lived world of experience synthesizes knowledge of the world. The hermeneutic, or interpretive, approach facilitates understanding from interpretation and incorporation of meanings provided in the text.

Research Approach

A phenomenologic-hermeneutic approach (Ray, 1991) consists of the generation of data by inquiring into the meaning of life-world experiences of participants through interviews and narrative discourse. Reflection is the means by which essential meanings of a phenomenon are revealed. Further reflection facilitates the interpretation of the text to transform data to interpretative themes and metathemes. A unity of meaning captured as a theory and conceptual model is a goal of this research approach.

Sample

This study was conducted in the Midwest region of the United States, at a medical centre with approximately 350 beds. Six nurse-administrators participated; they had the following titles: Assistant Vice-President, Head Nurse, Nursing Education Administrator, Staffing Coordinator, Director of the Maternal-Child Program, and Director of the Critical Care Nursing Unit. The sample is considered adequate to elicit valid data for a study of this nature. All participants were female from Anglo-American cultural backgrounds. Educational levels ranged from B.S.N to Ph.D. Nursing experience ranged from nine to 21 years. The study was approved by institutional review boards of both the hospital and a university. Informed consent was obtained in order to protect the human subjects.

Nurses who agreed to participate were asked to share their experiences and the meaning of their nursing administrative activity as a caring art. The concept of administration was defined as any position that was not considered a staff nurse role and that incorporated leadership and management responsibilities. The art of caring in nursing administration was considered an important topic of investigation. Administrators believed that humanistic attitudes within a business philosophy were essential for administrative practice in the medical centre.

Research Process

During interviews, participants were asked what caring in *nursing administration* meant to them. Responses directed the dialogue after the initial research question. The researcher probed further into the meaning of the art of caring by asking participants to share their experiences as nurse administrators. Interviews, approximately one hour in length, were tape recorded for transcription and analysis.

The six participants provided sufficient foundation in the dialogical encounters to establish validity of the findings in terms of the analysis of the narrative texts. After reflective analysis or “dwelling with” the transcribed texts of caring experiences, data were coded and classified into descriptive or essential themes, followed by interpretive themes. These interpretive themes and their attributes related to the distinct philosophies of art, which were characterized as metathemes. A theory was uncovered through reflective synthesis of and insight into all descriptive and interpretive data.

Results

The unity of meaning expressed as an ethical theory that emerged from the study of the art of caring in nursing administration was titled “Existential Authenticity.” Phenomenologic-hermeneutic theory is a synthesis of unity of meaning of reflective thought formulated both intuitively and deliberately from descriptions and interpretation of data for the specific purpose of illuminating knowledge of a phenomenon. The theory was arrived at by the intuitive action of directly apperceiving, from reflections of narrative text, a unified picture of a higher order of meaning (Polkinghorne, 1988), which deepened and enlarged understanding of the art of caring in nursing administration. Figure 1 illustrates the theory Nursing Administrative Caring Art: Existential Authenticity.

The theory reflects the substantive ground of caring as ethical and relational. Existential Authenticity depicted in the centre of the model shows that the purpose of nursing administration is an ethical mode of existing and illuminates the characteristic of authenticity (unconcealment to self and others) which grants the promise of truth. Surrounding the centre are the **themes** of economic-political-ethical valuing, recognizing caring, and relational processing. The themes relate to the philosophical theories of art: the **metathemes** of living form, imitation, and expression.

Figure 1 *Existential Authenticity: The Ethical Theory of the Art of Caring in Nursing Administration*



Living form as economic-political-ethical valuing, **imitation** as recognizing caring, and **expression** as relational processing show that the meaning of caring in nursing administration is a pattern of dynamic, rhythmic interconnectedness. This holistic pattern highlights the form and life of the art of caring as both material and sensory, which can be recognized in ethical thoughts, feelings, and actions. In other words, the ideal of the art of caring for nurse administrators complemented the ethical (Croce, 1979). It symbolizes authenticity, which is concerned with the manifestation of what is true. In this denotation, truth is understood as transparent (Quine, 1990). The philosopher Taylor (1991) points out that art in itself is bound to others. The meaning of caring to nurse administrators revealed this attachment. The meaning was transparent, hence self-evident. In their expressions of caring, nurse administrators disclosed what lay deepest within the human spirit – an ethic of living caring for the good of their staff nurses and for the good of the organization.

Context of the Theory

Essential Themes

Twelve essential themes were uncovered in the phenomenological reflective analysis of the data from extensive narrative texts of the six

participants. Descriptions of the data, deemed essential, or integral, emerged as an expression of deep feeling and knowing about the dynamic “felt life” of caring in the organizational environment of the medical centre.

Table 1 <i>Essential Themes of Nurse Administrators' Descriptions of the Art of Caring</i>	
Themes	Descriptions
Choosing	<ul style="list-style-type: none"> • “Make the most of the moment we have and make the choice of how to spend this moment.”
Shaping	<ul style="list-style-type: none"> • “Caring shapes experience.”
Exchanging	<ul style="list-style-type: none"> • “Patient care is a commodity.”
Facilitating	<ul style="list-style-type: none"> • “Facilitate the one meaningful experience instead of using ritualistic behaviour.”
Feeling	<ul style="list-style-type: none"> • “A learned sense of feeling.”
Integrating	<ul style="list-style-type: none"> • “Caring that others care.”
Journeying	<ul style="list-style-type: none"> • “A personal journey – a journey in self-worth.”
Knowing	<ul style="list-style-type: none"> • “Take scientific knowledge and skill. Use them to help in such a way that the person doesn't realize that you are helping.” • “Using scientific knowledge and skill to understand how caring can be sustained in the hospital.”
Loving	<ul style="list-style-type: none"> • “Potential is love, and love is of God.”
Modelling	<ul style="list-style-type: none"> • “Humanistic caring is essential.”
Processing	<ul style="list-style-type: none"> • “Process with people.”
Valuing	<ul style="list-style-type: none"> • “The value of nursing: to care holistically.”

Table 1 shows the essential themes of the nurse administrators' expressions of caring art. They first manifested deep personal feeling and value about the meaning of the art of caring, and then related those meanings to the administration of nursing. Some of these expressions were eloquent, such as “caring shapes experience” and “caring's potential is love, and love is of God.” Caring also was viewed as “a personal journey...in self worth.” Other expressions about caring were “facilitating meaningful experiences for staff nurses” and “caring that others care.” Nurse administrators were distressed that some non-nurse

administrators and staff nurses did not see caring as significant to the mission of the hospital. One nurse administrator described caring as "using scientific knowledge and skill to understand how caring can be sustained in the hospital." The insight gleaned from reflecting on essential themes phenomenologically or before hermeneutic interpretation was engaged revealed that caring was an ethical, spiritual, and humanistic process integral with the science and skill of administrative nursing.

Interpretive Themes

Engaging the hermeneutic process facilitated interpretation of deeper levels of meaning of the data. In the hermeneutic, or interpretive, process, the researcher discovered that the data mirrored the philosophies of art (metathemes): form, imitation, and expression (Rader, 1979). The interpretive themes of caring art were Economic-Political-Ethical Valuing, Recognizing Caring, and Relational Processing.

Table 2 <i>Metathemes of Art, Themes, and Attributes of Caring Art in Nursing Administration</i>		
Metathemes of Art	Interpretive Caring Themes	Attributes of Caring Art
Living Form	Economic-Political-Ethical Valuing	<ul style="list-style-type: none"> • Exchanging commodity values • Negotiating the politics • Valuing the ethic of caring
Imitation	Recognizing Caring	<ul style="list-style-type: none"> • Sensing needs • Motivating reciprocity • Modelling caring
Expression	Relational Processing	<ul style="list-style-type: none"> • Processing relationships • Interacting-participating • Integrating caring

Universally, the meaning of the data showed that there were differently organized realms of meaning, "matter, life, and consciousness" (Polkinghorne, 1988, p. 2), which actually complemented the philosophies of art. The following is a description and discussion of the philosophies of art: living form, imitation, and expression as they appertain to the meaning of the experience of administrative caring art.

Administrative caring art as Living Form: economic-political-ethical valuing. Form is one of the oldest concepts in the philosophy of art. It has both visible and conceptual connotations (Tatarkiewicz, 1973). Those visible characteristics of form are material and relate to nature; those conceptual are sensuous (Bungay, 1987). In this study, form was apprehended as living form – the art of feeling and thought as well as vitality and spirit, in terms of the material (Langer, 1951, 1953). For example, economic and political motifs conjoined with ethical valuing. The unity formed an integration or pattern of mind, body, and spirit in a network of human caring activity that affected the good of the nurses whom nurse administrators were responsible for within the political and economic spheres of the hospital.

The *metatheme of Living Form: with the theme economic-political ethical valuing* and its three attributes – **exchanging commodity values, negotiating the politics, and valuing the ethic of caring** – show that the caring expressions of nurse administrators are bound to the complex organization. Narrative examples of the attribute **exchanging commodity values** were: “make caring tangible, and evident in administration,” “patient care is a commodity (economic good or value),” “when we as nurses are removed from the bedside, it’s easier to make commodity decisions.” Narrative examples of the attribute **negotiating the politics** were: “nurses are political beings (powerful in the organization),” “women are innately political but don’t talk about it; they aren’t acculturated to see the political as positive,” “the role of the nurse administrator is making the bedside nurse’s job easier,” “the nurse administrator is a system coordinator; nurses are the system and know what impinges on them.” Narrative examples of the attribute **valuing the ethic of caring** were: “the nurse administrator needs to be caring and shouldn’t be like other administrators,” “keep nurses in nursing administration and retain the core of nursing values of caring,” “value of nursing is to care holistically,” “nurse administrator integrates nursing values into decisions – ethical decision maker.”

The art of caring embodies the economic, the political, and the ethical within the idea of value. Its meaning is understood as a “good” or an ethical value and a commodity in the organization where caring relationships are solidified. Ethical caring action, or the concept of the good of caring in the organization, shapes political and economic experiences and is shaped by them. Although caring has been identified as an economic resource by some nurse researchers (Diamond, 1985; Nyberg, 1990a, 1990b, 1993; Ray, 1987, 1989; Ray et al. 1995; Smerke, 1988; Valentine, 1989), the concept of caring generally is not perceived as an economic resource. The meaning of the experience, however,

points out that caring is valued as both an interpersonal and an economic resource within the organization by nurse administrators. Caring is sustained through ethical decision-making and action in political negotiations and economic decisions. The living form of caring in nursing administration thus integrates rational thought and human feeling – a dominant view in aesthetic theory (Bungay, 1987) and a paradoxical view in nursing (Johnson, 1996).

Nursing administration caring art as Imitation: recognizing caring. The focus on imitation refers to both the Greek concept of art as imitation of nature and Aristotle's views of imitation as recognition (Gadamer, 1986). Within every work of art lies the power of a spiritual energy that generates order (Gadamer). Recognition of this order is associated with truth and trustworthiness. This notion is similar to Gadamer's perception in that – in things we see – we see what is permanent and essential in them. Imitation reveals the authentic reality of a thing. Imitation thus refers to recognition of what is true, and within the notion of imitation it tells what "true" art is (Bungay, 1987).

The *metatheme of Imitation: with its theme, Recognizing caring* and its three attributes – **sensing needs, motivating reciprocity, and modelling caring** – illuminates the point that caring actions are visible as a structural practice. Narrative examples of the attribute of **sensing needs** were: "be willing to invest concern, time, and resources in nurses' life problems," "respect and enhance nurses to help develop them more fully," "have an ability to listen; help nurses define for themselves whether nursing fits with what they think it is to help them to stay in a caring mode," "let your nurses know what it's like to be wounded too, vulnerable," "be honest and help nurses talk about problems; reinforce caring." Narrative examples of **motivating reciprocity** were: "what is the motivation to care for the patient by the nurse? It's a two-way process. Patients feel gratified at whomever will meet their needs. Nurses need gratitude for caring," "in the doctor-nurse relationship physicians respond to respect; before, they expected it, now when you show caring they 'fall all over' you – it's a reciprocal reaction," "by responding in a more understanding way, you come across as a more caring person." Narrative examples of **modelling caring** were: "role models show a caring attitude with the expectation that this attitude will be conveyed to patients," "what is the motivation for caring on the part of the patient or nurse? If nurses are overwhelmed, they quickly lose caring," "model caring for others; be a mentor. If staff nurses are not surrounded by caring people, how can they care for patients?" "the nurse administrator needs to be sensitive to nurses in crisis. She must demonstrate care for each individual," "emotional and spiritual concern

must be demonstrated so that nurses' physical tasks shared with the patient are a manifestation of caring," "don't say one thing and do something else; it's a dangerous philosophy in nursing administration so carry through with your philosophy. Be truthful; there must be truth behind the saying 'The door is always open'."

The theme of Recognizing Caring supports the notion that what is central in the nurse administrator's life is a correlation between belief and action. This is authentic caring. In other words, a caring philosophy is transparent; it shines through the person caring and is evident in action. Nurse administrators also recognized their role as encompassing the ability to sense needs and motivate the nurses to whom they were responsible by personally caring for them. Caring was recognized as caring by the way in which nurse administrators communicated and acted. As such, nurse administrators mentored and counselled their staff nurses so that not only was their caring a reflection of nurse administrators' caring for staff nurses, but also that it could be reflected in the care given by staff nurses to patients. The art also represented the reality of the organizational context within which professional caring was lived out. Again, the expressions of caring exposed the art of imitation in the themes of sensing needs, reciprocal motivation, and modelling caring by essentially showing that true art must be visible or recognizable.

Nursing administrative caring art as Expression: relational processing. Expression is an influential idea in the history of aesthetics. In the 18th century, the world view of expression displaced the previous concepts of imitation and form as dominant theories of art. Expression grew out of musical aesthetics. In visual works of art, it was defined in terms of the communicative content of a portrait. All beauty was interpreted relative to the expression of mood, feeling, or spirit. There was consensus that "first, art is expression, and second, that spirit, feeling, or mood is expressed" (Rader, 1979, p. 5). An example would be to listen to the themes of Peter and his grandfather in Prokofiev's *Peter and the Wolf*, or the dying swan in *Swan Lake*. Like the characters portrayed, the music sounds joyful and expansive, gruff, or passionately sad. Pratt remarked, "Music sounds the way emotions feel" (Rader, p. 5). Feeling in this sense refers to Langer's view, which encompasses everything, from physical sensation, pain, comfort, and excitement to the most complex emotions related to the intellect or human consciousness (Langer, 1953).

The *metatheme of Expression: with its theme of relational processing* and its three attributes – **processing relationships, interacting-participating,**

and integrating caring – shows that understanding caring is understanding relationships. Narrative examples of **processing relationships** were: “nursing administration is a process which needs to be learned to be successful; the key is relationships,” “the art of nursing administration is processing with people, sensitivity to staff,” “processing carefully is as important as having a humanistic philosophy.” Narrative examples of **interacting-participating** were: “interaction is fundamental,” “participating with various groups by design is the major energy of the participative process; exciting to participate in corporate activities – stressful but exciting.” Narrative examples of **integrating caring** were: “it’s okay to show you care – lots of nurturing, loving, and open expression of feelings, and humour as well,” “do little things for staff – feminine in nature, write cards and notes, buy flowers, do something special for your nurses,” “give psycho-emotional support for clinical nurses,” “concept of integration is the art of nursing administration – caring that others care.”

Nurse administrators demonstrated that caring was reflected in relationships – the intersubjective or the “I-Thou” (Buber, 1965). This sphere is where the “self and other,” through the active choice to participate and interact, is processed or operationalized and realized by self and the other as authentic. By the ability to participate and interact in a humane and loving way with their staff and integrate a caring philosophy into expressive action, nurse administrators chose to express both actual feelings of caring and what they knew about human caring in relation to their administrative role. Expression in this sense was existential because it revealed what was essential in the structure of caring in nursing administration. A key notion of authenticity (Heidegger, cited in Solomon, 1988) is such that in the identity of an entity (a caring person), the person relates to its reality as a caring person. This was exemplified by the profound expression “caring that others care.” The expressive art of nursing administration is a mode of existing and acting. By choosing to connect with staff nurses to whom they were responsible through a caring philosophy and integrating caring into their own actions, nurse administrators underscored the primacy of caring as authentic relationship.

Discussion

Caring in relationship to others as an existential authentic process of the holistic unity of self-knowledge and action – feeling, knowing, and doing – is the foundation of caring in nursing administration; hence the unity of meaning, the theory of “Existential Authenticity.” Nurse

administrators had an aesthetic appreciation of the synthesis of the science of administration and management of humane and ethical values in the hospital system. The aesthetic attitude was expressed not only in a humane sense, but also in an evaluative or ethical sense. Overall, nurse administrators expressed the meaning of caring as directed toward the good of others. They applied "the principle of beneficence" – the central ethical principle of bioethics (Beauchamp & Childress, 1994). Caring art accordingly expresses an ethical vision of doing good or being ethical within political and economic administrative actions in the organizational context.

The knowledge and beliefs of caring peak in this theory to reflect the Platonic ideal of statespersonship as the highest form of art – that is, the art of nurturing human beings by a human caregiver exercising the art of choosing to be caring and having it freely accepted (Plato, cited in Klein, 1977). This highest art is inspired by a direct vision of the pure eternal forms of goodness, truth, and love – unchanging forms, the essential patterns of the meaning of humanness – what creates beauty (Plato, cited in Rader, 1979). The art of caring in nursing administration thus relates to the beautiful – that "which shines forth most clearly and draws us to itself...the very visibility of the ideal" (Plato, cited in Gadamer, 1986, p. 15).

Implications for Nursing

The results of this study present a call for the reformation of nursing work, specifically a model of nursing administration as an ethical caring form of practice – an art and science that reconsiders work as a virtue, the most enduring concept in the history of ethics (Pellegrino, 1995). They call for a reintegration of the moral agent or statesperson in the events of human life, particularly within the emerging economic focus of health care (Pellegrino). A new paradigm can be created both for education and for practice that, first, clearly supports nursing administration as a practice that values human caring in relation to business values, and, second, incorporates ethics into nursing administration and management sciences to meet the current challenge of re-engineering nursing and health care.

Administrative nursing research needs to study the relationship of staff-nurse caring and patient responses relative to the results of this study, which show that the leadership role of the nurse administrator is statespersonship. This high calling comes with a responsibility to more fully understand whether a theory of "Existential Authenticity" is truly transmitted to and lived out in the responses of staff nurses and

patients. Further research will be required to determine whether the caring data of staff nurses and patients actually complement or challenge the results of the present study.

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Date accepted: September 1996

Compte rendu de lectures

Culture et santé publique. Les Contributions de l'anthropologie à la prévention et à la promotion de la santé

Raymond Massé
Montréal: Gaëtan Morin, 1995. 499 pp.
ISBN 2-89105-565-9

Compte rendu par Johanne Archambault

Ce livre s'adresse à un large public composé d'intervenants, de planificateurs, de chercheurs et d'étudiants provenant de diverses disciplines et œuvrant dans le champ sociosanitaire. En fait, il intéressera tous ceux qui sont convaincus de la nécessité de bien saisir le point de vue des clients pour comprendre les comportements de santé et donc, pour mieux intervenir dans un contexte tant préventif que curatif.

La visée fondamentale de l'auteur est de favoriser l'émergence d'une nouvelle philosophie en santé publique, qui s'appuie sur le concept de culture et sur une définition anthropologique des personnes comme productrices de sens et de significations. L'argument d'un nécessaire virage en santé publique repose sur le constat des nombreux échecs de divers programmes de promotion et de prévention, attribuables à la négation de la culture des populations qu'ils prétendaient rejoindre. Plusieurs exemples d'échecs sont examinés, tel que : 1) l'échec des programmes de santé publique dans les pays en voie de développement (1^{re} partie); 2) l'échec des programmes destinés aux populations défavorisées des sociétés occidentales (3^e partie); 3) les difficultés d'adaptation des programmes de prévention à la réalité multiculturelle des sociétés modernes (4^e partie). L'insensibilité aux réalités socioculturelles des clientèles mine l'efficacité des activités et des programmes de prévention et de promotion de la santé. Aussi est-il impératif de développer des programmes d'intervention sensibles au savoir populaire et aux nouvelles réalités ethnoculturelles.

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Quoique les constats d'échec servent d'assise à l'argumentation et signalent l'urgence d'examiner nos modèles de pensée dans le cadre d'un contexte où les ressources se raréfient, l'ouvrage traite davantage de la quête et de l'exploration d'une nouvelle voie, celle offerte par l'anthropologie, pour poursuivre les efforts d'amélioration de la santé des personnes et des populations. Le développement des connaissances scientifiques, en mettant en relief la multiplicité et l'interactivité des déterminants de l'état de santé et les facteurs influant sur l'utilisation des services de santé, a permis de constater que la promotion et la prévention de la santé constituent des domaines complexes d'intervention. Cette complexité exige la mise à contribution de divers savoirs disciplinaires. Ici, l'auteur s'emploie à souligner l'apport de l'anthropologie à la *définition et à la mesure des problèmes de santé* (2^e partie) ainsi qu'à l'*élaboration de programmes de prévention et de promotion de la santé* (3^e partie) favorisant la circulation des messages sanitaires d'une culture à l'autre. Cette démonstration passe, entre autres, par un exposé sur la contribution de l'anthropologie à la compréhension : 1) des facteurs faisant obstacle à l'efficacité des programmes de prévention en santé publique internationale; 2) de la construction socioculturelle des facteurs de risque; 3) du rôle de la culture dans les conceptions du normal et du pathologique; 4) des définitions populaires de la maladie; 5) des facteurs socioculturels expliquant la sous-utilisation des services de santé. Outre la présentation initiale des cadres conceptuels de l'anthropologie (1^{re} partie), l'exposé est ponctué de multiples références à des modèles explicatifs et définitions issus de l'anthropologie, ainsi qu'à des études et à des cas concrets permettant de saisir l'utilité de la perspective anthropologique proposée par l'auteur.

Il est clair que l'on constate davantage l'importance de s'intéresser à la culture et aux visions des clients provenant d'autres groupes ethniques. Mais il est primordial, de dire l'auteur, de voir **tous les Québécois** comme porteurs de culture. On oublie que tous les Québécois ne partagent pas les mêmes interprétations de la maladie et des comportements de santé. Il faut saisir ces interprétations, conditionnées par leur culture ou sous-culture d'appartenance, de même que la logique sous-jacente à leurs comportements de santé, pour percer les barrières sociales et culturelles qui empêchent l'intégration des messages sanitaires. À cet égard, l'exemple de l'échec de certains programmes d'intervention destinés aux milieux défavorisés dans nos sociétés occidentales est très éloquent.

Cet ouvrage est résolument «interdisciplinaire» (terme utilisé dans la préface par Gilles Bibeau), en ce sens qu'il vise à favoriser le croisement des savoirs issus des sciences de la société et de la culture (socio-

logie et anthropologie) avec ceux de disciplines déjà largement mises à contribution en santé publique comme l'épidémiologie, la démographie et la psychologie sociale. À cet égard, l'auteur identifie, entre autres, des passerelles entre la perspective épidémiologique et la perspective anthropologique (2^e partie).

Que l'on endosse ou non le plaidoyer de l'auteur en faveur d'un nouveau paradigme en santé publique, on puisera, dans cet ouvrage, des éléments fondamentaux de réflexion qui remettent en question les modèles actuels de pensée véhiculés dans le domaine sociosanitaire. Pour ma part, ce plaidoyer m'a convaincue. Qu'en sera-t-il de vous ? Je vous convie à une lecture passionnante !

Book Review

Health Promotion in Canada: Provincial, National and International Perspectives

Ann Pederson, Michel O'Neill, and Irving Rootman (eds.)

Toronto: W.B. Saunders, 1994. 401 pp.

ISBN 0-920513-09-3

Reviewed by Louise Potvin

The introductory chapter of this collection of essays is aptly entitled "Tell Me a Story." With these four words, Ilona Kickbusch conveys the essence and tone of the book – which tells the story of the development of health promotion in Canada. Kickbusch's description is complemented by the reflections of non-Canadian authors, whose international perspective emphasizes the uniqueness of the Canadian experience. The editors "believe that Canada's contribution to the field has been both significant and misunderstood," adding that "this book aims both to celebrate and clarify it" (p. 1). Throughout the 24 chapters of the volume, one is given the impression that health promotion has been on the federal government agenda, its policies implemented mainly by public health officials. This impression is reinforced by the fact that most contributors use as landmarks for their discussion two federal documents – the Lalonde (1974) and Epp (1986) reports.

Five sections describe Canadian health promotion from as many viewpoints. "Conceptual Perspectives" (four chapters) introduces concepts useful for interpreting the sections that follow. One chapter presents an historical framework, one a sociological framework. Robin Badgley, in his historical reconstruction, considers publication of the Lalonde report a turning point and argues for a continuation of health education and promotion. Michel O'Neill and Ann Pederson see the sociology of knowledge and the sociology of social movements as useful for an understanding of the development of health promotion. Their thesis is that health promotion was a synthesis addressing many of the late-1970s critiques of health education and translating into a novel praxis diffused through a professional movement; a key element

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of this synthesis was a positive vision of health. The next chapter provides an overview of the positive models found in the literature. Ron Labonté closes this theoretical section with the argument that health promotion as a praxis emerging from the social movements of the 1970s collided with the bureaucratization of health that followed in the 1980s.

Two sections dealing with the national and provincial perspectives form the core of the book. Several themes emerge from these case studies, written by people who were involved at these levels. First, the case is strongly made that Health Canada took a leadership role, by creating the Health Promotion Directorate, in developing and fostering health promotion. Second, most provinces integrated some form of health promotion into their delivery systems, which gives fuel to Labonté's argument that health promotion is primarily a set of strategies for government health officials, and that therefore it is limited in its potential to lead to in-depth reform. Third, it appears that federally, and in many cases provincially, community development has been a central concern of health promotion programs and policies. Programs such as Healthy Cities found advocates at all levels, and many provinces created their own version of it. One caveat with these descriptions is that they were written during a period when most provinces were undergoing major reforms, and therefore many are likely to be obsolete.

In the fourth section, "International Perspectives," non-Canadian contributors reflect on the Canadian experience. Lawrence W. Green argues that although the Canadian collectivist and social vision of health promotion is often contrasted with the supposedly individualistic and liberal American version, the praxis of American health promotion is rooted in similar principles of community development. John Raeburn's brief account of the New Zealand experience serves as a warning: In an era of reform and budget constraints, health promotion programs might be among the first to be sacrificed by proponents of a neo-liberal ideology. Finally, David McQueen's report on the Canadian contribution to research in health promotion is refreshing. If not for this one chapter, the reader would be left with the impression that health promotion is exclusively a praxis, and hence that research has not been an important item on the Canadian agenda.

The two concluding chapters offer similar diagnoses and prognoses regarding the achievements of health promotion. While the editors seem optimistic, however, Trevor Hancock is sceptical. Both contributions argue that the health promotion agenda must be widely adopted outside the health establishment, but Hancock fears the constraints imposed by

globalization and industrialized capitalism, with their corollary of inequities and poverty, will precipitate further conservative changes. The editors, for their part, predict a diffusion of ideas around health promotion and a strengthening of the community development agenda. Three years after the publication of *Health Promotion in Canada*, it appears their optimism was justified. The final report of the National Forum on Health (1997) pleads for measures to reduce social and health inequalities and promote new partnerships at the community level, indicating that health promotion ideology may well survive and flourish.

There is no doubt that this book provides useful information on the evolution of health promotion in Canada. The fact that most of the authors were key players in this evolution adds credibility and renders it essential reading for anyone interested in the subject. Two factors, however, circumscribe the contribution of *Health Promotion in Canada*. First, the absence of a critical perspective makes the stories somewhat rosy and limits our understanding of how an innovation like health promotion develops and gains credibility. Second, the emphasis on integration of health promotion into the government agenda is to the detriment of an understanding of the research agenda.

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Happenings

Centres for Health Promotion Research in Canada

Miriam Stewart

The past decade has been exciting for health promotion research in Canada. An International Symposium on the Effectiveness of Health Promotion in 1996 reviewed impressive evidence regarding health promotion strategies in the 1986 Ottawa Charter for Health Promotion. In 1997, the Working Group on Determinants of Health of the National Forum on Health indicated that the broad approach, recommended in the symposium report, was consistent with their emphasis on the socio-economic-environmental factors that influence health practices and health outcomes. The Working Group on Striking a Balance endorsed rigorous evaluation of health promotion, disease prevention, and sickness care interventions. The National Forum itself recommended that priority be given to supporting gaps in knowledge about the impact of key determinants of health, outcome-oriented research, and dissemination of results (National Forum on Health, 1997a, 1997b). The health promotion research centres in Canada have played and will continue to play a key role in achieving the directions proposed by the National Forum on Health. The funding, structure, mandate, partners, staff, communication mechanisms, and contact numbers of the 15 centres are summarized in Table 1. Fourteen of these centres were launched in the past 10 years. Most centres were established with a threefold mandate: innovative health promotion research, community partnerships, and education and training. The policy function of the centres continues to evolve.

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Table 1 *Canadian Health Promotion Research Centres*

Centre, Location, Phone #	Funded by	Structure (committees)	Partners, Associates, Members	Newsletter/ Website	Mandate/ Mission
BC Consortium for HP Research (BCCHPR) Year founded: 1993 [includes 3 centres: Community HP Centre (U Vic), Gerontology Research Centre (SFU), Institute for Health Promotion Research (UBC)] 6248 Biological Sciences Rd. Vancouver, BC V6T 1Z4 (604) 822-2258 L Green, Director, UBC CJ Frankish, UBC G Gutman, Director, SFU M Hills, Director, U Vic	SSHRC NHRDP UBC Simon Fraser U U Victoria	Research team Project team Staff	Network of over 500 organizations & individuals – 107 Faculty associates – provincial & national HP & research networks; community; hospitals; government	BCCHPR insert in IHPR Bulletin and GRC News; http://www.ihpr.ubc.ca	– foster & facilitate collaboration on innovative, multi- disciplinary & action- oriented approaches to community-based HP research that merge expertise of community, professionals & policy makers
Health Promotion Research Group Year founded: 1993 Department of Community Health Sciences University of Calgary 3330 Hospital Dr. NW Calgary, AB T2N 4N1 (403) 220-6940 A Vollman, Director	University Faculties and Management	Collaboration on activities by many Faculties	35 members -- many disciplines; hospitals; Regional Health Authorities; Community Health Centres; governments; community groups; professional associations; NGO's		– facilitate collaboration between the university & other community resources in HP research, and to nurture multidisciplinary research in the area of HP that builds on this collaboration

Table 1 (cont'd) *Canadian Health Promotion Research Centres*

Centre, Location, Phone #	Funded by	Structure (committees)	Partners, Associates, Members	Newsletter/ Website	Mandate/ Mission
Alberta Centre for Well-Being Year founded: 1989 3rd Fl. Percy Page Centre 11759 Groat Rd. Edmonton, AB T5M 3K6 (403) 453-8692 ext. 6884 C Smith, Director	Alberta Sport, Recreation, Parks & Wildlife Foundation; Alberta Community Development; Alberta Health	Executive Management Group; Advisory Board	5800 multidisciplinary associates; Regional Health Authorities; non-profit groups; universities, Health Canada, Alberta Health, students, academics, researchers, health professionals	WellSpring Research Update www.health-in-action.org/well-being	– enhance health & well-being of Albertans by providing research, education and networking opportunities through coordinated, collaborative efforts
Centre for HP Studies Year founded: 1995 University of Alberta 13-127 A Clinical Sciences Building Edmonton, AB T6G 2G3 (403) 492-7385 D Wilson, Director	Alberta Health; Alberta Advanced Education and Career Development; Health Sciences Deans, U of Alberta	Coordinating Council of Health Sciences; HP Standing Committee; Community-based Advisory Committee (under development)	17 Regional Health Authorities; Alberta Centre for Well-Being; Lethbridge RCHP; Calgary HPRG; Alberta Cancer Board; Health Canada; Nechi Research, Training & HP Institute		
Regional Centre for HP and Community Studies Year founded: 1993 University of Lethbridge 4401 University Dr. Lethbridge, AB T1K 3M4 (403) 382-7152 J Kulig, Director	SSHRC NHRDP	Executive Committee Board of Directors Research Advisory Committee 76 research associates	Health Units; Treaty Health Boards; Community organizations; Boards of Education; Hospitals; other universities	Health Links http://www.uleth.ca/chp/	– promote & conduct community-based research on health & HP in southern AB having relevance to other regions of Canada – disseminate research widely

Table 1 (con'd) Canadian Health Promotion Research Centres

Centre, Location, Phone #	Funded by	Structure (committees)	Partners, Associates, Members	Newsletter/ Website	Mandate/ Mission
Prairie Region HP Research Centre Year founded: 1993 University of Saskatchewan Health Sciences Building 107 Wiggins Rd. Saskatoon, SK S7N 5E5 (306) 966-7932/7939 J Feather, Coordinator	SSHRC NHRDP	Management Board; 80+ community partners and 90+ research associates in 22 disciplines at 5 universities & in private consulting practice	5 universities; First Nations bands & Tribal Councils; local health districts; community health centres & organizations/groups; unions; professional organizations; government	Connections http://duke.usask.ca/~sproat	– foster/support HP research through interprovincial network of community organizations, practitioners, policy makers, & researchers in the 5 universities in the region
Centre for Applied Health Research Year founded: 1984 University of Waterloo 200 University Ave. West Rm 3116 Waterloo, ON N2L 3G1 (519) 855-1211 M Sharratt, Director	project-specific partners share in collaborative projects and clients pay for services (e.g., training & consulting)	Umbrella for several Centres (Ergonomics & Safety Consulting Service; Rehabilitation Education & Research, Alzheimer Research & Education) Board of Directors; Management Committee	70 associates from multi-disciplinary faculties; other universities; governments; industry, community organizations/agencies	CAHR News http://www.ahs.uwaterloo.ca/~cahr/cahr.html	– applied research in disease/ injury prevention & HP – collaborative, interdisciplinary work – develop, implement & evaluate new models for preventive health care, influencing population health
McMaster Research Centre for the Promotion of Women's Health Year founded: 1993 McMaster University Kenneth Taylor Hall 233/226a 1280 Main St. Hamilton, ON L8S 4M4 (905) 525-9140 ext 23316 M Hajdukowski-Ahmed & M O'Connor (co-chairs)	SSHRC NHRDP	Steering committee; Research Project Committees; Immigrant Women, Work and Health Advisory Committee	University researchers (29 research affiliates); service agencies; community groups; Public Health; District Health Council	Promoting Women's Wellness http://www.mcmaster.ca/mrcpowh	– focus on women, work health – identify work-related health concerns of women – develop & implement new strategies for promoting women's health – emphasis participatory action research

Table 1 (cont'd) *Canadian Health Promotion Research Centres*

Centre, Location, Phone #	Funded by	Structure (committees)	Partners, Associates, Members	Newsletter/ Website	Mandate/ Mission
Centre for Health Promotion Year founded: 1989 Banting Institute University of Toronto 100 College St., Suite 207 Toronto, ON M5G 1L5 (416) 978-1809 (includes 4 research units) I Rootman, Director	Community Health, Faculty of Medicine, University of Toronto; Bertha Rosenstadt Endowment Fund; Connaught Laboratories	Advisory Board; Community Advisory Committee; Members (29); Associates (125)	CPHA; city and regional public health depts; participACTION, Addiction Research Foundation; Ontario Prevention Clearing- house; Canadian Centre of Substance Abuse; hospitals; business; government	Information Update http://www.utoronto.ca/chp/	<ul style="list-style-type: none"> – contribute to the health and well-being of Canadians through basic and applied HP research, education and service – in a multi-disciplinary context it will activate, develop & evaluate new approaches to HP
Community Health Research Unit Year founded: 1989 University of Ottawa Dept. of Epidemiology 451 Smyth Rd. Ottawa, ON K1H 8M5 (613) 562-5800 ext 8262 N Edwards, Director	Ontario Ministry of Health	Management group; Personnel & dissemination committees; Think tanks	Ottawa-Carleton Health Dept.; Dept. of Epidemiology & Community Medicine; School of Nursing, University of Ottawa; Public health staff; community groups	CHRU Highlights; CHRU Perspectives http://www.uottawa.ca/academic/med/epid/chru.html	<ul style="list-style-type: none"> – enhance scientific basis for public health practice through development of new knowledge, foster evidence-based practice – understand, measure & test elements of public health for effective practice
Centre de recherche en promotion de la santé de Montréal Year founded: 1993 Université de Montréal 2375 ch. Côte Ste-Catherine Bureau 7100 Montréal, Québec H3C 3J7 (514) 343-6111 ext 8621 R Perreault, Director	SSHRC NHRDP	Association Committee; 30+ Research Associates from various disciplines; students participate in projects as interns	Public health units; youth groups; municipalities; daycares; CLSC's, school boards; hospitals; ethnic groups; international health units; unions; professional corporations	CRPSM Promotion	<ul style="list-style-type: none"> – evaluate the process of social change in order to promote a better quality of health & well-being within the mandates of: research, education, dissemination of information & partnership

Table 1 (cont'd) Canadian Health Promotion Research Centres

Centre, Location, Phone #	Funded by	Structure (committees)	Partners, Associates, Members	Newsletter/ Website	Mandate/ Mission
Groupe de recherche et d'intervention en promotion de la santé de l'Université Laval Fondé : 1990 École des Sciences infirmières Université Laval Cité universitaire Québec (Québec) G1K 7P4 (418) 656-3356 M O'Neill, co-directeur G Godin, co-directeur	Partenariats de recherche liés des projets et programmes particuliers	L'infrastructure regroupe des chercheurs de multiples disciplines en promotion de la santé (Laval et autres institutions partenaires)	Universités, gouvernements municipaux, provinciaux et fédéraux; hôpitaux; Ministères de la santé; organismes de santé nationaux et internationaux; fondations; associations professionnelles; organismes environnementaux	(page web en développement)	– oriente l'ensemble des activités de recherche, de diffusion des connaissances, de formation et de support
Atlantic HP Research Centre Year founded: 1993 Rm. 5200 Dentistry Building Dalhousie University 5981 University Ave. Halifax, NS B3H 3J5 (902) 494-2240 M Stewart, Director	SSHRC NHRDP	Advisory Board; Management Committee; Centre-Government Liaison Committee; Strategic Planning Committee	150 associates from various disciplines; academic researchers at Atlantic universities; health professionals; community groups; government	Health Promotion Atlantic http://is.dal.ca/~ahprc/ahprc.htm	– foster research that investigates the impact of self-help, mutual aid, coping and public participation on health behaviour, health status, health services use – facilitate research in Atlantic Canada

Educational Initiatives

Across the country, centres have embarked on educational endeavours which target students, practitioners, community groups and policy makers. The B.C. Consortium for Health Promotion Research, which encompasses three centres, has sponsored a series of seminars and workshops. The Institute for Health Promotion Research [IHPR] (UBC) conducts an annual summer Institute on Health Promotion Planning and Evaluation. Staff members of the three university-based centres teach courses in their respective academic departments. Simon Fraser University offers Health Promotion and Aging as one of two concentrations in its new Masters Program in Gerontology.

A goal of the Centre for Health Promotion Studies [CHPS] at the University of Alberta is "to provide and promote interdisciplinary graduate education and continuing education in health promotion." This is one site of formal university-based programs in health promotion. The post-graduate diploma and Master's of Science degree programs in Health Promotion were initiated in September 1996 and the distance learning component will commence in 1997/98 in collaboration with the University of Calgary and the University of Lethbridge. The director of the Regional Centre for Health Promotion and Community Studies [RCHPCS] in Lethbridge is an advisor for a research and management training program for the provincial Regional Health Authorities. Discussions are underway with U of A to provide opportunities for residents in Southern Alberta to access the CHPS programs. The education coordinator for the Alberta Centre for Well Being reports that numerous workshops, speaking tours, conferences (e.g., resiliency), training workshops, lecture series (e.g., women and health in the workplace), and workshops for community health councils (e.g., determinants of health) are planned for 1997. The Prairie Region Health Promotion Research Centre [PRHPRC] is conducting a Summer School August 6-9, 1997 (University of Saskatchewan), focused on issues, challenges and skills for health promotion. The Centre sponsored Health Promotion Research Conferences in Saskatchewan (1996) and in Manitoba (1997); frequently conducts workshops (e.g., community health needs assessment, participatory action research, program evaluation); and has a video library. Moreover, it is developing a partnership with Saskatchewan Health to respond to needs for health promotion training and education.

One goal of the Centre for Health Promotion [CHP] at the University of Toronto is to provide education and training about health and health promotion for students, educators, practitioners and the public

through a seminar series, teleconferences, symposia/conferences, schools, institutes, courses, interest groups, graduate and undergraduate education, and student exchanges. The Masters Program in Health Promotion at the University of Toronto has been in operation since 1978. The Health Promotion Summer School, offered annually, will take place in Ottawa June 16-20, 1997. Elsewhere in Ontario, the McMaster Research Centre for the Promotion of Women's Health [MRCPOWH] is co-sponsoring an Annual Summer Institute on Gerontology, June 2-13, 1997, and contributed to a conference on the Prevention of Violence. Workshops organized by MRCPOWH in 1996 and 1997 included *Describing the invisible: Problems of teachers, bank tellers and receptionists, and Selected estimates of costs of violence against women; Positive work environments for women and men with disabilities, and Women, body image and food*. The Centre for Applied Health Research [CAHR] (University of Waterloo) helped to create the Program Training and Consultation Centre and offered a "stages of change" workshop by videoconference to remote sites. This centre also co-hosts conferences and presentations and received funding for an Alzheimer Research and Education project which disseminates a resource manual and conducts workshops. The Community Health Research Unit [CHRU] (Ottawa) is applying to Human Resources Development Canada to participate in their summer career placement program for students interested in pursuing a career in health promotion research. The CHRU has encouraged Master's student involvement through internships and thesis projects and developed a framework for a public health/health promotion course in the Master's of Science in Nursing program.

Groupe de recherche et d'intervention en promotion de la santé [GRIPSUL] (Laval) engages in thesis supervision at the doctoral and master's level in health promotion and organizes master's courses (e.g., theories of health promotion, intervention strategies, community organization, educating for health) for students studying health promotion in nursing, community health, nutrition and physical activity programs. The Centre de recherche en promotion de la santé de Montréal has assisted in the preparation of future health promotion researchers among master's and doctoral students.

The Atlantic Health Promotion Research Centre [AHPRC] contributed to an interdisciplinary health promotion course and to the Program Advisory Committee for the PEI Health Promotion Summer Institute held in August 1996 and planned again for 1997. The AHPRC has sponsored numerous lectures on such topics as international development in health promotion, qualitative evaluation, social marketing, and women and substance use, and conducted workshops about such

issues as participatory research and health promotion proposal development.

A working group of the Canadian Consortium for Health Promotion Research, with representation from several health promotion research centres, examined the nature and scope of health promotion courses and programs in Canadian universities. The report, due this spring, recommends communication, collaboration and exchange of resources.

Projects and Publications

The B.C. Consortium has pursued a research agenda focused on participatory research. Fifty-three projects were listed in the 1996 Annual Report. The Consortium's research priorities for 1997 emphasize health care system reform and renewal, health promotion and population health strategies for groups at risk, and knowledge diffusion. Health Promotion and Aging is a designated research theme of the SFU Gerontology Research Centre. The Consortium had 49 peer-reviewed papers published in 1996. This consortium, like many centres for health promotion research, have exemplary track records of productivity in terms of research and reports. Table 2 provides an overview of selected projects and publications emanating from most Canadian centres. In addition to publishing newsletters (Table 1), most centres produce annual reports. Moreover, health promotion research centres are increasingly using the Internet to disseminate projects, publications and research results.

Common research themes include participatory methodologies, community empowerment, seniors' health promotion, disadvantaged groups, multicultural populations, resiliency, injury prevention, work environments, health promotion intervention strategies and dissemination/communication. One research theme – women's health – has emerged across several centres. For example, the AHPRC played a lead role in the development of the successful letter of intent and full proposal for the Maritime Centre of Excellence for Women's Health funded by Health Canada in 1996. The Director of AHPRC is research facilitator and co-chair of the Management Committee of the Maritime Centre. The PRHPRC was a key player in the successful funding of the Prairie Centre of Excellence for Women's Health. The Director of the PRHPRC is Vice-Chair of the Board of the Prairie Region Centre of Excellence for Women's Health. Several other health promotion research centres were involved in proposals for Centres of Excellence in Women's Health (e.g., B.C., Toronto). The McMaster centre from its inception

Table 2 *Centre Projects and Publications*

Centre	Selected Projects	Selected Publications
BC Consortium for Health Promotion Research (Victoria, Vancouver)	<ul style="list-style-type: none"> - Seniors independence research project on self-help, self-care and mutual aid - First Nations elder care initiative - Design and development of neighbourhood group homes - Kamloops women's action project - Mobility technology for older adults: Outcomes that matter - School and community action on nutrition (SCAN) - EMPOWER project - Stress and coping in student mothers 	<ul style="list-style-type: none"> - Dissemination research: Strengthening disease prevention and health promotion (CJPH) - Health Impact Assessment - The study of participatory research in health promotion/Royal Society of Canada - Facilitating healthful change: Testing models for community empowerment - Monography reviewing 14 prevention research centres in US
Health Promotion Research Group (Calgary)		<ul style="list-style-type: none"> - Lessons learned from initiatives related to health promotion in Alberta: Strategies for the development of effective partnerships
Alberta Centre for Well-Being (Edmonton)	<ul style="list-style-type: none"> - Alberta sport and recreation injury survey - Canadian active living program evaluation - Alberta Survey '97: Physical activity in Alberta - Attributable mortality due to sedentary living in Alberta - Survey/study of the benefits of high school athletics in Alberta 	<ul style="list-style-type: none"> - Physical activity and psychological well-being: Knowledge base, current issues and caveats - Tobacco pricing, taxation, consumption and revenue Alberta 1985-1995 - Canadian active living challenge program evaluation - Alberta sport and recreation injury survey
Centre for Health Promotion Studies (Edmonton)	<ul style="list-style-type: none"> - Post-graduate diploma and Master's degree program in health promotion - Distance learning 	

Table 2 (cont'd) Centre Projects and Publications

Centre	Selected Projects	Selected Publications
Regional Centre for Health Promotion and Community Studies (Lethbridge)	<ul style="list-style-type: none"> - Development of community-appropriate health promotion models in Southern Alberta - Implementation and evaluation of a smoking reduction/cessation program with Registered Nurses in three Canadian provinces - Bio-behavioural approach to increase resiliency for cancer patients - Study of resiliency in communities - Development of a community wellness centre in the Crowsnest Pass: Enhancing community competence and resiliency 	<ul style="list-style-type: none"> - Understanding rural health issues: An annotated bibliography - Surviving and thriving: Resiliency in the Crowsnest Pass - Discussion and expansion of the concept of resiliency: Summary of a think tank - A health and social needs assessment of Alberta Native seniors - Occupational health and safety needs assessment of farmers in southern central Alberta - Efficiency versus equality: Health reform in Canada - Community assessment of the Kanadier (Mexican) Mennonites
Prairie Region Health Promotion Research Centre (Saskatoon)	<ul style="list-style-type: none"> - Prairie Women's Health Centre of Excellence - Sharing knowledge from health promotion practice - Health Promotion Summer School 1997 	<ul style="list-style-type: none"> - Sharing knowledge gained from health promotion practice - Reflections on health promotion practice
Centre for Applied Health Research (Waterloo)	<ul style="list-style-type: none"> - Alzheimer research and education project - Residential elder assessment project 	
McMaster Research Centre for the Promotion of Women's Health (Hamilton)	<ul style="list-style-type: none"> - Immigrant women/work and health - Grassroots communities action and research program - Health promotion project with immigrant women survivors of torture - Economic model of domestic violence - How the work of community nurses affects their health and safety - Interview guide of stress indicators for immigrant, refugee and minority women - Leisure and women with disabilities: New directions for subjective experience - Analysis of barriers in integrating educated immigrant women into Canadian mainstream 	<ul style="list-style-type: none"> - Healthy work environments in community based health and social service agencies, Stage one report: Focus group findings - Support needs for women with multiple sclerosis - Positive work environments for women and men with disabilities: Focus group results

Table 2 (cont'd) *Centre Projects and Publications*

Centre	Selected Projects	Selected Publications
Centre for Health Promotion (Toronto)	<ul style="list-style-type: none"> - Priority women and smoking study - Self help mutual aid for seniors and their family caregivers - District Health Council planning - Health Communication Conference - Health Promotion Summer School 	<ul style="list-style-type: none"> - Effectiveness of health promotion - Study on youth and smoking: Plain packaging, health warnings, event marketing and price reductions - Self esteem health - Health promotion empowerment: Practice framework - Making research results meaningful
Community Health Research Unit (Ottawa)	<ul style="list-style-type: none"> - Guide your patients to a smoke free future - Development and testing of components of a multifaceted intervention program to reduce the incidence of smoking during pregnancy and postpartum of both women and their partners - Towards an understanding of condom use for HIV prevention: Applying the TTM - The determinants of HIV-related risk behaviour in high risk women - Health promotion with isolated seniors - Behavioural determinants of exercise change - Evaluation of breastfeeding support drop-ins - Elderly in need - Fall prevention for seniors - Partnerships for Heart Health 	<ul style="list-style-type: none"> - Smoking stages of change: Summary of development, implementation and evaluation - Mammography and clinical breast examination amongst non-immigrant and immigrant women in Ontario - Partnership success and evaluation: An analysis of the heart beat partnership stories - Evaluation of a high school quit and win smoking cessation program - Evaluation of the site: A pilot HIV prevention programme for injection drug users - Aging and health promotion: A participatory action research project with seniors - Use of assistive devices in fall prevention among community-living seniors - Risk factor measurement in the promotion of cardiovascular health - Health data for public health - Pre and post-natal smoking: A review of literature

Table 2 (cont'd) *Centre Projects and Publications*

Centre	Selected Projects	Selected Publications
Groupe de recherche et d'intervention en promotion de la santé de l'Université Laval (Québec)	<ul style="list-style-type: none"> – Relation attitude-comportement chez diverses clientèles – Méthodologie d'intervention politique en santé – Impact d'un programme de prévention du VIH chez les adolescents et adolescentes – Evaluation de villes et villages en santé 	<ul style="list-style-type: none"> – Attitudes et comportements de divers groupes re. MTS-SIDA – L'état de la promotion de la santé au Canada et au Québec
Atlantic Health Promotion Research Centre (Halifax)	<ul style="list-style-type: none"> – Priority women and smoking project – Resilience: Relevance to health promotion – Self-help mutual aid for seniors and their family caregivers research program (9 projects) – Resiliency in communities – Exploring the links between substance use and mental health: A discussion paper and a round table – Relationship of importance of health, self-efficacy, social support and selected demographics in health- promoting lifestyle in adolescent females – Adult asthmatics (self care) education project 	<ul style="list-style-type: none"> – Smoking among disadvantaged women: Causes and cessation – Disadvantaged women and smoking – Resilience in families: Challenges for health promotion – Fostering children's resilience – Community resilience: Strengths and challenges – The cystic fibrosis mother's group: Personal accounts of coping, shared experience and mutual support

focused on promotion of women's health. Representatives of other health promotion research centres are linked to women's health initiatives (e.g., Centre for Research in Women's Health, Toronto). The Directors of the Calgary and McMaster centres co-authored a paper for the Canada-U.S. Forum on Women's Health in July 1996. Finally, panellists with connections to both types of research centres will speak on the links between health promotion and women's health at the Fifth National Health Promotion Conference in Halifax in 1997.

Interdisciplinary Links

The array of disciplines represented in centres across the country covers the spectrum of health and health related fields. The diverse health fields and backgrounds include behavioural science, biomechanics, community health, dentistry, epidemiology, health administration, health economics, health education, health planning, human kinetics, kinesiology, medical geography, medicine, nursing, nutrition, occupational therapy, optometry, pharmacy, physiology, political science, psycholinguistics and psychology. Health-related disciplines and fields include: adult education, anthropology, biochemistry, commerce, community studies, demography, economics, education, environmental studies, gerontology, law, philosophy, physical education, recreation, social work, sociology, statistics, and urban planning. All centres are engaged in interdisciplinary and intersectoral work.

All initiatives of the B.C. Consortium are interdisciplinary. Departments and faculties with interests in health promotion are represented among associates. Seminars, faculty associate appointments, e-mail and newsletter networking, and invitations to serve as co-investigators on grant applications are successful mechanisms for promoting interdisciplinary links in the Consortium. The goals of the CHPS (U of A) are "to foster interdisciplinary research in health promotion and to provide and promote interdisciplinary graduate education and continuing education in health promotion." The CHPS is interdisciplinary in its organization, administration, staff, students and courses. A wide variety of disciplines is represented by the research associates of the RCHPCS (Lethbridge). Brown-bag lunch discussions, at which associates share their ideas and research, help to promote collegiality and equality among disciplines. Associates of the Alberta Centre for Well Being are primarily interested in behavioural psychology and physical activity. Activities are undertaken in partnership with varied disciplines in the network of 5,800 individuals. A proposed monthly speaker/seminar series open to everyone at the university should foster inter-

disciplinary connections among the different disciplines represented in the Calgary Health Promotion Research Group. There are more than 80 community partner organizations as well as 160 research associates in 22 disciplines in five universities encompassed within the PRHPRC.

The mission statement of the Centre for Health Promotion (Toronto) states: "In a multidisciplinary context, it will activate, develop and evaluate new approaches to health promotion." The 29 members and 125 associates represent diverse disciplines. A major strength of MRCPOWH (Hamilton) is its multidisciplinary focus with links to social sciences, humanities, business, and health sciences. Researchers from different disciplines work together on research committees, advisory boards and proposal writing. "This has greatly contributed to the understanding, evaluation and explanation of the complex issues of women, work and health promotion," according to Co-Director Mary O'Connor. The 60 to 70 faculty and associates in the CAHR (Waterloo) have varied backgrounds and expertise. The goals of this centre refer to providing a focus and resource base for collaborative interdisciplinary work. The investigators and associates of the CHRU (Ottawa) represent diverse disciplines. Mechanisms for promoting interdisciplinary links include think tanks that provide opportunities for people to "discuss, debate and collaborate on themes" (e.g., collectives, health indicators, community health interventions), interdisciplinary research projects, and seminars.

GRIPSUL (Laval) is multidisciplinary and multi-faculty. The more than 150 associates of AHPRC include representatives of health disciplines and related disciplines. Interdisciplinary links are promoted through project teams, conferences, workshops, newsletters, and lectures.

Nursing Involvement

Nurses are prominent within the interdisciplinary context of the health promotion research centres. Two post-doctoral fellows at IHPR (UBC) are faculty members, at the UBC School of Nursing, another is at the Université de Montréal, and two doctoral students are from the University of Victoria School of Nursing. Several projects of IHPR are directed by nurse principal investigators and the nursing school (UBC) has the largest number of faculty associates in the Centre. A co-principal investigator of the Tri-University B.C. Consortium and co-chair of the community-university health promotion centre in Victoria is a nurse. The director of the RCHPCS (Lethbridge) is a nurse. This centre is physically located in the School of Nursing and nursing faculty and

practitioners contribute as research associates. Nurses are also involved in the membership and leadership of the HPRG (Calgary) and the current Director is a nurse. "The Faculty of Nursing and community health nurses play a leading role in the Centre," according to the director of CHPS, Doug Wilson (U of A). "Individuals in the nursing faculties and others with nursing backgrounds are among the key health promotion researchers and practitioners with whom the Prairie Region centre works," says Director Joan Feather.

The Centre for Health Promotion (U of T) has undertaken a number of projects which involve nurses such as *Stressors and pleasures of pregnancy* (North York Community Health Promotion Research Unit), *Quality of life of the frail elderly* (Quality of Life Unit), and *Face-to-face support group for recently bereaved widows* (Seniors Self Help Mutual Aid Research Program). Many associates and members of the Toronto Centre have a background in nursing and the Dean of Nursing at U of T chairs the Advisory Board. Public health nurses worked closely with CHRU (Ottawa) researchers to design and pilot interventions in the *Fall Prevention* project and contributed to the formative evaluation and the counselling intervention in the *Postpartum Smoking Relapse* study. "Ultimately, most of our research projects would not press forward without the dedication and continued efforts of public health nurses." (Alanna Fox). Several affiliates in the McMaster Centre have major projects with the Nursing Effectiveness Utilization and Outcomes Research Unit. Faculty members in the School of Nursing have received research grants from MRCPOWH.

GRIPSUL has two co-directors situated in the School of Nursing at Laval University. Other professors in the School of Nursing have collaborated in this health promotion research centre and graduate teaching occurs primarily in nursing science and community health programs. The director of the AHPRC is a nurse and nurses have contributed to the work of the centre as research assistants and project coordinators. Sixteen associates of the AHPRC are nurses and nurses participate as members of project teams and Centre committees.

Sustainability

Long-term sustainability is a critical issue faced by all centres for health promotion research. The five-year funding commitment for the six NHRDP/SSHRC-funded centres concludes in 1998. The sustainability of the B.C. Consortium and the IHPR (UBC) is made possible through grants, contracts, and the endowment of a health promotion professorship matched by the province. Their Summer Institute generates profit,

and honoraria and fees are deposited in IHPR accounts. Recently, UBC committed to a second five-year contract for the director and core budget of IHPR. The SFU Master's Program in Gerontology has a tenure-stream position in Health Promotion and Aging, funded from the university base budget. The associated Gerontology Research Centre has committed to continued funding of a research associate in health promotion through grants, contracts and endowment funds.

The RCHPCS (Lethbridge) has developed partnerships with local regional health authorities and is seeking corporate sponsorship to maintain the funding of the centre. The CHPS (Edmonton) anticipates sustained need and funding for the two educational programs; and research grants and contacts that attract additional funding. The commitment of university and government partners should also enhance sustainability. Concerns about sustainability of the Alberta Centre for Well Being are being addressed by partnerships with corporate sectors, foundations and government, by charging for services, and by developing a membership strategy. The HPRG (Calgary) is undergoing strategic planning. Funding will be contingent upon projects undertaken and proposed interdisciplinary initiatives should foster the centre's visibility. The PRHPRC is progressing with plans for sustainability. Pertinent initiatives include a partnership with Saskatchewan Health to support and strengthen health promotion practice in the new health districts and a key role in various collaborative ventures, including an international linkage project to develop new teaching methods in health promotion based on a participatory and empowering model of primary health-care practice.

Besides seeking funds for individual projects, MRCPOWH will be applying to McMaster University for status and support within departmental or faculty structures. Training of graduate and undergraduate students continues, as do research and activism evolving from completed projects. Project-specific partners share in collaborative projects and clients pay for training and consulting services at the CAHR (Waterloo). The centre has also explored corporate sponsorship. Two initiatives have the potential to move CHRU (Ottawa) into a new direction – anticipated funding for a Centre for Behavioural Change and the Department of Epidemiology and Community Medicine's move towards a research institute format. The Centre for Health Promotion, like IHPR (UBC), receives core funding and infrastructure support from the University of Toronto.

GRIPSUL (Laval) is a non-funded informal centre. Its recent designation as a WHO collaborating centre and its national and international

links should help to sustain it in the future. The AHPRC conducted a search of potential donors targeted to business, government sources and foundations and developed a user-friendly profile of key projects to help market the centre. The centre is investigating registration as a charitable organization and subscription fees for its popular newsletter which reaches approximately 2,000 people. Clearly the struggle for survival continues.

Collaboration among Centres of Health Promotion Research

Alliances of and affiliations among centres lend credibility to particular projects and initiatives. For example, the B.C. Consortium collaborated with investigators in the centres at U of T and Laval, subcontracted another initiative to the Montreal Centre, and have a proposal pending for a collaborative project with U. Waterloo on a tobacco control study. The PRHPRC frequently uses members/associates of other health promotion research centres as resource people. They coordinated a multi-centre study on knowledge development in health promotion practice using a story-dialogue method and workshops hosted by various centres across Canada. The PRHPRC and MRCPOWH are working in partnership on the international linkage project referred to above.

The Toronto Centre collaborated with the AHPRC to conduct the NHRDP-funded research program on self-help mutual-aid for seniors and family caregivers and the Health Canada-funded study of disadvantaged women and smoking. The Toronto Centre launched the project *Making Research Results Meaningful* which entailed workshops hosted by other centres. Focus groups for the AHPRC's Health Canada-funded study of resilience were conducted by health promotion research centres in Toronto, Prairie Region and Montreal, and the Lethbridge and Atlantic Centres investigated community resilience in parallel studies. AHPRC and MRCPOWH are co-sponsoring the next national health promotion research conference. GRIPSUL has links with associates in Quebec and across Canada. Finally, two regional consortia have been formed, comprising four health promotion research centres in Alberta and the three centres in B.C.

National Front

Canadian Consortium for Health Promotion Research

In November 1996, the Canadian Consortium for Health Promotion, currently comprising the 15 health promotion research centres, was

established. The Consortium's mission is "to enable Canadians to have greater control of their health, through the development, dissemination and application of knowledge on the determinants of health and on health promotion initiatives." Its goals are to (1) contribute knowledge to inform policy and practice in health promotion and population health; (2) advocate for advancement of knowledge in population health promotion; (3) enhance collaboration in health promotion knowledge development; (4) nurture education, training and research in health promotion; (5) act as a focal point for linking regional networks in health promotion knowledge development; (6) scan the environment for developments in health promotion; (7) enhance communication of health promotion knowledge relevant to policy and practice; and (8) act as a Canadian focal point for knowledge development in health promotion at international and national levels (Rootman & Goodstadt, 1996). The Consortium will host an information session at the Fifth National Health Promotion Research Conference in July 1997 to highlight the mission/goals of the Consortium and its website, display information, materials and publications from individual centres, and invite new members.

In 1996, the Consortium submitted a position paper entitled *Health Promotion and Health Reform in Canada* to the National Forum on Health, which identified encouraging trends: establishment of the university-based health promotion centres/institutes; growing responsiveness of research funding agencies to supporting health promotion studies, increasing emphasis on evaluation; international recognition of Canada as leader in health promotion (e.g., two university-based centres are WHO collaborating centres); and national consensus on the role of health promotion in the public health community, reflected in the *Health Promotion Perspectives* project.

Health Promotion Perspectives Project

The health promotion research centres played an active role in the Canadian Public Health Association (CPHA) Perspectives Project. Representatives from the centres were corresponding members and were invited to participate in the national symposium in Ottawa in February 1995. Several centres organized or co-sponsored the provincial consultations and workshops associated with this project. Reports on these consensus-building workshops, surveys and teleconferences held in 10 provinces/territories were published by CPHA. The *Action Statement for Health Promotion in Canada*, approved by CPHA in July

1996, identifies the health promotion research centres as key actors in recommendations pertaining to evidence on effectiveness of healthy public policies, strengthening interdisciplinary training, analyzing and synthesizing knowledge-based practice, evaluation methods, training in health promotion research and theory, and dissemination of research results. A December 1996 update by CPHA referred to plans to follow up the discussion during the centres' meeting on November 21, 1996, regarding mechanisms to monitor priority areas in the Action Statement.

Centre Meetings

The first meeting of the centres on February 17-18, 1994, sponsored by Health Canada, is reported in the *Proceedings of the Meeting of the Health Promotion Research Centres on Knowledge Development* (Health Canada, 1994). This meeting re-examined priorities in knowledge development and areas for collaboration. The second meeting of the centres, held in December 1995, focused on disseminating findings of health promotion research, evaluating health promotion activity, and developing the capacity to influence the policy agenda. Brief descriptions of the centres, which were appended to the report, are updated in Table 1. The most recent meeting was held on November 20-21, 1996, in Ottawa, where participants discussed current issues, challenges and opportunities in health promotion, sustainability of centres, and the Canadian Consortium for Health Promotion Research.

A key contribution of the Health Promotion Development Division of Health Canada, which sponsored these meetings, is the paper by Hamilton and Bhatti entitled *Population health promotion: An integrated model of population health and health promotion* (Hamilton & Bhatti, 1995). The health promotion research centres provided feedback on the draft document. To date, over 30,000 copies have been distributed. The Health Promotion Development Division has also sponsored and funded research projects conducted by the centres.

Conferences

Representatives from centres also meet during national conferences. The first national health promotion research conference, held in Toronto in 1990, celebrated the creation of the Centre for Health Promotion. During the second conference in Vancouver in 1993 the Minister of Health announced the funding of six health promotion research centres

by NHRDP and SSHRC. In 1994, a third conference was held during the Learned Societies meeting in Calgary on the theme *Higher Altitudes in Health Promotion*. The fourth conference, held in Montreal in 1996, emphasized the links between health promotion and population health. The fifth conference, which will take place in Halifax on July 4-5, 1997 (funded by NHRDP, Women's Health Bureau, Health Promotion and Programs Branch), will focus on *Gender and Health: From Research to Policy*.

Research funding trends

The changing climate in health promotion research funding is reflected in the strategic planning exercises of MRC, NHRDP and SSHRC over the past few years. The document *NHRDP Toward 2001: Implementing Conceptual Program Changes* refers to five strategic research themes including population health (which encompasses health promotion issues such as determinants of health and access) and renewal and restructuring of the health system (which targets the distribution of resources among health promotion and other domains). The new Health Transition Fund, recommended by the National Forum on Health, will consider projects in "preventive health." The Canada Foundation for Innovation will invest in research capability and infrastructure and give priority to projects that contribute to quality of life and to improving health.

Conclusions

The significant strides in health promotion research in Canada over the past decade can be attributed in large part to these centres. The 1993 announcement proclaimed that the nationally funded centres for health promotion research "represent working partnerships between community groups, academic researchers, health care providers and policy makers addressing ways in which the health of all Canadians can best be promoted.... Each centre will perform innovative ground-breaking work." These NHRDP-SSHRC-funded centres and the other health promotion research centres in Canada collectively and collaboratively made major contributions to health promotion knowledge generation, practice and policy through their research and educational initiatives. Nurses will continue to play an important role in the achievements of these centres. Although the centres face complex challenges, an exciting and encouraging future looms on the horizon.

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Acknowledgements

The author gratefully acknowledges the important contributions of N. Hamilton (Health Promotion Development Division, Health Canada), S. Crowell (Atlantic Health Promotion Research Centre), J. Feather (Prairie Region Health Promotion Research Centre), L. Green and G. Gutman (B.C. Consortium for Health Promotion Research), A. Fox (Community Health Research Unit), M. O'Connor (McMaster Research Centre for the Promotion of Women's Health), R. Perreault (Centre de recherche en promotion de la santé de Montréal), I. Rootman (Centre for Health Promotion), M. Sharratt (Centre for Applied Health Research), B. Thurston and A. Vollman (Health Promotion Research Group), and D. Wilson (Centre for Health Promotion Studies). The assistance of AHPRC staff, in particular Sandra Crowell who developed Table 1 and Mary Ann Martell who typed this manuscript, is greatly appreciated.

Call for Papers

Loss & Bereavement

Winter 1997 (vol. 29, no. 4)

Manuscripts are invited that address issues related to loss and bereavement. Topics such as individual and family response to a variety of losses and new approaches to care are welcome. Preference will be given to research reports, especially those that give direction for utilization of findings in practice. However, thought or review papers dealing with ethical, legal, educational, and professional issues related to loss and bereavement are also invited.

Guest Editor: Dr. Betty Davies

Submission Deadline: July 15, 1997

Systems Research

Spring 1998 (vol. 30, no. 1)

The aim of this issue is to make a contribution to our knowledge of nursing and/or patient-care systems and their application to the organization, delivery, and evaluation of care. Topics with potential for enhancing the development and implementation of information systems as well as reports of testing and implementation are particularly solicited.

Guest Editor: Dr. Phyllis Giovannetti

Submission Deadline: September 15, 1997

Please send manuscripts to:

The Editor
Canadian Journal of Nursing Research
McGill University School of Nursing
3506 University Street
Montreal, QC H3A 2A7
Canada

Articles à publier

La perte et le deuil

Hiver 1997 (vol.29, no. 4)

On demande des manuscrits traitant des questions liées à la perte et au deuil. Les sujets tels que les réactions individuelle et familiale aux diverses pertes et les nouvelles méthodes pour ce qui a trait aux soins sont particulièrement les bienvenus. On recherche surtout des textes qui donnent une orientations pour l'utilisation des résultats dans la pratique. Cependant, on accueillera favorablement tout article de fond ou de synthèse traitant des questions déontologiques, juridiques, pédagogiques et professionnelles liées à la perte et au deuil.

Rédactrice invitée: D^{re} Betty Davies

Date limite pour les soumissions: le 15 juillet 1997

La recherche sur les systèmes

Printemps 1997 (vol.30, no. 1)

L'objectif du présent numéro est de participer à l'approfondissement de la connaissance en sciences infirmières sur les différents systèmes de soins prodigués aux usagés ainsi que leur mis en pratique au niveau de l'organisation, de la prestation et de l'évaluation des soins. On recherche surtout les sujets qui permettraient d'améliorer le développement et la mis en place de systèmes d'information ainsi que des études d'utilisation et d'implantation de tels systèmes. Ces sujets présentent un très grand intérêt.

Rédactrice invitée: D^{re} Phyllis Giovannetti

Date limite pour les soumissions: le 15 septembre 1997

Prière d'envoyer les manuscrits à:

La rédactrice en chef

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Procedure: Three double-spaced typewritten copies of the manuscript on 8 ½" x 11" paper are required. Articles may be written in French or English. Authors are requested not to put their name in the body of the text, which will be submitted for blind review. Only unpublished manuscripts are accepted. A written statement assigning copyright of the manuscript to the *Canadian Journal of Nursing Research* must accompany all submissions to the journal. Manuscripts are sent to: The Editor, *Canadian Journal of Nursing Research*, School of Nursing, McGill University, 3506 University Street, Montreal, QC H3A 2A7.

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All manuscripts must follow the fourth edition of the *Publication Manual of the American Psychological Association*. Research articles must follow the APA format for presentation of the literature review, research questions and hypotheses, method, and discussion. All articles must adhere to APA guidelines for references, tables, and figures. Do not use footnotes.

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This issue has been supported by an SSHRC (647-95-0048) grant.
Nous avons reçu les subventions du CRSHC (647-95-0048) pour ce numéro.

ISSN 0844-5621

The *Canadian Journal of Nursing Research* is indexed in /La *Revue canadienne de recherche en sciences infirmières* se retrouve dans les indexes suivants:

CINAHL; Health Care Management Studies; Hospital Abstract; Index de la santé et des services sociaux; Micromedia's Canadian Business & Current Affairs (CBCA) database; Nursing Abstracts; Sociological Abstracts (SA); Social Planning/Policy and Development Abstracts (SOPODA).

Dépot légal – Bibliothèque Nationale du Québec, 1997
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Cover, design & layout/Couverture, design & mise en page : Résolutive Globale, Montréal

Canadian Journal of Nursing Research
Revue canadienne de recherche en sciences infirmières

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