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

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## EDITORIAL

# From Nursing Papers to Research Journal: A 30-Year Odyssey

The year 1969 is associated with the landing of a man on the moon. Few will recall that in the same year the first Canadian scholarly nursing journal was founded, by Moyra Allen of McGill University. A much less seismic event than the moon landing, the launching of *Nursing Papers*, now known as the *Canadian Journal of Nursing Research*, was nonetheless a milestone in the evolution of academic nursing in Canada.

Allen, who was the editor for 15 years, envisioned a journal that would bring together thinkers from across the country to share ideas and engage in scholarly debate around issues that would shape the discipline and the profession. She set the tone of the journal by her choice of name and cover. The name *Nursing Papers* was meant to conjure up the image of scholars debating lofty ideas and ideals, questioning conventional wisdom, challenging and being challenged. The matte cover with its trellis border had as its focal point two birds looking outward and beyond, pondering the future. The two articles selected for the first issue established *Nursing Papers* as a journal devoted to practice, education, and research: these were Helen (Moogk) Elfert's description of women's experiences during labour, which could be considered a precursor of clinical descriptive studies; and Allen's description of the research design she developed to evaluate the Ryerson School of Nursing, Canada's first college nursing program.

During the early years, *Nursing Papers* was published bi-annually. Publication dates were erratic, largely dependent on the availability of material and financial resources. Each issue comprised fewer than 20 pages, usually two articles. Scholars were asked to submit seminal papers, position statements, keynote addresses. The papers dealt with questions surrounding university education, professional issues, and nursing research. Schools were invited to develop an issue of the Journal, featuring the work of their faculty. The format was modified as new sections, such as queries and responses by leading scholars, were added for the purpose of stimulating reflection and discourse. Authors were urged to submit manuscripts in both official languages. In the fall

of 1975 *Nursing Papers* was translated as *Perspectives en Nursing* and both versions of the name appeared on the cover, formalizing the bilingual character of the Journal; by 1977 abstracts were being translated into French.

It is hardly surprising that the preponderance of articles published in the first decade dealt with educational issues. Most were written by university faculty members prepared at the master's level, and they concerned a wide range of topics, from official government reports on changes to the education system, to specific university curricula, to the teaching of particular concepts and skills, to the socialization of students. The growth of research and research-mindedness began slowly but quickly gained momentum, corresponding to the increase in the numbers of graduate programs and doctorally prepared nurses. However, the majority of the early research studies focused on education: surveys of educational programs, comparative and evaluative studies of different teaching methods, descriptive studies of students as learners, and so forth.

Thirty years ago Canada had a mere handful of nurse-researchers. Relatively few articles in the early days of *Nursing Papers* dealt with clinical research, but in the 10th year of publication Judith Ritchie, one of the few clinical researchers, sounded the alarm in an invited editorial. Despite an increase in research activity, Ritchie commented, very little research was practice-focused; she called for a shift towards clinically based nursing research.

The 1970s proved to be a watershed decade in the conceptualization of nursing as a profession. Canadian nursing leaders debated the future role of the profession within the health-care system in the context of a host of events: the introduction of Medicare, publication of the Lalonde report with its focus on health and lifestyle, the rise of consumerism in health care, the critical mass of university-educated nurses, and the movement for an expanded role for nurses that was then transforming the profession south of the border. The debates on whether nursing should expand its role by taking over physician functions or by going into other areas of health care helped to reconceptualize nursing's role within a changing health-care system and gave rise to two large-scale evaluations: McMaster University's Burlington Randomized Control Study (of the nurse-practitioner role) and McGill's Comparative Studies of Nursing Roles.

By 1980 a dramatic shift in focus was evident. Although research on educational issues continued, clinical research was now the focus. Our senior scholars of today began to publish their doctoral work. It was

against this backdrop that, in 1984, Allen retired and Mary Ellen Jeans took over as editor. Dedicated to creating a more solid research journal, Jeans expanded the editorial board and established a more systematic peer-review process. In 1988 the name was changed to *Canadian Journal of Nursing Research* and the matte cover became a glossy burgundy and grey.

The ensuing period saw a slow but steady growth in nursing research. While the number of articles on empirically based research increased slowly, the number of those on theoretical issues grew more quickly — such issues as the conceptual base of nursing, methodological dilemmas, the development of instruments to measure nursing phenomena, and the debates over dissemination. This trend is hardly surprising, as “thinking” tends to precede “doing”; it reflected a growing interest in research. With the increased number of scholars engaged in clinical research came a corresponding increase in the number of descriptive studies of nursing phenomena and evaluative studies of specific nursing practices. These investigations began to define the scope and essence of nursing practice.

In 1993, the year I assumed editorship, the Journal was ready for an overhaul. We had a critical mass of senior scientists and many active clinical research programs. However, the Journal continued to be plagued with the problems that had existed since Allen’s days — lack of quality manuscripts and no funding. What was needed was a bold change, a new format and look; we would, however, continue to respect the traditional values upon which the Journal had been built: a commitment to discourse, innovation, and first-rate scholarship. Mary Grossman, the newly appointed associate editor, and I set out to transform the Journal. We adopted a focus-issue format and appointed senior scholars to serve as guest editors. We shaped and nurtured each issue and added depth to the focus topic through such sections as Discourse and Designer’s Corner. We invited eminent scholars to identify the challenges confronting the focus topic, provide insights, discuss trends, and propose solutions. At the same time, we established systems to improve the quality of scholarship and to put the Journal on a sound financial footing. The bilingual aspect of the Journal was strengthened with the appointment of an additional associate editor, Lise Talbot of the Université de Montréal. A new design was created for the Journal cover, in a discerning rich blue.

In planning this special anniversary issue, Anita Gagnon (McGill University), Francine Ducharme (Université de Montréal), and I pored over almost 200 papers from the past 30 years, searching out those that

have become classics inasmuch as their message still resonates today or their work was a first in the field, as well as those that have set nursing on a new course of thinking. The process of selection was not easy, and many a favoured article failed to make the final cut despite passionate protests from its supporter. Our planned 200 pages turned into 300, made possible by the generous contributions of our sponsors. We decided to treat the editorials separately. The papers fell into four categories: Educating for Nursing Practice, Conceptualizing Nursing, Expanding Nursing Horizons, and Developing Knowledge for Nursing Practice.

*Educating for Nursing Practice.* As might be expected, the majority of articles on education are from the early years of the Journal. Moyra Allen's "The development of clinical nursing situations on videotape for use via closed-circuit TV in the teaching of nursing" was perhaps the first NHRDP-funded study to systematically evaluate a teaching innovation. On reading Hester Kernen's two-decade-old "Tailoring nursing education programs to meet the nature of community needs" I didn't know whether to weep or rejoice: weep because Kernen's case for university-prepared nurses is still being made today; rejoice because of Kernen's visionary thinking. Sadly, I believe we have reason to weep, for we failed to make a sufficiently strong case and our pleas fell on deaf ears. Finally, we selected Lillian Bramwell and Elaine Hykawy's "The Delphi Technique: A possible tool for predicting future events in nursing education" because this rare opportunity to verify the accuracy of a prophet's predictions was too good to pass up.

*Conceptualizing Nursing.* The 1970s could be called the decade of conceptualizing nursing. Most of the articles we selected were published after 1978. At the second national nursing research conference, Allen and her team (of which I was a member) presented new theoretical formulations about the future role of nursing in the health-care system. Shirley Stinson, one of the doyennes of Canadian nursing research, predicted that historians would cite this meeting as a turning point in Canadian nursing because it defined a new role and set a new course. The ideas relating to different theoretical bases of nursing were published in Allen's seminal paper "Comparative theories of the expanded role and implications for nursing practice." The article by Carolyn Attridge and colleagues, "Implementing program philosophy through curricular decisions," was the first publication on the implementation of a new program where the curricular decision was guided by a specific perspective on nursing. Evelyn Adam, the Canadian guru of conceptual models, in her classic paper entitled simply "Modèles conceptuels," argues their importance in shaping a way of thinking and

providing a framework for practice. Finally, June Kikuchi, Canada's nurse-philosopher-researcher, has devoted her career to challenging us to conceptualize nursing. "Clarifying the nature and conceptualization about nursing" is part of her lifelong quest.

*Expanding Nursing Horizons.* The development and growth of nursing have been directly related to the profession's receptiveness to challenges from sociopolitical realities and contexts; insularity has been our worst enemy. Alice Baumgart's "Nursing and political action: The legacy of sexism" and Verna Huffman Splane's "Fashioning the future" represent the aspect of nursing that goes beyond itself, exhibiting a sensitivity to its regional and global contexts.

*Developing Knowledge for Nursing Practice.* In planning this issue we debated on how best to represent clinical research. The past 30 years, and especially the past 15, have seen a proliferation of clinical studies. After much discussion and agonizing, we decided that instead of publishing specific research studies we would choose seminal articles that reflected the debates in general and the state of the art in specific, substantive areas of practice. For the general debate we selected CAUSN's position paper, "Research in the university," which was published over 25 years ago, setting the direction for nursing research in Canada; and Dorothy Pringle's classic "Another twist of the double helix: Research and practice," which underscores the challenges of a practice discipline and the difficulties of eliminating the line between practice and research. To reflect the growth of substantive knowledge of the specific areas of practice we chose one article from each of the focus issues, in most cases the Discourse, because it outlined the challenges and trends within a specific area of nursing practice. In some of the focus issues the guest editor wrote the Discourse in a combined Guest Editorial/Discourse format. In these cases we edited and distilled the Discourse aspects of the editorial. For two of the focus issues we settled on a paper instead of the Discourse because of the thoroughness with which it discussed the conceptual and methodological issues.

This 30-year compilation of *Nursing Papers/Canadian Journal of Nursing Research* represents a treasure trove of challenges and developments in nursing's struggle for academic status and public recognition. The recognition has finally come. The politicians are acknowledging what the nursing profession — and to a lesser extent the public — has always known: there is no health-care system without nursing and no future for a quality health-care system without nursing research. As we go to press, the establishment of the Canadian Institutes of Health

Research has just been announced, with \$25 million designated specifically for nursing research.

As we enter a period of exponential growth in nursing research we are reminded of how far we have come in just three decades, the incredible progress we have made as a discipline and as a profession. We are grateful to the scholars on whose shoulders we stand and who have created the solid platform for the next launching. Perhaps for nursing the next decade will be as seismic as the lunar landing.

**Laurie N. Gottlieb**  
**Editor**

## ÉDITORIAL

# Le façonnement d'une revue de recherche : une odyssée de 30 ans

L'année 1969 a été celle des premiers pas sur la lune. Peu se souviennent qu'en cette même année, madame Moyra Allen de l'Université McGill mettait sur pied la première revue universitaire canadienne traitant des sciences infirmières. Quoique moins fulgurant que l'expédition lunaire, le lancement de la revue *Nursing Papers*, connue aujourd'hui sous le nom de la *Revue canadienne de recherche en sciences infirmières*, constitua néanmoins un point tournant dans l'évolution de cette discipline universitaire au Canada.

Selon la vision de madame Allen, qui en fut la rédactrice en chef pendant 15 ans, cette revue devait rassembler les grands cerveaux de tout le pays et constituer une plate-forme favorisant le partage d'idées et les débats scientifiques, en rapport à des questions qui exerceraient une importante influence sur la discipline et la profession. Son choix de nom et de page couverture donna le ton. Le titre *Nursing Papers* symbolisait l'image de chercheuses menant des débats sur des idées et des idéaux, remettant en question le savoir traditionnel et mettant à défi tout en étant elles-mêmes interpellées. La page couverture mate dotée d'une bordure treillis arborait deux oiseaux dont le regard interrogateur fixait l'horizon de l'avenir. Les deux articles choisis pour le premier numéro consacrèrent la revue *Nursing Papers* à la pratique, à l'éducation et à la recherche. L'un d'eux était un texte rédigé par madame Helen (Moogk) Elfert, dans lequel elle décrivait l'expérience des femmes pendant l'accouchement. Cet article annonçait la venue des études descriptives cliniques. L'autre texte, signé de madame Allen, décrivait une approche de recherche qu'elle avait élaborée pour évaluer le Ryerson School of Nursing. Cette institution était la première au Canada à offrir un programme de pratique infirmière de niveau collégial.

Au cours des premières années, la revue *Nursing Papers* était publiée deux fois l'an. Les dates de parution s'avéraient imprévisibles, puisqu'elles dépendaient de la soumission de matériel et des ressources financières disponibles. Chaque numéro comportait moins de 20 pages, soit habituellement deux articles. Les chercheuses étaient invitées à soumettre des articles faisant autorité, des énoncés de position et des

mots d'ordre. Ces textes traitaient de questions concernant la formation universitaire, la profession et la recherche infirmière. Les écoles étaient invitées à traiter l'un des thèmes de la revue en faisant état des travaux menés par leurs corps professoral. Le format fut modifié au fil de la création de nouvelles sections, telle la rubrique questions-réponses, rédigée par les chefs de file de la recherche. Cette rubrique visait à favoriser la réflexion et l'expression de discours. Les auteures furent invitées à soumettre leurs manuscrits dans les deux langues officielles. À l'automne de 1975, le titre *Nursing Papers* fut traduit par *Perspectives en Nursing*, et les deux versions du titre parurent à la page couverture, officialisant ainsi le caractère bilingue de la revue. En 1977, la traduction de résumés d'articles vers le français constituait une pratique établie.

Il n'est pas étonnant de constater que la plus grande part du contenu publié au cours de la première décennie traitait de questions liées à l'éducation. La plupart des articles étaient rédigés par des membres de facultés universitaires qui détenaient une formation de deuxième cycle. Ils traitaient d'un large éventail de sujets — entre autres, les rapports officiels gouvernementaux sur les changements dans le système de l'éducation, les programmes universitaires spécifiques, l'enseignement de compétences et de concepts particuliers, et la socialisation des étudiantes. La multiplication des recherches et l'intégration d'une attitude favorisant celle-ci s'amorcèrent lentement, pour ensuite croître rapidement, ce qui correspondait à une augmentation des rangs d'infirmières formées aux deuxième et troisième cycles. Toutefois, la plupart des premières recherches favorisaient le thème de l'éducation : des enquêtes sur les programmes d'éducation, des études comparatives et évaluatives sur différentes méthodes d'enseignement, des études descriptives sur les étudiantes en tant que personnes en processus d'apprentissage et ainsi de suite.

Il y a trente ans, les infirmières-chercheuses étaient en petit nombre au pays. La revue *Perspectives en Nursing* des premières années contenaient relativement peu d'articles traitant de recherches cliniques. Toutefois, à la 10<sup>e</sup> année de parution, madame Judith Ritchie, l'une des rares chercheuses-cliniciennes, sonna l'alarme, dans la rubrique *Collaborations spéciales*. Selon elle, peu d'études se concentraient sur la pratique, et ce malgré une hausse d'activités de recherche.

Les années 70 furent mémorables pour la conceptualisation de la pratique infirmière en tant que profession. Les chefs de file canadiennes en sciences infirmières menèrent des débats sur le futur rôle de la profession au sein d'un système de santé évoluant dans un contexte riche

en événements : la mise en place de l'Assurance-maladie ; la publication du rapport Lalonde, un document mettant l'accent sur la santé et les modes de vie ; la hausse de la consommation liée aux soins de santé ; la masse critique de diplômées universitaires ; et le mouvement pour un élargissement du rôle des infirmières, qui transformait la profession chez nos voisins du sud. Le débat à l'effet que la profession devait élargir son rôle et prendre en main les tâches des médecins ou s'introduire dans d'autres créneaux de santé aiguilla la reconceptualisation du rôle infirmier au sein d'un système de soins en transformation. Ce débat donna lieu aussi à la création de deux méthodes d'évaluation à grande échelle : l'étude Burlington sur échantillon aléatoire et contrôlé (du rôle de l'infirmière-praticienne), de McMaster, et l'étude comparative des rôles de la pratique infirmière, de McGill.

Déjà en 1980, on constatait une importante transformation quant aux thèmes abordés. Même si les recherches sur des questions d'éducation se poursuivaient, la recherche clinique prenait maintenant préséance. Nos chercheuses reconnues d'aujourd'hui amorcèrent la publication de leur travaux de doctorat. C'était donc dans ce contexte qu'en 1984, madame Allen se retira. Madame Mary Ellen Jeans prit la relève en tant que rédactrice en chef. Dédiée à développer davantage l'aspect recherche de la revue, madame Jeans agrandit le comité de rédaction et établit un processus d'évaluation par des pairs plus systématique. En 1988, le titre de la revue fut changé. Celle-ci devint la *Revue canadienne de recherche en sciences infirmières*, et la page couverture prit une allure bourgogne et grise, avec un fini glacé.

La période suivante fut témoin d'une lente mais constante croissance en recherche infirmière. Bien que le nombre d'articles présentant des recherches de type empirique augmentait lentement, celui d'articles traitant de questions théoriques croissait plus rapidement — des questions tels les fondements conceptuels de la profession, les dilemmes méthodologiques, le développement d'instruments pour mesurer les phénomènes de la pratique, et les débats sur la diffusion. La présence de cette tendance n'est pas surprenante, puisque « la réflexion » précède généralement « l'action » ; elle reflétait aussi un intérêt croissant pour la recherche. Le nombre de plus en plus grand de chercheuses œuvrant à des recherches cliniques fut accompagné d'une hausse d'études descriptives sur les phénomènes de la pratique ainsi que d'études évaluatives sur les pratiques infirmières spécifiques. Ces recherches ont défini l'étendue et l'essence de la pratique infirmière.

En 1993, l'année où je pris le flambeau en tant que rédactrice en chef, une restructuration de la revue s'imposait. La profession compor-

taient une masse critique d'éminentes scientifiques ainsi que de nombreux programmes de recherche clinique en cours. Toutefois, les problèmes qui existaient depuis l'époque de madame Allen constituaient toujours un fardeau pour la revue — un manque d'articles de qualité et un financement inadéquat. Nous avions besoin d'un changement radical, d'un nouveau format et d'une nouvelle conception. Toutefois, nous voulions continuer à respecter les valeurs traditionnelles sur lesquelles reposaient la revue depuis le début : un engagement favorisant le discours, l'innovation et la recherche de fine pointe. Madame Mary Grossman, la nouvelle rédactrice adjointe, et moi-même avons donc amorcé la transformation de la revue. Nous avons adopté un format « numéro-thème » et nous avons sollicité des collaborations spéciales auprès d'éminentes chercheuses. Nous avons façonné chaque numéro avec grands soins tout en approfondissant chacun des thèmes par l'intermédiaire de rubriques telles *Discours* et *Le coin du concepteur*. Nous avons invité d'éminentes chercheuses à identifier les défis liés aux thèmes, à fournir des points de vue sur les questions, à débattre des tendances et à proposer des solutions. Dans un même temps, nous avons mis en place des systèmes pour améliorer la qualité des articles et consolider la situation financière de la revue. L'aspect bilingue a été renforcé par le biais de la nomination d'une rédactrice en chef adjointe, madame Lise Talbot, de l'Université de Montréal. Une nouvelle conception a été adoptée pour la page couverture, avec des tons d'un bleu riche et d'allure distincte.

Dans le cadre de l'élaboration de ce numéro spécial-anniversaire, mesdames Anita Gagnon (Université McGill) et Francine Ducharme (Université de Montréal) ainsi que moi-même avons examiné près de 200 articles qui ont été publiés au cours des 30 dernières années. Nous cherchions ceux qui sont devenus des « classiques », donc des articles dont le contenu est toujours actuel, qui constituaient une première dans le domaine ou qui présentaient une nouvelle voie de réflexion dans la profession. Le processus de sélection s'avéra difficile et plusieurs articles très appréciés ne franchirent pas la ligne d'arrivée, malgré les protestations passionnées de celles qui en présentaient les mérites. Les 200 pages que nous avions prévues ont pris l'allure de 300, grâce aux généreuses contributions de la part de commanditaires. Nous avons décidé de traiter les éditoriaux de façon séparée. Les articles ont été répertoriés selon quatre catégories : *Transmettre le savoir en pratique infirmière*, *Conceptualiser la profession infirmière*, *Introduire de nouveaux horizons en sciences infirmières*, et *Développer le savoir destiné à la pratique infirmière*.

*Transmettre le savoir en pratique infirmière.* Comme on pouvait s'y attendre, la plupart des articles concernant l'éducation datent des premières années de la revue. L'article de madame Moyra Allen, intitulé « The development of clinical nursing situations on videotape for use via closed-circuit TV in the teaching of nursing » constitua peut-être la première recherche financée par le PNRDS destinée à évaluer, de façon systématique, un outil pédagogique novateur. En lisant l'article de madame Hester Kernen, intitulé « Tailoring nursing education programs to meet the nature of community needs », lequel remonte à deux décennies, je ne savais si je ne devais pleurer ou me réjouir : pleurer en raison du fait que le plaidoyer de madame Kernen en faveur d'une formation universitaire pour les infirmières constitue toujours une lutte actuelle ; me réjouir de sa pensée avant-gardiste. Malheureusement, je suis d'avis que nous devons plutôt pleurer, puisque notre plaidoyer n'a pas été assez convainquant et qu'il s'est heurté à de sourdes oreilles. Finalement, nous avons choisi l'article de mesdames Lillian Bramwell et Elaine Hykawy, intitulé « The Delphi Technique : A possible tool for predicting future events in nursing education », parce que nous ne pouvions absolument pas rater l'occasion de vérifier l'exactitude des prévisions d'une prophète.

*Conceptualiser la profession infirmière.* Les années 70 pourraient être nommées la décennie de la conceptualisation de la profession. La plupart des articles choisis ont été publiés après 1978. À la deuxième conférence nationale en recherche infirmière, madame Allen et son équipe (de laquelle je faisais partie) ont présenté de nouvelles formulations théoriques concernant le futur rôle de la pratique infirmière au sein du système de soins de santé. Madame Shirley Stinson, l'une des doyennes de la recherche infirmière au Canada, prédisait que les historiens qualifieraient cette rencontre de tournant historique en ce qui a trait à la pratique canadienne, puisqu'elle assignerait à la profession un nouveau rôle et une nouvelle direction. Les idées traitant de différents fondements théoriques en sciences infirmières ont été publiées dans le cadre de l'article précurseur de madame Allen, intitulé « Comparative theories of the expanded role and implications for nursing practice ». L'article de madame Carolyn Attridge et collègues, intitulé « Implementing program philosophy through curricular decisions » constituait la première publication traitant de la mise en place d'un nouveau programme dans lequel le contenu avait été élaboré en fonction d'une perspective spécifique en sciences infirmières. Madame Evelyn Adam, la gourou canadienne des modèles conceptuels, défend leur importance quant à l'élaboration d'une façon de penser et la constitution d'un cadre de travail pour la pratique, dans son article classique intitulé simple-

ment « Modèles conceptuels ». Puis, madame June Kikuchi, l'infirmière-philosophe-chercheuse du pays, a consacré sa carrière à nous lancer le défi de conceptualiser la profession. « Clarifying the nature and conceptualization about nursing » constitue pour elle une quête qu'elle poursuit depuis toujours.

*Introduire de nouveaux horizons en sciences infirmières.* Le développement et la croissance des sciences infirmières sont directement liés à l'ouverture de la profession face aux défis créés par les réalités et les contextes sociopolitiques. L'esprit insulaire a donc été notre pire ennemi. L'article de madame Alice Baumgart, intitulé « Nursing and political action : The legacy of sexism » et celui de madame Verna Huffman Splane, « Fashioning the future », représentent les dimensions de la profession qui vont au-delà des sciences infirmières, et fait appel à une sensibilité aux contextes régionaux et mondiaux.

*Développer le savoir destiné à la pratique infirmière.* Au cours de la planification de ce numéro, nous avons débattu de la meilleure façon de représenter la recherche clinique. Les 30 dernières années, notamment les 15 dernières, ont été le théâtre d'une prolifération de recherches cliniques. À la suite de discussions multiples et ardues, nous avons décidé de ne pas publier des recherches spécifiques mais plutôt des articles précurseurs reflétant les débats généraux et les idées de fine pointe appartenant à d'importants domaines spécifiques de la pratique. En ce qui a trait au débat général, nous avons choisi l'exposé de position de l'ACEUN, intitulé « Research in the university », dont la publication remonte au-delà de vingt-cinq ans et qui établit une direction pour les recherches en sciences infirmières au Canada. Nous avons choisi aussi le classique de madame Dorothy Pringle, intitulé « Another twist of the double helix : Research and practice », qui souligne les défis d'une discipline liée à la pratique et les difficultés à éliminer le fossé entre la pratique et la recherche. Pour illustrer la croissance du savoir dans les domaines spécifiques de la pratique, nous avons choisi un article dans chaque numéro-thème, notamment celui de la rubrique *Discours* dans la plupart des cas, parce qu'il résume les défis et les tendances au sein d'un domaine spécifique de la pratique infirmière. Dans certains numéros-thèmes, la signataire de la *Collaboration spéciale* fusionnait cette rubrique avec le *Discours*, selon une formule combinée. Dans de tels cas, nous avons révisé et dilué les éléments discours contenus dans l'éditorial. Pour deux des numéros-thèmes, nous avons choisi de publier un article plutôt que le contenu du *Discours*, en raison de la rigueur utilisée dans le traitement des questions conceptuelles et méthodologiques.

Cette compilation de *Perspectives en Nursing/Revue canadienne de recherche en sciences infirmières* des 30 dernières années est une véritable mine d'or qui présente les défis de l'heure et le chemin parcouru dans la lutte qu'à dû mener la profession pour obtenir une reconnaissance dans le monde de la recherche et sur la place publique. Cette reconnaissance est enfin établie. Les politiciens reconnaissent ce que la profession infirmière — et à un moindre degré le public — a toujours su : le système des soins de santé ne peut exister sans la pratique infirmière et il ne peut prétendre à des services de qualité sans l'existence de recherches dans cette discipline. Comme nous allons à l'impression, la création des Instituts canadiens de recherche en santé vient d'être annoncée ainsi que l'injection de 25 millions de dollars qui seront alloués à la recherche infirmière.

La croissance exponentielle de la recherche infirmière, riche en possibilités inimaginables, nous rappelle tout le chemin parcouru en trois décennies ainsi que les progrès réalisés par la discipline et la profession. Nous désirons témoigner notre reconnaissance envers les chercheuses qui ont accompli un travail de pionnières et qui ont mis en place les solides fondements desquels nous nous lancerons vers une nouvelle étape. Peut-être la prochaine décennie produira-t-elle, pour la profession, les mêmes effets fulgurants qu'ont généré les premiers pas sur la Lune.

**Laurie N. Gottlieb**  
**Rédactrice en chef**



# **Do Editors Have Anything to Teach Us? A Review of 30 Years of Journal Editorials**

**Anita J. Gagnon**

The role of the published journal article seems clear to most people. Readers look to it for new information or knowledge, which they will then use to inform their own clinical, administrative, or research practices. The author looks to it as a means of sharing the insights gained from various practice domains.

The role of the editorial, however, varies with the editor and is not directly (or even indirectly, perhaps) dependent on what readers perceive their needs to be. Given that there are as many roles for editorials as there are editors, the question arises: *What role have editorials played in this Journal over the last 30 years?* On a more practical note, a second question might be: *Should we be reading these editorials?*

In an effort to find out what might be learned about the role of CJNR editorials over the past three decades, I undertook an analysis of their authorship and content. I reviewed 86 editorials (guest editorials excluded), 38 published under Moyra Allen's editorship (1969-84), 32 under that of Mary Ellen Jeans (1984-92), and 18 under that of Laurie Gottlieb (1992- ).

## **Authorship**

Authorship has not been restricted to the Journal editor. In fact, there has been a great deal of variation, especially during Allen's tenure. Allen shared editorial authorship with nurse leaders from across Canada, their respective institutions being responsible for the issue in which their editorial appeared. These editorialists included representatives from the universities of Western Ontario, Toronto, British Columbia, Montreal, and Alberta, as well as Dalhousie and McGill. Jeans continued this tradition for the first third of her tenure but gradually turned to authorship exclusively by the editor. In Gottlieb's time only the editor has written editorials, although this period also saw the

introduction of the guest editorial, recalling the Journal's early days of shared editorial authorship.

### Content

The very early editorials focused on inviting readers to contribute articles and critical responses. The Journal was a "medium for assessing problems, posing questions, describing ideas and plans of action by persons concerned with nursing research and with nursing education in our universities" [1(1), 2]. There were frequent requests for financial contributions, detailing data from financial statements and citing subscription rates. The editorials also provided exact numbers of responses to published articles, giving the reader an opportunity to determine whether the Journal was effectively fulfilling its role as a medium for discussion. As participants in the Journal, readers were presented with a description of each challenge and proposed solution. In the absence of anticipated spontaneous feedback (in the form of letters and subscriptions), for example, editorials suggested peer reviewing, advertising, and the appointment of Journal "ambassadors" (years three and four).

Once representatives of other universities had agreed to take responsibility for an entire issue, the editorials suggested that still others take up the challenge. Journal content also became the subject of editorials, with the editor introducing readers to what they would be seeing within.

In the ninth year of publication an editorial described the establishment of a Review Board and the rigorous review process now so familiar to us all. Also appearing were requests for scholarly analysis of issues related to clinical practice, rather than education, along with discussions of doctoral preparation for nurses. Some editorials offered general information, such as announcement of the Research and Development Fund of Dalhousie University and presentation of CAUSN's accreditation criteria. Towards the end of Allen's tenure more research-related editorials began to appear; these included challenges to authors to submit manuscripts dealing with studies of clinical questions and addressing specific topics as well as discussions of methodology, particularly the use of qualitative methods in nursing research.

"Lessons" for readers began with Jeans's editorials, which suggests that perhaps Allen's goal of establishing a medium for discussion and debate among nurse leaders had been met and that the next step was to help readers develop their authoring and research skills. Authorship

lessons included instructions in basic writing skills, the process of writing for publication, "double" publication rules, and the role of reviewers. Research lessons included team etiquette and how to access a computerized clearinghouse for nursing research.

The editorials during this period rarely dealt with educational approaches, and for the first time they addressed research beyond nursing. There were discussions on the need for external lobbying to solicit support for nursing research — along with an announcement of support for nurse scholars from the Medical Research Council/National Health Research and Development Program. Editorials covered international nursing research and the role of Canadian nursing research in the global picture. Other issues discussed were the development of measuring tools in nursing, the question of whether research results from the United States could be generalized to Canada, use of various methodologies, and the importance of examining both clinical and statistical significance in describing results.

Under Gottlieb's tenure the editorials have returned to an examination of nursing itself: the role of nurses in health promotion, the danger of "insularity" in nursing, the nurse-practitioner movement, family nursing, defining nursing, and mentorship. This shift suggests that Jeans's apparent goal of educating readers in writing, reviewing, and conducting research has been met — or very nearly — and that Gottlieb hopes to blend the objectives of her two predecessors. Promoting excellence in practice by examining it, as suggested by Allen, while using the tools advanced by Jeans, is the logical next step in helping to develop the profession.

In these later years there has been a call to "get on board" — the globalization of information and the human genome project, for example, presenting unique opportunities for nursing. However, there has been a caution against the trend to "digest" research instead of analysing original studies and against the push from certain sectors to lower standards for entry into nursing programs in order to meet an expected shortage of nurses.

### **Role**

During Allen's tenure the editorials were meant to elicit a direct response (submission of manuscripts, reaction to published work, subscriptions), but they were also intended to play a truly active part in developing the profession in Canada; the establishment of an academic journal seems to have been secondary to the goal of consolidating and strengthening the community of Canadian nurse leaders.

Under Jeans's editorship the role of editorials was threefold: educational — lessons in writing and publishing manuscripts and in conducting research; promotional — the importance of political astuteness and lobbying; and informational — the larger research picture, both external to the nursing community and international.

Finally, during Gottlieb's tenure the role of editorials has been to challenge readers to examine nursing practice itself and to ensure high standards and thus excellence in nursing.

Although the particular function of the editorials has changed with each editor, when examined as a whole they serve, clearly, both to reflect the state of the profession and to stimulate its growth and development. Those of us who aspire to participate in this process are likely to find it easy to answer the second question posed above: *Should we be reading these editorials?* Resoundingly, YES!

# **A-t-on encore quelque chose à apprendre des éditorialistes ? Une rétrospective des 30 années d'éditoriaux de la Revue canadienne de recherche en sciences infirmières**

**Anita J. Gagnon**

Le rôle d'un article publié dans une revue ou un journal spécialisé semble relativement concret pour la plupart des gens. Le lecteur ou la lectrice l'aborde comme source d'information et de connaissances nouvelles dont il se servira par la suite pour améliorer sa pratique clinique, administrative ou ses activités de recherche. L'auteur(e), pour sa part, le perçoit comme un moyen de partager son vécu dans divers contextes de pratique.

La vocation de l'éditorial varie toutefois selon son rédacteur ou sa rédactrice et s'écarte de tout lien direct, voire indirect, avec la perception qu'ont les lecteurs et lectrices de leurs besoins. Si l'on prend pour acquis que les éditoriaux comptent autant de rôles que d'auteur(e)s, une question s'impose : *Quel rôle les éditoriaux ont-ils joué dans la Revue au cours de leurs 30 ans d'existence ?* En termes plus pratiques, la question se formule ainsi : *Ces éditoriaux valent-ils la peine d'être lus ?*

Dans le but d'identifier ce qui peut être retenu des éditoriaux de la RCRSI en terme de vocation au cours des trois dernières décennies, j'ai décidé d'en examiner la provenance et le contenu. Je me suis ainsi penchée sur 86 éditoriaux (en excluant les collaborations spéciales), soit 38 textes publiés sous la responsabilité éditoriale de madame Moyra Allen (1969-84), 32 autres sous celle de madame Mary Ellen Jeans (1984-92) et les 18 derniers sous celle de madame Laurie Gottlieb (1992-).

## **Les auteures des éditoriaux**

La rédaction des éditoriaux est loin d'avoir toujours été du ressort exclusif de la rédactrice en chef. Au contraire, plusieurs formes d'éditoriaux nous ont été suggérées au fil du temps, surtout sous l'influence de madame Allen. Cette dernière a partagé sa tâche d'écriture éditoriale

avec des chefs de file de la profession situées d'un bout à l'autre du pays, en partant du principe que leurs établissements respectifs seraient responsables du numéro où devait paraître leur éditorial. Parmi ces éditorialistes ont figuré des membres des universités de l'Ouest de l'Ontario, ainsi que de Toronto, de la Colombie-Britannique, de Montréal et d'Alberta, et des universités Dalhousie et McGill. Pendant que madame Jeans a tenu à poursuivre le premier tiers de son règne dans cette tradition, celle-ci s'est progressivement tournée vers une rédaction plus exclusivement réservée aux soins de la rédactrice en chef. Avec madame Gottlieb, tous les éditoriaux furent également confiés à la plume de la rédactrice en chef mais ce fut aussi la naissance de l'éditorial établi par collaboration spéciale, tout à fait à l'image de la RCRSI à ses débuts, alors qu'on variait la paternité des éditoriaux.

### **Le contenu rédactionnel**

Les tous premiers éditoriaux visaient surtout à inciter les lectrices à contribuer des articles et émettre leurs opinions critiques. La Revue se voulait un moyen d'évaluer les problématiques, de poser des questions, de décrire des idées et plans d'action par le biais de personnes préoccupées par la recherche infirmière et l'enseignement de la profession dans nos universités [1(1), 2]. Les éditoriaux servaient souvent aux demandes de contributions financières, offrant des détails sur les données d'états financiers et sur les tarifs d'abonnement. Ils offraient aussi nombre de réponses à des articles publiés, donnant ainsi l'occasion aux lectrices de juger de l'efficacité de la Revue en tant que média d'appel à la discussion. En tant que participantes de la Revue, les lectrices recevaient une description de tous les défis présents, accompagnés des solutions proposées. En l'absence d'une réaction spontanée (sous forme de lettres ou d'abonnements), les éditoriaux pouvaient devenir précurseurs, à titre d'exemple, d'évaluations par des pairs, d'initiatives publicitaires ou encore servir à la nomination d'ambassadrices (années trois et quatre). Lorsque des universitaires eurent accepté la responsabilité d'un numéro tout entier, leurs éditoriaux suggéraient que d'autres encore viennent relever le défi. Le contenu rédactionnel de la Revue devint alors l'objet de ses éditoriaux où la rédactrice avait pour objectif de plonger ses lectrices dans le vif des sujets qui allaient suivre.

Dans sa neuvième année de parution, la Revue annonçait la mise sur pied d'un comité de révision et faisait état du rigoureux processus de révision avec lequel nous sommes toutes devenues si familières aujourd'hui. On a vu naître aussi des demandes d'analyse scientifique

en rapport à des numéros portant sur la pratique clinique plutôt que sur l'enseignement. À cela s'ajoutait le thème de la préparation au doctorat des membres de la profession infirmière. Certains éditoriaux offraient de l'information à caractère plus général comme, par exemple, l'annonce de la création du Fonds de recherche et de développement de la Dalhousie University et l'introduction des critères d'accréditation de l'ACEUN. Vers la fin du mandat de madame Allen, les éditoriaux tendaient de façon plus marquée vers la recherche. Certains d'entre eux lancaient le défi à toutes de soumettre leurs études traitant de questions cliniques, d'autres s'intéressaient à certains sujets spécifiques en faisant le point sur la méthodologie et plus particulièrement sur le recours aux méthodes qualitatives dans le domaine de la recherche infirmière.

Des « leçons » à l'intention des lectrices firent leur apparition avec les éditoriaux de madame Jeans. À prime abord, l'initiative suggère que le but de créer un véhicule favorisant le questionnement et le débat à la tête de la profession avait été atteint et qu'il fallait maintenant passer à l'étape suivante, soit celle d'amener les lectrices à parfaire leurs aptitudes à l'écriture et à la recherche. Les leçons portant sur la rédaction comprenaient l'enseignement des principes rédactionnels de base, le processus d'écrire aux fins d'être publiée, les règles de la « double » publication et enfin, le rôle rempli par les réviseuses. Du côté de la recherche, la formation touchait les règles d'or du travail d'équipe et l'accession aux centres de documentation informatisés pertinents aux sphères de la recherche infirmière.

Les éditoriaux de cette période ont rarement traité des approches d'enseignement. Pour la première fois, ceux-ci abordaient plutôt la recherche au-delà du cadre de la pratique infirmière. Plusieurs éditoriaux cherchaient à démontrer la pertinence du lobbying à l'externe dans le but de solliciter de l'appui au profit de la recherche infirmière, et faisaient en même temps l'annonce de l'appui accordé aux infirmières-chercheuses par le Conseil des recherches médicales sous le Programme national de recherche et de développement en matière de santé. Les éditoriaux couvraient des sujets relevant de la recherche infirmière à l'échelle internationale et de la présence canadienne sur la scène mondiale. D'autres préoccupations à l'ordre du jour furent la création d'outils de mesure destinés aux sciences infirmières, la pertinence des recherches menées au États-Unis en rapport aux réalités canadiennes, le recours aux diverses méthodologies existantes et l'importance de se pencher autant sur les aspects cliniques que statistiques dans l'interprétation des résultats obtenus.

Sous madame Gottlieb, les éditoriaux ont de nouveau fait l'examen de la profession en soi, notamment le rôle des infirmières en matière de promotion de la santé, les dangers de « l'esprit insulaire », le mouvement infirmières-praticiennes, la pratique infirmière en milieu familial, une redéfinition de la pratique et du mentorat au sein de la profession. Ce changement de cap indique que la mission apparente que madame Jeans s'était donnée à l'égard d'éduquer ses lectrices en termes d'écriture, de révision et de recherche avait été remplie — ou, du moins, presque — et que madame Gottlieb espère maintenant en arriver à un amalgame des deux visions l'ayant précédée. Promouvoir l'excellence au sein de la pratique infirmière en la passant au crible, tout comme l'avait suggéré madame Allen, à l'aide des outils introduits par madame Jeans, semble être la voie la plus naturelle à suivre dans l'expansion des frontières de la profession.

Ces dernières années, les membres de la profession sont invitées à participer aux projets novateurs. La mondialisation de l'information et le projet de génôme humain, entre autres, offrent des perspectives sans précédent. Il y a toutefois lieu de faire preuve de prudence à l'égard des courants voulant « consommer » la recherche plutôt que procéder à l'examen de ce qui s'est fait antérieurement et aussi devant les pressions de certains secteurs désireux de réduire les critères d'acceptation aux programmes de pratique infirmière pour palier à la pénurie anticipée dans ce secteur.

### Le rôle de l'éditorial

Les éditoriaux parus pendant la période où madame Allen fut rédactrice en chef visaient surtout à susciter une réponse directe de la part des lectrices (soumission de manuscrits, réactions aux ouvrages publiés, abonnements) mais ils étaient aussi conçus en fonction de leur part active véritable dans l'évolution de la profession au Canada. En fait, la création d'une revue consacrée à la recherche semble être née du désir de consolider et renforcer les rangs parmi les chefs de file de la profession.

Sous la responsabilité éditoriale de madame Jeans, la formule des éditoriaux était proposée en trois principaux volets, soit la formation — leçons en écriture et en publication d'études et perfectionnement du travail de recherche ; la promotion — l'importance d'une présence sur la scène politique et d'un recours au lobbying ; et l'information — sur le domaine de la recherche dans sa globalité, parfois au-delà du cadre de la profession infirmière et même à l'échelle internationale.

*A-t-on encore quelque chose à apprendre des éditorialistes ?*

Finalement, sous la tutelle de madame Gottlieb, le rôle des éditoriaux se situait à inviter les lectrices à faire l'examen de la profession elle-même et opter pour des normes de qualité très élevées et donc d'excellence, au sein de la pratique infirmière.

Même si la vocation première des éditoriaux a maintes fois changé à l'image de chacune des rédactrices, en examiner l'ensemble donne un net aperçu de la profession et le tout vient former un tremplin qui en assure le dynamisme et l'expansion des horizons. Chez celles qui aspirent à prendre part à ce mouvement perpendiculaire, on trouvera certainement plus facile de répondre à la question du début : *Les éditoriaux valent-ils la peine d'être lus ?* Un OUI retentissant s'impose !



**SECTION I**

Educating for  
Nursing Practice

*Transmettre le savoir  
en pratique infirmière*



# **The Development of Clinical Nursing Situations on Videotape for Use Via Closed-Circuit TV in the Teaching of Nursing**

**F. Moyra Allen**

We elected originally in this research project to develop videotapes depicting clinical situations in nursing and to assess their effectiveness in the teaching of nursing. To accomplish these ends we chose to film on videotape the everyday, real-life situations that persons and their families experience in various parts of our health delivery system. We focused on the recipient — professionals and others were incidental and were taped as they entered and participated within the situation we were taping. We taped persons and their families in hospital, clinic, and home; at critical points and throughout their illnesses; of differing ages — the infant to the aged; and, in addition, persons in contact with various professionals.

We have discovered within our videotapes a means to revolutionize the system of nursing education. Before, nurses in the teaching situation have rarely had the opportunity to examine a nursing situation as it occurs and develops; to study the whole situation of a patient and his family through the various phases of his health problem within the short time period of a videotape; to re-experience and re-examine a situation over and over again, to pick up cues and observations which one becomes aware of through recurrent experiences with the same situation. One does not have the opportunity in real life to view a situation a second time, to validate one's impressions or to reject them. In fact, our videotapes provide the same opportunity as the "replays" in televised hockey, a greatly enhanced and expanded opportunity for learning; but in the case of nursing, of highly complex situations. Students must learn *how to learn* from real-life situations on videotape. It has been our experience that in viewing videotapes, nurses tend to place value on actions based on the standards of a "textbook picture" of either the nurse or the patient and, therefore, fail to see or to respond to the situation as it exists.

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## Research Report

**Rationale.** Schools of nursing encounter difficulties in obtaining the amount and type of clinical experience which they require to prepare nurses. If we are able to provide effective clinical experiences on videotape, we shall have greater command over the number of nurses who can be educated. Furthermore, the known content of taped situations permits the educator greater control over what is learned and ultimately over the quality of nursing education.

**Taping.** Emphasis shifted from taping the nursing of patients to taping the patients themselves, their families, and whatever professional personnel entered into the situation during the taping process. This modification enabled us to utilize the tapes for the original purposes: observation and assessment of the patient situation by the individual student or group of students. It was discovered in the first year of the research proper, in tapes focusing on the nurse, that an audience evaluated the nurse in a type of *a priori* fashion without much consideration of the patient. Such an approach tends to parallel the textbook presentation of nursing and therefore is already available to us. By focusing on the patient, we were able to direct the audience's observation to the patient situation — to observe, analyze, and discuss the nature and requirements of it. The patient over time in many settings and under many conditions with varying professionals is not available in any medium — not even from the patient himself. One is not with him for such long periods nor can experiences with patients be restudied, reassessed and, in a sense, rediscovered.

**Validation.** Validation sessions were held to gain a consensus on the content of the tapes by experts in various aspects of nursing from across Canada. Validators were asked to view a tape and to answer specific questions which were subsequently analyzed for nursing content.

The major finding from the validation sessions was that experts from across the country view nursing differently. *The nature of observations, the needs of patients, the characteristics of effective nursing and of the successful delivery of health services varied a good deal from one person to another.* Validity could only be established at a general level of content. Therefore, it is premature to consider any final validation of the content of the tapes at this time. Rather, we must assist nurses (and others) to study the tapes to add to their pool of experiential data — material which, heretofore, has been lacking. If the potential of these tapes can be exploited, nurses can be made aware of a new realm of reality in the situations with which they deal. Undoubtedly, a similar phenomenon exists when we consider

the evaluation of health care, for our findings suggest that professionals within one field vary in their observations and assessments and in the criteria they utilize for evaluating care and services.

### **Experiment to Evaluate the Effectiveness of Videotapes in the Teaching of Nursing**

An experiment was designed to evaluate the effectiveness of videotapes in the teaching of nursing. Senior students in two hospital schools of nursing were used as the test groups and the experiment focused on the nursing of aged persons.

#### ***Introduction***

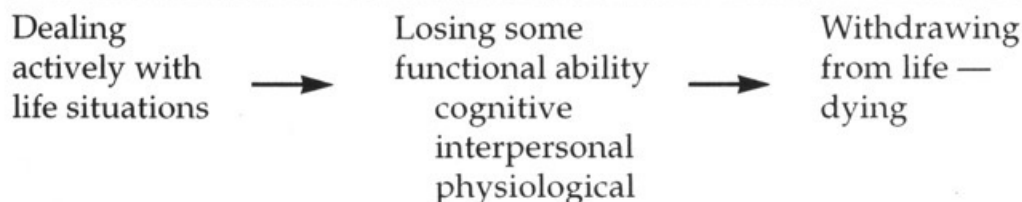
Students have experiences in nursing aged persons throughout their educational program, such as the relevant aspects of a number of courses; nursing elderly patients; individual and group discussions with instructors, nursing staff, students, and other health professionals; plus a variety of extracurricular experiences. The nursing of aged persons is, in particular, an emphasis of some senior experiences in medical-surgical nursing, when the student is expected to respond to the varying forces and influences of a patient situation by making a nursing judgment and plan of care. At the same time students may be given the opportunity to act as team leader with a group of staff to provide care for a larger number of patients, many of whom are older persons.

The experiment in teaching was directed towards answering the following question:

*To what extent does the introduction of videotapes portraying the response of elderly persons to illness, hospitalization, and treatment, and the response of nurses in caring for these patients, augment the student's potential to nurse aged persons?*

#### ***Theory\****

##### *A Continuum — Process of Aging*



\*A point of view based on the analysis of a number of videotapes along with study of the rapidly increasing bibliography on the subject.

Throughout life individuals develop notions of their personal freedom and independence in activities of living. In old age, persons continue to maintain these notions while coping with the phases of the aging process. Elderly persons who become ill are placed in a position of dependency and their reaction to this state varies in view of their past experience and stage of aging. Thus a person still dealing actively with life may exhibit a high degree of dependency in so doing; while another person may demonstrate much autonomy of self in approaching death. In other words, aging is reflected in the varying stages of disengagement of the individual from life, and to some extent, independently of this disengagement, individuals perceive their ability to control what happens to them, the decisions they make, and the choices or alternatives that are available to them.

In addition to the perceptions and status of the individual person, the nurse has a method for making decisions about a person's needs, areas of autonomy, the types and number of choices, etc. Her approach to this problem may be established *a priori* for the varying phases of aging and disengagement or, on the other hand, she may respond to the individual and assist him to make his perceptions and ideas of living operative for him within the hospital or other community setting. Thus we have differential responses of nursing to aging persons and to their lifestyle.

### Design

Experimental designs were developed to fit in with the actual teaching programs in process in the latter half of the third year of the two hospital schools; in other words, an experimental design in natural laboratory settings. The following plan outlines the experimental designs followed for schools A and B, in which 0 stands for *pre* or *post test* and X for *experimental variable*.

School A			
	Pre test	Experimental Variable	Post test
Group 1			0 <sub>2</sub>
Group 2	0 <sub>1</sub>		0 <sub>2</sub>
Group 3	0 <sub>1</sub>	X <sub>1</sub> X <sub>2</sub>	0 <sub>2</sub>

The post test for Group 1 assesses the student's potential to nurse aged persons towards the end of the last instructional experience in the school of nursing and, therefore, provides information on the effectiveness of the usual teaching methods. The pre and post tests in Group 2 identify the difference in potential at the beginning of the instructional

experience and at the end of the usual instruction which students receive. The pre and post tests in Group 3 identify the effectiveness of the videotape in augmenting the potential of students to nurse aged persons. It was hypothesized that:

1. The difference between pre and post test scores in Group 3 is greater than the difference in Group 2.
2. The post test scores in Group 3 are higher than those in Groups 1 and 2.

### ***Validity and Reliability***

The three groups were tested in subsequent months. The groups were relatively separate during the three months because of the experiences planned; however, some opportunity existed for Group 2 to gain knowledge from Group 1, and Group 3 from both Groups 1 and 2; hence the rationale for introducing the experimental variable in Group 3, the last group chronologically. The decision to introduce the experimental variable in Group 3 protects the experimental variable in that the problem of contamination from the experimental to the control groups is eliminated. However, the decision theoretically favours the hypotheses in that any information which is passed on from Groups 1 and 2 to Group 3 may lead to a greater initial potential for nursing aged patients in Group 3. Pre test scores for Groups 2 and 3 should help to assess this problem: Are pre test scores for Group 3 higher than those in Group 2?

It is unfortunate that there were not four natural groups so that an experimental group without pre testing might have been assessed. It is expected that the pre test exercise alerts respondents so that post test scores will be somewhat higher given no instruction at all. However, the extent of the problem can be assessed from the scores of Groups 1 and 2. The decision to pre test the experimental group was made to provide information on the problem described in the previous paragraph as well as to assess the equivalence of the experimental group with at least one other group.

#### **School B**

	Pre test	Experimental Variable	Post test
Group 1	$0_1$		$0_2$
Group 2			$0_2$
Group 3	$0_1$	$X_1 \quad X_2$	$0_2$
Group 4		$X_1 \quad X_2$	$0_2$

In addition to the control and experimental groups in School A, School B in Group 4 provides information on the effectiveness of the experimental variable (the post test) minus the interaction of effects due to pre testing. As will be noted later, this is a critical condition for this particular experiment. It was hypothesized that:

1. The difference between pre and post test scores in Group 3 is greater than the difference in Group 1.
2. The post test scores in Groups 3 and 4 are higher than those in Groups 1 and 2.

The situation in School B allowed for four natural groups so that an experimental group without pre testing could be assessed.

### *The Experimental Variable*

Selections from videotapes made during 1971 of nurses caring for elderly people (real-life situations) were made on the basis of variation in sex, age, type of illness, degree and type of disengagement, and degree of independence or autonomy on the part of the patient, and variation in the nurses' responses to these patients. Disengagement and independence in the patient and type of response in the nurse had been validated to some extent by a small number of judges who were able to view and study the tapes over time.

At a convenient time during the second-third weeks of the instructional program for Group 3 of School A and in February for Groups 3 and 4 of School B, two sessions were held a few days apart in which the videotapes were shown to the groups of students. Post-viewing discussions were held with the whole group focusing on their observations of the aged person and the nurse's response. Instructions to the group were as follows:

The videotape you will see shows the response of a number of aged persons to (Session 1) and one person through the stages of (Session 2) illness, hospitalization, and treatment as well as the nursing of these persons. After the tape there will be an opportunity to discuss your observations with others in the class and to consider their meaning to you in nursing aged persons.

The discussion session was led by the project director. She introduced the discussion by asking for their observations and continued throughout by clarifying and summarizing the group's response periodically. At no time did the discussion leader introduce content on aging or nursing the aged nor did she introduce her observations of the tape. Each discussion lasted for 20–45 minutes.

### *The Test Procedure*

It was expected that the videotapes depicting the nursing of aged persons in hospital would sensitize the viewers to variation in needs and responses of older people and to the approaches which nurses use and the problems they experience in caring for the aged. Given this expectation it was assumed that the viewers of the videotapes, i.e. the experimental group, should have greater potential for nursing elderly persons. Nursing potential is described as a combination of variation and specificity, terms which are defined in the following section. To determine whether the expectation was justified, data were collected from students by asking them to respond in a test situation. The construction of the test and the analysis of the responses were based on the theoretical approach to aging described earlier, i.e. disengagement and the patient's and nurse's responses.

### *Test Questions (Pre and Post Tests)*

A content analysis of the respondent's answers was carried out to determine the number, variation, and specificity of ideas relating to the elderly patient and to the nurse.

- Quantity — Number of ideas relating to elderly patient and to nurse, per response.
- Specificity — Description of particular, discrete, or specific needs as contrasted with general or global statements: a characteristic of each idea.
- Variation — Differences in types of needs and aspects of needs and differences in kinds of response to illness, indicating awareness of a variety of psychological, physiological, and sociological factors.

Theoretically the Potential for Nursing Aged Persons was determined in the following manner:

$$\begin{array}{ccc} \text{Quantitative Index} & \times & \text{Qualitative Index} \\ \text{(No. of ideas)} & & \text{(Variation } \times \text{ Specificity)} \\ \text{Nursing Potential} & = & \text{N(VS)} \end{array}$$

### *Analysis of Findings*

The mean test scores for each group in Schools A and B follow:

Mean<sup>1</sup> — Assumes the four test scores to be of interval variables.

Mean<sup>2</sup> — Assumes the scores of Questions 2 and 4 to be of interval variables.

Pre test		Experimental Variable		Post test
School A				
Group 1				0 <sub>2</sub> (Jan. 27) (N = 28) M <sup>1</sup> = 12.9 M <sup>2</sup> = 9.0
Group 2	0 <sub>1</sub> (Feb. 4) (N = 33) M <sup>1</sup> = 11.9 M <sup>2</sup> = 8.4			0 <sub>2</sub> (Feb. 25) (N = 24) M <sup>1</sup> = 10.2 M <sup>2</sup> = 7.4
Group 3	0 <sub>1</sub> (Mar. 2) (N = 33) M <sup>1</sup> = 11.93 M <sup>2</sup> = 8.1	X <sub>1</sub> (Mar. 13)	X <sub>2</sub> (Mar. 20)	0 <sub>2</sub> (Mar. 24) (N = 12) M <sup>1</sup> = 11.8 M <sup>2</sup> = 8.6
School B				
Group 1	0 <sub>1</sub> (Jan. 25) (N = 12) M <sup>1</sup> = 11.3 M <sup>2</sup> = 7.6			0 <sub>2</sub> (Feb. 7) (N = 12) M <sup>1</sup> = 11.5 M <sup>2</sup> = 7.2
Group 2				0 <sub>2</sub> (Feb. 7) (N = 6) M <sup>1</sup> = 11.3 M <sup>2</sup> = 7.7
Group 3	0 <sub>1</sub> (Feb. 7) (N = 9) M <sup>1</sup> = 11.9 M <sup>2</sup> = 7.7	X <sub>1</sub> (Feb. 11)	X <sub>2</sub> (Feb. 15)	0 <sub>2</sub> (Feb. 18) (N = 7) M <sup>1</sup> = 11.6 M <sup>2</sup> = 6.9
Group 4		X <sub>1</sub> (Feb. 11)	X <sub>2</sub> (Feb. 15)	0 <sub>2</sub> (Feb. 18) (N = 9) M <sup>1</sup> = 12.3 M <sup>2</sup> = 8.4

We note that the first hypothesis has not been upheld. Post test scores are higher than pre test scores in only two instances: a difference of 0.5 points for Mean<sup>2</sup>, Group 3, of School A and 0.2 points for Mean<sup>1</sup>, Group 1, of School B (differences insignificant). In fact, post test scores are lower than pre test scores in both control and experimental groups. The second hypothesis has not been upheld. Post test scores are not higher for the experimental groups than for the control groups, with the exception of Group 4 of School B (difference insignificant).

How can one account for the failure to uphold the hypotheses? Many factors came to light during the process of the experiment; one notes immediately the mortality between the pre and post test groups, particularly in School A where the numbers are larger. The mortality in Group 3 of School A was almost 66.6%.

### **Problems with Experiment**

#### *Choice of Groups*

The senior classes in two hospital schools of nursing were selected as the test groups. According to the schedule of each school, the class was divided into groupings for the purposes of learning to nurse in different clinical experiences and to participate in the accompanying instruction. These natural groupings could readily be divided into control and experimental groups for purposes of the experiment. The situation seemed ideal. These two groups were among a number of last classes to graduate from hospital schools in Quebec and, as the CEGEP system of nursing education was new, it did not seem reasonable to inflict experimentation upon them at such an early date.

It became clear as the experiment proceeded that these students had learned to nurse and, at the point of graduation, did not feel the need to learn more about nursing. The method of handling the experimental variable, i.e. the introduction of videotapes, would have to have been approached quite differently if the experiment were to have had a reasonable opportunity of success.

#### *Videotapes of Reality Situations*

Students had learned ways of responding to older people and they found it difficult to focus on a situation of an older person and expect that they would find anything different. Comments such as the following were made by the respondents:

*"We know about older people, we know how to nurse them."*

*"We are sick of older people, we've had too many to care for."*

*"We know about meeting the needs of the older person and treating the person as an individual."*

Having used these same videotapes with the validators and also with students in the baccalaureate and master's program in the university, it has become increasingly clear that students (as well as teachers) have to learn *how to learn* from these real-life situations. They are being

asked to observe and assess on the basis of the data or information provided from the situation and not to bring to the situation an *a priori* or preplanned statement of what the patient needs and what should be done for him.

As the nursing profession wishes at this time to move from prescriptive nursing to observation and the gathering of information as the basis for assessment, the value of the reality situation on videotapes has increased tremendously.

### *Effects of Pre Testing*

With the exception of Group 1 in School B, pre testing was associated with lower post test scores. The same test was used in both pre and post test situations. Students felt that they would answer the second time as the first, so frequently in the post test students referred the reader to their first answer or made only a brief response.

A post test containing different questions from the pre test had been considered earlier, but rejected on the basis of problems of validity and reliability. The other possibility of a multiple choice type test was not feasible given the time span of the experiment. To attempt to validate items and standardize a test when no criterial base existed for selecting the best answer would have been sheer expediency and at best have demonstrated the truth of the self-fulfilling hypothesis.

The high mortality rate, particularly in the experimental group in School A, coupled with the slight differences in pre and post test scores, leads us to regard the results of the experiment as inconclusive and certainly provides no firm evidence for either the acceptance or rejection of the hypotheses. However, a number of interesting bits of information may be gleaned from the results.

It is fortunate that one experimental group was carried out without pre testing (Group 4, School B). It may be noted that this group has the highest post test score of all the groups in School B, leading us to wonder whether the experimental variable (videotapes) had been instrumental in augmenting student learning. It is unfortunate that in the whole experiment only one of the three experimental groups was not pre tested.

The factor of time seems to have had a different result in School A as compared with School B. In School A the scores seemed to decline from one group to the next, that is, from the end of January to the end of March, whereas in School B the scores tend to increase from one

group to the next. In School B, one might infer a maturation or learning factor to account for the increase; however, contamination of the successive groups is an acceptable alternative to explain this situation. In fact, the latter alternative may help to explain this phenomenon in School A, in that contamination of successive groups may have resulted in loss of interest and rejection of the experiment.

### **Conclusions and Recommendations**

Owing to the inconclusive results of the experiment, it is suggested that a second experimental situation be devised to evaluate the effectiveness of videotapes in the teaching of nursing. To enhance the probability of this experiment being successful and the hypothesis being upheld, the following changes would be required.

- (a) Introduce the experimental variable (videotape) near the beginning of a nursing program before students have learned a *way of learning* about nursing and before they have actually learned to nurse. It became clear in reflecting on the original plan and on how people learn that there is more opportunity to influence learning when students are changing and learning a great deal (the beginning of a nursing program) as compared with the end when the rate of learning has decelerated and students feel they know how to nurse.
- (b) Maintain the experimental variable in contact with the group over a sufficient period of time for it to be effective. We learned that videotapes, which present reality, demand a new approach to the teaching of nursing, resulting in the learning of different content, i.e. way of nursing. For this reason, it would be necessary to introduce the experimental variable, videotapes, for a whole course, i.e. a semester course.
- (c) If (a) and (b) were acted upon, then students would learn a good deal in the course and would feel themselves that their response to the post test would differ considerably from that of the pre test. In the experiment just completed, students expressed frustration in responding to the post test as they felt their response would be the same as to the pre test.



# **The Delphi Technique: A Possible Tool for Predicting Future Events in Nursing Education**

**Lillian Bramwell and Elaine Hykawy**

The 27-year interval since World War II has witnessed far-reaching change in social, economic, and political institutions. The literature indicates no deceleration of this process (Doyle & Goodwill, 1971; Enzer, 1971). In fact, Toffler (1971) suggests that we are now experiencing "...the dizzying disorientation brought about by the premature arrival of the future..." (p. 11). The transition from a fatalistic acceptance of the inevitability of future events to a more positive consideration of "futures" planning is quite recent. "Once we think of futures as events which are at least partly subject to choice and control, we can work toward improving long-range planning" (Helmer, 1970, p. 1).

Several techniques have been developed to assist in predicting future events. Among these is the Delphi Technique (Helmer, 1966), which is a procedure for organizing and sharing expert forecasts about the future. It has been used in a variety of educational settings (Anderson, 1970; Clarke & Coutts, 1970; Cyphert & Gant, 1970; Doyle & Goodwill, 1971; Jacobsen, 1970). No studies using this technique were found in nursing literature, although individuals have made predictions about future events in nursing education (Burnside & Lenburg, 1970; Mussallem, 1970) and others have recommended that such studies be done (Applund, 1966; Seyffer, 1965).

A survey of the literature showed that the advantages of using the Delphi Technique in forecasting were as follows. It can involve a number of individuals from a wide geographical area while avoiding the disadvantages of the committee method (Campbell & Hitchin, 1968; Clarke & Coutts, 1970; Doyle & Goodwill, 1971). The influence of status and forceful personalities among panel members is eliminated (Cyphert & Gant, 1970; Doyle & Goodwill) and the problem of commitment to a publicly stated opinion is avoided (Cyphert & Gant; Doyle & Goodwill).

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Criticisms encountered included the following. Criteria for the identification and selection of experts have not been established (Anderson, 1970; Campbell & Hitchin, 1968; Cyphert & Gant, 1970; Helmer, 1966; Helmer & Rescher, 1959). Scholars in the same discipline tend to think along the same lines which may cause them to arrive at a consensus of opinion without considering all relevant factors (Boehm, 1970). The process of adapting panellist responses from Questionnaire I for use in subsequent questionnaire rounds may result in inaccurate translations of panellist predictions (Boehm; Helmer, 1966). And finally, not enough is known about the thought processes that are involved when the future is considered (Helmer, 1966; Weaver, 1971).

Despite these limitations, it has been recommended that studies employing the Delphi Technique be continued in order to further refine the technique and to explore its applications.

### **Purpose of the Study**

The purpose of this study was to explore the potential of the Delphi Technique in predicting events of the next 50 years in nursing education. In employing the technique, data were collected about the events that will occur, when they will occur, and the degree of consensus reached by the group on events and time.

### **Definition of Terms**

The Delphi Technique is "...a carefully designed program of sequential, individual interrogations (usually conducted through questionnaires...), interspersed with information feedback on the opinions expressed by the other participants in previous rounds" (Helmer, 1970, p. 4).

Experts in this study included persons who are presently involved in nursing education as planners, researchers, or teachers at universities, colleges, hospitals, professional or government agencies.

Consensus means that at least 75% of the panellists (or 10 of 13) agree that a specified prediction will occur within a certain time interval.

Dissenting opinions are predictions which do not fall within the time interval in which the largest number of panellists agree that the event will occur.

### **Limitations**

The limitations of this study arose from two sources — the Delphi Technique and the sample. The limitations arising from the technique itself were: the inability of individuals to project into the future; the need to think of all other future developments that would affect nursing education in the future, e.g. technology, health problems, primary and secondary educational systems; the possibility of vague or ambiguous questions; and the possibility of responses being self-fulfilling and/or self-defeating prophecies. Limitations arising from the sample were the small number of panellists and the restriction of panellist selection to Ontario.

### **Assumptions**

The following assumptions were held: respondents are competent in the field of nursing education; responses are individual, no advice is sought from other respondents; and responses are based on rational judgement.

### **Method**

#### ***Sample Selection***

Experts were selected on the basis of educational level, rank in educational institution and/or position in agency or organization. All experts who were selected as panellists had at least a master's degree. The selected panel consisted of 16 members as follows: seven assistant professors or higher in university nursing programs, three directors from diploma nursing programs, two directors from nursing service administration in hospitals, three executive officers from professional nursing organizations, and one nursing consultant from a government agency. There was one refusal to participate from a diploma nursing program director and two non-responses from university professors. The remaining 13 panellists completed the study.

#### ***The Delphi Technique***

Four rounds, each involving a questionnaire and questionnaire analysis, were conducted in the following manner.

**Round I.** Panellists were requested to make a maximum of 10 predictions regarding the future of nursing education in the next 50 years. A grouping and collation of responses was done to reduce the number of predictions to a manageable size.

**Round II.** The predictions were presented and the panellists were asked to predict in which time interval they would occur. The time intervals had been defined by the investigators as 1972–1980, 1980–1990, 1990–2000, 2000–2020, later, and never. Results were tabulated and reported for each statement in terms of number and predictions in each time interval.

**Round III.** Panellists received feedback of their Round II predictions plus the corresponding response from the total group for each statement. If a panellist's prediction differed from the group response, she was requested to revise her prediction or to support her position. The results were again tabulated and reported for each statement. Statements achieving consensus were announced. Reasons for dissenting opinions were incorporated into the next questionnaire.

**Round IV.** Panellists were asked to reconsider their predictions in view of the dissenting opinions and to revise them if they so desired. The additional predictions that achieved consensus were identified. A description of events that would occur in the future, as predicted by the consensus of the panel of experts, was composed and sent to the panellists.

Reactions to the Delphi Technique were also obtained from the panellists. These were categorized and compared with reactions to the Delphi Technique reported in the literature.

## **Results**

The data are presented in two sections for each round: part (a) describes panellists' reactions to each questionnaire and part (b) describes the results of each questionnaire regarding events, timing, and consensus.

### **Round I**

- (a) Of 16 panellists selected two did not respond; one refused to participate, saying that it would be too time-consuming; two accepted dubiously, one questioning the time factor and one questioning her own expertise. The remaining 11 accepted without comment, for a total of 13 panellists.
- (b) Of a total number of 120 statements submitted by panellists, 31 were rejected because they were not directly concerned with nursing education. The remaining 89 were grouped by the investigators with assistance in interpretation from an arbiter on statements that were unclear to the investigators. The state-

ments were then combined to form a total of 38 statements for Questionnaire II. This combining and grouping was possible due to repetition and similarity of predictions. Statements that were selected included words and phrases used by panellists so that the original intent could be transmitted and so that panellists would recognize their own contributions. The following 38 statements comprised Questionnaire II.

1. Teacher's role will be that of resource person and counsellor to aid the student towards maximum personal growth.
2. Students will progress through the curriculum as slowly or as rapidly as they are individually able.
3. Students will apprentice with skilled nursing practitioners, who are actively practising and who will serve as role models.
4. There will be a return of an internship for specialty services and nursing service will again become involved in the education of nurses.
5. Nursing education will not be as popular to high school graduates.
6. There will be an increased enrolment in basic baccalaureate programs.
7. An increase in the male student population will occur.
8. Nursing educators will be expected to maintain their clinical competence by a return to the practice of nursing.
9. All levels of nursing, diploma and higher, will be exposed to nursing research in their courses of study.
10. Students will learn to give care wherever there are health programs, in space, under water, in the north or in another country. (Electronic translators will permit conversation in any language.)
11. Students will learn to give care in a variety of communities and cultures with persons of all age groups.
12. Nurse educators will become more knowledgeable about social, medical, and economic problems in the developing countries and their effect on nursing care and will communicate this to their students.
13. All education programs will become future-oriented because even now, as they exist, they are obsolete.
14. There will be very few nursing administrative positions available in departments of nursing, freeing nurse educators to teach.

15. Clinical specialization at the doctoral level will develop rapidly.
16. Clinical specialization at the master's level will develop rapidly.
17. Increasing numbers of nurses will seek graduate education including post-doctoral education.
18. There will be a high percentage of interdisciplinary (core) programs offered to nursing students enrolled in both community college and university programs.
19. There will be a health sciences faculty, multidisciplinary in nature, which will develop the overall health worker concept.
20. Through co-operative effort, students in the health disciplines will develop community studies and projects.
21. Nursing assistant programs will be upgraded to eventually replace the present diploma nursing programs.
22. All nurses will be prepared in a two-year core program (diploma) at the community college level with ready access to university study — baccalaureate — master's — doctoral levels. (Ladder concept.)
23. Certification courses in all clinical specialties will be offered to graduates of core programs (diploma) and degree programs, through both the community college and university faculties of nursing.
24. All nurses will be required to return to school for refresher courses every three to five years in order to ensure that their knowledge is current.
25. Nurse educators in Canada will try to develop programs for graduate students from underdeveloped countries.
26. University schools of nursing will have to give more attention to developing clinical competence in their graduates, e.g. internship.
27. Nursing curricula will consist of a series of problem areas, gradated according to depth of clinical judgement required for assessment and nursing intervention.
28. Schools of nursing as they exist will pass away and with them will pass the rigidly imposed structure for nursing education.
29. There will be no classrooms, no classes, no group clinical experience. There will be an enormous resource centre at each centre for nursing education using, in common with other disciplines, computer banks of information, instructional programs, and simulated people.

30. Diploma nursing programs as such will cease to exist and will be replaced by highly skilled technologists in varieties of sub-specialties emerging out of specialized institutions.
31. Psychomotor skills will cease to be emphasized in nursing programs to be replaced by theory in the principles of care particularly related to mental health aspects.
32. Students will gather information and test their knowledge in their homes, using individual computer consoles for information retrieval and computer assisted instruction.
33. With computer assistance in manipulating patient data for purposes of diagnosing and prescribing treatment, educational programs will focus on prevention, psychological support, and adaptation to environment.
34. Audio-visual devices (video-phone, video-tape, closed circuit TV) will be used to demonstrate and to evaluate nursing care performance.
35. Simulated people with responses programmed by computer will provide laboratory experience for beginning physical and social skills to permit the student to see the effects of nursing intervention.
36. Basic university programs for the preparation of the high school graduate in nursing education will be considered uneconomical and will be phased out.
37. Basic preparation of the registered nurse will no longer include hospital maternity nursing. This will become a continuing education specialty.
38. Standards in nursing education will be set by persons who are not nurses.

### *Round II*

- (a) Thirteen panellists indicated in which time interval predicted events would occur. Six panellists qualified their responses and six panellists edited some of the statements.
- (b) Consensus was reached on one statement — number 6.

### *Round III*

- (a) Panellists reconsidered their predictions in view of what other panellists had predicted and gave reasons for opinions which differed from the majority. One panellist commented on the ambiguity of the statements, and of 13 respondents, 12 stated reasons for dissenting opinions.

**Table 1** *Consensus Reached by Panellists on Future Events in Nursing Education, by Round and Time Interval*

Round in which consensus reached	Future events in nursing education	Time of Occurrence					
		1972–1980	1980–1990	1990–2000	2000–2020	Later	Never
II	There will be an increased enrolment in basic baccalaureate programs.	X					
III	Nursing educators will be expected to maintain their clinical competence by a return to the practice of nursing.	X					
III	All levels of nursing, diploma and higher, will be exposed to nursing research in their courses of study.	X					
III	There will be very few nursing administrative positions available in departments of nursing, freeing nurse educators to teach.		X				
III	There will be a high percentage of interdisciplinary (core) programs offered to nursing students enrolled in both community college and university programs.		X				
III	There will be a health sciences faculty, multidisciplinary in nature, which will develop the overall health worker concept.		X				
III	Through co-operative effort, students in the health disciplines will develop community studies and projects.	X					
III	All nurses will be prepared in a two-year core program (diploma) at the community college level with ready access to university study – baccalaureate – master's – doctoral levels. (Ladder concept.)		X				

Round in which consensus reached	Future events in nursing education	Time of Occurrence					
		1972–1980	1980–1990	1990–2000	2000–2020	Later	Never
III	All nurses will be required to return to school for refresher courses every three to five years in order to ensure that their knowledge is current.		X				
III	University schools of nursing will have to give more attention to developing clinical competence in their graduates, e.g. internship.	X					
III	Nursing curricula will consist of a series of problem areas, gradated according to depth of clinical judgements required for assessment and nursing intervention.	X					
III	Schools of nursing as they exist will pass away and with them will pass the rigidly imposed structure for nursing education.		X				
III	Audio-visual devices (video-phone, video-tape, closed circuit TV) will be used to demonstrate and to evaluate nursing care performance.	X					
IV	Certification courses in all clinical specialties will be offered to graduates of core programs (diploma) and degree programs, through both the community college and university faculties of nursing.	X					
IV	Simulated people with responses programmed by computer will provide laboratory experience for beginning physical and social skills to permit the student to see the effects of nursing intervention.			X			

- (b) Consensus was reached on 12 additional statements (see Table 1).

#### **Round IV**

- (a) Reactions to the Delphi Technique were, for the most part, positive, e.g., "Stimulated thinking and discussion about nursing in the future," "forced one to think by self about difficult and complex nursing issues," and "encouraged futures planning." One panellist felt that the tool had some validity because consensus was reached on a number of events.

Negative responses included "frustrated by the lack of discussion with colleagues," "would have preferred direct interchange," and "insufficient time for reflection" (mentioned by several panellists). One panellist recommended that the study be conducted on a larger scale with a specific purpose for application of findings.

Panellists suggested that the Delphi Technique could be used in the following ways: to solve problems and make decisions in nursing service administration, to make manpower predictions, to stimulate discussion groups, to determine the ability of a group to reach consensus, and to determine future-oriented objectives.

- (b) Consensus was reached on two additional statements (see Table 1), for a total of 15 out of 38 statements, all occurring between the years 1972 and 2000.

#### **Discussion and Conclusion**

The present study explored the potential use of the Delphi Technique in predicting future events in nursing education. The technique, as described in the literature and as used in this study, has a number of limitations. Simon (1969, p. 274) has questioned the use of expert opinion, suggesting that expert opinion is better used as guidance rather than as final data. The procedure for selecting experts to function as panel members has not been adequately delineated. Helmer and Rescher (1959) gave two requirements for panel selection, knowledge in the field and degree of accuracy in predictions. The first criterion was followed in this study in that rank at the university and position in the agency were considered. It was not possible to measure for accuracy of past predictions due to lack of developed methods of measurement.

Not enough is presently known about thought processes that are involved when attempts are made to conceptualize the future (Weaver, 1971). How much are predictions based upon rational judgement, background knowledge, past experience, intuition, and/or wishful thinking? At the present time there is no reliable method for differentiating between objective and subjective predictions. In other words, it is difficult to separate the "will happen" from the "should happen" (Weaver). It may also be argued that personal bias could invalidate judgements and/or the rationality of decision-making, particularly when only those with dissenting opinions are asked to support their position. Finally, even though the predictions are made by experts, consensus is reached, and arguments are rationally supported, unforeseen events such as scientific breakthroughs may render the predictions inaccurate.

The predicted events about which consensus was achieved were similar to those suggested by Mussallem (1970) and Burnside and Lenburg (1970), with the exception of those relating to a systems approach and open enrolment. These were not predicted by panellists in this study.

In spite of limitations, the response from panellists was positive (no attrition, expression of interest, and suggestions for potential uses). This suggests that the Delphi Technique merits further study and use in other contexts. Weaver states that the Delphi Technique seems to have promising application as a tool for teaching persons "...to think about the future in a more complex way than they ordinarily would" (Weaver, 1971, p. 271). This suggestion was supported by the panellists in this study.

In summary, the investigators would recommend: replicating this study with a larger and more geographically representative sample, combining the Delphi Technique with other future-oriented methodologies, and using the technique for purposes other than prediction.

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# Baccalaureate Preparation for the Nurse Practitioner: When Will We Ever Learn?

E. Mary Buzzell

En février 1976, l'auteure du présent article était invitée à prendre la parole au congrès annuel de l'Association canadienne des écoles universitaires de nursing, section de l'Ouest. La conférence portait sur la question suivante : « Devrait-on considérer le programme du baccalauréat comme étant la formation de base pour "l'infirmier praticien" ? » Voici la réponse qu'elle y a apporté.

In February 1976 the author was invited to address the annual conference of the Western Region, Canadian Association of University Schools of Nursing, on the question "Should the baccalaureate program be the basic preparation for the 'nurse practitioner'?" Her response follows.

Why are we discussing this question in February 1976? Why is it still a question at all? A review of some of the statements, studies, and papers so very familiar to us now pinpoints the stalemate in our decision-making related to the "nurse practitioner." Recall the *Report of the Committee on Clinical Training for Medical Services in the North* (Canada, 1970); the *National Conference on Assistance to the Physician*, 1971 (Canada, 1972a); "The expanded role of the nurse: A joint statement of CNA/CMA" (Canadian Nurses Association & Canadian Medical Association, 1973); the Boudreau report (Canada, 1972b); and special issues of *Nursing Papers* (1974) and *Nursing Clinics of North America* (Huffman Splane [Ed.], 1975) on the subject.

Why are student nurses still asking what faculty believe about the "nurse practitioner," and asking whether they will be prepared as "nurse practitioners" when they graduate? "If not now, when?" they ask, "if not now, why not?" Can we expect our students to be committed when we cannot commit ourselves?

Can we blame governments and physicians for deciding for us when we have no strong position or no position at all from CAUSN on the issue?

How many university school of nursing faculties — entire faculties — have spent time accepting or rejecting the Boudreau report and its

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implications for baccalaureate nursing? How many have a clear statement of their beliefs on this issue with a clearly identifiable action plan? How many have identified faculty learning needs for the expanded role and taken action to have these needs met? Are most of us today still in the position described by one of our colleagues two years ago?

Although the faculty as a whole has not, as yet, taken a definitive stand on the role and preparation of the nurse in primary care, during the past few years individual faculty members been keeping a finger on the pulse of the local, provincial and national scenes as they relate to the nurse in primary care and the need for this role. (Brown, 1974)

I submit that six years is an incredibly long time to be observing. To be asking the question we are asking today is, to me, an indication we have failed to practise what we teach: problem-solving, decision-making, and carrying out a plan of action. Decisions such as this one confront us more and more, decisions which must be made if we as a profession are not to forfeit the opportunity to affect our future. Faculty must tear off their protective masks and engage in decision-making. They must be willing to say "I believe" or "I think" and to take strong positions on the issues at stake, such as the question before us.

The fact that this question is still being asked means, to me, that we are facing resistance. What *are* the commonly-held forms of resistance among nurse educators, against incorporating "nurse practitioner" functions into the baccalaureate program? Five major arguments come to mind, and I shall look at each in some detail.

### **Resistance I: "The 'nurse practitioner' is a mini-doctor."**

I see this as the "What's-in-a-name-game" which we continue to perpetuate in an effort to avoid the task of critically examining the functions that the "nurse practitioner" can, will, and might carry out according to the dictates of the setting. Like the phrase "baccalaureate nurse" and the phrase "nurse practitioner" (at this point in time), "mini-doctor" may mean anything, everything, or next-to-nothing. Hence, to argue that the "nurse practitioner" is a mini-doctor is to waste time and energy. "Our real task is to develop understanding of the full capacity and contribution of nurses and thus to go beyond the debate on definitions..." (Kergin, 1975). Many faculty members who are proponents of the mini-doctor school do not speak from direct observation in the practice setting, but from academia. My experience has been that nurses functioning as "nurse practitioners" are more aware of their functions as nurses, more aware of the need for a different kind of nursing practice, and more aware of their capabilities to provide highly significant

contributions to help the patient cope with his problems, needs, or situations. Rather than "mini-doctoring," I believe a sector of nursing has finally "recognized the need for a different kind of nursing practice and moved forward to provide it" (*Nursing Outlook*, 1974). Though their numbers are small, their impact on patient care is considerable.

**Resistance II: "There is no need for the 'nurse practitioner'."**

How do we know?

Because of our confusion, we are not united and are thus in no position to sell the idea to the consumer. Again, we are our own worst enemies.

In Ontario the Pickering report (*Report of the Special Study Regarding the Medical Association in Ontario*, 1973, 1974) and other studies have given evidence that consumers are irate with the impersonality of care and irate with the lack of availability, continuity, and accessibility of health care — primary health care in particular. Why has nursing responded neither to consumers nor to government? How can we continue to believe that there is no need when "evidence at hand suggests a future strengthening of community health services and a gradual re-direction of resources from the tertiary health care sectors toward primary care sectors"? (Kergin, 1976). As educators for the 21st century, are we meeting our own needs or those of our learners? "We have somehow managed to persuade ourselves that we are too busy to think, too busy to read, too busy to look back, and too busy to look ahead" (Cousins, 1971).

**Resistance III: "There is no time in the curriculum for anything more."**

Too many nursing faculty members seem to hope the whole idea will go away; this attitude pervades entire faculties. They argue that there is no more time for any more knowledge, skill, or clinical experience within present programs. Time use must be re-examined in the light of the future. Some educational prescriptions for our learners are rooted in the past, not based in the present or planned for the future. Educational programs must be designed for the realities of practice. Re-evaluation of ourselves is imperative, keeping in mind that we have a strong tendency to meet our own personal needs in curriculum, and to believe these are the future needs of our graduates. Unless we are able to introspect, to help our learners move to the future, to prepare ourselves to meet the challenge of tomorrow both theoretically and clinically, I submit we should withdraw from the university. Faculty must

be expected and prepared to work in the community as well as in institutions. The time for theorizing is past. We must address ourselves to the realities of practice of tomorrow and make the time for the needed content and experience in our curricula. The complacency that exists among many faculty members within our schools is very dangerous.

**Resistance IV:** *"The baccalaureate nurse does not have the maturity and experience to perform the functions of a 'nurse practitioner'."*

Several thoughts come to mind in response to this statement. What do we mean by maturity, and by experience? Who says maturity comes with experience? What are we, as faculty, doing to facilitate growth, maturity, and independence throughout our programs? Are we fostering an adult climate for learning? How? We have spent years arguing the case of experience and maturity while addressing ourselves to the benefits of such moves as

- from the certification program for public health nursing to the incorporation of public health nursing into B.Sc.N. programs;
- from the "sandwich" approach to baccalaureate nursing to the integrated approach; and
- and from the three-year diploma program to the two-year program.

With all our concerns, no nursing studies have documented that specific amounts of either education or experience are necessary for a safe beginning practitioner to function effectively. We need to spend less time on these arguments and give more time to our quality of thought with regard to the functions of the "nurse practitioner."

**Resistance V:** *"All that is needed to prepare the B.Sc.N. student for the 'nurse practitioner' role is history-taking and physical assessment skills."*

One year ago, the CAUSN Committee Report on Accreditation was accepted. This implies our acceptance of the concept of program relevance — the degree to which baccalaureate programs are responding to the needs of the community. Relevance means more than the simple addition of history-taking and physical examination skills. If we say baccalaureate students are prepared to function as "nurse practitioners" can we say, for example, that they are prepared to handle the commonly-occurring undifferentiated acute and chronic problems in primary care? Has the pendulum swung too far? In preparation for the Ontario Region CAUSN June annual meeting, a questionnaire was sent

to each university school of nursing on the expanded role. One response to the question "What is your faculty's operational definition of the expanded role of the nurse?" (Roman & Steels, 1976) reads as follows:

The focus of his/her practice is client-centered in which he/she applies the nursing process for the promotion of health of individuals, families and communities, utilizing advanced theory skills in varied settings.

While I believe students must be prepared for health promotion and health maintenance, this must not be to the exclusion of having our graduates prepared to advise on and participate in the management of illness in primary care. It is easy to say that the addition of history-taking and physical assessment skills qualifies the B.Sc.N. graduate to be a competent "nurse practitioner." It is hard work for nursing education to critically examine its own presenting problems by asking such questions as the ones formulated by Roman and Steels (1976):

- What is our operational definition of the expanded role of the nurse?
- What are the roles and functions relevant to this definition?
- What specific knowledge, skills, and attitudes does the learner in our program require to perform the expanded role as defined?
- What opportunities are provided for learners to acquire knowledge, skills, and attitudes relating to the expanded role in each year of the program?
- What resources are used to facilitate learning in the expanded role?

I believe anything less than a good history and detailed examination of the curriculum in relation to this issue leads to the perpetuation of patchwork in the curriculum. This need for curriculum re-examination has definite implications for faculty members. We know that

one of the realities of life is that any major change constitutes a threat. Changes, or proposals to institute changes, suggest that what one has acquired or developed is somewhat imperfect. Renovations of basic programs and the incorporation of new knowledge, skills and attitudes is bound to create strong resistance within faculty members, especially faculty who are comfortable with the way things are done now and who are anxious about unknown products. (Kergin, 1976)

Many of us do not have all the skills, knowledge, and attitudes required to function in the expanded role. Can we continue to allow our deficits

to hamper our learners from becoming and remaining skilful? How can our deficits be made up now?

### **Government Policy — Some Implications**

I would like to look at some implications arising out of our indecision with regard to the "nurse practitioner" for government policy in Ontario.

A number of community health centres have been opened in the province. The government — more than organized nursing — can see the value of the nursing service the "nurse practitioner" can provide. Little nursing input has been forthcoming as pertains to functions, contracts, and working conditions drawn up by the government. Organized nursing, knowing the situation, has made little effort to clarify the position or to speak on behalf of nursing.

At a meeting of the Ontario Council of Health (the senior recommending body to the Minister of Health) over a year ago, 60 health professionals met to discuss the role, need, educational preparation, legal status, and remuneration for the "nurse practitioner" in primary care. The government document arising out of this meeting has been available for well over six months. One of the statements pertinent to baccalaureate nursing refers to continuing education programs for nurse practitioners, and reads as follows:

For the time being, programs for the preparation of nurse practitioners should be placed in the health science complex. Since there appears to be no relationship between the nurse practitioners' effectiveness and whether their basic nursing education was a degree or a diploma, nurses with both qualifications should be accepted. (Ontario, 1975, p. 6)

No position statement from ORCAUSN was included with materials distributed before the conference. The meeting left the eight university schools of nursing in the usual position of having to respond to government statements rather than providing leadership in the development of policy. Lack of a clear position resulted in the statement that "in the future, the basic preparation of nurses, both at diploma and university levels, should be suitably modified to reflect this broadened concept of nursing" (Ontario, 1975, p. 5). I need not elaborate on the problems arising out of that remark, now written in the report. Claire Fagin expressed my feelings well when she said:

At Lehman College we participated in the preparation of videotapes on physical assessment. It strikes fear in my heart when I hear from our distributor that many community colleges are interested in purchasing the tapes so that they may include this kind of content in their associate degree programs in nursing. (Fagin, 1976)

The same situation is occurring here.

It is my sincere belief that this group can take the lead and make a worthwhile contribution to the CAUSN statement on the baccalaureate nurse if a Western Region decision is made to do so in these two days. I fear it will not be when I see the full agenda, and this disappoints me no end. Will we still be asking "Should the baccalaureate program be the basic preparation for the nurse practitioner?" in 1977? The longer we procrastinate, the sooner government and physicians will decide for us.

The College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario have been meeting regarding procedures the College of Physicians and Surgeons would like to delegate to the "nurse practitioner." When health teaching comes up as one item they would like to delegate to us, I can only state that the voice of professional nursing has not made itself heard nearly enough. If we believe we have staked out a claim for assessment and promotion of health status, we have failed to communicate clearly.

These examples suffice to illustrate my grave concerns — concerns pointing rightly to us for our slowness, indecision, and passivity.

I believe there is no more time for indecision. I believe the baccalaureate program should be the basic preparation for the "nurse practitioner." I believe it is up to us to make the necessary curriculum changes now so that the knowledge, skills, and attitudes needed to function in the role under discussion are provided for us in our university schools of nursing.

I believe it is of the utmost urgency that we (1) answer the question "What is a baccalaureate nurse?" nationally; and (2) become vocal nationally about baccalaureate nursing before groups of consumers, government policy-makers, and allied health professionals.

We have graduates we believe in, nurses who are valuable, flexible, adaptable, reliable, and capable of rendering quality service. Let us commit ourselves now to describing these nurses clearly and to promoting them proudly and loudly.

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# Tailoring Nursing Education Programs to Meet the Nature of Community Needs

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La conception d'un programme qui permet aux infirmières de répondre aux besoins de la collectivité oblige les professeurs d'université à résoudre une foule de questions difficiles sur la composition de telle ou telle collectivité, la nature de ses besoins en matière de santé et sur le rôle que devront être capables d'assumer les futures infirmières. Les responsables de ces programmes se heurtent à beaucoup d'obstacles : Les restrictions budgétaires qui affectent aujourd'hui les universités, le nombre relativement restreint de candidates qualifiées pour les postes d'enseignement, les possibilités limitées en matière d'études supérieures en sciences infirmières au Canada et la confusion qui règne quant aux responsabilités que les infirmières professionnelles sont à même d'assumer et le cadre dans lequel elles doivent recevoir leur formation. Le problème crucial est de savoir si le grade de bachelier constituera le point d'entrée pour exercer la profession d'infirmière dans l'avenir. Par conséquent, il faut établir une distinction nette entre le rôle et les fonctions d'une infirmière bachelière et ceux d'une infirmière dont la formation a duré moins longtemps. Pour résoudre ce problème, il faudra consulter les autorités qui émettent le permis d'exercice, déterminer les ressources financières et autres et obtenir l'appui des associations professionnelles, des syndicats, des employeurs, d'autres travailleurs de la santé et de la population en général.

The invitation to be your theme speaker is an honour and a responsibility which I accepted willingly but with many misgivings. The theme as stated incorporates a philosophy that is basic to planning any educational program which prepares candidates for entrance to professional practice, since professions accept an obligation to be of service to society. Yet within the theme lies a broad range of questions pertinent to our concerns as members of the nursing profession and members of the academic community. Selection from that range proved even more difficult than I had anticipated. There are also connotations to the term "tailoring" which have troubled my thoughts. This word usually refers to a process which involves consultation with the purchaser, selection by him of a design and fabric suited to his wishes, measurement and meticulous attention to construct with exact fit. If the tailoring is successful the result is a garment that is functional and appropriate to the

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needs of the purchaser. Are the nursing education programs which we tailor proving to be functional and appropriate in meeting the needs of our purchasers — ultimately the community — and can we hope to achieve an exact fit?

I propose to develop a focus within the theme by reviewing briefly the nature of community needs which our programs are attempting to meet and the areas of unmet need which we could or should meet. Against this background I intend to examine the degree of freedom we have and the types of constraints placed on us in tailoring our programs, and then to identify what seem to be crucial issues to be faced.

The education programs which are CAUSN's primary concern are, by definition, programs of nursing education within a university system. A majority of these are programs at the baccalaureate level which prepare candidates for entry into practice as registered nurses. Each university school was established in response to environmental conditions unique to its location at the time but with shared values about the aims of university education for nursing. Although the pace and form of development has varied among schools, all in recent years have been active in curriculum evaluation and revision reflecting recognition of the rapid changes taking place in Canada's health care system and the increasing demands being placed on nursing. Whatever the approach used, the process of curriculum revision has included the assessment of changing community health needs, the acceptance of an obligation for nursing to contribute to meeting those needs, and a redefinition of the specific role of the nurse who is prepared in a university program.

It should be noted that the nursing profession supports both a diploma and a degree route for entry into practice as a registered nurse. Faculty responsible for diploma programs would also carry out an assessment of community nursing needs and make decisions as to the range and level of needs the diploma program should prepare its graduates to meet. Because of the lack of differentiation of legal status at the point of entry to practice, it is not too surprising for an assumption to be made by the community in general that there is little difference between the beginning practitioner who has a degree and one who has a diploma. When both are employed on the staff of a hospital the expectation is that either can cope with a broad range of nursing needs and decisions as assigned by the employing agency.

Because of the method of university financing and the provincial responsibility for education there is some expectation that the community of immediate concern to university nursing programs will be the

region or province in which the university is situated, with specific attention to the health needs of various population groups within that community. Yet there is also a valid point of view which argues that universities are, at the least, a national resource rather than a regional or provincial resource. The mobility of Canadians within Canada and in travel to other parts of the world, the reception of immigrants to this country, and the mobility of health professionals as they pursue career opportunities are all influences towards using a broad definition of community. So a decision has to be made about the extent of community we intend to serve, the sources of data we will use to identify the nature of present health needs, and the trends to be anticipated for the future. For an audience such as this, it is hardly necessary to mention the many sources of data about the needs for health care both in terms of demands for and utilization of services and in the statistical evidence of unmet needs. Much of these data, for example morbidity and mortality rates, have substantiated the need for curative services during illness but provide only indications of need for care to promote health maintenance and health-enhancing behaviour. Documents such as Lalonde's (1974) *A New Perspective on the Health of Canadians* have encouraged health professionals and the general public to accept a more comprehensive definition of the nature of health needs and this has been reflected in the design of nursing education programs by university faculty.

I have suggested that a realistic assessment of community health needs can be made with existing data. The clarification of nursing needs within the complex of total health needs is more difficult, possibly because the definition of nursing is diffuse, expands and contracts in relation to the presence or absence of other health professionals, and varies with the education and career aspirations of its practitioners.

For many years, and more forcefully within the past decade, attention has been given to re-defining the role of nursing and clarifying the contribution that nurses can make to health care as independent professionals in a collaborative rather than a dependent role. Frequently innovative nurse researchers and writers have formulated proposals for improvements in health care based on a more independent role for the nurse which incorporates caring and decision-making functions which many nurses recognize as already within their competence. One such proposal, "An open health care system model" by Madeleine Leininger (1973), provides for attention to the social, cultural, and environmental aspects of the client community and emphasizes health promotion, health maintenance, and health restoration. It is interesting to compare this with the model proposed in *The Community Health Centre in Canada*

(Hasting, 1972) in which there is more constraint placed on the role of the nurse. Another example of creative redefinition of the nurse's role is being carried out in the demonstration of "The Workshop" under the direction of Dr. Moyra Allen at McGill. These models, among others, have highlighted methods of practice and a level of competence which many nurses believe are appropriate for nursing and would be effective ways of meeting needs for health care, some of which are now neglected. Yet others, along with physicians and administrators, view these models as too independent of medical authority to be safe or organizationally acceptable.

Many examples could be cited of expansion and contraction of the nurse's role in relation to the supply and availability of other health workers, especially physicians. The degree of responsibility for diagnosis and treatment expected of nurses posted in northern areas is well known and such nurses suffer a special form of culture shock when they return to large hospitals in southern Canada and find their role sharply constricted. In this province when the Nurse Practitioner Pilot Project was under way there was a definite change in acceptance of this role by physicians as the likelihood of an increasing supply of physicians in rural communities developed.

There is considerable evidence that a broader perception of nursing responsibility and of capacity for a more independent role is held by nurses prepared in a baccalaureate program and is demonstrated early in their practice. This is partially a result of the scope and length of their educational experience and may also reflect a different approach to career selection from that held by those who choose a shorter program of preparation. Evidence is accumulating that the changing health care system could use a larger proportion of nurses with preparation at the baccalaureate level and will require sharper delineation at entry to practice between the roles and responsibilities of baccalaureate nurses and those with shorter preparation. There have been many attempts to grapple with the implications of the quality of our present system of education for meeting emerging needs for nursing. The *Report of the Alberta Task Force on Nursing Education* (Alberta, 1975) presents an analysis of community needs for nursing on which are based recommendations for changes in education. This report is of interest not only because of the expansion of university nursing education which it proposes but also because it is a report of the Department of Advanced Education and Manpower.

In general, university nursing programs at the baccalaureate level have accepted a generic model as functional and have designed pro-

grams to enable the graduate to enter nursing practice in a variety of settings, to use a self-directing, problem-solving approach, and to be accountable for her continued learning and competence in practice. Response to changing community needs has been shown by recent curriculum changes such as increased emphasis on concepts of health promotion and health maintenance, on mastery of more comprehensive skills of health assessment, and on greater attention to health needs and health care of the aging client.

Specialization in a clinical area of practice or in functional areas of teaching and administration is not now regarded as appropriate in the undergraduate program, although the student may have various options during the baccalaureate program that will allow some introduction to these areas. Specialization with mastery of a selected area of practice is included in programs of graduate study.

From evidence collected in surveys of graduates we — as university teachers — believe we have programs that supply our communities with practitioners who are prepared to deal with major health needs and to demonstrate competence in a broad spectrum of nursing activities. If this is so, can we be satisfied to have areas where these nurses are needed but not employed? A major area of unmet need for effective health care is among Native groups both in rural areas and as migrants into cities. Although needs for illness care persist and graduates have preparation to care for patients with acute illness, are we making adequate provision to deal more effectively with the need to help clients change behaviour and lifestyles likely to be injurious to health? Some writers have suggested that universities have not served society well as innovators and promoters of needed change in the health care system. Dr. Marguerite Schaefer (1974) deals with this role of the university as a "fighter for change" and contrasts it with the ideal of the university as the preserver of knowledge which works "to promote *gradual* social program." This criticism of universities as somewhat inflexible and slow in responding to a need for change is specifically directed at nursing programs in universities by Jeanne Marie Hurd (1979). She is critical not only of curricula but also of the educational methods and their effects on students.

Other questions that could be raised by each of us about the "fit" of nursing education programs to the needs of the community might include:

- What community need is our program *primarily* designed to meet?

- Are we measuring the output of the program in ways that are reliable and have validity for the public that provides the resources for our use?
- To whom and how do we communicate information about the aims and accomplishments of our program?
- To what extent have we accepted the judgement of consumers about nursing needs in identifying and selecting those that our program should aim to meet?
- Can the program focus on the needs of the outside community and simultaneously meet the academic standards of the university community?
- What of the needs of the student community that gains entrance to our program, personal needs for development through education and vocational need for a credential that is portable in the wider community where they seek employment?
- What consideration do we give to the needs expressed by our professional community, our colleagues in associations and in service agencies?
- Are we prepared to state priorities among community needs that our program could meet and, in a time of restricted funding for university education, select those that we will meet?

My hypothesis is that although we have been conscientious and persistent in our attempts to tailor university nursing education programs to meet community needs for nursing, our perception of the nature of those needs is congruent only in part with the perception of other members of the community. Our perception differs from that of many consumers of health care, from members of other health professions, from funding agencies, and from many colleagues in other fields of nursing. A recent example of this gap in perception occurred during a conversation I had at the Convocation Tea. I was speaking to a friend of one of the graduates of the post-R.N. program. After a complimentary remark about the graduate's achievement her friend said, "What does she plan to do? Now that she has her degree she won't go back to nursing." Let me hasten to add that I do not imply that our perceptions are in error, but until we find ways to close that gap we will lack credibility and support. Perhaps we should state that our programs are designed to meet only certain selected needs within the range of the community's total nursing needs. If this be so, then, as members of a profession that supports both a diploma route and a degree route to

registration for nursing practice, we must work with colleagues in nursing to clarify public understanding of the dual system.

What evidence do I have to support this hypothesis? One consistent indicator is that employment practices and personnel policies in a substantial number of health care institutions give only token emphasis to the desirability of a baccalaureate degree in nursing as a qualification for nursing practice. Advertisements for positions as head nurse, supervisor, or director convey a clear message when they state, following a requirement about experience, "baccalaureate degree desirable," with some adding "but not required." These same institutions do not appear to believe there is any relationship between initial recruitment of B.S.N. graduates and their later availability within the agency for promotion. On the other hand these employers may have found that new graduates from university programs do not practise in a way that meets the nursing needs of patients in their care. The difficulties new graduates face in coping with "reality shock" have been described vividly by Marlene Kramer (1974). Others have referred to different kinds of difficulty and suggested that these result from inadequacies in the educational program. This is the point of view of Jeanne Marie Hurd, to whom reference was made earlier.

Another kind of evidence is supplied by requests from employers who identify a need for post-diploma courses of specialization. The Canadian Nurses Association in 1973 issued a position statement on Specialization in Nursing based on work done by Hall, Baumgart, and Stinson (1972) which recommended such courses. The response to requests for short courses of specialization has been uneven at best. If we perceive these needs but believe that such educational programs cannot be appropriately provided by the university, do we take action to encourage development elsewhere? We may deplore the "quick fix" approach of a multitude of short courses, particularly if there is an expectation that these will add up to meet requirements for a degree. But in terms of the urgency of the need, and the time and freedom of nurses to enroll in more comprehensive educational programs, short courses may be a realistic answer.

Another type of gap in perception sometimes exists in regard to the educational opportunities needed for registered nurses to achieve the B.S.N. On one hand it is difficult to accurately assess the demand for such opportunities and the motivation for continuing in an academic program. On the other hand it is difficult, particularly for women who have family responsibilities, to perceive the objectives of a university program as tailored to meet their needs. Add to this a certain difficulty

in achieving flexibility within a university system, compounded by the need of the system to deploy resources in the most economical way possible, and the perception of unmet need in the professional community may be reinforced.

Many of you could bring forth evidence to disprove my hypothesis and argue convincingly that differences in perception of need would not be a problem if we could produce a critical mass of nurses with university education. Better prepared nurses would demonstrate that nursing and health care needs could be effectively met. It seems logical then to advocate the baccalaureate degree as the basic preparation for entry into the practice of professional nursing. Other personnel prepared in different programs identified as non-professional patient-care assistants would function in association with and under the direction of the nurse. This is the proposal outlined in the American Nurses Association (1975) position paper and is the basis of the Resolution on Entry into Professional Practice approved by the New York State Nurses Association in 1974 for implementation by 1985. A similar proposal was presented by the Alberta Task Force (Alberta, 1975) with a specific timetable for achievement through a combination of university-based baccalaureate programs and articulated baccalaureate programs.

A recommendation regarding the baccalaureate degree as mandatory for entry into practice has been discussed by CAUSN on more than one occasion with reactions ranging from enthusiastic acceptance to extreme caution. Three intermediate points on that scale could be classified as reluctant approval in principle, delay until further evidence is presented, and a clear willingness only to back into the future.

Although a mandatory degree program seems inevitable to many, it is still primarily at the stage of examination and review among those involved in university nursing programs and some groups within nursing associations. There is a paucity of evidence that the wider community — the consumers of nursing care and the government departments responsible for funding nursing service — share these perceptions of the nature of the needs for nursing that should be met and that could be met most effectively by nurses prepared for practice in a university program of nursing education. We may believe that their view of need for nursing is simplistic and tied to a model which perceives nursing as needed most to assist with cure of illness of an acute and/or life-threatening nature. Recognition is given to the need for sufficient quantity of nurses, where and when the need is apparent, but the prevailing view of the wider community is that the cost of the nursing component within health care should be restrained, and that the addi-

tional time and cost of university preparation should be required for only a small proportion of the work force. It is now 15 years since the Hall Commission (Canada, 1964) included a recommendation that 25% of the supply of registered nurses should be prepared at the baccalaureate level. Progress towards that goal has been slow.

Some administrators of nursing service have contributed to and supported a perception of the nature of community nursing needs similar to the above and as a consequence have required that staff have university preparation for practice. This is the situation in many public health nursing agencies where vigorous recruitment has secured a high proportion of staff with a baccalaureate degree.

Dr. Margaret McClure of New York spoke to the WRCAUSN meeting in Winnipeg in February 1979 (McClure, 1979) and emphasized the requirement for improved education of nurses as the basis for competence. She made particular reference to the perception of this need by Nursing Service Administrators in New York and their conviction that baccalaureate education was a prerequisite for the assurance of quality nursing service in hospitals. The sequel to their conviction was their action in bringing to the New York State Nurses Association the resolution to which I referred earlier. Their personnel policies in hiring staff nurses reflect this conviction.

But I reiterate — there is a gap between our perception of the nature of nursing needs and the perception of the community which we aim to serve. I suggest that gap will exist until we find ways of demonstrating conclusively that there are serious unmet needs which could be ameliorated by nursing practitioners prepared in education programs which we tailor to meet those needs. The community — and governments which set policy and determine the allocation of funds for the range of health services — will then have a more comprehensive understanding of the cost-benefit ratio of university nursing education programs and will make informed judgements whether or not to supply the resources we believe are necessary.

I have attempted to show that as nurse educators we are concerned that the educational programs we design should competently prepare practitioners of nursing to meet the present and future needs of the community, or communities, we serve. I have suggested that we are aware of changed needs and increasing demands placed on nurses and that we acknowledge the fact that, although in Canada access to health care is regarded as a right, there are significant areas of unmet need here in this country. Against this background let us consider what

freedom we have and what constraints are placed on us in tailoring university programs in nursing education.

We have one important freedom that we have perhaps failed to recognize as a freedom. I refer to the dual system of educational preparation for nurse registration/licensure. This permits us freedom from the direct pressures of responsibility for a quantitative supply of nurses in response to the fluctuating market. There are adequate numbers of diploma programs, and, since the larger proportion of the nurse manpower reaches the market from those programs, we are free to consider emerging needs and to select our areas for concentration.

Another freedom that we have is the availability to us of the resources of the university. This provides support in curriculum implementation because there are general basic classes shared with students in different colleges. The university setting also allows faculty to evaluate their endeavours in teaching, research, and scholarly and professional work. Associated with this is the concept of academic freedom to pursue excellence in a climate of responsibility and mutual respect.

As you will see, these examples of freedom also carry with them concomitant restraints. The dual system of preparation for entry into the practice of nursing contributes to widespread misunderstanding of the role and responsibility of nursing. And, in the agencies where services are provided to meet the nursing needs of clients and the community, there are not only registered nurses with two levels of preparation. There is, in addition, a large group of other persons with varying kinds of preparation classified as nursing personnel. Confusion about who is a professional nurse, what responsibilities she can handle, and in what educational setting she should be prepared presents a major constraint for future planning.

In the present context of university budget restrictions, it is hardly necessary to comment that the access to university resources does not imply unlimited freedom. Nonetheless, I do not believe that there is evidence that the financial resources that flow through other channels to support nursing education programs are much more liberal.

A serious constraint in terms of resources is the relatively small supply of well-qualified candidates for faculty positions and the limited opportunities for graduate study in nursing available in Canada for members of the nursing profession who wish to embark on an academic career. This constraint has been highlighted by the conference on doctoral education in nursing held in November 1978 (Canadian Nurses Association, 1979). The magnitude of the need for well-pre-

pared teachers in nursing is greater when we include in the estimate the numbers of qualified teachers required by the diploma programs.

One aspect of this constraint is that of the desirable balance between expertise as a clinical practitioner of nursing and expertise in other areas such as teaching, curriculum, nursing administration, and research. As a practice profession we must address ourselves to the problems of practice including the need to ensure that nurses maintain and improve competence as nursing practitioners and that this element, to me the core of the profession, is retained under the control of nursing. As we observe the influences on the practice of nursing and situations in which non-nurses are acquiring greater control over the administration of patient care including nursing care, we can forecast further shifts in decision-making authority away from nurses so that others will decide the parameters of nursing practice and the priorities to be set. It is crucial that students in their educational program be taught by nurses whose commitment to and accountability for clinical practice is unequivocal whatever their major area of teaching or their specialization as practitioners.

Reference has been made to the lack of understanding by the public of the present responsibilities of nurses and their potential for changed contributions to health care. Everyone knows what a nurse is, or at least they are familiar with such symbols as the cap, and they have an ideal of a person who gives compassionate care during illness with a continuing devotion to duty. I would suggest that this traditional image of the nurse and the consequent favourable impression the public retains was the result of much contact, planned and unplanned, between nurses and the community they served which was reflected in a perception of nursing that is part of folklore. This limited outdated image must be replaced. This can only be achieved if we give more attention to co-operative work with consumers in assessing the health care needs of their community. We must encourage them to explore with us the ways in which the potential of nurses for improved services is now untapped or restricted, and how this potential can be released.

One other constraint that I wish to mention before leaving this topic is the constraint imposed by our difficulties as members of a profession in which the majority are women. Strong social values about the role of women influence the priorities that women may give to the needs and requirements of their career and to their professional affiliations. One area in which ambivalence affects our functioning may be seen in variations in quality and persistence of nurses' involvement in broad issues of importance to the progress and power of the nursing profession.

There is evidence that nurses, as a group, do not show consistent support for their association and for their colleagues in nursing. Disagreement is healthy and essential for productive change but we must find ways of eliminating divisiveness once the issues have been discussed and a decision reached. It is a serious constraint when nurses as a group do not support the endeavours of their colleagues and instead allow themselves to be aligned with the aims of other professions and/or authorities who in their own interests — not the interests of improvement of health care — do not wish nursing to become independent, competitive, and powerful. This question, which was categorized as an issue of unity among nurses, was presented in an interesting and convincing fashion as an article in *American Journal of Nursing* (1975) recording a discussion among a group of well-known American nurses.

In conclusion, then, what are the issues to be faced if university nursing education programs are to achieve a more exact "fit" to the nature of community needs for nursing? First, there is an issue of credibility in our definition of the *nature* of community needs which our graduates are prepared to meet. This occurs among a large number of the average nurse members of the profession; it occurs among other health care workers; and it occurs among the members of the community who are consumers of health care.

There is also an issue of our credibility with non-nurse members of the university community. How are we like other nursing education programs and how different? In what ways are we similar to other faculties and how dissimilar? Can we achieve greater clarity about what our mission and place should be vis-à-vis other university programs?

Second, there is the issue of achieving acceptance of the baccalaureate degree as the requirement for entry to the practice of nursing or supporting a clear division of the role and functions for each of two levels of registered nurses. Resolution of this issue will involve consultation with the registration bodies, determination of financing and other resources, achievement of support from professional associations, unions, employers, other health care workers, and the general public, our community.

Third, if decisions are taken that the baccalaureate degree will be required as the entry to practice, subsequent issues will have to be resolved. Would there be adequate numbers of candidates to meet the needs, and would they accept this obligation of greater preparation time? Would there be sufficient nurses remaining in practice over time to justify the social cost of the longer program with the concomitant

need for greater educational costs for preparation of faculty, and for administrators and specialists in service agencies?

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## SECTION II

# Conceptualizing Nursing

*Conceptualiser la  
profession infirmière*



# Comparative Theories of the Expanded Role in Nursing and Implications for Nursing Practice: A Working Paper

F. Moyra Allen

Le nursing, dans son évolution, est considéré soit comme un prolongement dans le domaine de la médecine, c.-à.-d. comme assurant un rôle d'assistant ou de substitut du médecin, ou encore comme un élargissement dans un domaine des services de santé pour faire le pont avec les divers services. Ici, il s'agit d'un rôle complémentaire par rapport à celui des autres professionnels de la santé. La première approche demande des connaissances et des compétences médicales supplémentaires, alors que la seconde favorise une amplification de la fonction essentielle du nursing. Ces deux perspectives caractéristiques quant aux nouveaux rôles du nursing se distinguent d'après les dimensions suivantes : type de problème, envergure de la difficulté, perspective, moyens d'évaluation de la situation, base de la planification des soins, délais, et modalité d'évaluation. L'étude considère que la pratique du nursing peut être distinguée selon ces dimensions et l'hypothèse suppose que ces deux approches du nursing provoquent des résultats différents pour les sujets et pour les familles; de plus, chaque approche, pour être viable, requiert des relations d'équipe différentes. L'hypothèse est à l'étude dans le cadre d'une recherche comparative dans trois milieux de soins primaires.

During recent years in the development of health services in Canada and the United States, much emphasis has been placed on the "expanding role" of the nurse. The nature of this expansion seems to take on different characteristics depending upon which health professionals instigate the role innovation and what their views of nursing are.

The Research Unit in Nursing and Health Care at McGill is studying nursing as it is carried out in several settings where different perceptions of an expanded nursing role are being implemented. A basic assumption, developed in the paper that follows, is that this expansion is perceived in one of two ways — as a *replacement* function or as a *complemental* function, relative to the knowledge and skills of other health professionals, e.g. the physician. For each approach, characteristic notions of health and nursing practice are described. The research is directed towards demonstrating that differing approaches to nursing yield differing outcomes for individuals/families. This working paper presents the theoretical underpinnings of our ongoing research project.

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### Approaches to an Expanded Nursing Role

Physicians concerned with the diagnosis and treatment of illness and the prevention of disease perceive the development of nursing as an expansion into the field of medicine, that is, incorporating a portion of the doctor's knowledge and skills. This role is termed the *assistant-to-the-physician* function; in outlying areas it approaches a complete replacement function. Building on either diploma or baccalaureate basic preparation, the doctor assumes, at least initially, a major share of the instruction in preparing nurses for this type of expanded role. Nurse practitioner practice in primary care settings most closely approximates this version of the expanded function of nursing.

Nurses, on the other hand, particularly those in university settings where philosophies of nursing are being rationalized, tend to perceive the expansion of nursing in one of two ways.

First, the expansion is within the realm of medical knowledge and associated skills are required for the treatment and care of those who are ill, both acute and chronic. This role shares most of the characteristics of the *replacement* function, as the expansion is based on increasing the medical knowledge and skills of the nurse so that her understanding of the pathological processes, diagnosis, and treatment closely parallels that of the medical person. Although the medical aspects are favoured in expanding the role in the direction of replacement, nursing has attempted to attend also to the psychological and social components which prevail in each particular illness situation. This role is played by persons with baccalaureate or master's preparation where the program emphasis has been on specialized preparation in nursing, that is, medical, psychiatric, community health, geriatrics. It can be found in acute care settings as well as in settings outside the hospital, such as solo practice or group practice with physicians.

Second, the expanded role for nursing is being enacted in primary care settings where emphasis is on the development and maintenance of family health. Here nursing is concerned over time with the family unit, with everyday health practices at the levels of both the individual and the family, with healthy ways of dealing or coping with life situations and problems, with family health given a long-term health problem of a family member, and with follow-up when family members are involved with other health professionals. This expansion of the nurse's role is viewed as *complemental* in that it does not replace that of other health professionals, but adds another dimension to health care service. It is an expansion of nursing into areas of need which are

unmet and unfulfilled at this time; it is also an expansion of the core of what nursing basically is. Knowledge for the complementary function is found, in particular, in the study of the humanities and social sciences. Skills to perform this function are derived from the ability to be responsive to the individual/family both in perception and assessment and in planning and practice. Generic programs in nursing at the baccalaureate level which include a science base, both biological and social, can prepare the individual for this type of expanded function. Preparation at the master's level is required if the nurse is to acquire greater expertise.

The following paper describes the theoretical base for each type of expanded function, replacement and complementary, one an expansion into medicine, the other an expansion of the substance of nursing. These variations in perception of nursing were noted in earlier writings of the author (Allen, 1977; Allen & Reidy, 1971).

## **Views of Health and Implications for Nursing Practice**

### ***Health and the Replacement Function***

Health is freedom from superimposed or unnatural influences. Health is seen as the pristine state pre-existing disorder or disease, or as the newly achieved state resulting from the eradication of the superimposed disorder. (Blum, 1974, p. 78)

This notion of health has provided the basis for developing a medical science and is, therefore, evident in nursing activities serving the *replacement* function. It requires a form of health care in which the goal is to keep people free from disease. The identifying features of a plan to achieve this goal are:

1. screening procedures and checkups to rule out disease;
2. prophylactic measures, such as immunization to prevent specific illnesses;
3. "good" health habits to increase resistance to disease, for example: nutrition, elimination, personal hygiene, rest and exercise, work and recreation; and
4. early diagnosis, treatment, and rehabilitation.

The individual who implements a health care regime contingent on Blum's (1974) definition of health may be identified by the following behaviours. The person practises "good" health habits and institutes reliable measures to prevent disease. He is concerned with illness and looks for reassurance that he is not ill. He is informed and knowledgeable about disease. If sickness does arise he seeks treatment and follows

the regime with care and precision. He is a "heavy" utilizer of health services. He views health professionals as having the knowledge to keep him well and he looks for direction to these sources. He tends to adhere to learned ways — health habits and knowledge — and, therefore, experiences difficulty in modifying his behaviour to meet changing health concepts as well as his own needs.

In the assistant-to-the-physician role, the physician has a decisive part in determining the tasks nurses will perform in preventive, curative, and rehabilitative care. To date, nurses in this role have functioned by screening patients and performing the initial workup of physical examination and medical history. In some situations, this focus is extended to include the standard medical treatment regime for the specific problem as well as the subsequent follow-up.

The function of nursing expands as it moves from the assistant-to-the-physician role to replacement of a major part of the physician's work — assessment, treatment, prevention, rehabilitation, follow-up. For this reason, the replacement function tends to follow the medical approach, dealing with common problems about which there is a relatively large body of knowledge and for which there are accepted approaches and solutions. To this end, the nurse accumulates a large body of knowledge; she knows what to look for, what to observe, and what information to gather; she is skilled at attaching meaning to evidence; and she arrives, once the data are amassed, at a reasonable assessment. The treatment plan follows logically, and long-term evaluation relates to the expected outcomes as indicated by the diagnosis.

### *Health and the Complementary Function*

Health is a continuing property, potentially measurable by the individual's ability to rally from insults, whether chemical, physical, infectious, psychological or social. Rallying is measured by completeness and speed. Any insult may have a "training function" and recovery will often be to a slightly *higher* level of health. The person or body learns something. (Audy, 1971)

An exploratory, responsive approach to health care is adopted by those who see health as a characteristic of a functioning life system, including nurses whose practice is described as *complementary*. Health care in this framework concentrates on assisting the individual/family to develop ways of dealing with everyday situations in a health-promoting fashion. It assumes that developing abilities of this nature builds and augments the potential for health of the individual/family. The family gains some control over the minor and major events in their lives. The

individual/family learns a way of being healthy which is responsive to situations over time.

This notion of health is identified with the following behaviours in the individual/family. They discuss and share information on common problems, they seek out relevant sources of information and knowledge, and they work out plans of action. Each individual has some input into the situation if it is relevant to him. The family plan ahead and make long-term approaches to situations; there are few crises. They use health professionals judiciously, learning to rely on their own judgement and resources in most situations. They approach the professional with relevant and organized information and with some assessment and plan, which they seek to discuss and work out with the professional. They look for outcomes from the plan as feedback and make use of it in further planning. They wish to be healthy and pursue this goal by fashioning their approach to the needs of the situation, thereby learning more about how to achieve health as they go along.

The expanded role of the nurse in this context derives from a *complemental* function, a function in addition to that provided by other professionals. It is an expansion of the core attributes and tasks of nursing into problem areas where health services remain in an inchoate state. A major gap is to be filled in services directed towards family health: assistance in developing individual/family practices which have a positive benefit for health at the levels of both the individual and the family; guidance in the growth and development of children so that they learn constructive health practices; and assistance to families in coping with chronic illness and other long-term problems in a healthful fashion. To these ends, nursing practice develops an exploratory and developmental approach. Emphasis is placed on the assessment phase with the individual/family as a primary source of information, on strengthening individual/family potential as the major component of a plan of action, and on gathering evidence of individual/family responses as a basis for further planning and development.

### **Two Characteristic Approaches to Nursing**

The above conceptions of nursing practice underscore a study of the performance of nurses in primary care settings. Initial investigation identified certain aspects of practice as critical to the approach taken by the nurse. These distinctions between *replacement* and *complemental* were particularly marked at seven points:

### Replacement Function

### Complemental Function

1. *Problem*: What is the focus of the nurse in a particular individual/family situation?

Problem is perceived as *illness* — basically medical conditions involved in the individual or family, that is, any disease, including diagnosed psychiatric illness, and the etiology, pathology, symptomatology, diagnosis, treatment, prevention, etc.

Focus is on the *health* aspect, that is, situations related to the individual/family's coping either with a medical condition of the individual/family or with their accommodation to the events of daily living, including both customary situations and unusual ones (crises).

2. *Size of concern*: What is the size of the unit (persons involved) within which the nurse perceives the problem to be?

Problem is described as a phenomenon of the *individual*; it may be assessed at this level and/or as it affects the family and individuals therein.

Problem is described as a phenomenon of the *family*; it may be assessed at this level and/or as it affects individuals or groups of individuals therein.

3. *Perspective*: What is the extent and complexity of the problem as perceived by the nurse?

Problem is viewed as a *closed* system, with a beginning and an end, isolated from other happenings and limited in time, that is, *episodic*.

Problem is viewed as an *open system*, which develops, changes, influences and is influenced by other life events; it is seen over time (*long term*).

4. *Assessment*: What sources of information and knowledge does the nurse draw upon to identify the problem of the individual/family?

Nurse uses existing knowledge and experience to define the situation for her; relying on the logical structure of diagnosis to guide her *a priori* notions of what information and evidence to obtain and factors to relate.

Nurse observes and gathers information from the individual/family, seeks other sources for related information (library, other professionals, etc.), and brings her own knowledge and experience to bear on the problem; working in an exploratory fashion, she seeks to rationalize the evidence from these sources within the most probable explanatory framework.

5. *Plan of care*: Upon which attributes within the individual/family does the nurse establish the plan of care?

Nurse bases her plan on the lacks and failures which underlie the person's problem.

Nurse recognizes and utilizes strengths and positive forces (potential) in the individual/family situation as a basis for action.

### Replacement Function

### Complemental Function

6. *Time frame*: How are interventions for the individual/family timed?

Nurse "zooms in" with the concrete aspects of the plan in a precise and orderly fashion.

Implementation of the plan is characterized by a "wait" period directed towards achieving the best "fit" of action to the individual/family situation.

7. *Evaluation*: What is the nurse's approach in identifying outcomes of the plan as feedback for further assessment and planning?

Nurse assesses the extent to which the *objectives* of the plan have been achieved, noting discrepancies between the individual's behaviour and expected outcomes. Further planning to remedy deviations is based upon strengthening the plan and reinforcing its methods.

Nurse notes the individual/family *responses* to the plan of care and fashions the plan further on these outcomes. Objectives and purpose are achieved as outcomes become visible.

In summary, we have described some dimensions of nursing practice. Preliminary investigation of data garnered from observations and nursing records indicates that nurses implementing the complementary type of expanded function of nursing differ on these dimensions from nurses implementing the replacement type of expanded function. In addition, our present hypothesis suggests that these two approaches to nursing have differential outcomes for individuals and families and require differing sets of team relationships to be viable. This hypothesis is being tested in a comparative study involving three primary care settings each located within a large hospital in one urban setting.

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# Implementing Program Philosophy Through Curricular Decisions

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L'article décrit la logique interne, la réalisation et les résultats de l'expérience clinique dans un programme novateur en sciences infirmières. Les étudiants, détenteurs d'un baccalauréat es arts ou es sciences, abordent directement les sciences infirmières dans le cadre d'une maîtrise. Ce programme original a été conçu pour former des infirmiers capables d'assumer des fonctions de responsabilité dans le système canadien de prestations de soins en matière de santé, tout en tenant compte de la constante évolution du système. Le programme d'études constitue une tentative ayant pour but le développement de valeurs profondément enracinées au sujet de la santé, de la famille et de la discipline. Enfin, les auteurs présentent les résultats des décisions relatives au programme d'études durant le premier semestre en vue d'une mise en application de la philosophie sous-jacente.

## Introduction

This article represents curriculum development in progress. It describes for the reader the rationale, implementation, and outcomes of the first clinical nursing experience for a different type of student in a different nursing program.

The program in question is an innovative program in graduate nursing education (M.Sc.(A).) initiated at McGill University School of Nursing in September 1976. The program has certain unique features in that it draws baccalaureate graduates of arts and science who have no preparation in nursing. An emergent curriculum style closely adapted to the needs and characteristics of this new type of student would prepare the person according to a strongly valued model of nursing which itself has certain unique properties and emphases. The following is a description of the first clinical experience these students undertake upon entry into the program, the rationale behind it, some observations of its effect, and the implications these observations have for future curriculum development.

## Curricular Rationale

In making decisions about this first critical learning experience, three sets of factors were considered: the characteristics of the students, the beliefs about teaching and learning held by faculty, and the approach to nursing valued by the school.

### *Student Characteristics*

While not much was known about baccalaureate, non-nurse graduates as recruits for master's programs in nursing, these students were expected to be mature, highly motivated individuals with a sound academic background who could bring fresh perspectives to nursing. They were also thought to possess a high degree of self-direction in their approach to learning and to be able to tolerate a certain amount of ambiguity and insecurity. With appropriate learning experiences, they could be helped to develop their nursing in potentially different and creative ways given the different basis from which they would begin.

### *Beliefs about Teaching and Learning*

The faculty members in the program held strong beliefs about the most appropriate ways of helping graduate students learn about nursing. For students, these included discovering meaningful/relevant knowledge for themselves, learning to manage/direct their own learning and nursing, deriving knowledge and skill in nursing through the description and analysis of their own nursing and its effects, and using rational and defensible means to accomplish the above. For faculty, certain approaches were also strongly valued. These included structuring the broad parameters of experiences which fostered the approach to nursing valued by the school, and working with students' educational needs and interests as they arose within the curricular situations in which students were placed.

### *Beliefs about Nursing*

As it is not appropriate here to document fully the approach to nursing valued and fostered by the school (Allen, 1979), a description of its more important features follows.

A primary focus of nursing must be on health. Health is seen as not merely an absence of illness, nor as simply a capacity to cope with problems as they arise. Rather it is viewed as an active process where one learns from all life events and uses this knowledge to function in more

thoughtful, autonomous, and productive ways. Illness and other crises, as part of life events, are only one aspect of nursing's concern. This view of health and nursing is broad and suggests few limits to the type of problems which legitimately fall within the nurse's purview.

The primary unit of concern for the nurse is seen to be the *family* unit. The nurse therefore defines health/illness situations in terms of the family rather than the individual. For example, she is concerned with the development of children in healthful ways, with the adaptation families make in coping with illness and other life events. Issues of this kind tend to be broad, complex, and changing, influencing and influenced by other family/life events. They are viewed, understood, and often best worked with *over time*. In helping families/individuals to deal with and learn from these events, the nurse must meld her professional knowledge and expertise with the understanding she has gained of the family with whom she works. This results in a broad range of possible approaches to the practice of nursing in a single situation.

Given these beliefs, the data collection and assessment phases of the nursing process are seen as open, exploratory, and ongoing. The nursing plan, with its focus towards health, makes use of the strengths, resources, and other positive forces in the family rather than weaknesses, lacks, and limitations which may exist. The *collaboration* of nurse and client is seen as important at every phase of the nursing process. This results in a unique nursing plan where the nurse's response is tailored to each situation she encounters.

### **Curricular Design**

What first experience would best fit these learner characteristics and these strongly valued beliefs about nursing, teaching, and learning? First, the philosophical emphasis on health and family suggested a community and family experience away from the individual and illness-orientation of the usual hospital institution. It also suggested a selection of families who were not experiencing illnesses of a severe nature. Second, the perspectives about the complex nature of nursing problems, about the importance of exploratory, ongoing assessments and situationally tailored plans, suggested a longitudinal experience with families where students might become familiar with particular family health concerns, and begin to work with these in some deliberative and relevant fashion. Third, the view of the prospective learner as intelligent and mature, capable of considerable self-direction, suggested an experience where the student could work independently with fami-

lies without *a priori* instruction or modelling of “the way it’s supposed to be.” For these reasons, in their first clinical experience, students were assigned two healthy families in the community, with whom they would work closely for at least their first academic year. The bulk of the work would take place in their clients’ homes, for the most part independent of faculty or other direct supervision. For the initial four months of their program these families would comprise the only clinical contact with patients the student would have. The direction and supervision of this experience was to be done through fieldnotes, tutorials, seminars, and assignments of various kinds.

### *Selection of Families*

The selection of families for this experience was given careful consideration. Faculty wanted students to focus on health and healthy living. Therefore families with members with severe, acute, or major debilitating chronic illnesses were to be avoided. Such families could be healthy but beginning students, operating with a lay perspective of what nurses do, might become preoccupied with the more obvious disease process and difficulties it caused. Severe and obvious illness can create “noise” in the healthy family system and disguise from the student the normal patterns of family living. Moreover, at this early stage the students were not prepared to deal with the very specific nursing needs such families might present.

Other factors were considered. Faculty wanted families who would represent different stages of both family and individual growth and development, who were typical of major utilizers of health care services, and who would provide opportunities for students to contact other agents and agencies of the health system. Such a scheme would enable students to see the array of resources available and to develop some idea of nursing’s place among them.

Two types of contrasting families were chosen: the first, an elderly family; the second, a young and developing family expecting a baby in the near future. The former would provide the student with opportunities to gain first-hand experience with the problems and solutions of growing older in today’s society. The latter would enable the student to learn about and participate in a common experience of family life — the birth and incorporation into the family unit of a new infant. Hereby, the students would nurse the expectant mother in the prenatal, perinatal, and postnatal periods in hospital and at home.

To secure elderly families, voluntary agencies providing services for the elderly were approached and permission to enter their clients' homes was obtained from both agency and client. Entrance was typically via some kind of Friendly Visitor program which provided social and other (shopping, transportation) services for these families. While this provided easy access to a bank of elderly clients, entry via a Friendly Visitor role sometimes led to client expectations of the student which were not intended by the program and which could be difficult for the student to alter. Faculty also learned, after the first year's experiences, that some clients so gained were not families in any sense of the word but were widows or widowers, lonely, without social networks of any kind, making it more difficult for a student to develop a concept of "family."

Expectant families were chosen whose date of delivery was in late January. This gave students the opportunity to begin to know and work with the families prenatally, as well as to complete a clinical experience in an obstetrical unit. These experiences would help to prepare the student to nurse the family throughout the period of labour and delivery and thereafter.

### **Nature of Supervision**

Students began home visits to clients within three weeks of their entry into the program. In seminar during the preceding period, students had an opportunity to read and discuss some of the concepts central to the program (nursing, health, family, etc.). Despite their seemingly sophisticated background, most students had traditional ideas about nursing in this early period. Though they had access to information available about their prospective clients, students were not given specific guidelines for how to handle a home visit, nor were they accompanied by a faculty member. Students reacted to the absence of such guidelines in different ways. Some decided to use their first visit to gather information, to "get to know" the family, and did not think they could prepare themselves in advance. Others felt the need for more structure and went to elaborate lengths to find books or articles that outlined "all the things you need to know" to enter a client's home and begin to "nurse." An example of such an attitude is the following:

*First when I went in, I read about the elderly and goals and home assessment and stuff and I went [with] a head full of ideas [and]... objectives. Looking for skid mats, looking for hand rails...sweet smells, fresh paint, kitchen utensils. I guess I spent a couple of months fishing around really trying to meet ideals, you know, wanting her to move into the most*

*modern [apartment], getting her a roommate. All these ideas I had for the ultimate in what I thought elderly people should be living like.<sup>1</sup>*

The belief that these students should be allowed to discover and develop their nursing identities while capitalizing on their unorthodox backgrounds precluded the use of "modelling" in this first experience. It was the faculty's view that the student would become aware of her own strengths and limitations, as she experienced successes and difficulties, as she established rapport, learned communication skills and planned care in collaboration with her clients. It was only after the student became more confident in her own skills that she could be expected to examine the work of others. For this reason it was generally a few months into the experience before the teacher might choose to "model" a particular approach in an effort to assist the students to solve problems they were encountering.

The curricular events to guide the independent experience consisted of weekly individual tutorial sessions where there was examination of fieldnotes of family visits, as well as seminar discussions of important concepts and clinical experiences, and term papers which forced students to look back and review these longitudinal experiences that they might see more clearly both their own and their clients' change and development.

### *Fieldnotes and Tutorials*

For each family visit, students submitted detailed fieldnotes describing events to their faculty advisor. These were intended to be a complete description of the physical and social environment, the verbal and non-verbal communication, and the student's interpretation of these. As such, they formed the basis for the advisor's work, with the student providing information about the student's perspective and analysis of the situation at this early point in the program. Since these notes provided the primary source of data about the students' work with clients, it was crucial that they quickly learn (through coaching, questioning, challenging) to provide as complete a picture as possible. It was in these intensive sessions that faculty provided the support and guidance which pushed students to follow their own leads, to direct their own learning, and to begin to develop their own nursing. Students were encouraged to observe and assess, to plan and act, to evaluate and

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<sup>1</sup>All student remarks are taken from C. Attridge's unpublished research data, 1976-1980.

revise. The faculty directed students to an orientation which fit the philosophy of the program through the questions they asked and the alternatives they raised.

For example, in the following interaction the student illustrates how her advisor took her report of a prescriptive first client visit, and with simple questioning pointed her towards the concepts of responsiveness and collaboration, so important in the School's philosophy of nursing.

*Student: When I went into this situation [pregnant family] the very first time I had very definite ideas about what I was going into this for... [I was to be] a sort of resource, an information resource for her, and it would be an opportunity for me to see what pregnancy was all about, and to see a labour and delivery. So when I went in there I must say I had not psyched out the situation [laughing]. I just sort of walked right in and said, "That's what I'm here for."*

*Interviewer: Where did you get that idea from?*

*Student: In my head...nobody said anything [about what I should do], so... that's what I came up with. So I went in the first day and told her [client] we are going to talk about these things and those things and if you have any questions you can ask about these things and if I don't know the answers I can look them up for you. Which in retrospect is amusing 'cause she didn't want any information at all hardly. And I had no sense — I mean, I was completely insensitive to what she wanted!*

*Interviewer: Mmmmm*

*Student: So, after I handed in fieldnotes, Marie [the advisor] said in the fieldnotes, "Did you ask what she wants?" [laughs], which I thought was a very wise question. It really got me thinking. That was the first inkling I had, and it didn't come from me, it came from Marie, that there are other approaches to take and that the purpose of my being there was broader than just to give her information on health, breast-feeding and things like that. That sort of made me back up, loosen up, and let her [the client] take the controls a bit over what was going on.*

When students focused on the problems, weaknesses, lacks, and limitations of their clients, as they invariably did, advisors countered by guiding the students to see and use the strengths, the potentials and resources, their families possessed. Communication skills, relationship establishment and termination, nursing process, social networks, family roles, and the like were themes arising from clinical work that were discussed in both tutorial sessions and seminar. Advisors had to operate from a broad, generalized knowledge base, to resist the temptation to

nurse clients through the student, to tread the fine line between too much and too little direction and support, and to be prepared to risk student error in judgement or intervention. Every attempt was made to direct students to needed resources and information without usurping their roles as primary workers in their client situations. As many avenues as possible were opened but it was the student who had to develop and use them.

The tutorial format, one-to-one, had distinct advantages. First, the beginning characteristics and subsequent learning of each student could be individually assessed and teaching strategies carefully tailored and paced to her educational needs. For example, students who entered the program with well-developed interpersonal skills could move quickly into other areas of learning. Second, the format also drew into sharp focus individual obstacles to learning, such as rigidly held values, inadequate knowledge, poor judgement, and the like. There were some disadvantages. The approach demanded considerable time and energy from advisors who were dealing with students on an individual basis. Since the student group was small in number the task was easier.

### *Term Papers and Seminars*

Through written assignments, students were forced to summarize and examine their long-term family experiences as a related sequence of activities. For many students, this served to crystallize their progress. It helped them to look at development in themselves and in their clients over time, phenomena which are less clear to students when immersed in their day-to-day work with clients. Assignments later in the year asked students to generalize from their particular family circumstances, to select and discuss concepts which were applicable to a wider variety of families.

The seminar experience created opportunities for students to learn vicariously from each other's experiences and to examine concepts which seemed common to many or all students. Parts of these three-hour sessions were carefully structured to introduce content which could be used for concept-building. At other times, the discussions arose from the descriptions of their own nursing that students brought to the group. Seminars worked more or less well in this early stage, dependent as they were on the nature of the group dynamics involved, the ability of students to risk in public, the degree to which they were able to assume responsibility for seminar direction. At times seminars were successful; at others they seemed slow-paced and less productive.

### **Effects: Process and Outcomes**

While, with most students, the experience planted the seeds of important features of the program's approach to nursing and learning, it also produced some unanticipated effects.

#### *The Nature of Nursing: Client, Focus, and Process*

First, for most students, the experience set firmly in place a perspective which sees the client — individual or family — as part of a much larger life-space. He has a history and a future; he is a part of a complex milieu and his milieu is a part of him. The students saw, experienced, and learned to value this definition of client. They carried it to other settings where they nursed and they experienced frustration when there was only limited access to clients' broad circumstances.

Second, the experience began to widen students' perception of the situations with which nurses worked. Most students entered the program with an image of nursing that was predominantly illness-oriented, physical/technical care-centred, and hospital-based (see Attridge, 1981). The community experiences began to broaden these parameters to include a variety of concerns other than illness, many of which might be seen to fall within the realm of health and healthful living.

*Student: [describing some of the things she was doing with her pregnant client] I mean she was going through a lot of transitions in a foreign culture with a new husband whom she had never met before she married [him]...she needed somebody to be there to support her through those transitions...*

The occasional student resisted altogether the push of the faculty away from a strictly illness orientation, and eventually left the program.

Third, students began to realize that almost everything they did in their client situations was legitimized by faculty as part of nursing as long as it met certain criteria. It must be rational: that is, it must be based in some kind of reasonable evidence. It must fit: that is, it should suit the particular circumstances within which the student was working. It must be constructive: that is, directed towards some positive benefits for the clients involved. Students assumed a variety of roles and functions. They acted as facilitators, problem-solvers, advocates, information researchers, negotiators, coordinators, companions, care-givers, emotional supporters. There were some restrictions here

which students soon learned. The companion, Friendly Visitor role was not approved by faculty if this role did not soon develop beyond the level of friendship. Students themselves were uncomfortable with the limitations of this role and strove to go beyond it to incorporate professionally defensible activities although they learned to accept and value friendship as an important part of relationships with their clients.

Certainly, almost all students widened their views of their clients, increasing considerably the amount, kind, and quality of the data they obtained and the number of interpretations they could draw. Some, however, were consistently hesitant in taking action, continuing to collect information and demonstrating a lack of certainty about when data were sufficient to warrant intervention. Some, in their efforts to be "collaborative" and "responsive," tended to assume a more passive than active role in their work with clients.

These were observations about some students which became clearer later in the program. How much of this hesitancy can be attributed to the nature of the early experiences is uncertain, but it is likely that the tendency to vacillate is not corrected by a program which explores the variety of approaches in nursing practice and which often deals with non-crisis events that do not call for immediate or predetermined interventions. Students who had this difficulty needed far more specific suggestions and follow-up of their nursing than did others within the program.

### *The Pacing of Work*

Students learned to conduct their nursing according to the pace of family life and the demands of the situation. The passage of time in families and in the community proceeded much more slowly than in, for example, the more fast-moving institutional setting. Students learned they had time to collect data about clients, look up information, discuss with advisors, move back to their clients, and to repeat this process with generally no urgency to meet particular time pressures that were often inherent in acute-care nursing in institutional settings. Learning and nursing proceeded at the student's and the client's pace. Though this "slower" pace was suited to the independent learning that was demanded of the students, it caused, for many, the need to readjust suddenly and considerably when they entered more quickly paced nursing settings.

### *Familiarity with the Health Care System*

As intended, most students came in contact with a variety of representatives and agencies of the health care system through their clients. It was not unusual, for example, that an elderly client became ill, was admitted to hospital or nursing home, or even died; that an expectant mother attended prenatal classes or clinics; that a young child had minor surgery in hospital; that a widowed spouse entered an elderly residential home. Students encountered physicians, nurses, social workers and acted as mediators between client and health care agents, informing, explaining, and facilitating interaction between them.

*Student: At that particular time, she [the client] was viewed as a lady with low intelligence and someone that doesn't co-operate very well. This was the general attitude of staff. Since I was accessible and I knew her [to be different], I decided to change their image. I went on a quiet day...and had a chance to talk with a particular nurse who was very familiar with [the client]. [student goes on to describe how staff nurse agreed and decided the client just needed a little more time and understanding]*

An interesting and rather provocative observation was that students viewed these extensions of the formal health care system from within the client's perspective and, in several instances, assumed a client advocate role:

*Student: The social workers got her a ticket to [go home to] Frobisher Bay the next day...and she just wasn't ready to go. She thought maybe things would change [for the better] now with the baby here and everything. I could very well understand her side, I mean "He's the father of my child and I don't want to leave right now" and...I conveyed this message... [but] they said no, she either goes tomorrow or she doesn't go at all.*

*Interviewer: They were deciding what was best for her?*

*Student: Yeah! And she realized this too — she said, "How can they?" and I said, "I agree with you."*

Students learned to value strongly the opportunity to be independent, responsible, and self-directed, values which are quite congruent with the program philosophy. However, their acceptance of these values resulted in considerable frustration when they encountered the more tightly controlled and much more constrained environment of the hospital centre. Some students had difficulty making an adjustment to that environment and voiced frequent and strong criticism of it.

### Summary

This description of a small slice of a new three-year graduate program is intended to illustrate how faculty made curricular decisions which they hoped would reflect and implement strongly valued beliefs about nursing, teaching, and graduate education. It also highlights the fact that each decision results in a variety of effects — some anticipated and desired, some unintended and less productive. The fact that curricular planning may have a variety of outcomes is accepted (at least in theory) by those who make these decisions. However, the expectations in terms of outcomes tend towards an often unrealistic ideal. A careful consideration of the variety of outcomes, and the willingness to make judgments about the relative value versus the drawbacks of curricular decisions, becomes a critical element of whatever plans are made.

In this case the results of the curricular experience described here have, for the most part, been perceived as gratifying, and faculty are satisfied with the extent to which it has achieved the goals to which they aspired. It remains for faculty to examine and deal with some of the side effects of this experience, for example, its impact on student adjustment to the acute-care setting, and, by so doing, develop further its potential to achieve program goals.

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# Modèles conceptuels

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While theoretical pluralism is certainly an advantage for a nursing programme, it is questioned whether it is also desirable to have a curriculum based on more than 1 conceptual model for nursing. As the precursor of a theory, a conceptual model for nursing is a global perspective for the discipline; as such, it indicates nursing's particular focus and the phenomena that are of concern to nursing. As an explicit frame of reference, a model specifies that for which nurses must be accountable. Nursing practice, education, and research always have some conceptual point of departure. When that departure point is specific to nursing and when it is composed of assumptions, values, and the 6 major units, it is a conceptual model. The criteria for evaluating a conceptual model are social utility, social congruence, and social significance. A curriculum based on one conceptual model for nursing should help students develop the distinct professional identity they need in order to assert themselves as members of the interdisciplinary health team. A program that has several conceptual bases may, on the contrary, be anti-pedagogical.

Le thème « Pluralisme théorique et pédagogie » suscite tout naturellement une discussion sur les modèles conceptuels. D'une part, les modèles pour la profession d'infirmière sont souvent confondus avec des théories et, d'autre part, les modèles conceptuels sont quelquefois sujets à controverse lorsqu'il est question de pédagogie en sciences infirmières. Une question se pose alors : est-il compatible avec la pédagogie d'avoir à la base d'un seul programme d'études plus d'un seul modèle conceptuel ? Plus précisément, est-il pédagogique de baser un programme de formation sur plusieurs conceptions de la profession d'infirmière ?

Il est certes avantageux d'avoir une pluralité de théories dans un programme. Il est moins certain qu'il soit souhaitable d'avoir, dans un seul programme, une pluralité de modèles conceptuels. À cette période de notre histoire professionnelle, il est certainement heureux qu'il existe plusieurs modèles conceptuels ; je ne questionne nullement davantage d'avoir à choisir parmi plusieurs conceptions de notre discipline. Ce que je questionne, c'est l'adoption de plusieurs conceptuels dans un seul milieu. Ce que je remets en question, c'est le fait qu'un programme de formation professionnelle s'inspirerait de plusieurs conceptions de

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la profession. Si un pédagogue peut se servir de plusieurs théories, peut-il se baser sur plusieurs modèles conceptuels à la fois ?

Les dictionnaires nous rappellent que, dans l'antiquité, un pédagogue était un esclave — un esclave qui menait à l'école les jeunes garçons. Dans les temps modernes, un pédagogue est celui qui enseigne aux enfants, celui qui a soin de leur éducation. De nos jours, un pédagogue en sciences infirmières est donc la personne qui a soin de la formation des futures infirmières et infirmiers. Ce pédagogue, en planifiant pour ses étudiantes diverses expériences d'apprentissage, se sert d'une multiplicité de théories. Le programme entier est cependant élaboré à partir d'une conception de la profession et cette conception, avouée ou non, guide le choix des multiples théories utilisées.

Afin d'examiner la question — Est-il pédagogique d'avoir plus d'un modèle conceptuel à la base d'un seul programme de formation ? — je traiterai d'abord de ce qu'est un modèle sur notre vie professionnelle et, enfin, des critères d'évaluation pour un modèle conceptuel.

### Qu'est-ce qu'un modèle conceptuel ?

Un modèle conceptuel est une conception, une abstraction, une façon de conceptualiser une réalité. Un modèle conceptuel *pour* la profession d'infirmière est une conception *de* la profession d'infirmière. Sans le qualificatif « conceptuel », le mot modèle est souvent perçu comme synonyme de modalité, de méthode ou d'exemple à suivre (Adam, 1983). Un modèle *conceptuel* est forcément plus abstrait qu'une méthode. Un modèle conceptuel pour une profession est une façon de conceptualiser ce que la même profession pourrait ou devrait être. Il y a lieu d'insister sur les mots « pourrait ou devrait être ». Un modèle conceptuel pour la profession d'infirmière n'est pas une définition de la profession ; il n'est pas ce que sont les soins infirmiers mais plutôt une conception de ce qu'ils pourraient ou devraient être. Le jour viendra peut-être où nous dirons que la profession est ce qu'aujourd'hui nous voudrions qu'elle soit. Les soins infirmiers ne sont pas, actuellement, ce qu'ils pourraient devenir. Ce qu'ils pourraient devenir est précisé dans un modèle conceptuel.

Un modèle conceptuel *pour* une discipline est donc une conception globale de la même discipline — une perspective distincte pour cette discipline. Une discipline (Roy et Roberts, 1981) est un domaine d'investigation marqué d'une perspective unique. Le fait même de parler de la discipline d'infirmière laisse supposer que notre domaine a, en

effet, une perspective qui nous distingue des autres professions de la santé, une perspective qui indique une façon de regarder les phénomènes du monde réel. Donaldson et Crowley (1978) font une distinction entre les disciplines académiques et les disciplines professionnelles ; les sciences infirmières, ayant un but pratique de service, se situent parmi les disciplines professionnelles. Les mêmes auteurs précisent que chaque discipline a évolué à partir d'une perspective distincte qui a déterminé les phénomènes d'intérêt particulier à cette discipline. Si notre domaine d'investigation est vraiment une discipline, il est alors caractérisé par une perspective distincte. Un modèle conceptuel précise cette perspective.

Un modèle conceptuel pour notre profession est donc une perspective distincte et globale qui caractérise notre profession. Une longue discussion sur la définition d'une profession, d'une demi-profession, d'une profession naissante, déborderait les cadres de ce texte. Rappelons qu'on parle, de façon courante, de la profession d'infirmière comme on parle de la profession d'avocat ou de la profession de médecin ; les infirmières se comptent parmi les professions de la santé, parmi les professions d'aide et les professions de service. C'est, en effet, depuis 1541 que le mot profession a la signification de « vocation savante » ; trente-cinq ans plus tard, en 1576, le sens du mot s'est élargi pour comprendre toute vocation ou emploi au moyen duquel une personne gagne sa vie (Cogan, 1953, p. 34). Dans le présent article, le mot profession a donc le sens d'un domaine de préoccupation humaine qui exige des études avancées.

Plusieurs auteurs (Chance, 1982 ; Fawcett, 1980 ; Lancaster et Lancaster, 1981 ; Newman, 1979) s'accordent pour dire qu'un modèle conceptuel n'est pas une théorie, mais plutôt le précurseur d'une théorie. En effet, un modèle conceptuel n'est pas fait de propositions interreliées ; il n'est pas constitué d'hypothèses vérifiées. Un modèle n'explique pas une partie du monde empirique ; il ne décrit pas des phénomènes du monde réel et il ne prédit pas des aspects de la réalité. Un modèle conceptuel pour une discipline indique plutôt les phénomènes qui sont d'un intérêt particulier pour cette discipline ; il spécifie le centre d'intérêt de la discipline et ainsi peut conduire à l'élaboration d'une théorie qui, elle, servira à expliquer, décrire, prédire, diriger, et faire comprendre une partie du monde empirique (Roy et Roberts, 1981). Une théorie est donc utile à plus d'une profession. Un modèle conceptuel pour une discipline n'est, par contre, utile qu'à cette même discipline.

Si un modèle conceptuel est une conception de notre profession, l'inverse n'est pas nécessairement vrai. Toute conception de notre discipline n'est pas un modèle conceptuel. Chaque lecteur, infirmière, infirmier ou non, a certainement une conception personnelle de la profession d'infirmière. Il semble difficile, voire impossible, de ne pas en avoir une. Certaines de ces conceptions personnelles sont claires et précises ; d'autres sont un peu floues et donc difficilement communicables. C'est lorsqu'une conception est claire et précise, lorsqu'elle est complète et explicite, qu'elle s'appelle modèle conceptuel. Afin de mériter le nom de « modèle conceptuel », une conception doit, selon Johnson (Riehl et Roy, 1980, p. 7), comprendre postulats, valeurs et six éléments (Figure 1). Ces trois composantes forment un tout cohérent. Prendre des parties de plusieurs modèles pour en faire un modèle éclectique ne serait donc pas un procédé souhaitable ; ce faisant, on risquerait de perdre la cohérence interne et la logique intrinsèque au modèle et ainsi aller à l'encontre d'une perspective globale.

**Figure 1** *Les composantes d'un modèle conceptuel pour une discipline*

Postulats

Valeurs

Éléments : *But*, idéal et délimité, du professionnel  
*Client* — la cible de l'activité professionnelle  
*Rôle social* du professionnel  
*Source de la difficulté*, éprouvée par le client  
*Intervention* du professionnel (centre et modes)  
*Conséquences* de l'activité professionnelle

Les postulats proviennent soit d'une théorie, soit de la pratique, soit des deux à la fois. Certaines infirmières privilégient un modèle qui est fondé surtout sur une théorie ; d'autres, voyant notre discipline profondément enracinée dans la clinique, lui préfèrent un modèle qui découle surtout de la pratique. Dans les deux cas, les postulats sont vérifiables s'ils ne sont pas déjà vérifiés. Un postulat commun à plusieurs modèles est l'énoncé suivant : la personne est un être bio-psycho-social.

Les valeurs, quant à elles, ne sont pas sujettes aux critères de vérité. Ce sont les valeurs qui touchent à la profession et elles doivent s'accorder avec les valeurs de la société que sert la même profession. Une valeur retrouvée dans plusieurs modèles est la croyance que la profes-

sion d'infirmière apporte une contribution importante dans le domaine de la santé.

Quant aux six éléments, ils sont soutenus par les postulats et les valeurs et ils précisent les paramètres conceptuels de la discipline.

### L'influence du modèle conceptuel

La conception qu'une infirmière a de sa propre discipline exerce forcément une certaine influence sur ses activités professionnelles. Lorsque cette conception est claire et précise, complète et explicite, c'est-à-dire un modèle conceptuel, elle lui fournit des directives, sous forme d'abstractions, pour la pratique, la recherche et la formation infirmières. Quel que soit son champ d'activité, l'infirmière est guidée par l'image mentale qu'elle a du service qu'elle rend à la société. Praticienne, chercheur ou enseignante, ou administratrice d'un de ces secteurs, l'infirmière a un point de départ conceptuel; elle a une perspective globale.

Le point de départ conceptuel influe sur la pratique infirmière. Que son milieu d'exercice soit un hôpital, un centre de santé, une école, une résidence privée ou une entreprise, l'infirmière vise un but idéal et délimité, elle conçoit son client de façon précise et elle assume un rôle social particulier; de plus, elle reconnaît des problèmes de santé qui relèvent de sa compétence spécifique, elle envisage son intervention selon les modes à sa disposition et elle s'attend à certaines conséquences voulues. Sa perspective globale est la même, que son client soit malade ou en santé, qu'il soit jeune ou âgé, et qu'il ait un diagnostic cardiaque, orthopédique, psychiatrique ou autre. La praticienne peut-elle s'inspirer simultanément de plus d'une perspective globale? Peut-elle viser plus d'un but à la fois? Peut-elle conceptualiser son client de plus d'une façon, etc.?

Quant à la recherche, l'infirmière tient à faire de la recherche *infirmière*, à faire avancer la science *infirmière* et à contribuer aux connaissances propres à sa discipline. L'infirmière-chercheur identifie un problème de recherche *infirmière* en fonction de la perspective qui la caractérise.

La recherche infirmière, effectuée à partir d'une perspective distincte, peut conduire à l'élaboration d'une théorie. Il ne s'agira pas d'une théorie des sciences infirmières, ni d'une théorie des soins infirmiers, ni, non plus, d'une théorie de la profession mais plutôt d'une théorie en sciences infirmières. La nuance est beaucoup plus qu'une question de mots. Une théorie étant un système de propositions qui sert à décrire, à expliquer, à prédire, à diriger, et à faire comprendre une

partie du monde empirique (Roy et Roberts, 1981), il n'est pas nécessaire — il est peut-être même impossible — d'avoir une théorie *de* la profession d'infirmière. Notre discipline n'est pas, en elle-même, un sujet d'investigation scientifique (Johnson, 1978). Une théorie *de* la discipline servirait à décrire, à expliquer et à prédire le service professionnel qu'offre l'infirmière, ce qui n'est guère souhaitable. Ce qui est, par contre, extrêmement souhaitable, c'est d'élaborer des théories concernant les phénomènes qui intéressent l'infirmière. Et quels phénomènes intéressent l'infirmière-chercheur ? La réponse est dans la conception qu'elle a de sa discipline. La réponse est dans son modèle conceptuel. Cette réponse peut s'exprimer en termes d'équilibre, d'indépendance ou d'adaptation, pour ne nommer que trois possibilités. Il reste que le point de départ conceptuel, en précisant les phénomènes d'intérêt particulier à la discipline, oriente les questions de recherche ; la perspective, distincte à la discipline, spécifie les problèmes de santé qui sont du ressort de l'infirmière et oriente ainsi la recherche d'intervention pour prévenir et résoudre ces problèmes.

Si la perspective de la discipline n'est pas claire, l'infirmière-chercheur est tentée d'emprunter son point de départ conceptuel à une autre discipline — souvent celle dans laquelle elle a fait ses études supérieures. Si les phénomènes qui sont d'intérêt particulier à sa propre profession ne sont pas identifiés, l'infirmière-chercheur s'applique à étudier les phénomènes qui sont d'intérêt particulier à une autre profession. Elle s'engage peut-être dans la recherche expérimentale avant que les variables spécifiques à cette recherche soient déterminées (Johnson, 1978, p. 9), avant que les termes descriptifs soient identifiés. Ainsi, ce chercheur fait de la recherche, mais s'agit-il de recherche *infirmière* ? Ce chercheur fera avancer la science, ce qui est certes important, mais fera-t-il avancer la science *infirmière* ? La recherche effectuée *par* une infirmière n'est peut-être pas recherche *infirmière*. Il est préférable, sans aucun doute, de faire avancer les sciences en général que de ne rien faire. Toutefois, il est stimulant de penser qu'un jour le temps et les énergies des infirmières-chercheurs seront investis dans l'étude des phénomènes tels les sept sous-systèmes de comportements, les quatre modes d'adaptation ou les quatorze besoins à satisfaire, pour reprendre les mêmes exemples déjà cités. Différents groupes de recherche choisiront différentes perspectives et chaque perspective conduira à des théories différentes et donc à différentes connaissances. Mais un groupe de chercheurs peut-il partir de plus d'une seule perspective ?

Qui sait ? Un jour les théories en sciences infirmières seront peut-être aussi utiles aux autres professionnels de la santé, que les théories

provenant d'autres disciplines sont aujourd'hui utiles aux infirmières. Ce jour-là, il faudra reprendre la discussion du pluralisme théorique !

Le modèle conceptuel exerce également une influence sur la formation infirmière. Un programme d'études est forcément basé sur une conception quelconque et lorsque la conception est un modèle conceptuel, l'étudiante est formée à poursuivre un but spécifique, à conceptualiser le client de façon explicite, à jouer un rôle social précis et ainsi de suite. Un programme de formation, basé sur une conception explicite, ne favorisera-t-il pas, chez l'étudiante, le développement d'une identité professionnelle distincte ? Cette identité n'encouragera-t-elle pas, chez la même étudiante, la créativité, l'individualité et l'utilisation judicieuse de son intuition en même temps qu'elle facilite l'intégration des connaissances scientifiques provenant de plusieurs théories ?

Il est important de préciser que le modèle conceptuel ne figure pas au programme comme une matière à enseigner parmi d'autres. Au contraire, le modèle est à la base du programme ; il est le point de départ conceptuel de tout le programme. Le modèle sert de charpente à laquelle on peut rattacher une grande variété de cours. Quel que soit le niveau de formation, là où les pédagogues prétendent former les infirmières, il y a une image mentale de la profession qui est transmise aux étudiantes. Stevens (1979, p. 130) l'appelle le modèle pour la discipline qui est communiqué aux étudiantes au moyen du modèle pour le curriculum. L'image mentale que les professeurs communiquent, consciemment ou non, exerce naturellement une influence sur les étudiantes. Il faut donc se poser deux questions : Est-il pédagogique, à l'intérieur d'un seul programme, de leur transmettre plus d'une conception de leur profession ? Est-il pédagogique de transmettre une conception qui n'est ni claire ni explicite ? Dans les deux cas, les étudiantes risquent de terminer leur programme sans avoir développé une identité professionnelle distincte et sans avoir acquis une idée claire de leur mandat social. Pourtant, nous envoyons nos jeunes bachelières dans le monde compétitif d'aujourd'hui en les exhortant à être des agents de changement et des travailleurs de la santé au même titre que les autres professionnels dans l'équipe interdisciplinaire. Nous incitons nos diplômés à s'affirmer en tant que femme ou en tant qu'homme et à apporter une contribution significative dans l'arène de la santé. Exiger autant de nos diplômés, sans leur fournir une base conceptuelle précise, risque d'attirer sur nous, de la part de ces même diplômés, des accusations d'injustice sociale.

Il est tout à fait légitime d'enseigner aux étudiantes qu'il existe plusieurs modèles conceptuels et que différents programmes s'inspirent de différentes bases conceptuelles. Le danger d'injustice envers les étudiantes existe lorsque leur programme de formation n'a pas de base conceptuelle précise et explicite.

Avant de terminer la discussion de l'influence qu'exerce sur nos activités un modèle conceptuel, il convient de rappeler qu'un modèle n'en est cependant que le point de départ. L'infirmière — praticienne, chercheur ou éducatrice — a besoin de beaucoup de connaissances dans les sciences humaines et biologiques. Elle doit avoir un bon jugement, de la maturité, et utiliser des méthodes systématiques de travail. L'infirmière doit également avoir des habiletés à établir et à maintenir une relation interpersonnelle qui sera perçue par le client comme une relation d'aide. Un modèle conceptuel ne remplace nullement les autres attributs nécessaires à l'infirmière; un modèle lui sert plutôt de charpente sur laquelle bâtir ses habiletés et ses connaissances, une charpente qui donne un sens à toutes ses activités, en apparence peut-être, disparates.

### **Les critères d'évaluation d'un modèle conceptuel**

Nous avons vu qu'un modèle n'est pas une théorie; il s'ensuit qu'un modèle n'est pas jugé selon les mêmes critères qu'une théorie. Un modèle conceptuel n'est pas à valider dans le sens de vérifier une hypothèse ou de valider une proposition. La question «Le modèle X est-il vrai?» ne se pose pas (Johnson, 1974, p. 376). Le critère de vérité n'est pas approprié à une conception globale de toute une discipline. Toutefois, le modèle n'est pas à accepter aveuglément. Il y a des questions à poser, des normes à considérer, mais elles ne sont pas celles utilisées pour juger une théorie.

Les critères d'évaluation d'un modèle conceptuel, publiés depuis plusieurs années déjà (Johnson, 1974), ne sont pas toujours connus et bon nombre d'infirmières continuent à considérer les modèles comme des théories manquées ou des théories non-validées.

Les trois critères sont extrinsèques à la substance du modèle. Afin de décider si un modèle est «bon» ou «pas bon» pour une profession, on fait appel, non pas à la substance du modèle, mais plutôt aux décisions sociales en ce qui concerne la profession. Il s'agit de la congruence sociale, de la signification sociale et de l'utilité sociale du service professionnel lequel découle du modèle conceptuel. Il est entendu que ces décisions sociales ne peuvent être prises avant que notre service à la

société s'inspire d'un modèle précis. Le jour où la pratique, la recherche et la formation infirmières s'inspireront du modèle X, on pourra évaluer le modèle X. De même, si dans d'autres milieux les trois champs d'activité étaient basés sur le modèle Y, alors on pourrait évaluer le modèle Y. Pour ce faire, il faudrait obtenir de la société, c'est-à-dire de la part des bénéficiaires, des clients, des patients, des malades, des consommateurs, les réponses à plusieurs questions.

Tout d'abord, en ce qui concerne la congruence sociale, les questions pourraient être les suivantes : les décisions et les interventions infirmières, qui découlent du modèle X, correspondent-elles aux attentes de la société ? Le service professionnel, qui est basé sur le modèle X, concorde-t-il avec les attentes des bénéficiaires du même service ? Nous savons, aujourd'hui, que la pratique infirmière n'est pas tout à fait ce qu'elle pourrait devenir ; les clients qui auront l'occasion de connaître une nouvelle pratique échangeront peut-être leurs attentes actuelles pour d'autres. La société aimerait peut-être avoir des attentes autres que celles qui lui sont possibles aujourd'hui. Quoi qu'il en soit, le premier critère pour évaluer un modèle conceptuel est celui de la congruence sociale du service qui en découle.

Le deuxième critère est la signification sociale. Il s'agit d'obtenir des réponses aux questions suivantes : Le service professionnel, qui s'inspire du modèle X, a-t-il un impact significatif sur la santé des bénéficiaires ? Les décisions et les interventions infirmières, qui découlent du modèle X, exercent-elles une influence positive sur la santé des gens ? Si la profession d'infirmière disparaissait, la perte serait-elle significative ? Ce critère de signification sociale nous rappelle que l'existence même de notre service professionnel dépend d'un besoin de la société.

Quant au troisième critère, celui de l'utilité sociale, il s'agit de l'utilité du modèle pour les membres de la profession. Le modèle X est-il suffisamment clair et précis pour fournir des directives pour la pratique, la recherche et la formation infirmière ? Plus spécifiquement, le modèle X est-il assez clair et complet pour être la base de la pratique dans toutes les situations ? Le modèle X indique-t-il le but des soins infirmiers, quel que soit le milieu d'exercice et quel que soit le diagnostic médical ? Indique-t-il clairement comment conceptualiser le client, qu'il soit jeune ou âgé, qu'il soit malade ou en santé ? Le modèle, précise-t-il le rôle social de l'infirmière et ainsi de suite ?

Aux infirmières-chercheurs, le modèle X est-il utile ? Est-il assez explicite pour indiquer les phénomènes d'intérêt particulier à la discipline ? Le modèle, suggère-t-il des questions de recherche à poser et précise-t-il le genre de connaissances qu'il faut développer ?

Pour l'éducatrice, le modèle X offre-t-il une image mentale assez claire pour que les étudiantes développent une identité professionnelle distincte ? Le modèle est-il suffisamment précis pour être à la base d'un programme d'études ? Indique-t-il en quoi consiste les matières propres à la profession, les matières connexes qui sont nécessaires et les théories qui sont essentielles pour former une infirmière ?

Il est facile de voir qu'on ne peut évaluer le modèle X, ni le modèle Y, selon les trois critères de congruence, signification et utilité sociales, avant que le modèle X et le modèle Y deviennent la base conceptuelle de la pratique, la recherche et la formation et ce, dans plusieurs milieux. Pourtant, certaines infirmières hésitent à adopter un modèle parce qu'il n'a pas encore fait ses preuves. Après tout, le modèle choisi ne sera peut-être pas le bon, le meilleur, le « vrai ». Briser ce cercle vicieux demande un certain courage car il y a certes un élément de risque dans l'adoption d'une conception explicite. Il serait utile de considérer, pendant un moment, le risque couru lorsque nos activités professionnelles s'inspirent d'une conception floue et incomplète. Puisque notre pratique, notre recherche et notre enseignement sont toujours basés sur quelque chose, considérons une base conceptuelle qui n'est pas trop claire et précise. Cette base a-t-elle fait ses preuves ? Cette base est-elle la bonne, la vraie, la meilleure ? Nous n'avons pas cette assurance. Notre conception privée et personnelle représente peut-être un risque aussi grand — sinon plus grand — que celui d'adopter un modèle conceptuel.

### D'autres considérations

S'inspirer d'une conception explicite est extrêmement exigeant. Si les infirmières s'engagent vers un but précis, elles seront appelées à rendre des comptes sur la réalisation de ce but. Si les éducateurs s'engagent à former les étudiantes pour un rôle social spécifique, ils seront appelés à rendre des comptes sur le rendement de leurs diplômés. Et si les chercheurs s'engagent à ajouter aux connaissances concernant des phénomènes particuliers, ils seront appelés à rendre des comptes sur le corps de connaissances qui se développe. Comme toute autre profession de service, nous avons des responsabilités sociales et nous avons toujours valorisé le sens des responsabilités. Un modèle conceptuel ne fait que préciser ce dont nous sommes responsables.

Les divers modèles conceptuels qui existent ont été publiés, pour la plupart, par les infirmières américaines. Ils ne sont pas cependant des modèles américains. Ces modèles sont des conceptions de notre profession laquelle dépasse, de loin, les frontières géographiques d'un seul

pays. Je ne crois pas qu'un modèle ait nécessairement la nationalité de son auteur. Cependant, le modèle n'est pas nécessairement universel, puisque les valeurs sous-jacentes ne concordent peut-être pas avec les valeurs de toutes les sociétés.

Dans le même ordre d'idées, un modèle élaboré par une infirmière au Manitoba ne sera pas un modèle manitobain, pas plus qu'un modèle conçu par une Québécoise ne sera un modèle québécois. L'auteur peut être de la Colombie-Britannique ou de Terre-Neuve ; son modèle sera une conception de la discipline et la discipline ne se limite pas à une région géographique. Les postulats qui ne sont acceptables qu'à un seul pays ne seront pas les postulats à la base de toute une profession. Parce que les termes du modèle sont abstraits, ils doivent offrir une perspective très large.

Le choix d'un modèle conceptuel ainsi que la création d'un nouveau modèle se font en fonction de leur évaluation éventuelle, c'est-à-dire la congruence, la signification et l'utilité sociales. Ceci exige, forcément, qu'on y retrouve les postulats, les valeurs et les six éléments. La conceptualisation de ce que notre discipline pourrait ou devrait être est un long processus qui dépend, non seulement d'un apport rationnel et scientifique, mais aussi d'intuition, d'introspection et d'expérience professionnelle. Une infirmière qui commence ce long processus évitera de se restreindre à une période de temps déterminée ; elle n'acceptera pas non plus d'élaborer un modèle conceptuel comme une production à effectuer sur commande. Stevens (1979) nous met également en garde contre un travail de groupe lorsque la tâche est celle de conceptualiser.

Tout ce qui s'appelle modèle n'est pas nécessairement un modèle conceptuel pour une discipline. Un « modèle d'intervention », par exemple, se limite souvent à une intervention précise dans une situation précise. Un « modèle de soins » traite souvent d'un ou des aspects de la pratique, sans offrir de direction pour la formation et la recherche. Un modèle pour un curriculum est une façon de voir un programme d'études, que ce dernier soit en mathématiques, en géographie ou en sciences infirmières. Par contre, un modèle conceptuel pour les sciences infirmières n'est utile qu'à la discipline infirmière.

### **Conclusion**

La question du départ était : Est-il pédagogique d'avoir, à la base d'un seul programme de formation, plus d'une conception de la profession d'infirmière ? Selon moi, la réponse est non. Au nom d'une identité professionnelle distincte pour nos diplômés, au nom d'une con-

tribution importante à la santé des bénéficiaires et au nom de l'avancement de la science infirmière, je soutiens qu'à la base de chaque programme de formation, il ne faut qu'un seul modèle conceptuel.

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# 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 80s, 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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**SECTION III**

Expanding  
Nursing Horizons

*Introduire de  
nouveaux horizons  
en sciences infirmières*

## **Nurses and Political Action: The Legacy of Sexism**

**Alice J. Baumgart**

Le présent article examine la situation des infirmières en tant que groupe de pression selon deux perspectives : celle du conformisme des femmes aux stéréotypes sexistes traditionnels et celle de leur situation désavantageuse dans la hiérarchie de la structure d'organisation. Afin d'accroître le pouvoir de négociation des infirmières en matière politique, l'auteure puise dans les écrits pertinents et propose des modifications dans la structure des services infirmiers. Ces changements se fondent surtout sur une décentralisation hiérarchique ainsi que sur la création au sein des organismes, de groupes conjoints formés de membres du personnel ainsi que de l'administration. Ces groupes seraient chargés d'élaborer les politiques et les normes de la pratique infirmière dans les organismes de santé. Le sexisme que pratiquent les hommes qui obtiennent le pouvoir politique au Canada représente encore de nos jours une force importante qui influence les résultats de l'action politique des infirmières.

The 1970s witnessed a reawakening of the political consciousness of nurses. Not since the struggle for registration at the turn of the century has political action assumed so high a priority on the agenda of organized nursing groups. Fuelled by social and political forces such as the women's movement and the shift from entrepreneurial to political power in Canadian health services, organized nursing associations in Canada have begun to define themselves as political pressure or interest groups having a direct, continuous, and active role in influencing health policy.

The problem for most organized nursing groups in Canada is that their views on policy matters have rarely been heard and found plausible, much less accepted. The women's movement has helped to bring into sharp focus some of the fundamental causes. Most nurses are women, and the cultural conditioning and opportunities of women have been such to effectively exclude them from the corridors of power in our society.

If nursing is to keep up the pressure to have its interests better represented, it is important for nurses, individually and collectively, to be aware of some of the ways in which sexism contributed to their political inexperience and lack of political influence.

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### Politics and the Male-Female Sexual Dynamic

Politics in health care, as elsewhere, consists in exercising power, consolidating power, or effecting a change in power relationships — or put more crudely, working the system to advance one's interests.

In Canadian society, men, to a large extent, have appropriated the positions of power and authority in public life. Men have also controlled the production of ideas, images, and symbols by which social relations are expressed and ordered (Smith, 1975). It is men's perspectives which have determined which issues or problems are considered salient and whose views to credit or discredit. Further, the policies and procedures of most major social institutions have been built on male values and have been designed to protect and promote male interests (Wood, 1978-79).

Consequently, women who have sought access to traditionally male preserves have not been able to count on society for much encouragement or on the male power-holders for fair treatment. Indeed, until the mid-1960's, the social climate in Canada was basically hostile to the notion of women taking their fair share of political power. The accepted social norm was that politics and the holding of power were incompatible with "femininity" and the "nature" of women. The control of power was seen as requiring a high degree of rationality, objectivity, and stability, properties thought to be lacking or undesirable in females. Women who breached the boundaries of acceptable female behaviour by seeking or obtaining power were considered deviant, unnatural, disturbed, or utterly unhappy.

The strength of these social dictates has rendered problematic women's participation in even the most basic political act, the casting of a vote. Although the situation is changing, the finding that women vote less often than men is one of the most thoroughly documented in social science (Safilios-Rothschild, 1974).

Perhaps the most visible effect of the ideology that "politics is not for women" is the small number of females who have sought or won elective office. Based on the number of women elected to Canada's House of Commons to date, it has been estimated that it would take 842 years for women to achieve equal representation with men ("Emergence," 1980).

Negative images and beliefs about women and power are beginning to lose their deterrent effect as more women seek political office and individuals such as Flora MacDonald in Canada and Margaret

Thatcher in Britain emerge as political superstars holding "blue chip" political posts. But there is still a long way to go. Available evidence suggests that in vital ways women in political life remain second-class citizens. The reasons may be found in the reciprocal effects of women's political socialization and the structure of political institutions.

### **Women's Political Socialization**

In the nursing literature and in much of the research and writing on women in North America, the socialization paradigm is the most common way of explaining the difficulties women face on entering public life. This perspective also provides the foundation for popular repair programs for women such as assertiveness training and corporate political exercises described in best sellers like *Games Mother Never Taught You*.

The socialization paradigm takes as its starting point that male and female children are encouraged from birth to behave and think differently. For females, the object of socialization has traditionally been preparation for the private world of wife, mother, and housewife, and the characteristics assigned to females have included warmth and emotional expressiveness, dependence, submissiveness, and passivity. For men, socialization practices have been aimed at preparing them for public life where the achievement of success requires traits such as aggressiveness, intellectual agility, and independence (Tavris & Offir, 1977).

Thus, according to the socialization paradigm, the traditional division of masculine and feminine roles has deprived women of an adequate political education, undermined their motivation to become politically active, and encouraged them to devalue both themselves and other women. That is, to the extent that women have adopted as a guide to life "the ideal female" stereotype, they have grown up psychologically and experientially handicapped for participation in mainstream political roles (McCormack, 1975).

The results of many studies of sex differences in political behaviour may be viewed as consistent with a socialization analysis. For example, in line with the sex stereotype that politics and femininity are incompatible, studies have generally shown that women are less interested, less informed, and less involved with voting than men (McCormack, 1975; Safilios-Rothschild, 1974). Another common finding in political studies is that women tend to vote more conservatively than men and are less inclined towards radical social changes and protests (Safilios-

Rothschild). There is also considerable evidence that women vote as their husbands do, presumably using their vote to reassure their husbands of their "femininity" and superior knowledge and judgement in such "masculine" spheres (Safilios-Rothschild).

The tendency among women to undervalue themselves and to hold other women in low regard is apparently on the wane in North America (Tavris & Offir, 1977). However, the lingering effects of traditional socialization practices may be seen in the results of a recent Common Market poll in which about half of the men and over 80% of the women surveyed expressed a preference for male political representatives ("Fewer Women," 1980). In a similar vein, in a 1972 American study close to two thirds of the men and women sampled ascribed to the belief that "most men are better suited emotionally to politics than are most women" (Safilios-Rothschild, 1974). Canadian data from the 1960s cited in the *Report of the Royal Commission on the Status of Women in Canada* (1970) may be slightly more encouraging. Polls conducted by the Canadian Institute of Public Opinion in 1964 and 1969 have shown that a majority of respondents favoured women playing an important role in politics, including assumption of federal leadership positions. A greater obstacle to fuller participation of women in Canadian political life is the lack of confidence women have in their ability to influence politics. According to a 1968 study by Meisel, women have a very low sense of political efficacy in comparison to men (*Report*, 1970).

Research on women who have "made it to the top" in political life provides further evidence of women's conformity to traditional sex stereotypes. For example, studies have shown that women often take to the political floor less than men and use a different style in presenting their opinions. Their presentations and speeches tend to be restricted to feminine subjects such as family, health, housing, and children. On subjects considered areas of "masculine" competence — economics, national defence, foreign affairs, and so on — the voice of women has rarely been heard (Safilios-Rothschild, 1974).

Undoubtedly, the degree to which women have been socialized to live in a different world from men has played a part in producing the behaviours just described. However, as sociologist Jessie Barnard has noted, "emphasis on socialization merely offers an easy way out, it does not open doors" (Tavris & Offir, 1977).

It leads women to believe that the problem lies almost wholly within their own psychology and education; that women must

somehow change if they are to be admitted to the decision-making and policy strata of society. As nurses frequently express it, "nurses are their own worst enemies." Mounting evidence suggests that a more adequate explanation of the obstacles to women in political life may be found in the disadvantaged organizational circumstances in which most women find themselves.

### **Structural Determinants of Women's Political Behaviour**

The case for a structural explanation of the performance of women in public life has been most fully elaborated by Kanter (1977a). According to Kanter, the difficulties faced by women around issues of power and leadership are built into the dramatically different division of labour between men and women in most organizations. Typically, women are clustered at the bottom of organizational hierarchies; they occupy most of the lower-echelon positions having few prospects for mobility or the exercise of system-wide power. Kanter argues that it is these disadvantaged organizational circumstances, rather than sex differences or sex-role socialization, that define and shape the behaviour of and towards women in public life. From her analyses of large-scale organizations, Kanter (1977a) has identified three factors as critical in limiting the influence of women in decision-making and policy spheres: blocked opportunities for advancement; limited power to mobilize resources; and the problem of tokenism whereby women are kept "in their place" in situations where men vastly outnumber them.

#### ***Blocked Opportunity***

Kanter (1977b) has found that in positions of blocked opportunity or little mobility, people — be they men or women — respond with various forms of disengagement such as depressed aspirations and self-image, lower commitment to work, and reduced feelings of competence. In contrast, in high-opportunity positions, people have high aspirations and self-esteem, value their competence, and engage in various forms of active change-oriented behaviour. In other words, blocked opportunities create a vicious cycle: women tend to hold organizational positions offering limited opportunities for advancement and growth; being disadvantageously placed in the opportunity structure they lower their aspirations and orientations to accord with reality and so are less likely to be perceived as promotable.

### *Powerlessness*

Kanter (1976, 1977a) contends that a similar interaction exists between the current distribution of men and women in the power structure of organizations and their leadership behaviour and political influence. As she notes, women have been handicapped by both their low-visibility, low-status positions in organizations and their limited access to the informal social networks, sponsors, and peer alliances which pervade organizational life (Kanter, 1976).

Thus, they tend to be caught in a self-perpetuating downward cycle of disadvantage. They are isolated from other power-holders and so, even if occupying a leadership position, may have little influence. Further, and probably more incapacitating, powerlessness has been shown to produce the rigid, controlling, authoritarian leadership behaviour caricatured in the "mean and bossy woman" stereotype (Kanter, 1976). Blocked from exercising power, powerless leaders substitute the satisfaction of lording it over others. Unable to move ahead, they hold back talented subordinates and restrict opportunities for their growth and autonomy. In turn, these behaviours provoke resistance and so contribute to a further restriction of power (Kanter, 1977a). Kanter (1977a) concludes: "Power issues occupy center stage, not because individuals are greedy for more, but because some people are incapacitated without it" (p. 205).

### *Tokenism*

The third factor that Kanter (1977b) believes is critical in limiting the influence of women in decision-making and policy spheres is tokenism, a problem occurring in situations where women typically find themselves alone or nearly alone in a peer group of men. Such "skewed" groups not only perceive the token woman in a stereotyped way, but they also pressure her to behave in conformity with that stereotype.

In short, the dynamics of tokenism trap women in limited roles that give them the security of "a place" but with little choice about accepting the perspectives of the dominants. They find it hard to gain credibility; they face misperceptions about their role and competencies; they are more likely to be excluded from the networks by which informal socialization occurs and politics behind the formal system are exposed; and they have fewer opportunities to be sponsored. In a process analagous to the biological response to a foreign body, women become isolated both physically and symbolically. Thus, the dominant men are able to preserve their positions of eminence and power.

### **Structural Constraints and Political Influence**

From the structural perspective just elaborated, it may be inferred that the political influence of women is restrained not so much by their own lack of political consciousness and skills, but because of the greater power that has operated against them. What scant research has been done on women's efforts to gain a stronger foothold in political arenas supports this contention. For example, in a rare study of the activities of women's organizations, Dubeck (1977) found that the influence of two elite groups in Cincinnati from 1920 to 1945 varied with the type of issue and the extent to which a shift in power was a part of that issue. As one might expect, efforts to solve social problems, especially in fields congruent with "feminine" interests, were most successful (although by no means all of such efforts were successful). Those concerned with power-related issues, such as government reorganization or the appointment of women to senior decision-making bodies, were least effective. A study by Vickers ("Emergence," 1980), a political scientist at Carleton University, also offers useful insights into ways by which women are kept "in their place" in political life by being nominated in low-opportunity constituencies. Her survey of 1,200 women who ran for elective office in municipal, provincial, and federal levels of government in Canada between 1945 and 1975 shows that 63% of the candidates contested ridings in which their party had not won in the previous five elections. It is also interesting to note the extent to which the opportunities afforded by familial encouragement and immersion in political communication networks have been virtually essential for the election of women to the Canadian House of Commons. Of the 18 women elected between 1921 and 1970, six were widows of former Members of Parliament and one was the wife of a former Member. Two of the widows were also daughters of former Members (*Report*, 1970).

Studies of interest-group activities in Canada provide further glimpses of the structural barriers to women in political life. As Hartle observes, "It is in the best interest of key actors in the legislative process to exclude some, perhaps most, interests from the process. The key question is, therefore, which interests do have access and why?" (Thompson & Stanbury, 1979, p. 38).

According to Thompson and Stanbury (1979), the policy system in Canada tends to give the edge to recognized interests, that is, groups possessing generous shares of political legitimacy among ministers, bureaucrats, and legislators and having prestige, wealth, organizational strength, and cohesion. They also note:

...the resistance of recognized groups and their bureaucratic sponsors to the recognition of new interests. Outsiders, interests that are not initially included in the policy-making or legislative process, must overcome the entrenched positions of those that are "close to the throne" if they are to win recognition for themselves. Furthermore, the barriers to group organization that can be erected by those having influence (recognized groups and their bureaucratic sponsors) are substantial, if subtle. (p. 38)

For nursing, a chastening demonstration of the exclusiveness of interest-group representation in Canada and the dynamics of maintaining it is provided, of course, by the medical profession. Indeed, Taylor (1960, 1978) has suggested that no other interest or pressure group has been so deeply involved in the initiation and execution of public policy and the use of pressure-group tactics to resist encroachment by other interest groups. This exclusiveness, especially in health care, is beginning to break down, however. With the advent of national health insurance and more recently the fiscal crisis in health care, medicine's degree of control over the delivery of services and the economic aspects of the system have come under direct challenge. More generally, concern over the narrowness of existing interest-group representation in Canada has led recent federal governments to open the legislative process to wider group representation (Thompson & Stanbury, 1979).

What does all this add up to in terms of nursing undertaking an enlarged political role in health care policy-making? What are the implications for nurses who might want to participate in the political process? How do they do it?

### **Mastering the Political Realities of Health Care**

Nursing in Canada appears to be making significant strides in at least one important aspect of interest-group politics, namely communicating and building relations with public decision-makers. In other words, nursing has been successful in gaining a measure of recognition as a key interest group in health care (Mussallem, 1977).

But recognition does not necessarily mean effective influence. Even though government now consults nursing more regularly on policy issues, policy decisions with far-reaching implications for nursing services and nursing education are still being made without the input of nurses. Where input is sought and even where nursing's views on particular issues are accepted, there is a tendency to ignore nursing's policy solutions. This is illustrated by the long-term-care program introduced by the British Columbia government in 1977. It was largely through the

pressure of organized nursing in that province that action was taken, but it is interesting to observe that while government accepted nursing's analysis of the need for such a program, they turned to more powerful interest groups to help decide on the program components (G. Parker, personal communication, March 2, 1978).

Noteworthy in this context is the degree to which sex-role stereotyping seriously constrains nursing's policy-influencing ability. Studies by Vance (1977) and Le Roux (1976) of the American nursing leadership suggest that stereotyped notions of nurses and what they do is a problem of significant proportions in the political domain. Although many nurses are now taking on independent and innovative roles in health care and a sizeable body of nursing research is accumulating, nurses are still widely viewed as merely executing physicians' orders. Their knowledge is downgraded in comparison to medical authority, even in areas where medicine has no demonstrable expertise.

This response does not differ greatly, of course, from the stereotyped reactions to women and women's knowledge wherein the sex of the person modifies the authority of their message (Goldberg, 1968). As sociologist D.E. Smith (1975) observes: "There seems to be something like a plus factor which adds force and persuasiveness to what men say and a minus factor which depreciates and weakens what is said by women" (p. 362).

Kanter's work (1976, 1977a, 1977b) suggests that it would be naive and politically hazardous to tackle the problem of sex-role stereotyping simply by attempting to bolster the persuasive powers of nurses or by cultivating a new public image of nursing. These strategies fiddle with effects rather than coming to grip with causes and so rationalize and maintain the existing power structure.

Though we have much to learn about the practical application of Kanter's model, her analyses underscore the importance of structural approaches to helping nurses gain greater political influence. Specifically, there is a need for strategies which take account of the structural forces that support stereotyping — blocked opportunity, powerlessness, and tokenism.

A first point of attack may therefore appropriately be the design of nursing services. Kanter (1977a) stresses decentralization or flattening of the hierarchy as among the more general and important strategies to adopt. As she points out, flattening the hierarchy has the virtue of increasing the number of leadership positions and adding to the visibility and power component of jobs. It also provides more persons with

access to the power structure of an organization. Additionally, Kanter stresses the need for opening channels of communication and making system knowledge such as budget, salaries, and the minutes of certain meetings more routinely available for everyone.

Cleland (1978) advocates the use of collective bargaining as an effective process for bringing about some of these changes. Her strategy is built on the principle of shared governance, that is, the creation of joint staff administrative groups who have responsibility for determining the policies and standards of nursing practice within an agency. To Cleland, shared governance represents an important means of democratizing the workplace and providing a more attractive work setting for professionally motivated nurses. It is also an important training mechanism for the development of decision-making and political-influence skills. Further, shared governance brings nurses from various agency units into regular communication with each other and so provides the opportunity for the development of social-support networks in nursing. Given the numerical advantage nurses enjoy in most agencies, shared governance also has immense potential for giving nurses greater political leverage at the system level.

Nurses, especially in leadership positions, also need to be educated about the problem of tokenism and some of the strategies for overcoming it. Particularly important in seeking representation for nurses in policy and decision-making bodies is the support network that might be put in place to help the nurse representative in a skewed group. Certainly, in some circumstances a more effective means of providing nursing input may be through the numerical advantage of the delegation.

No doubt there are many other strategies that should be explored. The crucial point remains. If the nursing profession is to gain effective influence in policy-making, the coupling of structural or organizational approaches with individual initiatives is the first requirement of success.

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# Fashioning the Future

Verna Huffman Splane

L'auteure suppose que les forces positives qui animent les affaires du monde ne sanctionnent en fin de compte ni l'anéantissement du globe ni l'assujettissement orwellien. S'appuyant sur cette confiance, l'auteur fait valoir que les êtres humains et notamment les personnes auxquelles l'article s'adresse — infirmières et éducateurs — peuvent faire face à l'avenir, confiants jusqu'à un certain point d'être en mesure de le modeler ou de l'influencer de façon significative. Cette donnée dépend toutefois des perspectives et de la compréhension qu'ils acquerront ainsi que de l'effort rationnel et soutenu qu'ils mettront à faire progresser leurs objectifs et rayonner leurs valeurs. Pour illustrer ce que sous-entend la réalisation des perspectives requises et l'acquisition des connaissances en vue d'une action efficace, l'article tire des exemples de la scène internationale et nationale de l'histoire de l'humanité au cours des 50 dernières années. Les exemples se rapportent en grande partie aux facteurs socio-économiques et culturels qui ont influencé le développement des systèmes de soins de santé et le rôle que les infirmières y ont joué. Sur la scène internationale, l'article évoque les politiques et les événements qui ont amené plus de 100 pays en développement à demander un nouvel ordre économique international, dont l'objectif central est de réduire ou, idéalement, d'éliminer la pauvreté. La pauvreté massive, comme le souligne l'article, est l'obstacle principal à la réalisation de l'objectif des Nations Unies qui vise la santé pour tous d'ici l'an 2000. Parlant des forces accumulées contre les politiques de santé rationnelles et humaines, tant sur le plan national qu'international, l'auteure conclut que les éducateurs dans le domaine de la santé doivent baser leur enseignement et leurs recherches sur le genre de problèmes planétaires et nationaux qu'aborde l'article.

The committee planning this conference of the Canadian Association of University Schools of Nursing, in choosing the theme *Fashioning the Future*, made two assumptions. One was that the human race has a future. The second was that human beings in general and nurse educators in particular can do something significant in fashioning it or at least those parts of it that concern us most: the health delivery system, the role of nursing within it, and most specifically, the responsibilities of the nurse educator.

How justified was the assumption that the human race has a future? The rise and fall of civilizations, Arnold Toynbee taught us, is the most persistent theme over the entire course of history (Toynbee, 1947). Even before the explosion of the atomic bomb in 1945, this century had surpassed all others in the toppling of empires, govern-

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ments, kings, and presidents and in the devastation and savagery of its wars and its genocidal massacres. What reasons, then, are there to suppose that, with an atomic, or rather a nuclear, arsenal burgeoning yearly in magnitude and menace, the human race has anything more than the ghost of a chance to survive through this decade, or the next, or the next?

The reasons are hard to come by. If humanity manages to escape nuclear annihilation, is not the most likely alternative the Orwellian world of total oppression of mind and body (Orwell, 1954)? A third and all-but-present threat is that of engulfment in the Tofflerian Third Wave of computer dominance (Toffler, 1981).

These and an array of other apocalyptic scenarios could be paraded to establish that humanity has either no future or one of such subjugation to seemingly uncontrollable forces as to make nonsense of the notion that it can be rationally and benignly fashioned.

### **Affirming the Future**

Yet these prophecies of doomsday death, Orwellian oppression, and computer domination must be rejected. Despite the earlier references to the ever present nuclear peril and the historic record of social disintegration and collapsing civilizations, there are and always have been grounds for hope. History records not only human meanness but human greatness, not only hate but also love. It provides a basis for a faith that, through whatever forces are at work in the universe and in human society, the human race will survive and human beings will not give in indefinitely to forces that deprive them of the exercise of human rights and freedoms, including the right to fashion the institutions on which their daily well-being depends.

Clearly this is not the place to spell out the historical case for this assertion, the assertion that humanity in general, and our tiny portion of it in particular, can proceed to address the future with a determined confidence.

If our task is to look at the future, and if the surest guide to the future is a perceptive reading of the past, there is merit in looking back through half a century and identifying developments and trends within the period that will carry forward significantly into any imaginable future.

Before embarking on that retrospective journey let me indicate the general lines on which this paper is proceeding. I propose, first, to

discuss developments from the past both internationally and nationally that have relevance to the topic and, second, to comment on the current health care system in Canada. The comments will raise many questions about nursing and nursing education in the coming decades.

## **The Last Half Century**

### *Internationally*

No one in 1933 could have foretold the nature and magnitude of the events and developments that were to occur internationally, nationally, and in all manner of our institutions, including the institution of health and the role of nursing in it.

The world in 1933 was in the depths of a depression in many ways like ours of 1983, with high unemployment and deep economic dislocations. Two new and very different figures were emerging on the international scene, where they would remain until their deaths some 12 turbulent years later. Hitler became Chancellor of Germany and opened the first Nazi concentration camp with all that implied for the subjugation of people. Roosevelt was inaugurated as President of the United States and, in contrast, within the year established the Tennessee Valley Authority, signalling thereby to the world a conviction that needs renewing in 1983, that governments need not cower helplessly before what are marketed as the immutable laws of conservative economics. The remainder of the 1930s were seven lean years in a world that could neither end the depression nor arrest the drift to war and to holocaust.

The 1940s, however, notwithstanding all the devastation of World War II, witnessed the regeneration of the human will and capacity for fashioning the future. The United Nations was born and the *Charter of Human Rights* adopted; the latter expressed humanity's finest aspirations and ideals, the former, together with its specialized agencies, offered structures for positive endeavours towards human well-being.

Among the range of international developments since the 1940s, four merit special attention: first, the birth of new sovereign nations from old colonial empires, raising the number of countries in the United Nations from 50 in 1945 to 157 in 1983; second, the vastly expanded world potential for producing and distributing wealth in the form of goods; third, the vastly increased potential for providing human services; fourth, the failure of the world's political and economic structures to utilize those potentials for social justice and human development.

The persistence and enormity of that failure, and particularly its effect on those new nations in the developing world, can be illustrated in many ways. One of the most telling for those of us whose professional commitments combine education and health is the international indicator of relative well-being, the Physical Quality of Life Index (North-South Institute, 1978, pp. 182-189). Combining data on life expectancy, infant mortality, and literacy, the Physical Quality of Life Index, indexed on a scale from 0 to 100, shows a world of rich northern industrialized nations with indexes in the 80s and 90s and of poor underdeveloped nations, largely in the southern hemisphere, with indexes in the 20s, 30s, and 40s.

Although the indications seem to stand as a testament of unjustifiable failure of our instruments of international action and of the exploitive policies of the multinational corporations they harbour, the story of the North-South relationship must not be depicted in wholly negative terms. Great, commendable, and partially successful efforts have been made by the United Nations and its associated agencies to grapple with the socio-economic problems of underdevelopment. Noteworthy among them is the success of the World Health Organization in the reduction, and in some instances the eradication, of communicable disease (although WHO's mandate goes well beyond the prevention of disease, as indicated later in this paper). Similar comments can be made about the multilateral and bilateral programs of developed countries such as Canada. Though these have been often misdirected or wasteful and sometimes harmful, they have had a positive impact on many Third World countries and those who seek to fashion the future must retain them and increase their effectiveness.

In the 1970s, two significant statements of purpose with implications for health and health personnel were made in the international community. The first was the Declaration of the Group of 77 (developing nations) made some 10 years ago to the General Assembly of United Nations. The Group demanded a New International Economic Order (NIEO). This challenge was a response from developing countries and new sovereign states to the failure of the programs of the United Nations and the industrialized countries to expedite solutions to the socio-economic problems of the Third World, notably the persistence of acute poverty and the deprivations that go with it. It was a concept aimed at establishing a more equitable balance of the world's goods and services between the developed and developing countries.

The reactions of developed countries to the New International Economic Order has been less than enthusiastic, although it has been

completely endorsed by WHO. The *Biennial Report of the Director General on the Work of WHO 1976-77* (World Health Organization [WHO] 1978b) indicates support for the aspirations expressed in the NIEO concept and states that WHO programs from that date will be developed with a concern for the role of health in promoting social and economic development. The acceptance of health as an integral part of development is described in this report as "a major stride in the direction of international social justice" (WHO, 1978b). The *Report* stresses that the determinants of health do not lie solely, or even primarily, in the field of health.

The second statement of purpose reflecting a new direction in the international field was proclaimed through the Declaration of Alma Ata, in 1978, from the International Conference on Primary Health Care sponsored jointly by WHO and the United Nations International Children's Emergency Fund (UNICEF). The global objective in this development was stated as "the attainment by all of the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO, 1978b, pp. 5). "Primary health care is the key to attaining this goal" (WHO, 1978a, pp. 17).

International developments during the recent past which have significance for health and health care systems can be found in the movements of ideas and peoples across international frontiers. The ideas include new concepts and practices which depart from the traditional Western concept of health and medical models and reflect those of other regions and more ancient cultures. Of equal significance is the movement of people, immigrants and refugees, transforming the ethnic composition of populations, such as Canada's. The refugee movement, which has every appearance of becoming a permanent phenomenon, will have a continuing and profound effect on population profiles and on health services throughout the world as the movement continues to grow.

Let me turn my comments on international developments in the last half century into two specific proposals as areas for consideration by nurse educators intent upon fashioning the future. First is the need for courses that deal with international health and international nursing. Such courses have, I believe, to deal with the kinds of socio-political concepts identified in this paper. It is only on the basis of some knowledge of international development and of factors that have been furthering and retarding it that students will comprehend and promote the international goals and objectives specific to the health

field. In this I am referring to the broad range of health and health-related matters that are vital to human survival with particular reference to the WHO-initiated objective to achieve health for all by the year 2000.

My second proposal relates to the need for programs which prepare nurses to provide transcultural health care. As the population in our country becomes increasingly multicultural, the need for health personnel who understand different cultural values, beliefs, and practices becomes more imperative. Canadian nurses have written with great sensitivity on their recognition of this needed change in nursing education (Davies & Yoshida, 1981).

These proposals for changes in Canadian nursing education flow directly from developments in the international field in the recent past and illustrate the importance of recognizing their significance in future planning at the national level.

### *Nationally*

When we look at national developments of the last half century, we need first to recognize the primacy of political and economic factors as they influence the future. Let me first comment on the economic factors, in which I include where and by whom macro-economic decisions are made. Economic factors over most of the period have been favourable to Canada. By being strategically placed in the great trading area of the northern hemisphere, by becoming good at some economic activities and competent in others, and by finding markets for and selling off our natural resources, Canada has grown rapidly. All international comparisons testify that most Canadians have been able to enjoy a high standard of living.

For a while at least, during that period, good political decisions, from a social point of view, were made; they were good because of the emphasis placed on human service programs, programs which ensured that people would never suffer again as they had in the depression of the 1930s. This was the purpose of the great wartime social documents such as the Haegerty report, the Marsh report, and the Green Book Proposals for Health Insurance that formed the basis for post-war planning in health and social welfare (Taylor, 1978). These documents expressed the national will to build the kind of comprehensive nationwide social security system that the industrialized states of Western Europe had put in place long since.

tion to learn the intervention and to practise it repeatedly over the intervention and post-intervention periods.

A final example involves Drs. Jacqueline Chapman and Ellen Hodnett, whose research program focuses on normal and high-risk perinatal nursing care. Jacquie is facing the same situation as Ruth and those of us on the urinary incontinence study: she needs to train all the staff in the neonatal intensive-care unit in caring for extremely premature infants, using a new theoretical approach. This is very difficult in a stressful environment in which the nurses feel overloaded, where they frequently work "short," and where the vacancy rate is high. Dracup (1987) concluded, from her review of research on critical-care nursing, that the stress experienced by nurses, including those in neonatal units, was due to heavy workload as a result of inadequate staffing, rather than due to the nature of such patient-care demands as dying patients and worried families. Ellen could encounter problems trying to implement her proposed study, which involves trying to influence the behaviour of labour and delivery-room nurses to have them incorporate selected research findings into their practices, by using a significant peer who is respected by them. It is essentially a study of how to diffuse results from earlier studies of hers, but it, too, is dependent on a stable staff that can identify one of their peers as a model practitioner. Relief staff cannot do this, and if they do, they do not stay around to be influenced.

We could be in difficulty in trying to carry out all these studies.

I have been very worried about the crisis in nursing since it began to erupt into the media early last fall, but I have to admit that my major concerns were about its effect on our teaching programs and future recruitment of students. It was not until we were notified that we were funded and began to try to implement the urinary incontinence study that I recognized its impact on research. That, in turn, caused me to review the research programs to which we are committed on the faculty. I have been extremely proud of these programs because they are so clinically focused and because they are designed by nurse researchers with sound and current clinical skills. However, we have a real dilemma: just as we have the manpower and the funding to provide opportunities to undertake relevant clinical nursing research, we find the practice environments in crisis and unable to sustain research studies that involve the nurses. We are in a position to undertake descriptive studies of phenomena, but the studies that are being affected are those in which the descriptive phase has been done, the intervention has been identified and, for most, piloted, and now the test

lishment, over the next 10 years, of senior federal nursing positions to provide consultant services to the Department of National Health and Welfare and to the provinces in the developmental stages of the health care system. Significant to nursing was the appointment of a nurse to the Hall Commission in 1961, the Commission which produced the *Charter of Health for Canadians* (1964).

Throughout this period, the record shows that the CNA has represented nurses well. A comparison of Association briefs to the first Hall Commission in 1962 (Canadian Nurses Association [CNA], 1962) and the second one in 1980 (CNA, 1980) reflects increased sophistication and skill in articulating nursing views as well as a decided change in perspective. The earlier brief contained 24 recommendations, 21 of which related to nursing. Its one specific reference to the health care system was in these terms: "No recommendations are made to the overall organization of health services and financing [which] are subjects for government and legislation" (CNA, 1962, pp. ii). The 1980 brief, in contrast, includes eight recommendations focusing on the health care system in terms of legislation, federal-provincial relationships, health care research, and health education. This document was described by Justice Hall as one of the best briefs received by the Commission and worthy of the closest attention from all levels of government.

National nursing leadership in the period under review has progressed in various ways, moving from a reactive to a proactive role in seeking input to policy decisions on national health, and advancing from a limited nursing viewpoint to a health system perspective. It demonstrates increasing competence in functioning in the broader field of national affairs.

Between 1967 and 1977 Canada's health system, though incomplete and flawed in certain ways, functioned in essential harmony with the principles of the *Charter of Health for Canadians* formulated in the *Report of the Royal Commission on Health Services* (Hall, 1964). Under the conditional shared cost provisions of federal legislation, the provinces were required to adhere to the principles of accessibility, universality, comprehensiveness, portability, and public administration.

For a variety of reasons, including declining economic growth which prompted federal financial authorities to wish to move away from open-ended shared cost programs, together with the pressure of some provinces to be freed of federal constraints, a decision was made in 1977 to place the funding of health and post-secondary education on a block funding basis, a decision that was formalized that year in the federal *Established Programs Financing Act*. It was not long before a

number of provinces began to abandon their undertaking to adhere to the principles that had prevailed under earlier arrangements. By 1980 extra billing by physicians and the imposition of extra charges for various health services had sufficiently eroded the health system to prompt the appointment of a second Hall Commission. The report of its findings and recommendations affirming the earlier principles and condemning extra billing have not arrested the deterioration of the system (Hall, 1980).

By the beginning of the 1980s there was no doubt that the health care system in Canada was in the process of change, real and potential change, through pressure from forces within and without governments. The system was subject to the constraints of an economic recession, the impact of a technological revolution, and the demands of a health-oriented population. Further, it was undermined by medical and commercial interests and was vulnerable as a political issue in the federal-provincial struggle over the division of powers.

Other changes began to appear in the health care field. Opposition to the medicalization of society, exemplified by Ivan Illich's (1975) *Medical Nemesis*, appeared in the mid-1970s, followed by the emergence of new patterns of care initiated by the women's movement and consumer groups. The holistic health movement appeared, emphasizing an appreciation of the whole person and reaffirming the importance of the mind and spirit in health and healing. There was a rediscovery of the significance of the environment, and *A New Perspective on the Health of Canadians* (Lalonde, 1974) gave lifestyle a new importance. New categories of personnel appeared as part of traditional health teams and the concept of health itself came under review and redefinition.

### **The Current Status of Health Care in Canada**

As we moved into the 1980s the most significant change was the continuing deterioration, referred to earlier, in the national health insurance system. This began towards the end of the last decade, with an increasingly relaxed attitude in the provincial governments to the basic principles of accessibility and universality.

In response to calls for remedial action to arrest the erosion of the system and to recommendations of a Parliamentary Task Force on Federal Provincial Fiscal Arrangements (Government of Canada, 1981), the federal Minister of National Health and Welfare proceeded in May of 1982 to propose to the provinces a basis for federal-provincial collaboration to be incorporated in new legislation to be called the *Canada*

*Health Act*. The proposed Act would combine the *Hospital Insurance and Diagnostic Services Act* and the *National Medical Care Act* into one piece of legislation and, in the words of the Minister, would seek to ensure "100 percent universal entitlement to basic health insurance in Canada without financial or other barriers" (Bégin, 1982b, p. 13). However, this position is being strenuously attacked by medical associations, by the allied insurance industry, and by most provinces.

Let me identify some of the issues. Speaking before the Canadian and American Public Health associations' meeting in Montreal in November 1982, Monique Bégin, the Minister of National Health and Welfare, described the complexities involved in deciding on future courses of action for health within the federal-provincial structure. In response to her rhetorical question "Where, then, are we going?" she described the alternatives for a choice of direction, their potential impact on the health of Canadians, and the problems inherent in their implementation. The Minister pointed out that, in times of economic growth, the development of alternatives had been encouraged with funding from federal and provincial governments. This initiative had resulted in many imaginative programs which allowed a wider choice of health care for providers, consumers, and policy-makers (Bégin, 1982a). Nursing examples of these are well documented by the Canadian Nurses Association in its 1980 brief (CNA, 1980) "Putting 'health' into health care."

Madame Bégin identified a number of alternatives but focused particularly on the proposal "to use the nurse as the point of first contact and the doctor as the final point of referral" (Bégin, 1982a, pp. 3-4). Acknowledging the potential in this proposal for more efficient and effective resource allocation, she identified two conditions necessary to implement it: the support of both senior levels of government, and the support of other provider groups and consumers.

In expanding on these proposals, the Minister identified two major problems. First, increasing nurse utilization would affect the current growing supply of physicians in the country by virtue of reducing the role of physicians. The Minister stated that the opposition of the medical associations to such change has been expressed publicly in a variety of ways and that such opposition creates political difficulty in facilitating this change. Second, in the absence of a strong ground swell of public support for utilizing the nurse in an alternative role, she pointed out that it would be extremely difficult to carry it through. As indicated, the *Canada Health Act* proposal is strongly opposed by the Canadian Medical Association. The CMA favours its own privatization

scheme, which would move Canada away from universality and return Canadians to the two-tier system which we had up to the late 1960s. This would divide Canadians again into those who could pay for services and those who could not. Other opposition comes from the insurance companies and from provincial governments on the basis, in the first instance, of the profit motive, and in the second, that it represents a violation of provincial rights.

The nursing profession, through the CNA, has declared its position on the proposed Act in a brief to the Minister of National Health and Welfare (CNA, 1982). It expresses support for the proposals in the areas of universality, comprehensiveness, portability, and the maintenance of standards in the system. It affirms, however, its earlier position that the proposed legislation should provide nursing services in an extended role as an entry, and perhaps the most cost-effective entry, to the system (CNA, 1980). The Minister's comments of November 1982 (Bégin, 1982a) identifying problems associated with the CNA proposal bear careful examination. Madame Bégin indicated that to implement the proposal that the nurse be an entry to the health care system would require the support of four separate groups: the federal government, the provincial government, the other health care providers, and the consumers, or public.

The current status of support from the four groups can be summarized as follows: the federal Minister's expressed public interest in the proposal might be interpreted as a positive reaction from the senior level of government; the position of provincial governments remains unclear; among other health providers there is some support from organizations such as the Canadian Health Coalition while, according to the Minister, there is declared opposition from the medical profession; from the public, there is relative silence. That score shows tentative support from one group; no reading on the second; a divided position in the third, including opposition from the major medical providers; and limited response from the fourth.

What significance can be drawn from that reaction? My attempt to analyze it has raised questions which I believe must be answered by nurses themselves. The first relates to the public. How can the public's silence be interpreted? Is it lack of information or lack of interest? If it is the former, why does the public not know of the proposal? Who should have told them? Since it is a nursing proposal that would affect how the public enters the health system, is it the responsibility of members of the nursing profession to interpret it?

This line of reasoning leads to the question of how well informed and committed to the idea are nurses themselves. Is the profession united on this issue? To gain support for any major change requires interpretation by an informed and committed membership working individually and collectively at all levels. If lack of unity or commitment exists within nursing itself, then the priority becomes the development of strategies to correct that situation. Among the already committed, what new initiatives can be taken by nurse practitioners, nurse educators, and nurse administrators? Can they, and should they, promote and facilitate progress towards involving membership in supporting the proposal to make the nurse an entrance point into the system?

With regard to the attitude of provincial governments, what additional measures should be taken in the political arena to achieve support from this level of government, which is responsible for the health care system in its own province? Finally, the opposition from the medical profession, with which nurses have traditionally had the closest ties, gives cause for concern. The two professions, medicine and nursing, are already at odds on the basic issues of universality and accessibility in the health care system. Despite these divergent views are there new approaches that should be made to achieve understanding, if not agreement, on positions to ensure that future working relationships do not jeopardize the provision of health care to people?

Notwithstanding our desire to have the support of the medical profession in this struggle to see nursing more fully and appropriately utilized in the provision of health care, it is important to recognize where the real power on public issues resides. On at least two previous occasions involving major national issues, the *Health and Diagnostic Services Act* of 1958 and the *National Medical Care Act* of 1966, it was political will, the voice of the people, which determined the outcome in those struggles rather than the views of the medical profession or the commercial interests, both of which opposed the legislation. Using those precedents as a guide, the nursing profession must develop new strategies to gain public support for its proposals — strategies that should involve membership at every level.

### Conclusion

The purpose of this paper is to provide a broad framework for charting the future for nursing education in Canada. It will be apparent that I have dealt only with certain broad policy issues, internationally and nationally. There are other questions of immense importance: entry to

the practice of nursing; new and extended ways of maximizing the technological and information systems to provide continuing education and baccalaureate programs beyond the university setting; the impact of technological change on future students and faculty; and the moral and ethical aspects related to high technology. These examples could be described as among the professional, technological, and ethical imperatives of both today and tomorrow.

Without diminishing their importance let me end on the note with which I began. I would describe it as an expression of faith — faith that we can have a future and that we can play a part in fashioning it. But it is a contingent or conditional faith. It holds that humanity's future depends on the nature of our perspectives and understandings. It holds further that we, as educators in the health field, have special responsibilities and opportunities to undergird our teaching and research with a continuing appreciation and understanding of the kind of global and national issues this paper has touched on.

What I aspire for this conference are fruitful deliberations as we seek to fashion a future, a future in which such global objectives as health for all people by the year 2000 may, in fact, be attained; a future in which we, in Canada, have developed to the optimum the role that nursing can play in a health care system that truly honours the principles set out in the *Charter of Health for Canadians*.

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## SECTION IV

Developing  
Knowledge for  
Nursing Practice

*Développer le savoir  
destiné à la pratique  
infirmière*



# **A Concept of Research in the University**

**Canadian Association of  
University Schools of Nursing**

A profession seeks knowledge to rationalize its practice. The question at issue is how the profession rationalizes the search for knowledge.

Historically, in the rationalization of practice, nursing drew first on knowledge of the simple needs of persons for care in illness. Later, with the institutionalization of services, nursing responded to the dicta of the organization as the basis for practice. With the expansion of knowledge in the social sciences and the increasing demands for health care from the public, nursing began to draw upon the sciences to generate hypotheses for testing in the practice of nursing. Today we can detect a movement away from the application of knowledge from related fields to a search for knowledge arising out of the practice of nursing itself.

The process of building knowledge in a field has been well documented in the sciences; this is the path which nursing must now take. Our first task is to gather as much information as possible on the variety of human situations, and of the results which accrue. From examination and an analysis of these data a picture of nursing will emerge, the concepts of which will require exploration and refinement and eventually development through the study of their relationships into a network of ideas, the hypostasis of nursing. At this stage the process of testing and experimentation will lead to further clarification and eventually to bodies of knowledge, and possibly competing bodies, on which to build more effective and predictive practice.

Research into the knowledge of practice reflects a profession's ethical commitment and concern for the public welfare, in that the criteria for quality performance derive from the comparative benefits and positive consequences which accrue to the individual or community under varying conditions of professional practice.

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1. To permit the development of nursing practice and to clarify its contribution within the health services, two types of research are needed:

- (a) The former objective implies the need for research oriented to the generation of knowledge which is pertinent to, and directs, the practice of nursing. Because such research requires field study, it is likely to be both extended in time and expensive and owing to its complexity the results may be suggestive rather than conclusive. For this type of research to flourish, criteria for funding need to be developed to permit and encourage these special characteristics.
- (b) In addition, nursing needs to participate fully in collaboration with persons in other health sciences to describe, demonstrate, and evaluate a variety of models or structures designed to permit a more efficient and effective health care delivery system.

The initiation and development of both these types of research are dependent upon financial support during the initial phase when nursing is studied and examined to evolve a research design and when health service models are conceived and elaborated within a research framework.

2. Research in nursing will develop increased sophistication only if more nurses are prepared at the master's and doctoral levels. The attainment of this goal is dependent upon the development of a pool of potential candidates, in particular from basic baccalaureate programs.

This brief is respectfully submitted to the Commission on behalf of the 22 institutional members of the Canadian Association of University Schools of Nursing. It outlines briefly certain premises concerning university nursing education and research, identifies the current status with regard to the development of nursing research in universities, and sets forth specific recommendations.

### **Premises Regarding University Nursing Education and Research**

Nursing is an integral part of the health professions within the university and within the system of health care delivery. The profession of nursing has an obligation to contribute effectively to research legitimate to its own and related disciplines and to research designed to improve the delivery of health care.

A faculty of nursing can best achieve its three primary objectives of education, research, and service in close collaboration with other health professionals within a health sciences division of a university. Such collaboration is enhanced by selected shared educational, research, and service endeavours.

Nursing functions within a human framework, comprising a complex framework of diverse variables. It has a particular role in the provision of health care which is distinct from, but closely interlocked with, that of other health professions. It is not possible, therefore, for nursing to adopt unmodified theory from other disciplines, to strictly follow many methodological tenets of these disciplines, nor to rely solely on experiential data, all of which have been used at times to achieve quick and simple, yet often ineffective, answers to nursing problems. Nursing theory must both arise from nursing practice and direct its development. It must have a firm base in principles drawn from the physical, biological, social, and behavioural sciences. Theory building requires sound descriptive research to yield fruitful hypotheses for subsequent testing through experimental designs. Identification of variables must also result from astute observation and assessment of practice. Methodological studies for the development of valid and reliable instruments are basic. Research in the delivery of health service requires freedom in experimentation with creative developmental projects for which precision in evaluation, particularly of impact, has yet to evolve. Those engaged in university research, education, and practice must all contribute to the testing of existing principles and theory, the acquisition of knowledge, and the continuous enrichment of practice through application of this knowledge. This makes mandatory the development of highly trained nurse clinician researchers.

The processes of nursing, research, and education are closely linked. The ultimate focus to which student learning is directed comprises a variety of essential components. Foremost is the interaction between the nurse and the individual, family, or community. Consideration of alternate courses of appropriate action by nurse and client alike is the outcome of scientific assessment of the client's position on the continuum of health and illness in conjunction with the factors determining that position. These bases of choice determine the design for health promotion, as well as for preventive, curative, or rehabilitative care and assessment of its effectiveness. Of necessity, the teacher in nursing must possess the investigative and decision-making skills inherent in the process of nursing and must be competent to assist students in the development of such skills. It is reasonable to expect the undergraduate student in nursing to develop an attitude of inquiry and

to become an intelligent research consumer and collaborator. This requires nursing education which incorporates the scientific approach and a broad basis in the physical, biological, social, and behavioural sciences. In graduate education, the student requires greater preparation for and more extensive experience in research, further study in general education, and concentration in nursing theory and practice. From graduate programs must come our competent nurse researchers, university teachers, and key personnel in nursing service.

### **Development of Nursing Research in Universities**

Tribute must be paid to those Canadian university schools of nursing which have pioneered graduate education in nursing and fostered research through their programs. Many projects undertaken by graduate students have provided valuable beginning experience in research; some have made a recognized contribution to nursing practice, education, and administration. A few nurse researchers on some university faculties have been engaged in noteworthy projects, primarily in the field of education or the delivery of health services. There is a commendable increasing emphasis in undergraduate programs on formal preparation in the rudiments of research and statistics, the encouragement of a spirit of inquiry, the sharpening of assessment skills, and the provision of a broad rigorous program of study as a firm foundation for graduate education. A climate conducive to research, both in the university and in the clinical field, is crucial. It is encouraging to note that such a climate is developing in some centres.

Nevertheless, the current situation in Canadian university schools of nursing leaves much to be desired if any real progress is to be made in nursing research. There are approximately 25 nurses in Canada with earned doctorates, 500 with master's degrees. There is great variation in the adequacy of the research component of master's programs which faculty have experienced. There is the emerging occasional planned program of ongoing education in research for faculty. On some campuses short intensive courses in research, statistics, and computer science are offered which are useful to the few faculty finding time to take advantage of them. The ready accessibility and sharing of human and material resources for the encouragement and facilitation of nursing research varies with individual universities, as does dissemination of information on research funding and findings.

With few exceptions, those nurses on university faculties holding doctoral or master's degrees are almost exclusively engaged in administration and/or teaching. The nature of nursing education demands a

small faculty/student ratio, yet budgets in nursing faculties rarely make adequate provision for this, nor do they extend to meeting the heavy committee and administrative demands crucial to ongoing curriculum development and implementation. The faculty member who is a nascent or experienced researcher often faces a schedule which precludes development of research designs, let alone their implementation. In addition, unallocated funds for research in nursing have rarely been available. As a result, faculty have found it impossible to develop a well-defined extensive and long-term program of research, segments of which could offer excellent experience to graduate students. Graduate student projects tend, therefore, to be isolated beginning investigations in circumscribed areas, using small samples and leading to little extension or replication. The picture has been further confounded by the few channels available in Canada for publication of nursing research reports.

Faculties of nursing, either individually or collectively, can partially rectify some of the aforementioned difficulties. Greater interdisciplinary-colleague encouragement and co-operation is needed in other instances. For three key problems, new measures and extended support are required. These problems are: insufficient numbers of well-qualified nurse researchers to conduct research and supervise graduate students; insufficient time for them to exercise their expertise; insufficient funds and accessibility to supporting services and personnel to facilitate their undertakings. This situation prompts the following recommendations.

### **Recommendations**

1. That substantial support be given to promote improved initial and ongoing education of nurse researchers, field investigators, and research assistants.
2. That there be budgetary provision for faculties of nursing to contribute effectively to the accepted teaching, research, and service objectives of the health sciences divisions of the university.
3. That unallocated funds be made available to deans and directors of nursing in universities where there are competent nurse researchers, adequate supporting services, and an appropriate milieu for research, such funds to be used for proposal development, pilot testing, and maintenance of supporting staffs between grants.
4. That granting agencies apportion reasonable amounts of money for annual allocation to nursing research in recognition of its current stage of development.



# Another Twist on the Double Helix: Research and Practice

Dorothy M. Pringle

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way...

The first line of this very familiar paragraph by Dickens in *A Tale of Two Cities* has been repeating itself in my brain now for about six months. After considerable thought, I decided to make the analysis of why this passage seems so relevant, the focus of my presentation. During these six months I have experienced, on the one hand, tremendous optimism, excitement, and a sense of endless possibilities; on the other, a sense of despair, hopelessness, and helplessness about nursing. My excitement is generated by the current opportunities for nursing research that have never been available to us before. My despair is found in the practice environment and the profound unhappiness expressed by many of our current practitioners of nursing who work in hospitals in Toronto. This disequilibrium, I believe, has serious implications for the continued development of nursing research, because of the inextricable relationship between nursing research and nursing practice. Fawcett (1978) introduced the idea of the double helix in her paper on the relationship between research and theory. I think a similar double helix exists between research and practice and hence the tide of my presentation.

I plan to do the following:

1. Reiterate the fundamental relationship between research and practice for those individuals who have yet to be convinced.
2. Review the position of nursing research in this country and contrast it with the situation of the practice environment.
3. Explore the implications in this environment for the conduct of research through some examples.

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4. Discuss the implications for academics and researchers, relative to this double helix in today's environment.

### **Research and Practice**

Fawcett (1978) used the double helix analogy to demonstrate the interdependence of theory and research.

The relationship between theory and research may be thought of as a double helix. Theory is one helix, spiralling from the conception of an idea through modifications and extensions to eventual confirmation or refutation. Research is the second helix, spiralling from identification of research questions through data collection and analysis of findings and recommendations for further study. (p. 50)

She went on to say that when research and theory are isolated from each other they become excursions into trivia. Jacobs and Huether (1978), in turn, focused on the theory-practice linkage and noted that nursing theory that was divorced from nursing practice had no reality about which to theorize or upon which to impose order. "Theory constructed without a serious consideration of practice will bear a tenuous relationship to practice. Conversely, practice without theory will be carried out intuitively." Research can be defined as the systematic process of examining the environment to generate theories about how it operates. Therefore, I have difficulty with Fawcett's separation of research from theory; it seems more reasonable to define research as a theory-generating process; in nursing the focus of this theory generation is practice. I should like to redefine the double helix using Fawcett's sense of it as follows. Practice is one helix, spiralling from individuals' demands for care or need for health education, through nurses' responses to those demands or needs, to the nurses' evaluation of the effectiveness of the responses. Research is the second helix, spiralling from questions that arise about the nature of the demands or needs, through tests of a series of responses for effectiveness, to determination of the most effective response and generalizing it.

This double helix is our *raison d'être*. If our research is not grounded in practice, we are wasting our time and wasting the money of funding agencies. Even if we are doing fundamental research in Doris Bloch's (1981) sense of it (that is, research that is not owned by any one discipline because the basic knowledge is not available), we must be able to describe the link to practice or we are left with a sense of "so what." It may be reasonable for researchers from non-applied disciplines to do research for the sake of knowing, but I am not convinced that nursing can afford this. However, I do not deny for a

minute the difficulty nurse researchers have in maintaining their practice skills because of the pressures they experience from education and academic administration. Consequently, if they are not able to practise, they must develop close working relationships with practitioners to be able to identify practice questions. Working only from the literature and remembered past experiences is not good enough.

Back in 1980, Kathryn Barnard (1980) defined the challenges of the decade we are just completing. These included increasing the generation of new knowledge through research and translating these findings into practice. In order to meet these challenges, we have to ensure the relevance of the clinical research we are doing and solve the difficulties of diffusion of the results into practice. Foster (1984), in a review article on cardiovascular nursing research, questioned whether or not the existing research literature reflected the true priorities and complexities of care in the real world of clinical practice. In answering her own question, she cited the fact that the most frequently studied topic in the cardiovascular nursing research on myocardial infarction was the relationship between stress and myocardial infarction. She questioned whether most cardiovascular nurses would identify stress as the most important priority with which they dealt. I do not think that this comment invalidates the research on stress that has been done, and continues to be done, but it does force those of us who are researchers to reflect on the relevance of what we do for practising nurses, as opposed to our own research agenda. Dennis and Strickland (1987) pointed out that, although there has been a significant increase in research on client problems and concerns, practising nurses still complain that much of this research is not relevant to them. These authors' explanation for this is the following:

The development of clinical nursing research and the integration of findings into nursing practice often bypasses the clinical nurse, who may be more in touch with the problems that need investigation. Because nurses in academic settings are more interested in advancing knowledge for the sake of knowledge, they are more likely to address client problems that are of greater interest to academia than to the clinical nurse. Since practice in any field tends to lag behind knowledge, the findings from this clinical research may be applicable only after certain other practice changes are made. (p. 26)

I think both Foster and these latter authors are talking about timing; what is relevant for the researcher at a given point in time may not be so for the clinician. This, however, is a significant problem in maintaining the credibility of the researcher with the practitioner.

The second challenge, diffusion, is even more difficult to address. As Caplan (1980) states, "Simply because information is timely, relevant, objective, and given to the right people in usable form" is no guarantee that it will be used. If we reject the comments of critics of the relevance of our research, and assume that the results our research generates are timely, objective, and given to the right people, it is still difficult to know how well we are doing, because translation of research findings into practice rarely makes its way into the literature. An exception to this is Karin Kirchhoff's 1982 study of the diffusion of research relevant to coronary precautions into critical care nursing environments. Her results are not encouraging, but her study is almost a decade old now and perhaps things have improved. She found that despite good published evidence of the inappropriateness of continuing to restrict very hot or cold beverages, and avoiding rectal temperatures and vigorous backrubs, the majority of critical-care units, in a random sample of all such units in accredited hospitals in the USA, still adhered to these practices. To rely on passive diffusion of research results is simply not adequate, because it is too slow, too haphazard, and potentially too unreliable. However, promoting active diffusion is an underdeveloped science. An approach with some potential for improving diffusion is Havelock's linkage model (Crane, 1985), which links the user or practice system with the resource or knowledge-generating system. This model envisions the source of the research questions as being in the user system and the solutions in the resource system; the two systems are involved in a reciprocal relationship with mechanisms between them that foster information exchange. If there is validity in this conception of improving diffusion, it is imperative that practice environments and academic researchers be creative in developing these reciprocal relationships.

Let me try to summarize the points I have been trying to make so far. First, there is a fundamental relationship between nursing research and clinical nursing practice that bears some of the same characteristics as the double helix of research and theory. However, there are at least two forces that create tension within this helix. One of them is generated by practising nurses: they question the relevance for their clinical work of much of the nursing research that is conducted. The second is raised by the researchers: they are discouraged about the diffusion of the results of their research into the practices of nurses. These two tensions, if not attended to, have the potential to create two solitudes, and if that happens the fundamental reason for doing nursing research would be lost; if you will, the double helix would unravel.

## **The Position of Nursing Research**

I want now to examine the first clause in Dickens's passage: "It was the best of times." When I think of the environment in Canada for nursing research now, relative to 10 or even five years ago, it is hard not to conclude that it is the best of times. That is not to convey that it could not get a whole lot better, and should, but we have opportunities now that we have never had before.

One of the indicators of this is the number of Ph.D.-prepared researchers. The Canadian Nurses Association reported last year that, as of 1986, there were 196 nurses with a Ph.D. in this country. That is not a large number given the demand for nurses with this level of preparation but it represents a 58% increase over the 124 who had this degree in 1982, which in turn was a 53% increase over the 81 who had it just two years earlier. The fact that McGill University and the University of Alberta admit students to study for a Ph.D. in nursing, and the University of British Columbia is planning to start a program in 1991, which is our target as well, means that we are in a position to accelerate this growth substantially.

This increase in researchers has been complemented by an increase in the number of research scholar or career awards that nurses hold. In Ontario this year the Ministry of Health provided a lump sum of \$300,000 to each health sciences centre, to fund a career award for either a nurse or a researcher from one of the rehabilitation therapies. In addition, for the first time, the regular research personnel award program of the Ministry funded a nurse in three of the schools. Last year the Medical Research Council (MRC) and the National Health Research and Development Program (NHRDP) jointly mounted a competition for research scholar awards. A total of 19 nursing programs submitted letters of intent, and six programs were invited to submit fully developed proposals. We do not yet have the final results from this competition but if we are even modestly successful in it, and we add in Dr. Joan Anderson who is funded from the NHRDP regular competition and the Ontario Ministry of Health initiatives, we have the potential to see the funding of upward of 15 nursing researchers whose time can be protected so that they can devote the majority of it to research. I believe that four research scholars was the highest number funded at any one time before now, so we may have more than triple that number this year, largely through these special initiatives. One of the most exciting aspects of these research scholarships is the fact that they will have all been awarded within the last year; we can look forward, just from this cadre, to from 50 to 65 years of protected research time in the cases of

these research scholars. Furthermore, the number of scholars will increase each year because this is an ongoing competition. Within five years it is reasonable to expect that another 20–30 scholars will be funded.

I see these special initiatives as having two positive effects. First, they require us to become programmatic in our research efforts. Not only is the individual researcher required to develop a program of research, but, perhaps more importantly, each school of nursing is forced to declare what its research focus is. This helps us to accomplish what Barnard challenged us to in the 1980s, focus our research. We will see the end of researchers spread out in a number of places each doing a little research on a topic; rather, we will find concentrations of research in specific areas in particular locations. Secondly, these initiatives signal a recognition, by government funding agencies, of the emergence of nursing research as a valid area of endeavour that needs to be supported. I hope and expect that additional opportunities will develop in the future: such things as summer stipends for undergraduate students interested in working with a researcher, and seed money for research. These types of programs, while they may seem like manna from heaven, would simply put us in the same category as the other health sciences in this country. I am so looking forward to the time when we will not require special initiatives; we will be mainline researchers with access to exactly the same resources as all the other mainline health science faculties.

There are other indications of the emergence of nursing research as a viable and valid endeavour. Through the efforts of Dr. Mary Ellen Jeans of McGill, the *Canadian Journal of Nursing Research* is, for the first time in its 20-year history, on a solid financial footing as a result of new and ongoing funding from the MRC. Nurses are embedded in the review committees of all the significant funding agencies in the country. This is not a new phenomenon, except in the case of MRC. In fact, I hesitated to comment on it because it seems so commonplace, yet it is in its very commonplaceness, if you will, that the realization of nursing's coming of age in the research world is found.

### **The Position of Nursing Practice**

"It was the worst of times" and "it was the winter of despair" are phrases that seem to capture the last nine months of institutional nursing in Toronto and, to a lesser extent, Ontario. If your only window on the situation was the media, you could conclude that a total of three

nurses were left to staff the Toronto General Hospital, and that each of them was dissatisfied, angry, and ready to leave the profession. I realize that across the country we are seeing a high level of union activity and that strikes are threatened in at least two provinces. It is not that activity I am referring to. It is the profound sense of unhappiness and despair that nurses are expressing about the conditions under which they are trying to nurse and the shortage of nurses we are experiencing in teaching hospitals in Toronto.

This latter situation has spawned four reports over the past winter, sponsored by the Minister of Health, the nursing union, the Registered Nurses Association of Ontario (RNAO), and the Association of Teaching Hospitals of Metro Toronto. The conclusions are similar. Nursing service is in a crisis. There is a significant degree of dissatisfaction with nursing among staff nurses; the majority state that, given the choice, they would not choose nursing again as a career and they would not recommend to others that they go into nursing. Salaries are too low and the salary range does not adequately recognize experience; lack of control over work schedules is intolerable; nursing administration is viewed as unsupportive; and nurses feel insignificant in the decision-making processes in the hospitals whether they relate to patient care or institutional governance.

Additional factors in the equation are the aging of the nursing workforce and a recognition by older nurses (i.e., those over 40) that the physical demands of nursing care, coupled with the physical demands of rotating across three shifts, are too strenuous for them to survive as full-time nurses; 45% of nurses in Ontario now work part-time. In response to this, Toronto has witnessed a blossoming of agencies that employ nurses part-time, pay them somewhat over the union scale, and charge the hospitals in the order of 50% over union scale. Many of the negative forces that are operating in these hospitals are encouraging nurses to give up full-time employment and to work for these agencies, where they can specify the number of shifts and the hours they will work each week. The higher pay scales mean that a nurse working four shifts a week of her choice for an agency can make close to the same wage as a nurse working full-time, with no control over her working hours, in a hospital. Meltz (1988), who carried out the RNAO study, also documented a tremendous increase in demand for registered nurses over the past 10 years, as a result of new hospital construction, increased acuity of patients in acute-care hospitals leading to a move to all RN staffing, and an expansion of home-care services. This increase in demand has not been accompanied by an increase in supply. Meltz

reported that in 1975 in Ontario 6,200 nurses graduated but enrolment in community college programs was cut almost in half that year in an over-response to what was perceived as a nursing surplus. By 1978 only 3,100 nurses graduated and 10 years later, in 1988, this number had only crept up to 3,900. The same scenario is found in Canada-wide figures, and the situation is projected to get worse through 1995. The annual graduating class is absorbed and most nurses are employed. We no longer have a pool of unemployed nurses staying home, raising their children, or otherwise creating meaning in their lives (Prescott, 1987). This inadequate supply, combined with the move to part-time employment by significant numbers of nurses, has led to real shortages in specific areas of nursing — particularly critical care, psychiatry, and long-term care — and to shortages in select geographic areas including teaching hospitals in downtown Toronto. This overall shortage, which in Toronto is in the order of 8%, means that many hospitals have 60–100 beds closed and nurses are shifted to units where they have no particular expertise or attachment. Consequently, bed closures may relieve the stress of overwork but add stress by dislocating colleagues from support and familiarity with the clinical area.

As well, the effect of this shortage means that on some units, on any given shift, half of the staff are relief. In some long-term-care settings the only regular nurse on a shift is the charge nurse and all the others are relief. Full-time nurses are regularly working overtime; that is, double shifts, or eight or nine eight-hour shifts or five or six 12-hour shifts in a row. A group of the teaching hospitals in Toronto developed a cartel of sorts; they embargoed the use of relief staff from agencies unless they were willing to accept hospital salary scale. This has been effective in the long term but in the meantime it put tremendous pressure on the existing staff. Overtime and working “short” became daily occurrences. Our fourth-year students got caught in it: they were viewed as another pair of hands who could help fill the void and hence they were asked to take on more than was educationally sound or reasonable, given their experience. Little guidance was available to them from staff, who were too busy surviving demands placed on them and too angry to assist students. This was a perfect opportunity to document the effect on patient care; of course we did not do this, because we did not recognize the research potential. Nevertheless, as Prescott (1987) states, it is not difficult to envision that patient care suffers because patients are not as closely monitored, that nursing-care planning rarely occurs, and that continuity of care goes out the window. All of these circumstances led to a deteriorating practice situation that is unstable and ready to erupt at any time.

### **Implications for Research**

What has all this to do with research? The answer is of course "everything." If we are to be relevant and if we have any hope of diffusing results of research into the clinical field, it is imperative that we have a stable practice environment with which to relate and with which to develop reciprocal relationships. In practice environments where the staff are unhappy and dissatisfied, they are unlikely to want to indulge in identifying practice problems that require investigation. These same staff are unlikely to want to put the effort into learning and adopting new practices developed through research. Furthermore, under such circumstances, staff nurses have neither the time nor the energy to participate in clinical research activities. I have given many talks on how to involve staff nurses in clinical nursing research and I have read many articles on the same topic (Fawcett, 1980). We all say the same things: provide release time for nurses to participate in studies, put nurses on research review committees, start journal clubs, fund nurses to attend conferences. These suggestions are ridiculous when nurses are working double shifts and there is no one to replace them on the units to allow them to attend committee meetings or go to conferences. I heard a number of senior nurse administrators discussing the revisions to the *Public Hospitals Act* that have just been passed in Ontario. This provides for staff nurses to sit on the senior hospital policy committees, including the Medical Advisory Committee. Their comments were to the effect that, while they agreed with the intent of the legislation, they wondered who would replace these nurses on the units while they were attending all these meetings — not that they were not willing to replace them; there were simply no nurses with whom to replace them.

Let me give you some examples of the way this current practice environment has an impact on research we are trying to conduct. I am co-investigator on a study with Anita Saltmarche, who is a clinical nurse specialist at Sunnybrook Hospital and cross-appointed to our faculty. The study concerns habit retraining to control urinary incontinence in older, institutionalized populations. The study is being conducted at Sunnybrook in their long-term-care unit, K-wing, which has nine units. We began designing this study over three years ago and, after a couple of rejections from the Ontario Ministry of Health and finally a "B" rating from NHRDP, we satisfactorily answered the questions and were funded, beginning in May. The study design called for selecting three units with high prevalence rates of incontinence, entering patients and randomly allocating them to either the control or experimental group, and then collecting data on the control group prior

to moving to the experimental intervention. This design was selected because the experimental manoeuvre called for training all the nursing staff on the three units in habit retraining, because the intervention, although not complex, had to be introduced 24 hours a day. A somewhat similar study conducted in Pennsylvania had used research nurses to deliver all the nursing care to patients, but the costs were exorbitant and questions of external validity were raised. By collecting control-group data first, we could control for potential contamination across the two groups. The budget included the costs of having a one-day workshop for all the nursing staff, by providing replacement costs for them. This approach seemed sound when we began submitting the proposal and, although we redesigned many aspects of it and rebudgeted with every resubmission, we never went back to this basic plan to train all the nursing staff. Now that we have the money and we are examining the units to identify which ones to include in terms of prevalence of incontinence, we have encountered an unanticipated problem. K-wing is experiencing a 30% vacancy rate, which means that a third to a half of all nurses on a given unit are relief. This puts us in a dilemma: how do we train all the staff to implement the manoeuvre with such a high relief to full-time staff ratio? We are entering patients without having solved this problem, and we are hoping that the nine months that we have until we introduce the experimental group will produce a more stable situation. Otherwise, we will have to manipulate the patient assignment across all shifts, for all patients, for the six-week intervention period and, one week later, follow-up. This is a significant design shift and one that may turn out not to be feasible.

Another example. Dr. Ruth Gallup, who is an Ontario Ministry of Health Career Scientist on our faculty, has developed a program of research on working with difficult psychiatric patients. I will remind you that psychiatry, like long-term care, is one of the areas with a very high vacancy rate. Ruth is in the process of designing an intervention to deal with patient behaviours that nurses perceive as difficult. Her plan is to have clinical nurse specialists teach key members of the nursing staff how to interpret and intervene when these behaviours are encountered; these key staff members would, in turn, provide peer supervision for the staff nurses. This model, which has a six-month baseline data-collection phase, a six-month intervention phase, and a further six-month post-intervention phase, is dependent on a stable staffing complement for testing. Not only must the key staff members be experienced and be viewed as credible by their peers, but the staff nurses themselves must be a stable force and have sufficient time and motiva-

tion to learn the intervention and to practise it repeatedly over the intervention and post-intervention periods.

A final example involves Drs. Jacqueline Chapman and Ellen Hodnett, whose research program focuses on normal and high-risk perinatal nursing care. Jacquie is facing the same situation as Ruth and those of us on the urinary incontinence study: she needs to train all the staff in the neonatal intensive-care unit in caring for extremely premature infants, using a new theoretical approach. This is very difficult in a stressful environment in which the nurses feel overloaded, where they frequently work "short," and where the vacancy rate is high. Dracup (1987) concluded, from her review of research on critical-care nursing, that the stress experienced by nurses, including those in neonatal units, was due to heavy workload as a result of inadequate staffing, rather than due to the nature of such patient-care demands as dying patients and worried families. Ellen could encounter problems trying to implement her proposed study, which involves trying to influence the behaviour of labour and delivery-room nurses to have them incorporate selected research findings into their practices, by using a significant peer who is respected by them. It is essentially a study of how to diffuse results from earlier studies of hers, but it, too, is dependent on a stable staff that can identify one of their peers as a model practitioner. Relief staff cannot do this, and if they do, they do not stay around to be influenced.

We could be in difficulty in trying to carry out all these studies.

I have been very worried about the crisis in nursing since it began to erupt into the media early last fall, but I have to admit that my major concerns were about its effect on our teaching programs and future recruitment of students. It was not until we were notified that we were funded and began to try to implement the urinary incontinence study that I recognized its impact on research. That, in turn, caused me to review the research programs to which we are committed on the faculty. I have been extremely proud of these programs because they are so clinically focused and because they are designed by nurse researchers with sound and current clinical skills. However, we have a real dilemma: just as we have the manpower and the funding to provide opportunities to undertake relevant clinical nursing research, we find the practice environments in crisis and unable to sustain research studies that involve the nurses. We are in a position to undertake descriptive studies of phenomena, but the studies that are being affected are those in which the descriptive phase has been done, the intervention has been identified and, for most, piloted, and now the test

is, in the real world, to determine whether it makes a difference to patient outcomes or the nurses' senses of competence and satisfaction.

### **Implications for Academics and Researchers**

This brings me to the most difficult part, what do we do? My most profound and yet, somehow, rather vague conclusion is that, as academics and researchers, we cannot ignore the crisis in the practice environment. Not only has it serious implications for the future of our discipline, but it has immediate implications for the development of nursing science. The crisis is more immediate in Toronto and Montreal than in most other locations, in terms of sheer shortages, but I think we can anticipate similar shortages in most health science locations in the future, as enrolments in schools of nursing decrease. Prescott's (1987) analysis of the current shortage in the USA is that it is much like the previous one in 1980 in that it is a perceived shortage, limited to selected hospitals and resulting from market restraints and geographic maldistribution of nurses. However, there is one critical difference between 1980 and now: the declining nursing school enrolments that will contribute to significant shortages in the future, as the demand for nurses increases. We are all too familiar with the Canadian propensity to mimic American trends 10 years later, so I am afraid that we can anticipate a similar supply and demand disequilibrium in this country. However, shortage is only one component of the problem; the other is dissatisfaction. I find it painful to hear and see nurses on television describe how they wish they had never entered nursing and are looking for ways out. The fact that, as a discipline, we have a high retention rate (Meltz, 1988) does not comfort me if the practising workforce hates what they are doing. I realize that, in fact, it is rarely nursing that nurses complain about, but rather it is the conditions under which they are forced to practise nursing that frustrates and defeats them. I hear that, but I am not sure our students hear that, or the public hears that, or their patients hear that.

Let me suggest some areas of activity that I think are necessary. As academics, we must show solidarity with practising nurses. The work-life of staff nurses is a critical force in our lives as well as theirs. This means becoming politically active and publicly supporting union demands for increased wages and improved shift allocations. We have to point out that improving the research environment without improving the practice environment is unacceptable. There are creative solutions to some of the worst aspects of nursing shifts. Our administrators have been anything but creative in acknowledging and implementing

them. We have to take some responsibility for that, because we have done such a lousy job of educating nursing administrators and influencing the education that hospital administrators receive. I think it is critical for staff nurses to feel supported by nurse researchers. There is no reason for them to support us in our demands on them if we do not support them in their demands on the system. It is not as though we have to compromise our principles to support the demands that are being articulated. Their demands are reasonable and legitimate. I must congratulate the British Columbia nurses' union for their strategy in refusing to do non-nursing tasks on their weekend job action. That is not a strike: it is a clear indication of the inappropriate use of a scarce nursing resource. I also congratulate the Quebec nurses for refusing to do overtime.

We should also increase our research activity on the worklife of nurses. Felton (1987) reviewed the literature on the effect of nurses' shift work on physiologic functions. The evidence is clear that shift work results in alteration in body temperature, quantity and quality of sleep, catecholamine excretion, and urinary excretion of a number of cations. Studies have linked these physiologic changes to altered job performance. I was struck by the fact that all studies, with one exception, were 10–17 years old. Furthermore, this is an example of research that has not diffused into practice. We are highly protective of airline pilots and other flight crew, in terms of limiting the total number of hours they may work at one stretch and within the course of a month, but we do none of those things with nurses. Would you rather have an over-tired stewardess or nurse? I believe this is just an example of the lack of regard for the work that nurses do and which is our responsibility to correct. As researchers, we have the tools to get the data to demonstrate our value.

It is important that we develop strong programs of research in nurse deployment. Our lack of educational programs in nursing administration is mirrored in our underdeveloped research in this area. We have too few researchers in this area and too few programs of research that are focused on staffing arrangements that reduce stress and increase productivity, self-scheduling and alternative shift arrangements, case management and other care-planning approaches, and workload measurement to determine staffing ratios. We have made significant strides in clinical practice research but it is important that nursing administrative research catch up or our gains will be short lived. Lynaugh and Fagin (1988) speak to this in the following passage:

It doesn't take a horticulturist to know that a beautiful tree has a very limited life span when the roots are unattended. It is crucial to include all nurses in our pursuit of autonomy, authority and development. Our leading thinkers must collaborate in solving the problems of the two thirds of nurses who work in hospitals. We need new organizations of work to enhance the position of all nurses and patients in the special modern institutions created for care of one group through reliance on the other.

It is unrealistic to expect nurses who do not feel valued, who are overworked and underpaid, who feel their opinions do not count because they are rarely solicited, and who are increasingly recognizing that, to stay competitive, they must get further education (which will not increase their salary, will not improve their working conditions, and will not lead to more influence in their workplaces) to work closely with researchers to identify significant clinical practice problems, to participate in the testing of interventions, and to pay attention to results of studies so they can learn new strategies that they can apply in patient care. We have a symbiotic relationship with practising nurses. Improving their circumstances will improve ours. Not improving their circumstances will defeat both of us. We're getting healthier, they're not. The double helix, the basic life process of nursing, requires a healthy research helix and a healthy practice helix.

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# Coping with What, When, Where, How — and So What?

Judith A. Ritchie

Concepts such as coping and adaptation are key elements in our nursing work — particularly since our goal is to work with people to improve their health. We face constantly the challenge of understanding people's behaviour and finding ways to help them as they live with illness situations and/or seek to improve their health. Richard Lazarus (1993) introduced a fundamental change in how we define coping and in how we should pursue coping research. He conceives coping behaviour as a process that changes over the course of a situation. Coping behaviour is dependent on the meaning of the event, the context, and the goals of the person in the situation. I believe that nurses find a "good fit" in the Lazarus emphasis on the *process* of coping. Our values and experience are consistent with his lack of *a priori* judgement about what is "appropriate" or "effective" coping. The fundamental questions in research about stress, coping, and adaptation are "coping with what?", "when?", "in what context?", "how?", and "with what outcome?". Nurse researchers must also ask questions about which nursing approaches are effective in helping people to cope in ways that enable them to achieve health.

Nurses have had a significant focus on coping and adaptation research for nearly two decades. The concepts of stressful situations, coping behaviours, influencing factors, coping outcomes, and the relationships among them are complex. Their investigation demands conceptual clarity and sophisticated research methods. Jalowiec (1993) and Rice (1993) conducted extensive reviews of nurses' research on stress and coping. They reached the following conclusions: most research has been descriptive and correlational in design; research questions commonly lack specificity in relation to the stressful event; studies often do not make links between the coping behaviours examined and the outcomes of those behaviours. They reported that most studies were based on Lazarus and Folkman's (1984) theoretical perspective of stress and coping, but very few were designed in ways consistent with that frame-

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work — for example, very few studies have longitudinal designs. Lazarus (1993) raises similar concerns about psychologists' and others' research. Browne, Byrne, Roberts, and Sword (1994) discuss many of these problems and pose some tantalizing suggestions for their solutions.

The question "coping with what?" is the particular focus of Hilton's (1994) Uncertainty Stress Scale. Other authors have focused on the context of coping, placing most emphasis on personal psychological variables that influence either the individual's appraisal of the stressful event, the coping strategies, or the outcomes of interest. These psychological variables include hopefulness, perceptions of self-efficacy or perfectionism, and coping resources of mastery and health and esteem and communication. Hirth and Stewart (1994) and Snowden, Cameron, and Dunham (1994) also examined the influence of external or situational resources such as social support. The findings of all these studies illustrate the impact of a multitude of factors on all phases of the stress and coping process. For example, it is clear that we must carefully examine the meaning or appraisal of the situation and the factors influencing that appraisal. Hilton reports differences in uncertainty scores depending on the nature of the situation and the individual's stage in the illness trajectory. Snowden et al. report that the actual demands of the child's illness or behaviour did not influence outcomes in any significant way. While all these authors raise important questions about appropriate interventions to assist people who are coping with stressful situations, there are very few studies that have assessed the effectiveness of nursing approaches to helping.

Many challenges in stress and coping research remain. Despite the many studies reported, we continue to know relatively little. How do appraisals of health or illness situations change over time and across situations? What is the influence of personal or situational factors on coping behaviour or outcomes? How does coping behaviour change throughout a stressful situation, across situations, with development? What types of nursing approaches are effective in helping people in stressful situations? And, most importantly, do any of these issues make a difference in the individual's, family's, or group's "adaptation"?

Indeed, we have not really clarified what it is we mean by "adaptation." Duffy (1987) challenges our concept of adaptation as a "benchmark of health." She raises important, and unsettling, questions that are similar to those Browne et al. (1994) raise. Duffy states, "Adaptation is a patriarchal mechanism for controlling society, because the group in control defines the norms. Adaptation is what the controlling group

says it is" (p. 186). I am reminded of an early mentor's view of children's and their families' behaviour in the difficult illness situations they faced. In response to health professionals' complaints or worries about "abnormal" behaviour, he always replied: "This is normal behaviour in an abnormal situation. Now, what can we do to help with the situation?" Duffy proposes that we extend our visions, go beyond setting a goal of adaptation as homeostasis, and adopt a transcendence model. The goal in such a model "is to transform the prevailing norms so that transformations are not limited by implicit rules, socio-cultural values, or laws of the community" (pp. 188–189). What is the "outcome" of interest in coping research? For O'Brien and Page (1994) and Snowdon et al. (1994), the outcome is "satisfaction"; for Hirth and Stewart (1994), it is the individual's assessment of "coping effectiveness." Are these the most important outcomes that nurses should measure? Would the relevant outcomes be different for different disciplines? How shall we decide what outcomes are relevant? Folkman (1991) proposes a solution that includes assessing both relevant outcomes and the "goodness of fit" between "(a) the person's appraisal of what is going on (primary appraisal) and what is actually going on, (b) the person's appraisal of coping options (secondary appraisal) and what the options actually are, and (c) the fit between the options for coping and actual coping processes" (p. 15). That solution adds another dimension to the complexity of research design in the area of coping and adaptation.

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## **Between Women: Nurses and Family Caregivers**

**Patricia McKeever**

Throughout Canada in recent years, contractionist policies have predominated in a labour market recession with high levels of unemployment. Government-funded health care has become overwhelmingly expensive, hence related policies and programs have undergone rapid and profound transformations (Dominelli, 1991). Correspondingly, there have been major reallocations in health-care work in both the public and private domains (Dowler, Jordan-Simpson, & Adams, 1992; Drover & Kerans, 1993). These changes have been especially dramatic in the burgeoning area of long-term care. "The family" is now held responsible for providing care to even the most severely disabled people, and the household has become the primary site for care delivery (Steel & Gezairy, 1994).

Although health-care activities have always been within the realm of domestic responsibilities, the scope and extent of these activities have changed remarkably in the last two decades. These changes have been associated with widespread sentiment against institutional care, the closure of long-term-care facilities (Switzky, Dudinski, Van Acker, & Gambro, 1988), and the increasingly large proportion of very old people in the population (Steel & Gezairy, 1994). In addition, advances in medicine, pharmacology, and biotechnology have led to decreased mortality rates and increased rates of severe chronic illness and disability among people of all ages (DeJong & Lifchez, 1983). Consequently, more people now require care at home that is complex, labour-intensive, and very expensive (Plough, 1981).

My aim in this paper is not to discredit the indisputably humane goals of the home-care movement, but rather to identify some negative consequences that deserve serious consideration. First and foremost, I believe that women currently are bearing a disproportionate share of the costs that are associated with chronic illness and disability. Because the traditional division of domestic labour undergirds government policies as essentially as do class relations, redistributive health-care prac-

tices have perpetuated gender inequalities (Fraser, 1987; Mayall, 1993; Wilson, 1982). Secondly, nurses and family caregivers are in ambiguous social positions and they have been pitted against one another in some untenable ways. Finally, nurses are losing wages and jobs, and family caregivers are forfeiting wages. Hence, both are losing employment benefits and pension entitlements and will have diminished lifetime earnings.

The current form of long-term care represents a "mixed economy" (Beecham, Knapp, & Fenyo, 1994). Families bear the major associated costs, unpaid women do most caregiving work, and nurses and cheaper health workers provide some relief and support. A chain of relationships links government and corporate interests to paid health-care workers, unpaid family caregivers, and people who have long-term care needs. At the bottom are family caregivers whose work has been appropriated from the domestic sphere and substituted for formerly paid nursing work. This transfer of work from paid to unpaid is a very unusual reversal of a long-term trend in capitalism (Glazer, 1988). It has been supported by the ideology of the market that proclaims competition and efficiency to be the major criteria by which to justify government expenditure and the ideologies of individualism, neoconservatism, and personal responsibility which justify the retrenchment of public services (Anderson, 1990; Simms, 1989; Sorochan & Beattie, 1994). In addition, because caregiving work is viewed as a low-status activity (Rosenberg, 1987), the fact that many nursing skills can be performed competently by lay women in household settings may have diminished further the societal value of nursing work.

Estes and Alford (1990) argue that home care can be seen as part of a larger process in which economic, sociocultural, and political problems are displaced into nonprofit services and the family in order to avert major fiscal crises. Without question, the deconstruction of the boundary between care given by nurses and that given by family caregivers in the home has led to fewer nursing positions and considerable public savings (Premier's Council on Health, Well-being and Social Justice, 1994). The fact that there also have been associated costs and some negative consequences now needs to be addressed.

### **Relationship Between Nurses and Family Caregivers**

Points of tension and conflict are inevitable between nurses and family caregivers, because contemporary home care occurs amidst ambiguity, very limited resources, and competing agendas. Both groups of women have few sources or past experiences to draw on as they try to meet

ambiguous and conflicting expectations. The household as the site of caregiving is problematic and awkward because it is the setting that traditionally has been considered a refuge from work and public interference (Graham, 1985; Rosenberg, 1987). In contrast to the institutional care milieu, family care is embedded in intimate, affective relationships that have histories and futures. Hence, home care is delivered in a complex interactional context which is characterized by tension as well as solicitude and warmth (Atkin, 1992).

Nurses are urged to form "partnerships" with family caregivers, to teach and supervise them and to provide "family-centred care." Hence, they are required to view family caregivers simultaneously as colleagues, subordinates, and people who themselves are in need of nursing care. Although the relationship between nurses and family caregivers has not been studied to date, it would appear that conflict and confusion are inevitable because these conceptualizations lead to mutually exclusive approaches. For example, there are usually clear disparities between the needs of family caregivers and those of care recipients that put at odds nurses' efforts to simultaneously maintain optimal patient care and ensure caregiver well-being (Twigg, 1992a).

Nurses and family caregivers must encroach on each other because their roles and relative status overlap and shift. For example, nurses give care based on their professional expertise whereas family caregivers rely on a skill repertoire that is specifically related to particular relatives' needs. Over time, most family caregivers develop a care regimen and a knowledge base so attuned to the care recipient's needs that their skill rarely can be matched by nurses (McKeever, 1992). On the other hand, nurses have more formal education, are invested with more authority, and enjoy a higher social status than most family caregivers, because only 35% of Canadian women have attained post-secondary school education (Statistics Canada, 1990). In summary, unusually complex negotiations related to authority, accountability, values, and the use of household space must prevail between these two groups of women.

### **Economic Consequences of Home Care**

Many of the economic consequences of home care are related to the fact that nurses and family caregivers are in competition for scarce public resources. Nurses are vying for jobs and wages and family caregivers desperately need more support services. In addition, most of the ongoing costs associated with home care are borne by families with a single wage-earner. Consequently, most nurses and family caregivers

work with few resources in contexts of financial distress (Glazer, 1988; McKeever, 1992; Scott, 1984). Although the occupational health conditions of home care have not been documented, it seems fair to suggest that they are far from satisfactory.

Finally, most family caregivers make significant economic sacrifices by quitting their jobs, working part-time, or not seeking employment at all. The majority do not have retirement or pension benefits and few participate in dental or prescription medication insurance plans (McKeever, 1992; Stone, 1994). Similarly, as more and more nursing work is performed by family caregivers and health aides, many nursing jobs have been lost or reduced to part-time positions. Currently there are many unemployed or underemployed nurses in Canada whose expected career paths, lifetime earning profiles, benefits, and pension savings have been seriously affected (Premier's Council, 1994). Hence, it is beyond dispute that, when long-term care is delivered in the home, women suffer serious immediate and long-term financial consequences.

### **Suggestions and Conclusions**

The combined effects of the economic recession, technological innovations, and unbalanced economic growth will increase the need for home care for the foreseeable future. The structural position of nurses and family caregivers remains subordinate to that of those who control household resources and determine policies and practices (Mayall, 1993). The challenge, therefore, is to alter the current arrangement so that responsibility and costs are distributed more equitably. I believe that nurses and family caregivers could contribute to meeting this challenge by working together to reconceptualize and repoliticize long-term care.

This task will not be easy, because the medical model still dominates the health-care system and absorbs most available resources. However, the enormous social value of female domestic work is finally being acknowledged (Theilheimer, 1994) and the concept of a clear division between the private and public domains is being discredited. Stacey and Davies (in Mayall, 1993) argue that paid health work such as home-care nursing actually occurs in an "intermediate domain." Situated between the private and the public domains, it complements, parallels, competes with, or replaces unpaid work in the private domain.

The concept of the intermediate domain can be used to facilitate recognition of the fact that the family and the state are indivisibly inter-

connected and that activities in one have significant implications for those taking place in the other. It also provides a framework that could be used to first understand and then ameliorate the tensions and adversarial relationships that develop between nurses and family caregivers. If nurses and family caregivers differentiated and clarified their respective roles, their mutual plight would become obvious. Together, they could lobby for their collective well-being. They could highlight the fact that they are performing an essential social service by supporting extraordinarily dependent people in the community. However, they are doing so with inadequate societal support and at great cost.

Davies (1983, pp. 39–41) argues that power, in its widest sense, is the ability to alter or influence the course of events and to create possibilities where none existed before. As social individuals, caregiving women hold simultaneous memberships in various *systems* of power within the private, intermediate, and public domains. If they used these positions as a source of control, it is possible that gender could be upturned to provide a powerful avenue for bargaining and exchange. Although it is not considered “feminine” for women to act together in public political protest, and women usually underestimate the value of the work that they do (Bielby & Bielby, 1988), there are few other options. Without positive public sentiment and acknowledgement, nurses and family caregivers will not fare well in the current policy environment.

Canadians espouse egalitarian values; therefore, both groups of caregiving women should expose inequitable practices and structures which support gender disparities. The nonprofit service sector could be shown to legitimate the economically driven system by removing and treating “social problems” through policies that are consistent with the ideology of individualism (Estes & Alford, 1990). If women are to bear the major responsibility for home care of the chronically ill, they must be able to discharge this responsibility in a context of societal support in which they have political power (Ruddick, 1989, p. 46).

Finally, most home-care research essentially continues to be driven by the *anti-institution* themes generated during the 1960s. The relationship between research findings and the rationalization of care suggests that investigators also have contributed to retrenchment practices (Simms, 1989). By reconceptualizing home care and recognizing the price it is exacting in its present form, nurse researchers would no longer contribute to this process. As I write, governments are seeking ways to divest themselves of more and more health and welfare expenditures. In that this means enlarging the invisible welfare system of

family caregivers and eliminating nursing jobs, this matter should command the immediate attention of researchers, clinicians, and family caregivers.

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# **Nursing Intervention Studies : Issues Related to Change and Timing in Children and Families**

**Laurie N. Gottlieb and Nancy Feeley**

Les cliniciens et les chercheurs doivent faire face à divers défis pour ce qui concerne l'élaboration et la mise à l'épreuve d'interventions infirmières ou de programmes pour des enfants et leurs familles. Nombre de ces défis sont liés aux questions de changement et de son opportunité. Le présent article examine certaines des questions importantes qui doivent être prises en considération lorsqu'on conçoit et on évalue les interventions auprès de cette population particulière. Les exemples illustrant ces questions sont tirés d'une étude qui a testé l'efficacité d'une intervention infirmière (basée sur le Modèle de McGill de soins infirmiers) dont l'objectif est d'améliorer l'adaptation psychosociale des enfants atteints de maladies chroniques. Les auteurs estiment que le fait de considérer ces questions avec attention améliorera l'élaboration des études sur l'intervention, l'évaluation de leurs résultats, et contribuera également à une plus grande connaissance dans ce domaine.

A variety of challenges confront clinicians and researchers involved in developing and testing nursing interventions or programs for children and their families. Many of these challenges relate to the issues of change and timing. This paper discusses some of the critical questions that must be considered when designing and evaluating interventions with this particular population. Issues are illustrated with examples from a study that tested the effectiveness of a nursing intervention (based on the McGill Model of Nursing) in improving the psychosocial adjustment of chronically ill children. The authors propose that careful consideration of these questions will improve the design of intervention studies and the evaluation of their outcomes, as well as contribute to the development of our knowledge in this domain.

The issue of change is at the very heart of nursing practice and the conduct of nursing science. Nursing interventions are typically employed to help clients and families bring about a desired change. Evaluation studies seek to examine to what extent an intervention has resulted in the desired change in the target population (those individuals, families, communities to which the intervention is directed). Recent trends in health-promotion intervention research indicate a broadening of focus to include not only changes in self (e.g., health behaviours and lifestyles), but also changes in environment (e.g., physical, social, eco-

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Reprinted from *Canadian Journal of Nursing Research*, 1995, Vol. 27, No. 1, 13-29. "Nursing Intervention Studies: Issues Related to Change and Timing," in Miriam J. Stewart, ed., *Community Nursing: Promoting Canadians' Health*, pp. 618-639. Copyright © 1995 by W.B. Saunders Canada. All rights reserved. Reprinted by permission of Harcourt Brace & Company Canada, Limited. (nomic). How clinicians and researchers conceptualize change and

change processes will shape the ways they choose to work with individuals and families and the methodologies we select to evaluate effectiveness.

Although change is ubiquitous, it often escapes scrutiny (Mahoney, 1991). Yet such scrutiny of change in client outcomes is necessary in community nursing practice. Limited financial resources and the demand for evidence of the effectiveness and efficiency of health care services have resulted in the recognition that there is a compelling need for research assessing the impact of community nursing practice on client health outcomes (Barriball & Mackenzie, 1993; Goepfinger, 1988; Kristjanson & Chalmers, 1991).

When designing intervention studies, researchers and clinicians are faced with two major decision-making areas. The first concerns decisions related to change. Such questions need to be considered as: *What are we trying to change? Who are we trying to change? How does change come about? How can we determine that change can be attributed in part to the intervention?* The second area concerns decisions related to the timing of the intervention. It is impossible for clinicians and researchers to consider change without confronting issues of timing. Timing is important as it relates to the design and implementation of the intervention and the measurement of its impact. The types of questions that need to be addressed here are: *When should the intervention occur? How long does an intervention have to continue to effect long-lasting change?* Another set of questions concerns timing as it relates to when outcome measures should be taken. Questions must be addressed such as: *When can we expect change to occur? How long will the change last?*

These were some of the questions that we confronted in designing a randomized control trial study to evaluate the effectiveness of a year-long home-based nursing intervention to enhance the psychosocial adjustment of children with a chronic condition (Pless et al., 1994). The nursing intervention was guided by the McGill Model of Nursing (Gottlieb & Rowat, 1987; Kravitz & Frey, 1989). The major features that characterize this model include a focus on overall health rather than illness and treatment, on all family members rather than the patient alone, on family goals rather than on the nurse's, and on family strengths rather than their deficits. According to this model, nursing takes place within a collaborative relationship wherein the nurse and the family jointly assume responsibility. The nurse's role is to structure learning experiences that empower families and enable them to define their issues of concern and arrive at approaches to meet their goals.

The purpose of this paper is to identify some issues and challenges specifically related to change and timing that need to be considered in intervention research with children and families in the community.

## **Conceptual and Methodological Issues Involving Change**

### ***What Are We Trying to Change? Understanding the Phenomenon***

The impetus for conducting an intervention study often comes about because clinicians and/or researchers identify an area in need of change and believe they know how to effect change. The first and most fundamental question that they must ask when designing an intervention study is: *What is the nature of the phenomenon that is being targeted for change?* The answer to this question is premised on theoretical understandings about the phenomenon targeted for change and knowledge about change and change processes. A thorough understanding of the phenomenon and its characteristics is required because certain phenomena are more amenable to change than others, and different methodological implications will arise depending on the nature of the phenomenon. For example, specific behaviours such as children's temper tantrums might be more readily changed than children's shyness. Temper tantrums are shaped by the type and amount of positive and negative reinforcement given by parents and others, whereas shyness is a temperament trait that is genetically influenced.

A subset of questions that need to be addressed to clarify the researcher's understanding of the characteristics of the phenomenon under study include: *What purpose does the phenomenon serve to the system's integrity and/or to its maintenance and organization? How does the phenomenon develop over time? How long has it been in place?* This knowledge will determine the type of change that can be expected and will help forecast how long the change should take to achieve. For example, phenomena that involve core processes, such as the construction of self (self-esteem, identity), values (valence), reality (order), and power (control), are more difficult to change because they develop slowly, involve deep structural changes within the organism and system, and maintain the system's integrity (Mahoney, 1991). Thus, an intervention of short duration would be unlikely to alter a child's self-esteem. This implies that intervention studies that target core processes need to be long-term to effect any perceptible, long-lasting changes. The issue of length and intensity of an intervention will be further discussed in this paper.

Another characteristic to consider is the form the phenomenon takes at various phases of development. This is particularly relevant to the study of young children. The issue here is that the phenomenon of interest may exhibit itself differently at different ages, as it evolves and changes. For example, if the researcher is interested in children's gross motor development, the researcher would observe turning and crawling in the infant, but with toddlers walking and running would be more appropriate indicators of gross motor development. Thus, the challenge is to determine what constitutes "same" but "analogous" behaviours across ages (Kessen, 1960). Consequently, when repeated assessments of the phenomenon are made over time as children grow and develop, different instruments may be required to measure the same phenomenon at different ages.

In our study, we assessed children's self-esteem with the Perceived Competency Scale for Children (Harter, 1982). Two different versions of this measure were used, one for children under seven years of age and another for children older than age seven. Harter developed these different versions because as children develop their notion of self-esteem becomes more complex and differentiated. For example, in younger children self-esteem is manifested in four areas (maternal acceptance, peer acceptance, physical competence, and cognitive competence), whereas for older children there are five specific domains of self-esteem (scholastic, athletic, and social competence, physical appearance, and behavioural conduct) and a general domain of global self-esteem.

The wide variability in the expression of the phenomenon of interest within age groups must also be considered. Variability can be affected by a multitude of factors such as genotype, gender, maturity determinants (e.g., taking on age-appropriate roles and responsibilities), cultural factors, co-occurrence of other life-course events (e.g., entry to school), and social/contextual factors (i.e., support, poverty, maternal employment) (Aldous, 1990; Walsh, 1983). This underscores the importance of including control or comparison groups in order to attribute change to the intervention and not to the factors listed above, as elaborated later in this paper.

Yet another question that must be addressed concerns the purpose of the intervention. *Does the intervention seek to develop the phenomenon, change it, or maintain it?* This is an important distinction both for shaping the intervention and for determining the types of outcomes to measure. If the goal of the intervention is to develop a new set of behaviours, then the intervention should focus on helping parents and children acquire new knowledge and develop new skills. Prenatal classes

and parenting programs are examples of interventions by community health nurses aimed at developing new knowledge and skills. When evaluating the effectiveness of the intervention, one would expect to find little evidence of the skill pre-intervention and some evidence of its development post-intervention. On the other hand, if the goal of the intervention is to change or alter a behaviour, the intervention may focus on extinguishing old behaviours, introducing new ones, and reinforcing them. For example, programs that are designed to alter unhealthy behaviours such as behavioural training programs for parents who have abused their children (Wolfe & Wekerle, 1993) would fall within this category. The analyses would focus on examining patterns of change and trends across time for the various behaviours. Finally, if the goal of the intervention is maintenance, the intervention would focus on support and reinforcement. Stability and consistency across time would be used as indices of maintenance.

### *Who Are We Trying to Change? Deciding on Who to Target for Change*

When working with children and families it is not always readily apparent who should be the focus of the intervention and subsequently the target of evaluation. In practice, community health nurses work at various levels of the family system and the larger environment to effect change. In designing a nursing intervention study, the researcher may decide to focus on: (1) individuals (i.e., mother, child), (2) subsystems (i.e., mother-child relationship), and/or (3) the family as a system, including their relationships with other social systems (i.e., extended family, health care system). Issues such as the knowledge of change and change processes, the potential differential rates of change among different family members, and who best can evaluate change need to be considered when making this decision.

*Knowledge of change and change processes.* It is important to understand the conditions that influence change in children and families and the mechanisms by which change takes place. These understandings usually derive from foundational knowledge about change and change processes. Researchers and clinicians need to articulate the theoretical bases of their perspective in planning and measuring change. For example, if the researcher subscribes to the theoretical position that the child is active and shapes the social environment (Sameroff, 1987), then the intervention would focus on the child only, and measures of change would focus on child outcomes. The child's social environment consists of the patterns of interactions and relationships that transpire between the child and other individuals. On the

other hand, if the researcher subscribes to the belief that the child is a passive agent whose behaviour is shaped by the social environment, then the intervenor would elect to work with the mother alone to change the child's behaviour. Assessment, therefore, would be concerned primarily with child outcomes and secondarily with parent outcomes. However, if the researcher subscribes to a constructivist view of development (Mahoney, 1991; Scarr, 1992) in which both the child and the environment are active, responsive agents, the nurse would work with both the child and the mother. Changes in both the child and the environment would be the focus of measurement.

In our intervention study with chronically ill children and their families, we were concerned with effecting change in both the child and the family environment. Hence, the nurses worked with the child, siblings, parents individually, and/or various dyads and triads within the family. There is empirical support for the effectiveness of such a multi-pronged approach to intervention. Reviews of the research on early childhood intervention programs and programs for maltreating parents have concluded that comprehensive interventions aimed at multiple levels of the child and family system are likely to be most effective in bringing about the desired outcomes in child development (Seitz, Rosenbaum, & Apfel, 1985; Wolfe & Wekerle, 1993; Zigler, Taussig, & Black, 1992).

A second theoretical notion underlying our study as well as many models of family nursing is that of family systems theory. Family systems theory posits that each individual and subsystem within the family operates interdependently, influencing and being influenced by the others (Minuchin, 1985). Change in one part of a family system may affect the total system, as well as its subsystems (Mercer, 1989). Although an intervention may be targeted at one family member, change in the other family members and the system as a whole may also occur. For example, an intervention whose focus is on the child may result in unexpected changes at other levels of the system (Gray & Wandersman, 1980). To capture these unexpected outcomes, multiple measures should be employed within and across domains of potential health outcomes for different individuals and subsystems. To continue with the example from our study, we used several standardized measures of child, parent, and family outcomes to measure the *a priori* hypothesized mechanisms and outcomes. In addition, we included a qualitative component to capture the unexpected. We interviewed the chronically ill child's primary caregiver (usually the mother) to explore their perceptions about what changes had occurred and how these

changes had come about (Ezer, Bray, & Gros, 1994). Mothers reported several outcomes that had not been captured with the standardized measures we had chosen. For example, they described the child taking more responsibility for the management of their chronic illness, gaining in self-confidence, and doing better in school.

*Different rates of change within families and between families.* Traditionally researchers have been concerned with measuring rates of change among different families. More recently attention has turned to examining rates of change within families. The impetus for this trend is the growing recognition that children, other family members, subsystems within the family, and the family system as a whole have their own developmental trajectory.

When families are being formed, experiencing novel events, or dealing with stressful situations, change will be more rapid because family processes (e.g., communication, decision-making) are being re-oriented and re-established. This implies that, depending on the kind of change desired, the intensity and the duration of nursing involvement required within families and across families may vary. When selecting an approach to intervening, the researcher should consider tailoring the intervention to the unique needs of each person and family. We will return to the issue of tailoring interventions later.

*Who will assess change?* An important decision that the researcher faces is who in the family will be asked to assess whether change has occurred. The most obvious choice is the individual targeted for change. However, in research with children and families this choice is not always straightforward, because children are often too young to respond to self-report measures. In the past, research has relied on mothers' reports to assess change in their children, as well as change in the family (Ball, McKenry, & Price-Bonham, 1983), because of their intimate knowledge of family life, the amount of time they spend with their children, and their availability to researchers. Although mothers' responses are important, theirs is just one of many perspectives on children and family life.

It has been commonly assumed that everyone in the family has one shared family environment and experiences that environment in the same way. However, recent empirical studies have pointed out that in fact this is not the case. Each family member has a different experience in their family and creates his/her own subjective meanings (Dunn & Plomin, 1990). For example, firstborn children have an inexperienced parent whereas later-born children have experienced parents. More-

over, each child has his/her own personality which may have a differential effect on how parents respond. These findings have important consequences for designing intervention studies. The implication of this principle is that the respondent must be kept constant across repeated measures. For example, in our study we were concerned with changes in the child's behaviour prior to and after the intervention. We asked parents to complete a standardized child behavioural checklist prior to the start of the intervention. If the mother completed the report at baseline and the father completed the assessment at the end of the intervention, we excluded these data from the analyses because mothers' perceptions and experiences may differ from those of fathers.

A second implication that arises as a result of the notion of non-shared environments concerns the use of multiple respondents. Traditionally researchers have used triangulation as a test of the validity of a measure. Triangulation is a term that commonly refers to the use of multiple measures to converge on a construct (Breitmayer, Ayres, & Knafl, 1993). Nonetheless, other purposes for triangulation have also been described (Knafl & Breitmayer, 1989). Multiple respondents have been considered necessary in family research in order to capture the complexity of family systems and obtain a comprehensive view of the family (Moriarty, 1990). However, given our current understanding, different family members' reports of the same phenomenon should be expected to diverge rather than converge. For example, when trying to assess how well children have done as a result of the intervention, the researcher may want to know whether change is apparent to both parents, as well as to those outside the family. She/he may also want to know whether the child's behaviour is consistent at home or at school. To this end, the researcher may elect to collect information about the child from the child him/herself, the child's siblings, peers, parents, teachers, and anyone else of relevance. However, the researcher should expect moderate correlations among individuals because children's behaviour is fairly consistent, but there is variability within this consistency. Children and adults may respond differently in different situations with different people.

### *How Does Change Come About? Pathways Towards Change*

Many evaluations of program effectiveness have failed to recognize that processes of development, individual differences in development, and environmental and contextual factors will lead to some children and families benefiting from an intervention, while others will remain the

same, and some may even be harmed by it. Increasingly researchers are recognizing that the question is not just *Does this intervention work?* but rather, *What intervention works with whom, in what domain of functioning and under what circumstances* (Dunst, Synder, & Mankinen, 1989; Gray & Wandersman, 1980). Two approaches to data analysis may facilitate an understanding in this area: (1) an examination of overall group differences (between group differences), and (2) an examination of within intervention group differences through case or profile analysis (Bergman, 1992; Gray & Wandersman). These two approaches to analysis should complement each other.

Careful documentation of the intervention will allow the researcher to track the processes that occur during the intervention, and will also yield the data needed for the profile analyses that may provide important insights into why the intervention worked for some children but not for others. For example, in our study the first set of analyses examined the differences between children who received nursing care and those who did not, with respect to child behaviour problems, role skills, and self-worth. In order to understand why and how some children benefited while others deteriorated over the course of the intervention, we conducted a profile-analysis. This was accomplished by compiling a profile of children's scores on many variables collected from many different sources (e.g., parent report on standardized measures, nurses' description of the each contact with the families during the course of the intervention, and parent interviews conducted post-intervention) (Gottlieb & Feeley, 1995). Improvement in child psychosocial adjustment was shown to be linked to the ability of the mother and/or child to become engaged in the intervention, the nature of the issues worked on, and the nurse's direct involvement with school-age children and adolescents.

### *How Can We Know That the Intervention Contributed to the Observed Change?*

Although it is difficult to attribute change solely to the intervention, nonetheless there are research procedures that, if followed, allow the researcher to infer that some of the change can be attributed to the intervention. This issue is all the more salient in research with children. Because change occurs at a more rapid pace in children, it is sometimes difficult to determine whether a change is due to another event occurring at the same time as the intervention, to the intervention, or to a naturally occurring developmental shift in the child (Rutter, 1983). To illus-

trate: After the birth of a second child, mothers commonly report an increase in toileting accidents in their preschool firstborns (Stewart, 1990). However, it is difficult to know if this is due to the preschoolers' way of dealing with the stress accompanying the sibling's birth or if it is due to a natural lapse that is part of the course of toilet training.

The use of a control or comparative group is the most common strategy to address this issue. Control is particularly important to establish in the study of both children and families, to counter the argument that change may have occurred as a result of maturation (Bailey & Simeonsson, 1986). In experiments, control is obtained through comparison of the participants who did and did not receive the intervention (Fugate-Woods, 1988). In addition, random assignment of study participants to either the intervention or control group (a critical feature of experimental designs) reduces the likelihood of systematic bias in the two groups with respect to any variables that might be linked to the outcome of interest (Polit & Hungler, 1989). The groups that are formed following random assignment should be comparable with respect to a variety of background characteristics.

In the event that one cannot use a control group, then comparative groups are a reasonable alternative. When studying naturally occurring events, such as the birth of a sibling, it is impossible to randomly assign firstborns to families having a new baby and those not. Instead, a comparison group can be selected from individuals known to be similar to those who will receive the intervention with respect to several pertinent characteristics that have been found to affect the phenomenon (Friedman, 1987). We will illustrate this point with an example of children's adjustment to a sibling's birth. In a second study undertaken by Gottlieb and Baillies (1995), the phenomenon under study concerned understanding firstborns' reactions during their mother's pregnancy. A group of only children whose mother was not pregnant served as the comparison. The comparison group was matched with the "pregnancy" group on age, because age has been found to influence firstborns' reactions to a sibling's birth (Gottlieb & Mendelson, 1990).

In summary, before undertaking the design and implementation of an intervention study with children and families, nurse researchers and clinicians need to spend considerable time gaining a thorough understanding about the phenomenon they are trying to change and the processes by which change comes about. Only when one has acquired this understanding is one ready to proceed to decisions related to timing.

### **Conceptual and Methodological Issues Involving Timing**

The issue of timing is critical to the design of intervention studies, particularly as it relates to the timing of the intervention and the measurement of outcomes. There are two specific questions that researchers need to examine: *When to intervene?* and *How long should the intervention last?* Underlying these questions is knowledge of when change is most likely to occur.

#### ***When to Intervene***

Change is more rapid and more readily achievable during a critical period, such as when core processes are being laid down and/or transformed as in infancy, early childhood, and adolescence. Many early-childhood intervention programs are premised on this assumption (Carnegie Corporation of New York, 1994; Hamburg, 1992). Change is also more achievable during periods of transition, critical life events, or stressful experiences. This is not surprising in light of the theoretical understanding of what happens during these periods (Schumacher & Meleis, 1994). These events make new demands, which in turn cause major disruptions to individuals and families. To meet these demands individuals and families must master new ways of coping, redefine existing relationships, learn new roles, and/or restructure a different sense of self. In attempting to meet these challenges, individuals and families are more vulnerable and consequently more open to change at these times.

Therefore, transitions, critical life events, or stressful experiences are important periods for growth. Nurses have a key role to play in promoting growth and change. If the goal of the intervention is to change core processes and develop new insights, knowledge, and skills, then these periods provide the best opportunity for entrée into the family. In our study, we decided to include families who had been living with the child's chronic condition for at least a year, and excluded those whose child had been recently diagnosed. Our choice may have made it more difficult to bring about change in child psychosocial adjustment because families had been living with the chronic illness for at least one year and as long as 14 years. There is some empirical evidence to suggest that the timing of an intervention plays a role in the process of change. Larson (1980) found that the timing of a home visitation program for mothers was critical in effecting positive mother-infant outcomes. Mothers who began the intervention during their pregnancy benefited more than mothers who began in the postpartum period. This suggests that interventions aimed at effecting change may be potentially more

effective at transitional periods in child and family development, such as the birth of the first child or when a child enters school; or during stressful periods, such as the diagnosis of a chronic illness. Although theoretically this seems to be the case, there have been few systematic studies to support these notions. Kristjanson and Chalmers (1991) observed there is currently little knowledge in the community health nursing literature concerning the most effective timing of interventions with families.

Even during critical periods, change is a dynamic process punctuated by phases of change intermingled with periods of stability (Mahoney, 1991). In contrast to the view that change and continuity are distinct and independent constructs (Fawcett, 1989; Hall, 1981, 1983), we ascribe to the perspective that change and continuity are separate but integrally related, co-dependent constructs (Liddle & Saba, 1983; Mahoney). Mahoney argues that stabilizing processes are self-protective inasmuch as they enable the person or family to function in the face of new demands without disintegrating or becoming disorganized. For example, when a new child is born a change in the family roles and relationships will occur, to incorporate the needs of the new child, but at the same time the family will adhere to old patterns of functioning (e.g., maintaining usual daily routines).

The co-existence of change and self-stabilizing processes helps to explain why change is difficult to achieve. Despite the need for longitudinal research, granting agencies tend to favour short-term intervention studies. Researchers may be confronted with having to choose between intense interventions with a small number of families and less intense intervention with a greater number of families (Gray & Wandersman, 1980). The aim of our study was to improve the psychosocial adjustment of children with a chronic illness and to prevent deterioration. We decided on a year-long intervention because we recognized that the study nurses would require time to develop relationships with the families and to help families work on bringing about the change they desired. Furthermore, we were aware that some families would take more time to develop a relationship with the nurse and that some would be resistant to the nurse's efforts to develop a relationship.

Our understanding of the balance between the need to change and the need to stabilize implies that nurses have to be sensitive to people's energy levels and readiness to change. Interventions must be tailored to the needs of families. The McGill Model of Nursing (Gottlieb & Rowat, 1987) recognizes the importance of timing and pacing. Moreover, there is empirical support for this position. Interventions

conducted with children and parents in early childhood have been shown to be more effective when the intervention is tailored to the needs, values, interests, and readiness of the participants and/or the community (Dunst et al., 1989). However, the clinical realities of timing potentially conflict with the imperatives of experimental designs. In spite of this understanding about change and stability, many disciplines, nursing included, still subscribe to the belief that a key to sound research design of intervention studies is the standardization of interventions (Edwards, 1993). Standardization means that all participants receive the same intervention, and is premised on the assumption that all individuals have the same needs and will respond in the same fashion.

One potential solution to this dilemma is to establish a "minimum" intervention and tailor further intervention to each family's needs. This was the method we employed in our study of families with a child with a chronic illness. The design called for a minimum number of contacts (one per month) that every family would receive regardless of need over the 12-month period (Pless et al., 1994). Additional contacts were scheduled based on families' needs. Each family, in collaboration with the nurse, determined the "dose" of nursing they would receive and set the agenda for their work together. To be able to attribute change to the intervention, the nurses documented the details of their nursing for each contact with the families. They maintained contact logs, which described who was present, how long the visit lasted, the location, and who initiated the contact. As well, they described the nature of families' concerns and goals and the types of nursing strategies they used. This enabled us to describe the intervention in depth and to examine the effects of the actual intervention on outcomes (Gottlieb & Feeley, 1995). The advantage was that the researcher could examine what actually happened for each participant. These data were important for the profile analysis described earlier.

Another potential solution is that utilized by Webster-Stratton (1992) to evaluate the effectiveness of a parenting program for parents of children with conduct disorders (Webster-Stratton, 1984). Groups of parents view a predetermined series of videotape vignettes of parent-child interactions. Although the overall program format and content are standardized, the actual administration of the program centres on the interests and concerns of the particular group.

When an intervention is standardized, documentation can still be important. It cannot be assumed that the intervention will be the same for all participants, particularly when the intervention takes place in the

home, or is delivered by several intervenors (Gray & Wandersman, 1980). A number of factors may contribute to variations in the intervention across participants. Thus, the researcher should acknowledge that there will probably be a discrepancy between the planned and actual intervention, and document as completely as possible the actual intervention that participants received (Goeppinger, 1988). Mechanisms for documenting the intervention (such as those that we described in the example from our study) must be developed prior to beginning the intervention. The difficulty the researcher will encounter is that documentation and analyses of these data are time-consuming and tedious for both the nurses and the researcher, and seldom considered worthwhile by funding sources.

### *How Long Should the Intervention Last?*

*How long does an intervention have to be to effect long-lasting change? How frequent should it be?* These questions underlie decisions about the intensity of the intervention. Researchers have little empirical data to guide them in answering these questions, as little is known about what "dose" of community nursing intervention is required to bring about change (Kristjanson & Chalmers, 1991). Research is needed to address this issue. However, knowledge of change processes suggests that an intervention needs to be of reasonable duration to bring about change, and should include "boosters" of the intervention (Clarke & Clarke, 1989). The effects of short-term early-childhood interventions seem to fade, while more successful programs provide intervention over time, supporting the child and their family through various phases of development (Zigler et al., 1992). There is some evidence that more intense interventions (high contact over a relatively short period of time) may be more effective. As a result, models currently in use in the domain of infant mental health and psychiatry advocate intensive work with the mother and child (Emde, 1988).

### *When Should Change Be Measured?*

Another aspect of timing that needs to be considered is when to measure change and then how to determine whether its effects are long-lasting. Although we suggested earlier that it may be best to intervene at the time of a transition, critical life event, or stressful experiences, this may not be the best time to assess the outcomes of an intervention. Rather, the researcher should assess outcomes once the transition has been completed. A thorough understanding of the phe-

nomenon of interest will be helpful. Specifically, knowledge of the timetable under which events unfold is needed to decide when to assess change. Good descriptive studies of developmental transitions, life-event trajectories, and the development of phenomena of interest to nurses are needed. Although there is great variability among individuals, the outer ranges of behaviour can be determined. For example, women between the ages of 18 and 45 are considered to be best equipped to meet the challenges and demands of motherhood. Currently, there is debate about the desirability and impact of a woman having a baby at 13 or 60.

Intervention studies typically assess change at just one point in time, usually immediately following the nursing intervention. The problem with this practice is that researchers may fail to observe change that has yet to emerge (Type II error), or may detect change that is only transitory (Type I error). Only repeated observations of sufficient duration after the completion of the intervention and replication studies will answer questions concerning the permanency of change.

Nurse researchers often expect short-term effects from any intervention. However, some have noted that this may be a highly unrealistic expectation, especially for infancy and early childhood when the effects of an intervention may not be stable (Emde, 1988). The possibility of delayed effects must also be considered in the design of intervention studies with children and families in the community. Developmental psychologists have become increasingly aware of the possibility of sleeper or delayed effects from follow-up studies of early child intervention programs (Emde). One major problem has been obtaining the funds for follow-up assessments. Furthermore, it may also be difficult to assess how long follow-up is required (Emde).

A case to support the need for multiple points of measurement of change is the study by Stein and Jessop (1991). At the end of the intervention, children who received the year-long home-care intervention were better adjusted than children in the control group, who received routine care. In a five-year follow-up study, the investigators found that the psychosocial adjustment of children who received the intervention continued to improve, while children in the control group remained stable. Thus, the gap between children who received the intervention and those who did not grew over time. Without these repeated measurements, the long-term effects of intervention would have gone undetected and the impact of this intervention would have been undermined.

## Conclusion

The past two decades of research have yielded rich descriptions of many nursing phenomena. As nursing develops, the discipline will continue to require this descriptive work. Nonetheless, in some domains nurses have accumulated sufficient knowledge to guide work with clients and families to bring about desired changes. As Ellis argued, nursing is a practice discipline and needs to conduct investigations that will improve practice and the knowledge upon which practice is based (Pressler & Fitzpatrick, 1988). Furthermore, as nursing moves forward in this decade of increasing accountability, there will be mounting pressure to demonstrate the outcomes and effectiveness of our nursing. In response to these forces, nurses are already encountering evidence of a growing number of intervention studies. This avenue of research will yield knowledge about how to work with children and families, and the effectiveness of approaches, with whom, and when.

As more researchers embark on this path, they need to pay heed to some of the fundamental questions raised here. Although the issues and questions we have raised are particularly salient for conducting research with children and families, many are highly relevant to the study of adults as well. While we have proposed answers to these questions, it can be anticipated that other nurse researchers' experiences will provide different answers and raise other questions. It is imperative that clinicians and researchers share their questions, insights about change, and approaches to the assessment of change with others. Only then will new methodological knowledge and new approaches to the designing and conduct of intervention studies emerge.

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# On the Humanities in Nursing

Myra E. Levine

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

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

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

“Ethics” has been a part of the curriculum ever since Nightingale regaled the probationers of St. Thomas with her homilies, a practice imitated in many schools of nursing afterwards. But ethics were really

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rules of etiquette — how proper young ladies behaved on the wards and in the halls of their residence. For years, pupil nurses were closely monitored by straight-laced house mothers who prowled the floors of the residence to be certain all was in order. The professional Code of Ethics was actually a code of etiquette. In 1968, the first of several revisions sought to eliminate the rules of etiquette and finally emphasize the ethical responsibilities of the nurse.

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

Nursing history was taught, but never accorded much importance, by either the instructors or the students. A minor course that had little relevance to their daily experience, the history of nursing was a casual interlude for tired students. But even more disheartening, the history of nursing institutions was not valued. The official papers that recorded the meaning and the purpose and development of the organization were not viewed as archival materials — but discarded — a history tossed away without a second thought. Efforts to recover the history of an organization was sometimes undertaken by alumnae associations, and, while the collections are valuable, they were undertaken by devoted alumnae not schooled in historiography. They were seldom catalogued in libraries and many were lost. When the Illinois Training School for Nurses (Shryver, 1930) was closed the remaining copies of its alumnae history were placed in the attic of a building at the University of Chicago, and upon request were sold for 10 cents each by Professor Nellie X. Hawkinson.

Nurses cherish the icons of its beginnings and its past, and yet the wisdom and experience of great nurse leaders — Lavinia Dock, Isabel Stewart, Katherine Densford, Janet Geister, Katherine Faville, and,

indeed, Nellie Hawkinson and many others — was imperfectly recorded for later generations. Lacking the historical record, the profession is poorly informed of nursing's actual role in the development of the health care system, in the creation and management of hospitals and public health agencies, and in defining the role of the professional nurse. Such a void in self-awareness critically affects the stature and growth of nursing as a vital, essential public service.

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

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

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

The inadequacy of nursing's grasp of philosophy was especially clear in the impact of theory on nursing. Philosophy should drive theory, but it is rare that theorists make explicit the philosophy that influenced their theory. More often, the philosophical roots are vague, the antecedents to identifiable philosophies barely recognizable. Instead, a "philosophy" is contrived — usually in a critique — from

assumptions and propositions offered by the theorist. It is characteristic of nursing theory that the antecedents are not clearly identified, philosophical or otherwise. Nurses have always developed processes or procedures and a posteriori sought to explain their provenance. Unhappily that has also been the pattern in the development of nursing theory.

Those few theorists who claim philosophy as the basis of their work tend to choose generalizations rather than identify a specific author. Others select a philosopher but limit the influence of — and in some instances misuse — the concepts they select. Seizing upon the idea of a “lived life,” the phenomenologists have promoted their own science of nursing — a “human science” — and dismiss the scientific method as reductionist and mechanistic. They cite Heidegger, Sartre, Merleau-Ponty, Buber, Marcel, and others as if there were no differences between them. An informed audience might have objected, but, as Stevens (1979, p. 37) suggested, theorists may have benefited by “nurses who mistakenly assume that any theory must have merit if they cannot understand it.”

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

Must it be the price of a professional education to forswear a liberal education? The expectation that every subject must demonstrate its usefulness has excluded those that enlarge the intellectual and aesthetic abilities of the individual. The nurse is witness. There should be no limits placed on the knowledge and sensitivity brought to the tasks of

nursing. The humanities promise a tempering and a gentling of the relationships between patient and nurse.

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

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# Sources in Nursing Historical Research: A Thorny Methodological Problem

Diana Mansell

Professionally trained nurse historians of Canadian nursing have intensified the interest in primary sources and the limitations associated with those sources of Canadian nursing history. These documents often pertain to the activities associated with a professional organization, hospital, or school of nursing. These sources shed light on developments in nursing but only from one perspective, that of leadership. Therefore, the picture of nursing that emerges is one-sided. This situation is not unique to nursing history research. It presents a methodological problem for all areas of historical research. In order to gain a more complete picture, the researcher requires evidence from the rank and file, or from those nurses who carried on with the practice of nursing.

The following anecdote appeared in the pages of a 1935 issue of *Canadian Nurse*:

Miss Marion Boa, a graduate of the School for Nurses of the Montreal General Hospital and of the McGill School for Graduate Nurses, has had a varied experience in administration and teaching in schools of nursing, and private duty nursing, and is now superintendent of the Aberdeen Hospital, New Glasgow, Nova Scotia. Being in need of an incubator for babies, and lacking the necessary funds, Miss Boa ingeniously improvised and had an inexpensive but efficient incubator made out of an ordinary wash boiler at a total of \$8.50... It all goes to prove that experience in the private duty field may be an excellent preparation for a hospital administrator, especially when it is amplified by the courses which are available in some of our Canadian universities.<sup>1</sup>

What can be learned about the life of the “ordinary” nurse, given the fragmentary nature of the evidence and the bias towards the elite that are so apparent in documentary reports? Most nurses began their careers as members of the rank and file and, like Marion Boa, clearly

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benefited from that experience. These nurses had little time to record their experiences and, not surprisingly, relevant documents are hard to find. This dearth of evidence has resulted in a less than complete historical picture of nursing in Canada.

Thus, nursing history tends to be a celebration of those individuals who brought the profession through its developmental stages. Information from the rank and file nurse, however, would aid researchers in their quest for answers to questions related to class, status, and ethnicity. Furthermore, this critical examination would give a voice to those nurses whose experience of the profession was perhaps not celebratory but one from which nurses and nursing today might benefit.

The raw material for the historian has always been the document. Indeed, it has been said: "There is no substitute for documents: no documents, no history."<sup>2</sup> In recent times, the definition of document has been expanded to include oral interviews, pictures, and artifacts. Nonetheless, for new disciplines such as nursing history traditional documentary sources provide the basis for any investigation.

The documentary sources available to the historian of Canadian nursing have certain limitations. As McPherson and Stuart recently noted:

Historians of nursing bemoan the fragmentary nature of documentary evidence... Certain segments of nurses have demonstrated a more pronounced consciousness than other women or other workers about the historical significance of their lives and have attempted to record their experiences and to preserve the records created by their peers. This has often skewed the historical record toward the elite, formally trained, full-time practitioners, and has oriented the record towards the socially respectable or celebratory, leaving more marginal practitioners silent.<sup>3</sup>

Since sources are fundamental to the task of the historian, what are the methodological limitations associated with reliance on sources created by nursing leaders or professional associations? The *Canadian Nurse*, for example, offers considerable information about leaders in Canadian nursing but little about the "ordinary" nurse. Indeed, from its inception in 1905 to 1960, it gave the reader only occasional glimpses into the life of the bedside nurse. Although *Canadian Nurse* was the only journal available to nurses in Canada, only 30% of nurses subscribed to it until the 1940s.<sup>4</sup> Furthermore, contributors to the journal tended to be

national, provincial, or local leaders — perhaps because the “ordinary” nurse was occupied with the delivery of her nursing services. Therefore, little information could be gleaned from the rank-and-file nurse.

The same holds true when the researcher turns to records of national and provincial professional associations. Individual nurses frequently became involved first with their local organizations, then moving to the provincial body, and, finally, the national body. The investigator encounters the same individuals again and again. Even though this leadership had a significant impact on the professional career of the individual nurse, these records do not reflect the lives of “ordinary” nurses.<sup>5</sup> In contrast to the leadership, the typical nurse often was married, offered her services in rural Canada, and was completely unaware of the activities of the professional association.<sup>6</sup>

Simply put, *Canadian Nurse* and records of various professional associations have significant limitations. Research based on these sources alone would portray Canadian nurses as a homogeneous group of white, Anglo-Saxon, Protestant, middle-class women. For example, a significant number of the recipients of honorary awards from the Canadian Nurses Association were members of the executives of provincial or national associations. Furthermore, *Canadian Nurse* had only four editors between 1905 and 1965, and during one eight-year period (1924–1932) Jean Scantlion Wilson held the positions of both journal editor and executive secretary of the Canadian Nurses Association.<sup>7</sup> The very limited number of nurses represented in these documents creates a definite bias. As a result, source material does not give a voice to those nurses who were actively involved in the mundane business of nursing.

Although it is impossible to obtain a full picture from these records alone, if they are combined with oral data, personal diaries, and correspondence a more complete story may be available. These sources have yet to be truly tapped. They tend to rest among the memorabilia and recollections of elderly nurses and their families, who may be unaware of their value. Acceptance of these new sources of data and the emergence of new technologies may make it possible to amplify the story of nursing.<sup>8</sup> In order to present a total history of nursing in Canada it is necessary to give voice to those who have remained silent, because, after all is said and done, “in the end it is the evidence itself that determines what case it is possible to make.”<sup>9</sup>

### Endnotes

1. "An improvised incubator." *Canadian Nurse*, 1935, 31(1), 17.
2. Paul Thompson, *The voice of the past: Oral history* (2nd ed.). New York: Oxford University Press, 1988, p. 51.
3. Kathryn McPherson & Meryn Stuart, "Writing nursing history in Canada: Issues and approaches." *Canadian Bulletin of Medical History*, 1994, 11(1), 16.
4. For further documentation, see *Canadian Nurse*, 18(8), 480; 26(3), 121; 36(9), 588.
5. See D. Percy correspondence, RG29, V-2355, National Archives of Canada, Ottawa.
6. Grace Agar. Audiotaped interview with the author in Calgary, 1988.
7. Canadian Nurses Association. *The leaf and the lamp*. Ottawa: Author, 1968, pp. 73-79.
8. Projects are underway in both Alberta and Ontario to rectify the situation.
9. Keith Windschuttle, *The killing of history: How a discipline is being murdered by literary critics and social theorists*. Macleay Press (Australia), 1991, p. 220.

## **Changes in Acute Care: Questions in Need of Answers**

**Mary Grossman and Laurie N. Gottlieb**

While the field of acute care is diverse, it can be conceptualized by a number of shared characteristics. Generally speaking, acute care deals with the assessment and treatment of sudden and unexpected illnesses or injuries. These events tend to be life-threatening and accompanied by severe pain. They may be characterized as either discrete or episodic events. Not surprisingly, the primary health objective is to save the patient's life. Consequently the field of acute care has depended on the advanced technologies and clinical expertise of tertiary care settings.

Dramatic changes in the health care system underscore the fact that acute care as we have known it is being revolutionized. Two trends in particular have the potential of threatening the health of families and communities; namely, early hospital discharge and reliance on families and local community clinics for the convalescence period. We use the word "potential" because of the paucity of research into their effects on the patient, family, and health care system.

The shifts from hospital to home care, from professional caregiving to family caregiving, have occurred at an unprecedented rate and have caught both the family and the community off-guard and ill-equipped to handle the demands of caring for the acutely ill patient at home. Patients are often discharged home in unstable conditions and require complex treatments. Most families lack the experience, knowledge, and specialized skills to care for their family member with confidence. What we often fail to appreciate is that many families have themselves been traumatized by the acute care episode and are in need of help.

Many of today's families lack the structure to support a caregiving role. Prior to the Industrial Revolution, the care of the ill fell to families. With the Industrial Revolution hospitals gradually assumed more responsibility for the care of the acutely ill. However, the family continued to play a major role. In fact, the traditional family structure enabled

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families to assume the responsibility of the care of its ill members. Even with the two-adult nuclear family with its clearly delineated roles that ascribed to women the roles of homemakers and care providers along with an extended family who often lived in close proximity, the emotional and financial burdens of caring for an ill member were enormous. Medicare was created to ease these burdens.

Unlike the family of yesteryear, today's family is at a great disadvantage. Many family structures are not resilient enough to absorb the strain of caring for an ill member. Mobility has weakened families' support network and many families find themselves bereft of a social network that can be counted upon to provide sustained help. Moreover, many women are unprepared to assume the role of care provider given their many other roles and responsibilities. In addition, this generation has come to expect that care for the ill is primarily the responsibility of professionals and institutions and find themselves inadequately prepared to assume the role of caregiver. They have also come to expect miracles from medical science and feel entitled to the very best and the very latest treatments and care. Furthermore, many communities lack the needed type of services, the appropriate personnel, and the financial resources to deal with the increased demands for service.

In order for nurses to meet the new clinical challenges brought about by shifts in health care, we need to reorient our research. Up until now, the major focus of our research of acute care has centred on the patient in hospital. Yet this orientation, although still important, is no longer sufficient to guide practice decisions, shape health care services, and influence policy. We need to ask ourselves such questions as: "What type of knowledge and clinical skills are required to nurse patients with higher acuity levels in hospital and at home?" "What is the impact of the acute event and the patient's illness on caregiver's health, psychological well-being, coping processes, and level of functioning in the short and long terms?" "What are the indicators of a family's readiness to assume the caregiving role?" "What happens to patients and families during the transition phase from tertiary care to home care?" "What type of services do families need, and from whom?" "What nursing strategies are most effective in supporting patients and families in coping with different phases of the acute event?" "What is the profile of families who can best benefit from nursing care?" "What type of health services do patients and families

require during different points in the convalescent trajectory?" "What is the role of nursing within a collaborative framework of multidisciplinary practice?" "What are the indicators that nursing has made a difference to patient and family outcomes?"

The profession that has knowledge of patients' and families' needs will not only find itself in a strong position to meet the many challenges of the new health care system but will also be in a unique position to influence its direction. The right type of knowledge is dependent on asking the right set of questions. We believe that nursing has been asking the right questions. Now what we need to do is to find the answers.



# Knowledge, Politics, Culture, and Gender: A Discourse Perspective

David G. Allen

In this short analysis, I want to discuss (a) a view of cultures and bodies as created within discourses and (b) the potential relationship between that creation and oppression. My main point is that the categories of "culture" and "gender" and their instances (Hmong, woman) are not theory neutral "descriptors" but theory-laden constructs inseparable from systems of injustice. We need to be very careful how we use them. Space constraints mean I'll only be able to indicate, not provide, supportive arguments.

Neither "culture" nor "gender" is an "object": there is no such "thing" as a culture. Nor are they independent variables. There is no such thing as a gender that is not already cultured. One is never a "man" and then an "Irish" man; one is an Irishman. To be an African American woman is not to be one thing, nor is it to be the same thing as a Chinese American woman. It's not possible to subtract African Americanness and Chineseness and end up with a generic "woman." Nor are there any cultures which are not already gendered. This is particularly obvious in cultures which use gendered articles ("el," "la"). But feminist scholarship has increasingly demonstrated the "gendered" nature of cultural positions such as "person" or "citizen" (Pateman, 1989; Young, 1990).

I'll start my discussion with culture because it has been less "naturalized" than "gender" (i.e., culture is not assumed to be organized around non-cultural, "natural," or "biological" reality such as "the body").

Cultures and cultural differences are not "discovered," they are *constructed* in the process of doing something else (Clifford & Marcus, 1986). A salient example is the current struggle over "American" or "family" values. This is not a struggle to "recover" or "decontaminate" a "lost" culture. It is a struggle to create one. And the struggle itself is

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as much a part of the culture that is created as the values around which the culture is organized. Ours is the sort of culture that has conflicts about what "counts" as "truly American" (McLaren, 1995). Culture is thus "written" (or spoken or imaged), created through these discursive acts. (By "discursive" I mean a series of conversations or texts that are organized around a similar topic or discursive object. Thus there are liberal, conservative, Russian, and Palestinian conversations that construct — differently — American culture. In this sense, "American culture" is a discursive object — the object of multiple discourses.)

These discourses within which a particular culture is constructed arise from different perspectives and have different purposes. Consequently, the representation of the culture varies. A frequent goal of the process is creating cultural identity as a means to a political end (e.g., unifying divergent perspectives; clarifying who has access to certain resources; creating a positive identity for group members) (Mohanty, 1992). Other goals include creating generalizations that facilitate talking or working across "differences." These are the goals that we see most often in the nursing literature as people attempt to identify meanings that are generally held by, say, Thai people, and have contributed to misunderstandings or conflict when care is provided by European Americans.

There are several problems, and many strengths, in such analyses of "cultural differences." But my focus is on conceptual and epistemological concerns. Conceptually, such analyses tend, of course, to be stereotypes or over-generalizations. They also tend to be ahistorical. They are "essentialist" in that they tend to portray each cultural position as a homogeneous set of relatively fixed characteristics (necessary and sufficient conditions for correctly characterizing a particular cultural configuration as "Thai"). This becomes most problematic when it is then applied as a taxonomy to individuals: "He's not really Thai."

More importantly, in the U.S. nursing literature they are almost always defined against an implicit "norm" that is European American (West, 1990). Description is always implicit comparison: one is saying, in effect, that "X is like Y or unlike Z." And description is always perspectival (Rorty, 1979). What is described depends on the position from which it is viewed. What might be background (or unimportant) from one perspective is foreground (or salient) from another. Since there is an infinite number of possible viewpoints, there is no such thing as a "complete" description. Thus the comparative and perspectival nature of discourses about any particular culture is inescapable. This should not be interpreted as meaning such discourses are always "biased."

"Bias" and "perspective" are synonymous *only* within an objectivist, foundationalist metaphysic that supposes some "god's eye" view that sees everything from nowhere in particular is possible. A perspective *may* be biased because it ignores counter-evidence it would normally accept, but it certainly need not be (Bernstein, 1988).

The perspectival nature of discourse about a culture is only problematic when it is obscured or denied within a narrative style that is objectivist or "scientific" in the neopositivist sense. Such objectivist discourses almost always fail to acknowledge that the "background" against which features are being "picked out" is the writer's own cultural context and particular purposes (Chandler, Davidson, & Harootunian, 1994). One can imagine that a "transcultural nurse" in China might pick out quite different features in describing Thai culture from an American nurse working in a shelter for abused women. And the features of Inuit culture that might be relevant from the perspective of planning childbirth services may be different from those that are relevant for planning substance-abuse services. These different discourses would construct different "Inuit cultures." This is not a problem. The problem is in not being explicit about the "standpoint" from which one is "writing" Thai or Inuit culture.

The problem of not being explicit becomes more serious when the writer is from a cultural position that has exploited or colonized the culture being written about. Please note that this is not an attribution about individuals, but about cultural positioning. I have not individually (at least not intentionally) participated in the colonization of Guatemala. But the United States (following Spain) certainly has. So if I study Guatemala, I do so carrying with me cultural assumptions that are not merely *different* from, but potentially *exploitive* of, Guatemalan culture. Consequently, there is considerable turmoil about whether the anthropological project, born of European colonial interests, can ever serve the interests of a colonized people (Bhabha, 1994; Marchand & Parpart, 1995; Patai, 1991; Stacey, 1991). There are, of course, similar concerns about European Americans studying African Americans or men studying women (Collins, 1990).

The epistemological problem is that these understandings of culture are based on an unexamined philosophical realism that assumes a culture is a "thing" that pre-exists its description and that ethnographers are simply "mirroring" (more or less well) the cultural entity. However, "culture is not a static object of analysis but a multiplicity of negotiated realities within historically contextualized (and contested) communicative processes" (Salazar, 1991, p. 98). Interestingly, at least

in U.S. nursing literature, many of these researchers hold self-avowed "constructionist" perspectives while writing as if the culture they are "representing" is an objective phenomenon. Thus they tend to under-theorize the framework from within which they are "describing" the culture.

A key point is that writing culture is a definitional act and, as such, always creates an "other," an "outsider," a "not us." This "other," then, is *defined* in relationship to the first position; this sets up a binary (us/them) in which the first term is privileged (i.e., in a descriptive sense it "sets the terms") and is often hierarchically located as superior, preferential, etc. (Said, 1978).

Another, empirical and political, problem with such descriptions is that in the nursing literature they tend to be nationalistic. Ethnic/cultural locations very often "happen" to be written within vocabularies of nationalist boundaries. My own examples (e.g., Chinese, Thai, etc.) have done this. Almost all current "nations" are, of course, colonialist creations. Even those that have had successful anticolonialist revolutions often stay mired in the binaries of nationalistic identities that are the mirror image of the colonialist project they attempted to purge (Said, 1993).

To conclude about culture: my two main points are that (1) culture is created, not discovered, and (2) when the standpoint from which it is created is inadequately articulated, the result is likely to participate in various forms of colonialist appropriations.

## *Gender*

The discourse around gender is somewhat easier to address, because the term "gender" was created to detach the social construction of sexual identities from the "real" biological differences of sex. There are three points I'd like to emphasize with respect to gender: (1) genders are not binary: any time we sort folks into two kinds (male/female, masculine/feminine, men/women) we are really talking sex, not gender; (2) the "body" is as much a cultural construction as "gender"; and (3) gender is always cultured.

My discussion of gender is linked to my discussion of culture in several ways. I can capture my main theme by saying "demographic categories" are theory-laden, not simply "descriptive," and they are not politically neutral (Mohanty, 1991). Thus I believe we need to be much more theoretically self-conscious about how we employ these cate-

gories in our theory, research, and practice (Allen, Allman, & Powers, 1991). Whenever one uses a social category that is *also* employed as a mechanism of social injustice, one is in danger of reproducing the conditions that perpetuate injustice. For example, the U.S. culture employs categories such as "gender" or "race" to privilege or restrict access to important cultural resources and opportunities (e.g., jobs, salaries, cultural authority, mortgages, housing). These categories operate ideologically in the sense that they become internalized into ways we think about other people (e.g., what we "expect") and ourselves (e.g., what we desire, our self-concepts). Consequently, when one thinks of *oneself* as a "man," one thinks in terms that are complicit with (but also escape, go beyond) sexism. When I identify my students or research participants as "women" or "African American" or "American Indian," I am using a social theory that these are "basic units of analysis."

And they are. But one reason they are is society itself uses them to structure opportunity and privilege. Often, however, people think "gender" is "basic" because it is grounded in a biological reality. This marks "gender" (and "race") as a different sort of demographic marker from "culture" or "ethnicity," because it presumes the former are "secured" by the natural order of things while the latter are secured by history and society.

I believe this conceptualization of gender is misleading in ways that are analogous to the way thinking of culture as a "thing" is misleading. In the short space I have here, I can briefly trace but one line of argument to suggest the concerns I have and a way out of them. I suggest we think of bodies (e.g., sex) as social objects, *not* "natural" (pre-social, "real").

Three lines of reasoning can help free us from this biologism. First, whatever else bodies are, they are discursive objects in exactly the same sense that cultures are (Jacobus, Keller, & Shuttleworth, 1990; Smith, 1990; Turner, 1984). We have numerous cultural conversations that construct the "body" in multiple ways. Biological conversations are only one set, although they are culturally privileged. There are fashion, fitness, penal, educational, and a host of other cultural discourses about bodies (Coward, 1985). But I'll stay with the biological because it has the most ideological hold on us, since we think it's not our conversation, but nature's own.

Second, biological taxonomies are theoretical, conventional, pragmatic ordering systems. They are internally inconsistent and historically and theoretically variable (Diprose & Ferrel, 1991; Lewontin, 1994;

Martin, 1994). Think, for example, about the assumptions behind assuming that "skin" marks off a "body" from its "environment," despite the fact this border is transitory (since we shed it regularly), permeable, and arbitrary (why not set the border in thermal terms?). Skin is a practical boundary only for certain purposes; for others it is irrelevant. Virtually no internally consistent biological taxonomic system, for example, sorts human bodies into only two sexes. Chromosomes do not. There are XXY, XYY, and a host of variations. Possession or non-possession of uterine tissue does not. External genitalia do not. And social taxonomies are even more multiple and overlapping (hence we wonder if gays or quiche-eaters are "real men") (Jaggar & Bordo, 1989).

Third, the body is always already cultural and historical (Oudshoorn, 1994; Turner, 1984). The differentiating of bodies increasingly starts before birth through technological identification of sex that immediately creates a different context for male and female fetuses. Once a child is born, social shaping of its body increases in intensity. Thinking this way requires us to take "seriously the ways in which diet, environment and the typical activities of a body may vary historically and create its capacities, its desires and its actual material form... the typical spheres of movement of men and women and their respective activities construct and recreate particular kinds of body to perform particular kinds of task" (Gatens, 1992, p. 130). There are no bodies (or organs) that are not already shaped by their cultural context.

To summarize, our descriptions of "culture" and "gender" are always perspectival social constructions. They always depend upon a host of theoretical assumptions and not upon some guarantee of correspondence to a "real" world independent of our conversations about it. And since these demographic categories are always already taken up by, created in, systems of injustice, we need to be extraordinarily careful not to supply further support for these systems by unintentionally reproducing ideological discourses under assumptions of descriptive neutrality.

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# Symptom Management: What We Know and What We Do

Celeste Johnston

Nursing has considered symptoms as perceptions, experiences which are often distressing, as opposed to the medical perspective which views symptoms as keys to diagnosis. Diminishing distressing symptoms has been at the essence of nursing since its inception. In her book *Notes on Nursing: What It Is and What It Is Not*, Florence Nightingale highlights the relief of pain and discomfort as central to nursing (Nightingale, 1946). Much knowledge has been acquired about certain distressing symptoms, particularly pain, but less about others. The mechanisms of pain, factors that exacerbate it, pharmacological agents that decrease it, and comfort measures that soothe it have all been studied by different disciplines, including nursing. There are even textbooks on the nursing management of pain where this information is detailed (Donovan & Watt-Watson, 1992).

However, there are still data suggesting that nurses do not utilize the knowledge they have regarding pain management (Abbott et al., 1992; Donovan, Dillon, & McGuire, 1987), particularly in children (Johnston, Abbott, Gray-Donald, & Jeans, 1992; Schecter, Allen, & Hanson, 1986). This is due, in part, to inconsistent knowledge and inconsistent beliefs about the value of changing practice among nurses. Howell, Foster, Hester, Vojir, and Miller (1996) describe the implementation of a pain management program for nurses in a pediatric setting. They clearly describe the process of the acquisition of knowledge by staff. From this description, the comprehensiveness involved in changing staff attitudes towards pain management is evident and can partly explain why less comprehensive and less rigorously implemented programs have failed. These authors followed through with their program and found that ultimately nurses truly "owned" components of the program's pain assessment and management strategies, as shown by their personal modifications which maintained the principles of the program.

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Another reason why nurses do not appear to manage pain adequately in spite of what is known about pain is, in fact, that there is such an abundance of knowledge that it is difficult to make decisions about which particular strategies to use in specific situations. Carroll (1996) discusses evidence-based practice in the area of pain management. She makes a strong case for the use of meta-analysis in the area of pain management, based on its strengths and the weaknesses of other approaches to synthesizing current knowledge. A caveat on the use of meta-analysis is that it can only be as strong as original articles are scientifically sound. Given the abundance of literature on pain management, this is less of a problem for that particular symptom.

While we do know a lot about physical pain, and while light is being shed on how we can use that knowledge in practice, the area of psychic pain is much less understood. Observation and documentation of symptoms of schizophrenia have been "medicalized," the goal being accurate diagnosis. Baker (1996), however, used qualitative methods to examine the subjective experience of patients suffering from schizophrenia and found that psychic pain was the overriding symptom, or distressing element of their experience. Furthermore, the fluctuating intensity of their psychic pain, as opposed to other symptoms, was a key signal of changes in their illness trajectory. The reports she was able to elicit from her participants of their emotional pain were moving and poignant. Baker puts these reports into a framework that can be used by nurses, taking the reports beyond a beginning appreciation of what their experience is like.

The major concerns of nursing, to both sift out what we really know about the symptom and use that knowledge in managing the symptom, apply to all symptoms.

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## Shadow and Substance: Values and Knowledge

Robin Weir, Gina Bohn Browne, and Jacqueline Roberts

Three umpires are sitting discussing the game and one says, "There's balls and there's strikes, and I call 'em the way they are." Another says, "There's balls and there's strikes, and I call 'em the way I see 'em." The third says, "There's balls and there's strikes, and they ain't nothin' until I call 'em." (Anderson, 1990, p. 75)

This essay is about the factors that influence the making of judgements in science: the shadow and the substance. We will review some studies that indicate the clear requirements of quality nursing research in order to examine outcomes and measures. The knowledge of methods assumes — and this is particularly true of quantitative traditions — objectivity or neutrality in the science of inquiry. The epistemological problem is that any process that generates and interprets outcome research is value-laden. Often left unexamined is the impact of the researcher's biases and values on the direction of the inquiry and the interpretation of findings. For example, we recently found that 45% of sole-supporting parents on welfare were depressed, as observed by the nurses. Our social scientist colleagues, from the same data set, noted, "Isn't it amazing that as many as 55% of sole-supporting parents on social assistance programs are not depressed?" Given the current emphasis on evidence-based nursing, who will raise questions concerning the impact of this value-laden evidence on practice, and on planning and policies, considering the nature and extent of our services?

Is there such a thing as comprehensiveness in science? What we set out to quantitatively measure or qualitatively *notice* reflects our values and assumptions about important variables, mechanisms, pathways, and interactions. We find what we intend to notice, or indeed fail to find what we did not even know enough to notice. Do we ever consider measuring simultaneously (noticing) the opposite, or the unintended effects — the harms and risks — as well as the benefits and impacts? Is the glass half empty or half full? Is it short or tall? Are the contents 7-

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Up or another soda? Is this even relevant? How does the reality of the simultaneous nature of multiple effects and states affect our inquiry and our interpretation of events? Will the results of our inquiry be affected by our failure to observe that the glass is opaque, not clear; red, not blue; effective or ineffective in alleviating thirst? We must notice what we intend to effect; however, once we do so, we often fail to notice something else. There is no such thing as value-free and meaning-free knowledge, nor is there objective or comprehensive information.

In the research process, however, the structure of the argument and the design of the study itself may help to control the bias of value-laden knowledge. From this perspective, we are required to seek the outcome in different situations, at controlled points in time, that may challenge assumptions or expectations. Time alone may produce unintended effects and expenses! In addressing selected methodological issues, Onyskiw (1996) and Sidani (1996) acknowledge the importance of the design features, including the need for a control group when evidence for changes in outcome, with or without exposure to the intervention, are required in order to produce an intended effect.

On the other hand, although certain measures of outcome may be reliable and valid, they assume, by definition, what is favourable and unfavourable — for example, measures of quality of life, coping strategies, and decision-making approaches. Should we wonder about the circumstances under which it is healthier to find a situation intolerable, meaningless, or unmanageable? Does adversity ever provide an advantage? Is adversity always faced alone, and what is most problematic or protective — the circumstance, the event, or the response? In such intolerable situations, what should be measured — the outcome, the input, the pathway, or the mechanism by which individuals succumb to or survive the circumstance? Or should all of the above be measured — the shadow and the substance?

Should we measure the clinically important change between groups or the minimally important change within an individual? Is it our intention to discriminate or to evaluate, to say that there is a difference or that there is an equivalence? Onyskiw (1996) suggests that the significance lies in not only the size of the effect, but also the variation in effectiveness that may lead to further inquiry. Harrison, Juniper, and Mitchell-DiCenso (1996) elaborate on the conditions that facilitate the choice of one option over another. Whichever one is chosen, the outcome of interest may be the alleviation of a symptom or a gain in competency. The important issue is whether a state of health has been reached. Onyskiw describes this state as "the level of the variable."

Bunn and O'Connor (1996) describe it as "the individual's valuation of the achievement of a goal."

Harrison et al. (1996) cogently argue that enhanced quality of life is the ultimate goal of most nursing interventions. Nursing practice aims to modify, when necessary, a person's response to their circumstance, to cast a different shadow on the same substance, or indeed to redefine the substance. Consequently, outcomes of interest may be the *capacity* to cope or not to cope with a deteriorating circumstance when other perspectives may view coping as the *mediator* or pathway variable to a state of peaceful death.

Individual, group, and system outcomes coexist. In noticing one level we can ignore another, and generalize that a benefit was produced in a group when in fact a subgroup of individuals deteriorated. People on antidepressant medication may sleep better, have more energy, and cry less, but some of these people may view themselves as broken or defective because they require medication. Gottlieb and Feeley (1996) demonstrate the value of studying the mechanisms by which change occurs and the power of analyzing subgroups in detail.

How do we deal with the uncertainty and error inherent in measurement? Does the information obtained from such measures inform the policy for the average (means, modes) or the practice policy for the exception (extremes)? Do we treat, according to the available evidence, on the basis of the "average" dose, or the "exceptional"? Are the standardized methods used in the "managed care" approach applicable to all people, across all contexts?

We may think service interventions produce favourable individual outcomes with no more expense to the system when, in reality, the cost is merely shifted from one sector to another. Consider the shift in expenditures from the health-care system to the family system, such as occurs in the case of home care. In contrast, reductions in social services generate health-care services, which shifts costs, however inappropriately, from one entitlement program to another. Outcomes, whether individual, systemic, or societal, require interpretation from multiple perspectives. We create reality, problems, or resources by the way in which we view them.

Given that reality is created by our view of it, the value of synthesis and integration of findings from a number of authors is clear. Onyskiw (1996) describes meta-analysis both as a way of integrating findings from quality studies and as criteria for judging it to be a good primary study to begin with. In this, she alludes to the importance in

outcome research of the research design, or the structure of the argument. When, in both the presence and the absence of the circumstance, service, or intervention, should one observe the effect, expense, outcome, or mechanisms?

Outcomes are values at different points in time and should not be considered a final truth. The goal is to "flirt with your hypotheses, but don't marry them!" (Freedman & Combs, 1996, p. 7).

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# **Trajectories and Transferability: Building Nursing Knowledge about Chronicity**

**Sharon Ogden Burke**

We have seen a shift in the generation of nursing knowledge, from biomedical, illness, and disease models (exemplified by "a diabetic patient") to psychosocial, educational models (exemplified by "a person with diabetes" or, more broadly, "a person with a chronic condition"). Behind this shift is a generic view of chronicity, one which posits that the psychosocial issues shared by individuals across hundreds of medical diagnostic groups outweigh those that are unique and biomedically based (Perrin et al., 1993). The psychosocial model recognizes the importance of the *effect* of the condition on the individual, as opposed to the condition alone. For example, it is from this generic perspective that Magyary and Brandt (1996) view children and their families as they cope with chronic conditions.

The shift to generic views of chronicity has not been absolute. Nearly all nursing researchers sensibly still report the disease categorizations of their subjects, while at the same time designing their research and discussing their findings with a view to generalizing to a broader population of persons with similar chronic conditions. This approach assumes that a generic view might be too simplistic and that abandonment of the medical categorizations might be premature. Generalizing about chronicity issues might be well served by the more multidimensional concept of illness trajectory. For example, Ellerton, Stewart, Ritchie, and Hirth (1996) studied children with three types of medical diagnoses in order to sample a range of illness trajectories.

The concept of chronic illness trajectory includes notions of direction of the short- and long-term course, the relative stability, and the degree of uncertainty about the course of the condition. Various groupings of trajectories that have been proposed include progressive, constant, relapsing, and episodic (Rolland, 1987; White & Lubkin, 1995; Wong, 1993).

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Two promising outcomes for knowledge development in nursing are implicit in the trajectory concept. First, trajectories could provide a way of grouping myriad chronic conditions into a smaller set of trajectories. Thus we would not need to replicate the same study with every possible medical diagnostic population before using descriptive findings with persons with similar trajectories. Hernandez's (1996) research concerned persons with diabetes; one wonders if her findings might have relevance for persons with similar trajectories — for example, those with renal disease.

The second implicit advantage for knowledge development is that similar trajectories might have common sets of nursing diagnoses and interventions. This is an attractive notion: experimental research with a group of persons with one medical diagnosis could have relevance for persons with other diagnoses, to the extent that they have similar trajectories.

However, researchers and evidence-based practitioners of nursing have been hesitant to make such leaps of logic for fear of overgeneralizing, influenced as we are by the logical positivist's view of such generalizing across medical diagnoses. When rigidly applied to research with persons with chronic conditions, direct clinical applicability of findings would be possible only after experimental research demonstrated cause-effect relationships in randomly selected samples from defined populations. Few can accept such a limited view. Furthermore, the logistics, time, and expense of replication of every study with persons in hundreds of other diagnostic groups would be daunting. More seriously, exclusive use of this approach would bias and limit knowledge generation, by restricting study to medical diagnostic groups that are sufficiently large in numbers. Sampling protocols based on logical positivist principles tend to exclude persons with less common medical diagnoses and persons with multiple problems, such as those with associated mental-health or learning problems. This creates a new generalizability issue, because the true population of persons with chronic conditions can never be sampled with strict adherence to this view.

An alternative concept to the logical positivist's generalizability construct is Lincoln and Guba's (1985) transferability. Transferability of research findings to clinical practice is judged by the user of the findings based on the fit of the sample and the findings to the practitioner's clients. Using the yardstick of transferability rather than generalizability as a guide, trajectories of chronic illnesses offer even more promise for knowledge generation.

It is tantalizing to imagine that transfer of research-based nursing knowledge might be possible across persons with similar trajectories but dissimilar medical diagnoses. So why has trajectory not replaced medical diagnosis in identifying populations for our nursing research? I suspect the answer lies, to a great extent, in how we recruit subjects within a biomedically oriented system.

Beyond the logistics of recruitment, there are still caveats to the transferability of research findings across medical diagnoses, but within trajectories. Age, stage or phase of the illness, and the nature of current stresses and tasks are factors that are apt to impinge on the applicability of the construct of transferability.

The age and developmental stage of the person with a chronic condition, and probably that of their family caregiver, can be expected to influence or override the notion of trajectory. It is not logical to extend the notion of trajectory to very young children or to others who cannot project into the future. At times, a parent's notions of their child's trajectories might be more relevant than those of the child.

It would be logical to hypothesize that the client's view of their condition's trajectory is most salient for nursing research when their current tasks or stresses are of a psychosocial nature. Nursing diagnoses that are predominantly psychosocial in content might be more apt to cluster under illness trajectories than nursing diagnoses that are pathophysiologically based. It would follow that a trajectory framework might be most suitable to nursing interventions that involve psychosocial support.

During acute phases — to the extent that the pathophysiological issues are paramount — an illness trajectory framework might not be as salient for our research or practice. Trajectories might not come into play during the course of initial diagnosis or acute exacerbations, for two reasons. First, pathophysiological issues are paramount. Second, trajectory is a cognitive construct that takes a person time to develop and bring into play. Thus in the early phases of a person's awareness of having a chronic condition, such as learning of the diagnosis and learning about treatment, biomedical frameworks might be in the forefront. However, as soon as the "long haul" (Rolland, 1987) of coping with the condition becomes the primary issue, trajectories may become relevant.

Our conceptual frameworks on death and dying could be viewed as a phase in chronic illness trajectories, although they have not traditionally been seen as such. In the context of a person's trajectory, the

final phases of illness are very well described compared with the long haul of coping with a chronic condition.

The next steps in building nursing knowledge about chronicity include synthesizing reviews of completed research, definitions, and measures of trajectories, and then using the concept of trajectories to inform subject selection. I suspect that common themes could be teased out of existing research through systematic reviews and synthesis of findings concerning persons with similar illness trajectories. Such systematic reviews will be hampered by a lack of information on the subjects' trajectories and will speculate, primarily informed by the medical diagnoses provided in the descriptions of subjects, in identifying types of trajectories.

As a result, a common recommendation in such reviews might be a call for operational definitions and measures of trajectory. Definition has already begun in the works referenced below. However, measurement for research and clinical uses is in its infancy and not likely to be well developed for some time.

In the meantime, the development of knowledge about chronicity would be enhanced if researchers considered trajectories in their sampling designs. Trajectory information could be included in descriptions of intake protocols, measures, findings, and discussions in research reports.

Early work on trajectories viewed them primarily from a professional, biomedical perspective. Later work has taken the perspective of the individual and the caregiver, in which psychosocial issues come to the fore. Other work on professional-client relationships has found that these two perspectives differ. This suggests that descriptions of subjects could include illness trajectories from more than one perspective — from those of the individual, the caregivers or other family members, or the health-care professionals. How often do researchers ask their subjects to give their views on the course of their condition or trajectory? I suspect we will be in for some surprises.

The concepts of trajectory and transferability hold promise for the enhancement of nursing knowledge about chronicity. I eagerly await the next generation of chronicity research.

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# Promotion de la santé : Enjeux pour l'an 2000

Michel O'Neill

## 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 (Badgley, 1994 ; Bunton et Macdonald, 1992 ; Green et Kreuter, 1991 ; 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).

### *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

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populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci» (Charte, 1986, p. 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, p. 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 (Evans, Barer et Marmor, 1994 ; Lalonde, 1974). D'autre part, il s'agit d'abord et surtout d'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 individua-

lisantes 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 (Hancock et Labonté, 1997; O'Neill, 1996; O'Neill, Rootman et Pederson, 1994; Rootman et Goodstadt, 1996).

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 (Bottroff, Johnson, Ratner et Hayduck, 1996; Stewart, 1995).

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 (Dallaire, 1991; Flynn, 1996; Milio, 1971) 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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# **Consumer/Patient Decision Support in the New Millennium: Where Should Our Research Take Us?**

**Annette M. O'Connor**

[W]hile Canada has a lot of health-related information, much of this information is neither accessible nor usable.... How can we develop methods and incentives which encourage providers, administrators, and policy makers to adopt best evidence into practices, programs and policies to support decisions related to...health care...what can be put in place to make it easier for the public to become more involved in the decision making process surrounding...health care and their personal health?

— National Forum on Health Key Strategic Direction:  
Using Better Evidence for Better Decisions

There is a growing interest in the area of decision making and the contributions of nurses to the science of decision support for patients. Several factors have contributed to this interest. The rise of consumerism and patient empowerment has shifted the emphasis from the more passive informed consent to informed choice. Health-services research in practice variations and the movement for evidence-based practice have stimulated the dissemination of clinical guidelines not only to practitioners but also to patients, particularly when the best course of treatment is uncertain; when the decision involves making value trade-offs among risks and benefits; or when patients can play a role in reducing inappropriate use of health services. The increase in technology assessments of current interventions using decision analysis has led to increased identification of treatment decisions that are "utility"- or "value"-sensitive — that is, dependent on the importance that patients place on the risks relative to the benefits. Large outcomes studies and overviews have provided stable estimates of benefits and risks among patient subgroups, which permits tailoring of decision aids. There is also considerable interest in the cost-effectiveness of adopting a more selective, patient preference-oriented approach and reserving interventions for those patients who consider the treatment

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benefits to outweigh the risks (for example, reserving palliative surgery for those patients who consider alleviation of their symptoms to be worth the surgical risks, rather than basing a surgical policy on the utilities of the average patient).

The role of practitioners in helping patients to make decisions varies according to the nature of the decisions, the preferences for control in decision making, and the expertise of clinicians and patients. Several practice guidelines advocate a shared decision-making approach, and Marilyn Rothert of the Faculty of Nursing at Michigan State University has described the various roles as follows: Practitioners provide information about the options available, the risks and benefits, and the health-care resources that are required and available; patients convey their value for the risks and benefits and the personal, financial, and instrumental resources that are available to help them make and implement the decision. Both Degner (Degner, Sloan, & Venkatesh, 1997) and Llewellyn-Thomas (1997) have contributed tools to facilitate this process.

Degner's tool (Degner et al., 1997) helps us to assess the role that patients want to play in decision making so that we can tailor our support to their needs. Her work raises as many questions as it answers. How do preferences vary among cultural groups? Which decisions are associated with stronger preferences for decision participation and which decisions are associated with weaker ones? How do preferences change over time? Should we tailor our counselling to decision-participation preferences or should we try to change them? If the former approach is advocated, which strategies work best with patients who have different participation profiles?

Llewellyn-Thomas (1997) has developed a strategy for helping patients to consider and communicate their values. How does this strategy improve the quality of patient-practitioner communication, the quality of the decision, and the outcomes of the decision? Are patients more likely, if this strategy is used, to choose alternatives consistent with their personal values? Will they be more satisfied with their decisions and more likely to stay with their decisions? What is the efficacy of this approach to values clarification relative to other approaches?

My colleagues and I highlighted the early phase of development for this field of inquiry in an annotated bibliography on decision-support interventions (O'Connor et al., 1997). Why only the early phase, when patient-education research has existed for well over 30 years? Decision support can be distinguished from general patient education by virtue of its: focus on alternatives, benefits, and risks; tailoring of information

to a patient's clinical risk profile; provision of detailed descriptions of the benefits and risks in functional terms; use of probabilities, when these are available, to describe the likelihood of benefits and risks; asking patients to consider their values either implicitly or explicitly during deliberation; and emphasis on choice and shared decision making. Decision support evolved from the general field of patient education through a fusion, in the late 1980s and the 1990s, of consumer and health-services research influences.

To date, most decision-support applications have been developed for patients with chronic or life-threatening diseases, particularly cancer. The focus has been on decisions about surgical or medical therapies, although a few studies have considered preventive, early-detection, end-of-life, and clinical-trial participation issues. The decisions are characterized by the need for careful deliberation about alternatives due to the risk or uncertainty of the outcomes or the value-laden nature of the decision where benefits need to be balanced against risks.

The approaches used to provide decision support vary widely, from personal counselling to the use of structured aids as adjuncts to counselling. Some include formal decision analytic methods in which the patient's utilities are elicited and incorporated into a decision tree. Others use a decision analytic perspective to structure the aid, but rely on the patient's intuitive choice, rather than a mathematical combination of probabilities and utilities, to guide action. Research over the past 15 years has demonstrated the poor correspondence between intuitive choices and those derived from expected-utility decision analysis. Advocates of the intuitive-choice approach maintain that decision analysis should not be used in prescribing choice because it is poor in describing actual decision behaviour. Proponents of decision analysis argue that individuals are incapable of processing complex information and therefore should be guided by logical mathematical models. This debate will probably continue as both approaches are applied and evaluated in clinical practice.

The decision aids vary in the ways in which the probability of benefits and risks are described (numerical, non-numerical) and illustrated (pie charts, bar charts, 100 figures). The approach to values clarification also varies (implicit, or explicit using tradeoff tasks, relevance charts, weigh scales, or utility assessments). The provision of normative information describing the opinions of experts and patients also differs. The impact of these variations on actual decisions has yet to be established.

The decision aids vary widely in mode and cost of delivery. They are presented via decision boards, interactive video discs, personal

computers, audiotapes, booklets, pamphlets, and group presentations. Their relative effectiveness, efficiency, and acceptability need to be evaluated.

The published studies evaluating decision aids are few in number and often have several methodological limitations. For example, only 14 of the 31 published studies used a randomized trial design and only five of these had a usual-care control arm. Even in these five studies, it was not always clear what the decision was and whether all patients were actively considering the decision. Moreover, most of the studies were limited in generalizability because of the small and non-random sampling. Therefore it is difficult to make any conclusive statements regarding the efficacy of decision support relative to usual care for a broad range of patients facing actual decisions.

Despite these limitations, the following trends have been noted. Decision-support strategies have received generally consistent positive ratings by patients in terms of feasibility, acceptability, length, balance, clarity, amount of information, and usefulness in decision making. Yet to be determined is the generalizability of these results to different groups who vary by age, education, ethnicity, and preferences for control in decision making and the comparative advantage of different approaches. Utilization of decision aids in general-education programs such as CHESS is fairly limited, because many users are not actually at that point in decision making.

Before/after studies have found that decision aids usually increase patients' general knowledge of alternatives, risks, and benefits after they are administered. However, there do not appear to be any gains in general knowledge when information about alternatives, benefits, and risks is presented via different delivery methods (e.g., video, brochure/pamphlet, group, audiotape, computer) or intensities of decision support. The lack of difference is presumably due to the considerable overlap in content provided in the different interventions.

Tailored decision aids have the potential to create realistic expectations (due to the tailored probabilistic information) and to clarify values (due to detailed information about outcomes from which value judgments can be formed and the explicit values-clarification exercises). There have been few studies to examine impact on expectations. In terms of clarifying values, three studies have shown that decision aids promote value congruence with decisions. More investigation is needed using these important endpoints, which tap two key differences between decision-aid interventions and usual-care approaches.

Both before/after and comparative studies have found the impact of decision aids on decisions to be quite variable. This variability may be the result of the nature of the decision, the strength of the baseline predispositions toward the issue, the degree to which the decision was hypothetical, or methodological limitations. Four of the five stronger randomized trials with patients at the point of decision making found no differences in decisions. The one exception was a study comparing information presentations on prostate screening (single sentence versus detailed information on benefits and risks). This is an area that clearly needs more investigation. Optimal study designs should have baseline predispositions, be randomized, have a control group, clearly define the decision, and recruit patients at the point of decision making.

Even less is known about the impact of decision aids on patients' satisfaction with the decision and with decision support. Practitioners' reactions to using decision aids are under-explored. Evaluations are also needed to determine the impact on long-term decision persistence, health outcomes, health-care utilization, and costs.

In conclusion, the National Forum on Health has challenged us to find ways of involving consumers/patients in decisions about their personal health. Many tools and approaches have been developed to assist us in helping our clients to make difficult decisions. However, the jury is still out regarding their effectiveness, efficiency, and suitability with different groups under different circumstances. We have our work cut out for us until well past the year 2000!

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# **Loss and Bereavement: Perspectives, Theories, Challenges**

**Jeanne Quint Benoliel**

Loss is a common experience in human existence. Major loss stimulates both personal and social responses, often of high intensity, as was observed throughout the world after the tragic accidental death of Princess Diana in 1997. Knowledge of loss and grief has been reflected in poetry, paintings, novels, myths, and plays across the centuries of recorded history. Understanding the complex influence of loss on human adaptations and collective responses has come about in the 20th century through scientific approaches to the creation of knowledge.

## **Historical Overview**

### *Origins of Studies on Loss*

The first systematic study on loss is credited to the psychoanalyst Freud (1957), who proposed that grief is a process in which loss is resolved through hypercathexis followed by gradual decathexis related to internalized bonds of attachment. Eliot identified the need for studies on family grief (1930) as well as for a social psychology of bereavement (1933). Lindemann's (1944) psychiatric study of acute-grief responses of survivors of a deadly nightclub fire served as a stimulus for the development of research and theory by investigators in many fields.

Research on loss and bereavement was closely associated with the emergence of the "death" movement in the 1950s and 1960s. Perspectives on mourning as a process of adaptation were found in the writings of Irion (1954) and Jackson (1957) in the field of pastoral psychology. Marris (1958) described the bereavement responses of women to the death of their spouse, and Parkes (1964) outlined the effects of bereavement on widows' mental and physical health. On the subject of catastrophic loss, Lifton (1963) wrote of the numbing effects of mass

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atomic death on the survivors of Hiroshima. Interest in the study of death led to systematic research in many disciplines, the emergence of interdisciplinary journals and organizations, and the development of death education for both lay persons and professionals (Pine, 1977).

### *Viewpoints and Theories*

Observation of the loss experiences of children led to clinical studies and, in turn, theories to explain the contribution of loss to human development. Proponents of psychoanalytic theory focused on reactions to loss and separation as tied to psychic conflicts in childhood (Peretz, 1970). Proponents of attachment theory (Bowlby, 1973, 1980) perceived grief as an adaptive response that takes account of present as well as past meanings of loss, and environmental as well as intrapsychic influences. Both perspectives provided the bases for subsequent studies on loss and bereavement in children and adolescents.

Knowledge of bereavement in adult life was stimulated by Parkes's (1972) studies, which included identification of predictor variables for estimating bereavement outcomes after the loss of a spouse (Parkes & Weiss, 1983). In a comprehensive review of research on loss, grief, and bereavement, Raphael (1983) found that the phenomena had been studied from many theoretical perspectives. She reported that studies focused on growing old, surviving disaster, and caregiving, in addition to death losses experienced by children, adolescents, and adults.

The proliferation of studies on loss and death in many fields brought new terminology to describe and explain the observations. Adding to the language of loss were concepts of anticipatory grief (Schoenberg, Carr, Kutscher, Peretz, & Goldberg, 1974), grief work (Worden, 1982), cultural variations in bereavement (Rosenblatt, Walsh, & Jackson, 1976), complicated mourning (Rando, 1992-93), disenfranchised grief (Doka, 1989), and transcendence of loss (Weenolsen, 1988). Research served to broaden our understanding of bereavement to include special meanings of parental grief (Klass, 1988), sibling bereavement in adolescents (Balk, 1990, 1996; Davies, 1991), and the effects of parental death on child adjustment (Worden & Silverman, 1996). By the 1990s, differences in viewpoint on the processes and outcomes of bereavement were stimulating debate in the literature on myths and misconceptions associated with loss and grief (Stroebe, van den Bout, & Schut, 1994; Wortman & Silver, 1989).

### ***Programs and Interventions***

A basic component of the hospice, begun in the 1960s to provide humane care to the dying, was bereavement services for survivors (Corr & Corr, 1983; Stoddard, 1978). The clinical needs of people struggling with various losses contributed to the development of grief counselling and grief therapy (Worden, 1982).

Crisis-intervention programs and teams had origins in Caplan's (1964) thinking on preventive psychiatry. Suicide-prevention programs were established in many communities, and crisis teams were assembled to manage disaster situations. Mutual-help groups sprang up in response to growing needs for assistance with bereavement. Among these were the Widow-to-Widow program initiated by Silverman (1980, 1986) and Compassionate Friends, an organization for bereaved parents (Klass, 1988). In the 1990s, guidelines were developed to help schools to set up bereavement services for students and staff (Stephenson, 1994).

Literature on how to assist bereaved persons and groups has grown extensively over the past two decades. This literature includes guidelines for clinical caregivers (Rando, 1984), proposals for helping children (Wass & Corr, 1984), strategies for assisting adolescents (Corr & Balk, 1996), and proposals to guide work with specific populations such as persons with AIDS and their survivors (Nord, 1996) and the bereaved elderly (Caserta & Lund, 1992).

## **Loss from a Nursing Perspective**

### ***Perspectives and Programs***

Nursing literature is rich in anecdotal accounts of loss and bereavement, which are often accompanied by proposals for clinical interventions. Research on terminal illness contributed to perspectives on personal loss, group loss, multiple loss (Benoliel, 1971, 1985a), professional loss associated with clinical practice (Benoliel, 1974), and guidelines for nursing practice (Benoliel, 1985b).

Bereavement research added perspectives on parental health and adaptation to the loss of a child (Miles, 1985; Williams & Nikolaisen, 1982), sources of guilt in parental bereavement (Johnson-Soderberg, 1981; Miles & Demi, 1983–84), family influences on sibling bereavement (Davies, 1988, 1991), and the salience of ongoing attachment in adolescent sibling bereavement (Hogan & Balk, 1990; Hogan & DeSantis,

1992). From research on widowhood came insights on grief resolution (Saunders, 1981), adjustment processes (Demi, 1984a), and health and coping among elderly widows (Gass, 1987; Heath, 1990). Studies in the 1990s have added perspectives on the search for meaning in loss (Steeves, 1996), grief among older women whose husbands died in hospice care (Jacob, 1996), loss associated with family caregiving in AIDS (Brown & Powell-Cope, 1995), and bereavement tasks of families (Steeves & Kahn, 1994).

Guided by clinical interests, nurses have helped to initiate assistance programs for various populations of bereaved persons. These programs include hospice services for children (Davies & Eng, 1995), a community-based bereavement network (Kirschling & Osmont, 1992–93), bereavement interventions in hospital emergency departments (Coolican & Pearce, 1995; Mian, 1990), and family bereavement services in pediatric oncology (Johnson, Rincon, Gober, & Rexin, 1993; Ruden, 1996). Nurses have also participated in the evaluation of support programs for parents (Heiney, Ruffin, & Goon-Johnson, 1995) and hospice bereavement services (Longman, 1993).

### *Models and Theories*

The search for outcome predictors was pioneered by Vachon and colleagues in their studies of conjugal bereavement (Vachon, Rogers, et al., 1982). More recently, Kristjanson and colleagues sought predictors of family functioning subsequent to the palliative-care experience (Kristjanson, Sloan, Dudgeon, & Adaskin, 1996). Tests of theory-based interventions were conducted by Vachon, Lyall, Rogers, Freedman-Letofsky, and Freeman (1980), who studied the effects of social support on adaptation among widows, and by Murphy and colleagues, who developed and tested a preventive intervention for bereaved parents after vehicle-related deaths of adolescent/adult children (Murphy, 1996; Murphy, Aroian, & Baugher 1989; Murphy, Baugher, et al., 1996).

Bereavement models in the 1980s were multidimensional and process-oriented (Demi, 1984b; Dimond, 1981; Murphy, 1983). Research evidence provided the base for models of parental bereavement guilt (Miles & Demi, 1983–84), caring in early pregnancy loss (Swanson-Kauffman, 1986), recovery from disaster loss (Murphy, 1989), a theory on adolescent sibling bereavement (Hogan & DeSantis, 1996), and an experiential theory of bereavement that encompassed the concept of personal growth (Hogan, Morse, & Tason, 1996). Developed to guide practice as well as research, this body of intellectual work by nurses

reflects a range of clinical situations of which loss and bereavement are salient components.

### *Current and Future Challenges*

As acceptance of loss and bereavement as serious human problems increased, so too did the numbers of people facing serious losses — many without the support of traditional family and kinship systems. The rapid pace of social and technological change has fostered environments in which human beings are vulnerable to the lethal effects of nuclear technology, virulent microorganisms, illegal drug use, and public and private violence (Benoliel, 1997). Around the world people are living with loss brought about by such human pursuits as warfare, terrorism, racism, genocide, and environmental contamination — which Leviton (1991) refers to as “horrendous death.”

The changed world of the late 20th century has brought with it a proliferation of groups living with multiple losses. These groups include refugees, the frail elderly, people with AIDS and their survivors, and persons disabled by injury and chronic mental and physical illness. This latter group is expected to grow in the next century. By World Health Organization projections, the leading causes of disease burden for the year 2020 are ischemic heart disease, unipolar major depression, and road accidents (Murray & Lopez, 1996).

In developed countries, bereavement services were slow to develop because they did not fit well with the organizing framework of disease and treatment. Funding for hospice and palliative care did not come easily, and the implementation of many of these services relied heavily on volunteers. Bereavement care has had low priority in the ranking of health-care needs and has relied on the good will of sensitive providers and the availability of resources from privately funded organizations. Private groups like the Red Cross have fulfilled basic needs and provided crisis services in situations of catastrophic loss affecting masses of people. Such crises, however, require help beyond that which can be provided by established agencies.

Nurses have been major players in confronting the challenges of loss and bereavement over the past 50 years. Meeting the new challenges of the 21st century will require them to move beyond the traditional ways of thinking about loss and grief — that is, as individual and family matters. Development of national and international programs geared to the human needs of large numbers of people will require new

perspectives on caregiving and new forms of leadership in interdisciplinary efforts to help bereaved persons in all parts of the world.

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# Will Evidence-Based Nursing Practice Make Practice Perfect?

Carole A. Estabrooks

La pratique ou la prise de décisions fondée sur des données probantes est en voie de devenir un secteur d'avenir dans le domaine des soins infirmiers et dans les professions de la santé en général. Ce concept, formulé par l'épidémiologiste britannique Archie Cochrane, a récemment été remis en vogue au Canada par le Forum national sur la santé qui s'est fait l'apôtre de la prise de décisions fondée sur des données probantes. Avant de faire des *soins infirmiers fondés sur des données probantes* notre mantra pour le XXI<sup>e</sup> siècle, il y aurait lieu d'examiner les origines et les répercussions de ce concept et d'approfondir certaines notions apparentées. Deux concepts importants devraient retenir notre attention, à savoir la nature et la structure des connaissances fondées sur la pratique et la nature et la structure de la preuve en général. À partir des résultats d'un sondage réalisé auprès d'infirmières dans l'Ouest du Canada, l'article décrit le vaste éventail de connaissances pratiques que les infirmières utilisent et qui sont en grande partie fondées sur l'expérience plutôt que sur la recherche.

Evidence-based practice, or evidence-based decision-making, is rapidly developing as a growth industry in nursing and the health professions more widely. It has its origins in the work of the British epidemiologist Archie Cochrane and has recently been re-energized in Canada by the National Forum on Health and its call for a culture of evidence-based decision-making. Before we adopt evidence-based nursing (EBN) as a mantra for the 21st century, we should examine its origins and its consequences, and we should probe related concepts, 2 of which are the nature and structure of practice-based knowledge and the nature and structure of evidence generally. Findings of a recent survey of nurses in western Canada are used to illustrate that nurses use a broad range of practice knowledge, much of which is experientially based rather than research-based.

## The Evidence in Evidence-Based Nursing

Though many clinicians might wish to use research in their practices, and though many researchers might wish to see the results of their studies put to good use, many factors get in the way of using research. We actually know very little about what makes *research use* happen or not happen. We are not even sure what *research use* really means, or what *research* is, or what the *evidence* in evidence-based practice really looks like. This is a significant problem when you consider that scien-

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tific knowledge is increasing exponentially and that, by some estimates, the scientific information available to us now will have increased by as much as 32 times by the year 2001 (Christman, 1991).

The purpose of this paper is to explore the origins of the evidence-based practice movement and some of its possible consequences for nursing, and to probe related concepts such as research utilization. It is argued that research utilization is a sub-set of evidence-based practice and that the term *evidence-based practice* ought to encompass a much broader range of evidence than the findings of scientific research. It is also argued that nursing would be well served by a critical examination of the evidence-based movement for its explicit and implicit assumptions, and for indications that it does actually bring improved patient and client outcomes as a result of improved nursing practice.

### The Origins of a Movement

Evidence-based practice is rapidly becoming a growth industry in nursing and the health professions generally. This is apparent in the emergence of the Cochrane Collaboration and the Cochrane Library, which houses the Database of Systematic Reviews (CDSR) and the Database of Abstracts of Reviews of Effectiveness (DARE), journals such as *Evidence-Based Nursing*, and centres such as the Joanna Briggs Institute for Evidence-Based Nursing in New Zealand. Nursing has some 25 years of experience with one dimension of evidence-based practice, research utilization. This experience dates from the large and often-cited Conduct and Utilization of Research in Nursing (CURN) project of the 1970s (Horsley, Crane, & Bingle, 1978; Horsley, Crane, Crabtree, & Wood, 1983) and from nursing's first empirical studies of the subject (Ketefian, 1975; Shore, 1972).

At the same time that nursing was experimenting with large research utilization initiatives such as CURN, Archie Cochrane had planted the seeds of the Cochrane Collaboration with the publication of his influential book (Cochrane, 1972). Those seeds came to fruition in 1993 when the Cochrane Collaboration was founded by individuals from nine countries (Chalmers, 1993). Today it is a global enterprise with centres scattered around the world and has been said to rival the Human Genome Project in its implications for modern medicine (Naylor, 1995). The Cochrane initiative has moved rapidly to infuse a new approach to teaching and practising in medicine. While it currently has a lesser influence on nursing, there is little doubt that this is an interim state. In fact as the Cochrane initiative continues to approach

critical mass it will be one of the major forces, in the Commonwealth countries, exerting pressure on nursing to adopt an evidence-based position. In the United States, where the Cochrane Collaboration seems to be less widely disseminated, the Agency for Health Care Policy and Research (AHCPR) may be exerting similar pressures. In medicine this evidence-based stance is called Evidence-Based Medicine (EBM). Calls for evidence-based decision-making, evidence-based practice, evidence-based nursing practice, and/or evidence-based nursing arise from the EBM movement, although in Canada these have received a recent boost from the National Forum on Health, which called for a culture of evidence-based decision-making (Evidence-Based Decision Making Working Group, 1997).

In 1992 the Evidence-Based Medicine Working Group published a manifesto, "Evidence-based medicine: A new approach to teaching the practice of medicine," in *JAMA*. This has become an official and core document of the official, albeit self-appointed, group responsible for implementing Cochrane's innovative 1970s ideas about pulling together research that had been done in particular areas, synthesizing it, and making it available to guide clinical practice. Whether Cochrane's revolutionary and important ideas have been truly rendered by the Working Group has yet to be determined. However, it is clear from the manifesto and from Sackett, Richardson, Rosenberg, and Haynes' (1997) book *Evidence-Based Medicine: How to Practice and Teach EBM* that the ideas are now more than ideas.

The EBM movement has been much criticized, the most recent rash of criticism being published in the *Journal of Evaluation in Clinical Practice*. The proponents of the movement have been accused of ignoring the context of clinical practice (Aveyard, 1997), de-emphasizing the need for an understanding of pathophysiology (Morgan, 1997), ignoring standard aspects of clinical training such as physical examination, promulgating medicine by numbers (Hampton, 1997) and worshipping statistical manoeuvres (Charlton, 1997), Taylor-like managerialism (Hunter, 1996) and authoritarianism (Shahar, 1997). Its elite proponents have been accused of being patronizing and condescending (Morgan) and of sometimes being anti-science (Hunter). Predictably, rebuttals of these and earlier criticisms have been published — see, for example, Sackett, Rosenberg, Gray, and Haynes (1996) and the Evidence-Based Working Group (1992) itself. In nursing we are seeing the emergence of a similar response to criticisms of evidence-based practice (DiCenso, Cullum, & Ciliska, 1998).

Some of the criticisms may be valid, others reactionary. Criticism in itself is healthy for any new intellectual undertaking. However, it is safe to say that EBM is more than a way of practising; it has taken on the qualities of a social movement whose purpose is, in part, and in addition to the obvious, the redistribution of power in medicine. If the movement is successful, the power base will move from the clinical specialists and sub-specialists to the clinical epidemiologists who are both the producers and the purveyors of the new knowledge needed for EBM. How will this affect nursing? Thus far the literature on evidence-based nursing (EBN) does not for the most part reflect an understanding that the term embodies more than just good nursing practice. In fact EBN is often treated as a moniker for research utilization.

Page (1996) refers to clinical freedom-fighters who believe in their inalienable right to freedom in clinical decision-making, and to intellectuals who think EBM is second-rate science. In nursing, however, we have not yet developed a serious critique. There are occasional warnings — Rafferty cautions that evidence-based practice can “make nurses responsible for issues that are beyond their control unless they are in an environment...where nurse led and evidence-based cultures are adequately supported” (Naish, 1997, p. 64). There is an occasional sweeping condemnation (Mitchell, 1997), based more in an opposing nursing epistemology than in a rational critique of the use of research in practice. And there are thoughtful papers — Mulhall (1998) raises provocative questions about the uses to which we put evidence-based practice, while Kitson (1997) cautions that:

...nursing may embrace the evidence-based movement without fully understanding the rules. And as written at the moment, the rules are about medical diagnosis, single clinical interventions, RCTs and meta-analyses...there is a limit to nursing evidence conforming to these criteria. What must not happen is that nurses are then excluded from the movement because their research is too poor or insufficient in rigour or size. (p. 38)

It behoves us to proceed thoughtfully and with caution — not rejecting the idea of evidence-based practice, but also not letting it become a tool to disempower clinicians or to cause more blaming of clinicians for not *doing it*. Scholars, students, and clinicians alike need to be critical consumers of nursing's writing on evidence-based practice. We must differentiate between information that contributes to better health outcomes — or to better practice in the name of eventual better outcomes — and information that is more relevant to our professionalization agenda. If we focus on the part of EBN and research utilization that has to do with improving patient and client outcomes, we find

good preliminary evidence that practice based on sound research affects outcomes positively.

Indications that research-based nursing interventions have the potential to positively affect client/patient outcomes include the following meta-analyses: Beck (1995); Blegen (1993); Broome, Lilis, and Smith (1989); Brown (1992); Brown and Grimes (1995); Devine (1992); Devine and Cook (1983, 1986); Devine and Reifschneider (1995); Goode et al. (1991); Hathaway (1986); Heater, Becker, and Olson (1988); Irvine and Evans (1995); Kinney, Burfitt, Stullenbarger, Rees, and DeBolt (1996); Krywanio (1996); Mullen, Mains, and Velez (1992); Mumford, Schlesinger, and Glass (1982); Olson, Heater, and Becker (1990); Schwartz, Moody, Yarandi, and Anderson (1987); and Theis and Johnson (1995). While promising, the results of these studies must be considered carefully. They represent often convincing arguments employed by the profession to advance its case for conducting and using research in nursing. However, these meta-analyses result in conclusions about the efficacy of interventions that are usually carried out under experimental or quasi-experimental conditions. Moving from these results to the practice setting and claiming that research, when used by clinicians, results in improved client/patient outcomes may be unwarranted. We have not studied most aspects of the dissemination, adoption, transfer, implementation, and utilization of research process in nursing. We do not know if *reinvention* (Larsen, 1980; Lewis & Siebold, 1993; Rice & Rogers, 1980; Rogers, 1988, 1995), for example, is a factor when research is moved from the study context to the practice context. If it is a factor, then the efficacy of an intervention under study conditions cannot necessarily be directly extrapolated to the practice setting.

## **Evidence-Based Nursing Practice and Research Utilization**

### ***What Is Research Utilization?***

When we speak of research utilization and the research utilization problem in nursing, we are speaking of the gap between what is known and what is done — how do we get valid, useful, and largely scientific information into the hands of, and used by, the clinician? Research utilization can be defined very broadly as *the use of research findings in any and all aspects of one's work as a registered nurse*. While there are specific kinds of research utilization, such as instrumental, conceptual, and persuasive (Estabrooks, 1997), at its simplest it is *the use of research*.

Most readers are familiar with instrumental research utilization. It is the direct application of research findings, often encountered in the form of procedures, clinical protocols, practice guidelines, standard care plans, new techniques, and so on. It is the kind of research use most often meant when we write about or try to create research-based practice in clinical settings. When we have tried to measure the extent to which nurses use research, it has almost always been instrumental use that we have been measuring.

It is likely that conceptual research use occurs more often — that is, nurses become aware of research findings, take them in, and let them inform their practice in ways that are often indirect. Research used this way serves an “enlightenment” function in their practice (Hasenfeld & Patti, 1992; Weiss, 1979). It may be that clinicians do or could incorporate qualitative research findings conceptually more easily than instrumentally.

There are many examples of persuasive research utilization in nursing. One of the most powerful is Florence Nightingale’s work in marshalling volumes of epidemiological data during the Crimean War and using them to persuade the Secretary of War and others of the need for radical reform in the British military, thus saving the lives of countless British soldiers. Nightingale’s broad and sweeping success in the persuasive use of research data to make policy changes that led directly to a measurable reduction in mortality, and the work of Lillian Wald, whose use of similar kinds of data led to significant reform in children’s health in the United States, stand as essentially unmatched achievements in the heritage of nursing. These are examples of persuasive use of research at the macro level. However, in much more modest and local ways nurses at all levels can and do use research as a means of persuasion (Estabrooks, 1997). This phenomenon remains, however, essentially unstudied.

### *What Is Evidence-Based Nursing Practice?*

EBN is, this author believes, much broader than research utilization, encompassing not only research findings, but other forms of practice knowledge as well. The term *evidence-based practice* has crept into nursing somewhat surreptitiously, and nursing has begun to use it without paying obvious attention to its origins or what it conveys to nurses, the public, politicians, and other health professionals. Since it has been argued that EBN has its origins in EBM, it might be instructive to explore some of the ways in which EBM has been defined:

Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett et al., 1996, p. 71)

Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician literature searching and the application of formal rules of evidence evaluating the clinical literature. (Evidence-Based Working Group, 1992, p. 2420)

Are these definitions compatible with the epistemological basis and practice of nursing? What assumptions underlie them? Is it true, as Sackett et al. (1996) suggest, that "evidence-based medicine is not restricted to randomised trials and meta-analyses" (p. 72), even though Sackett et al. also hold the randomized trial and syntheses of randomized trials as the "gold standards" of evidence? We would be well served by a clarification of what indeed we mean when we call for evidence-based practice/decision-making in nursing. Recently Mulhall defined EBN as "care concerning the incorporation of evidence from research, clinical expertise, and patient preferences into decisions about the health care of individual patients" (1998, p. 5). Is this the right definition for us? Does it lead to constructive answers to the questions posed above?

We talk of evidence-based practice and hold it as a core standard in many jurisdictions because we believe that if we had *it* we would have better nursing practice and hence better patient and client outcomes. We also find it attractive because we believe it would bolster our efforts to achieve full professionalization. But what do we actually mean by it? Do we mean to blend clinical judgement and research evidence? What kind of research will constitute legitimate research evidence? Are there forms of research other than scientific that we will deem legitimate forms of evidence for practice? How will we synthesise and incorporate different research findings that result from different methodological, and sometimes epistemological, research traditions? Will there be a hierarchy of research evidence? Of evidence in general? What will be the role of synthesized research findings? Are we presently equipped to synthesize all forms of research findings? Will our conceptualization of EBN be congruent with the needs of clinicians and the sources of knowledge they draw upon in their practices? What sources of practice knowledge *do* they draw upon? Are these related to EBN? Should they be?

### Sources of Practice Knowledge

The literature offers few studies on the kinds of knowledge that nurses use in their practice. Baessler et al. (1994) report some findings within the context of a larger report. Mulhall (1998) argues that nurses and consumers need more than scientific or economic evidence. Johnson and Ratner (1997) offer a theoretical discussion of the nature of practice knowledge, suggesting at a minimum that there is more to practice knowledge than scientific knowledge. Some 20 years ago Carper (1978) suggested that nursing knowledge could be classified into empirics (the science of nursing), aesthetics (the art of nursing), ethics (the moral component), and personal knowledge. As we begin a more intensive period of embracing the EBN agenda, Carper's classification is particularly suited to a conceptualization of evidence. The findings described in the following sections from a larger study of research utilization (Estabrooks, 1997) lend further support to a conceptualization of nursing knowledge, specifically *practice* knowledge, that is much broader than just scientific. It follows that such support also extends to our understanding of the extent and scope of the *evidence* in EBN.

<b>Table 1 Demographic Characteristics of Sample (n = 600)</b>		
<b>Characteristic</b>	<b>Sample</b>	<b>Population</b>
Age (mean)	41.70	41.25
<i>Sex</i>		
Female	97.5%	98.04%
Male	2.5%	1.96%
<i>Nursing Education</i>		
Diploma	70.8%	79.66%
Baccalaureate	25.2%	19.82%
Master's	0.50%	0.36%
Other	2.7%	negl.
<i>Clinical Area</i>		
General Hospital	41.8%	51.93%
Critical Care/Specialty	20.8%	19.10%
Geriatric/LTC	18.3%	12.05%
Public Health	9.3%	4.83%
Home Care	5.7%	6.18%
Other	3.8%	5.78%
<i>Hours Worked per Week</i> (average)	28.40	not avail.

## **Methods**

A randomly selected sample of 1,500 staff nurses was drawn from the Alberta Association of Registered Nurses (AARN) membership list on the annual registration form for the year ending September 30, 1996. The criterion for inclusion in the sample was: "actively engaged in the delivery of direct nursing care to patients or clients, i.e., choice of 'staff nurse' on the registration form." Dillman's (1978) methods were used to conduct a cross-sectional survey, which was mailed in early 1996. Reminders were mailed to non-respondents approximately 3, 6, and 9 weeks after the original mailout. A replacement questionnaire was included at week 6. A final useable sample of 600 (40%) was achieved. Comparison of the sample with the population of more than 15,000 staff nurses on demographic and related variables suggested it was comparable to the population from which it was drawn (see Table 1). Consent to participate was implied by returning the questionnaire.

## **Instrument**

Because there was no instrument suitable for the overall purposes of the study, a survey questionnaire was developed using standard procedures (e.g., Dillman, 1978; Fowler, 1993; Rossi, Wright, & Anderson, 1983). A pilot study was then conducted on a convenience sample ( $n = 23$ ) of post-baccalaureate and master's-level nursing students. The findings reported here arose from a series of 16 questions in a section beginning with the transition statement "The following questions relate to the kind of knowledge you use in your nursing practice." Twelve of the 16 questions were taken from Baessler et al.'s (1994) Research Utilization Questionnaire, with minor modifications in wording. Four questions were added (items j, n, o, and p) (see Table 2).

## **Findings**

The frequency with which nurses used the various sources of knowledge is reflected in mean scores for each item. Those scores ordered from most to least frequent are shown in Table 3. The two most frequently used knowledge sources were found to be experiential, followed by nursing school (3rd), workplace sources (4th and 5th), physician sources (6th and 7th), intuitions (8th), and what has worked for years (9th). Literature (whether in textbook or journal form) was found to rate in the bottom five for frequency. This is interesting given that for decades the primary, albeit passive, form of dissemination for researchers has been publication in journals, primarily scientific journals.

**Table 2** *Sources of Practice Knowledge Questions\**

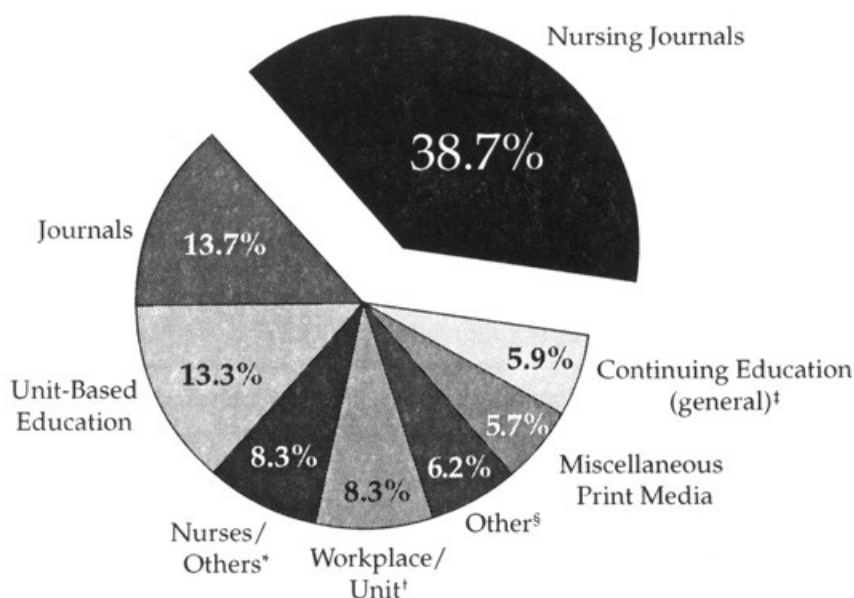
<b>2. The knowledge that I use in my practice is based on...</b>	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Frequently</b>	<b>Always</b>
a. information that I learn about each patient/client as an individual	1	2	3	4	5
b. my intuitions about what seems to be "right" for the patient/client	1	2	3	4	5
c. my personal experience of nursing patients/clients over time	1	2	3	4	5
d. information I learned in nursing school	1	2	3	4	5
e. what physicians discuss with me	1	2	3	4	5
f. new therapies and medications that I learn about after physicians order them for patients	1	2	3	4	5
g. articles published in medical journals	1	2	3	4	5
h. articles published in nursing journals	1	2	3	4	5
i. articles published in nursing research journals	1	2	3	4	5
j. information in textbooks	1	2	3	4	5
k. what has worked for me for years	1	2	3	4	5
l. the ways that I have always done it	1	2	3	4	5
m. the information my fellow nurses share	1	2	3	4	5
n. information I get from attending inservices/conferences	1	2	3	4	5
o. information I get from policy and procedure manuals	1	2	3	4	5
p. information I get from the media (e.g., popular magazines, television, the Internet, etc.)	1	2	3	4	5
*The questionnaire and permission to use it were obtained from Dr. Zane R. Wolf.					

**Table 3** *Mean Scores for Responses to Knowledge Source Questions (Range: 1 to 5) Rank Ordered*

Question	Mean Score	Standard Deviation	Median
a. Information that I learn about each patient/client as an individual	4.286	0.688	4
c. My personal experience of nursing patients/clients over time	4.109	0.697	4
d. Information I learned in nursing school	3.827	0.774	4
n. Information I get from attending inservices/conferences	3.774	0.740	4
o. Information I get from policy and procedure manuals	3.661	0.831	4
m. The information my fellow nurses share	3.637	0.582	4
e. What physicians discuss with me	3.614	0.806	4
f. New therapies and medications that I learn about after physicians order them for patients	3.606	0.828	4
b. My intuitions about what seems to be "right" for the patient/client	3.555	0.782	4
k. What has worked for me for years	3.537	0.737	4
j. Information in textbooks	3.355	0.812	3
h. Articles published in nursing journals	3.251	0.949	3
l. The ways that I have always done it	3.040	0.725	3
g. Articles published in medical journals	2.671	0.944	3
i. Articles published in nursing research journals	2.550	0.949	3
p. Information I get from the media (e.g., popular magazines, television, the Internet, etc.)	2.410	0.839	2

This raises interesting and potentially troubling issues. First, sources that could be evidence-based (textbooks and unit protocols) often are not, but form a non-trivial percentage of the sources nurses draw upon; second, a large percentage of knowledge that nurses use is not scientific; third, nurses use information from popular media sources, albeit less frequently, upon which they may increasingly draw practice inferences; and, finally — and of particular importance to educators — basic nursing education seems to play an ongoing role as a source of practice knowledge. The participants in this study had been out of their basic nursing education program an average of 18 years and their mean age was 41. They are going to be in the workforce for one or two more decades, and the basic nursing education upon which they will continue to draw will “age” with them. Even assuming they all had a maximally research-based education, the evidence is getting old. Nurses may always draw heavily upon their basic education as a source of practice knowledge. In many cases this makes sense, because the relative anatomical and physiological information has remained reasonably valid. But much of what is learned does not remain valid, and may not even be valid when it is learned. It seems clear that critical thinking skills have never been more urgently required than they are now in our basic education programs in nursing.

**Figure 1** *Sources of Research Information*



\* Includes other health-care workers

† Includes the workplace generally, and unit-based research projects

‡ Includes conferences, courses, and seminars

§ Includes popular media, the library, and other miscellaneous sources

### *Sources of Research Knowledge*

To the open-ended question "What is the one most common source from which you learn about research findings?" the majority of nurses (52.3%) gave journals as the response. Of these, 38.7% clearly identified nursing journals. Of the nursing journals, nurses identified 9.9% as either the *AARN Newsletter* or *Canadian Nurse*. Nurses identified 13.7% of sources as simply journals. These results are shown in greater detail in Figure 1.

Literature sources overall were found to be a relatively infrequent source of knowledge for practice, but here a specific type of knowledge (i.e., research) was the subject of inquiry. Nursing journals made up the largest category, followed by other journals and unit-based education. Journals accounted for over half of the sources of research knowledge. However, other analyses of these data revealed that the primary journals the nurses were reading were not research journals, but rather the trade magazines *Canadian Nurse* and the *AARN Newsletter*. Over half the nurses (54.2% and 52.3%, respectively) reported reading *Canadian Nurse* and the *AARN Newsletter* more than eight times a year. Only 16.2% reported reading the next most commonly read journal, *Nursing*, more than eight times a year. In fact, the *modal* response for nursing journals other than *Canadian Nurse* or the *AARN Newsletter* was "never."

What can we learn from this? At a minimum we can infer that traditional scientific journals are not very effective as dissemination vehicles. Second, we may be able to put our provincial and national trade magazines to greater use in the dissemination of research. However, even larger issues related to the utility of traditional print media as main research dissemination vehicles and the gap between publishing for scientific credit and publishing for consumption by clinicians are raised.

### **A Perspective on Evidence**

What do we as a profession sanction as legitimate evidence? The implicit and often explicit assumption has been that the evidence in evidence-based practice is scientific fact derived from scientifically sound individual studies. Further, there has been a strong bias in favour of those studies taking the form of the randomized controlled trial (RCT), the "gold standard" of evidence (Sackett et al., 1996). RCTs certainly form the basis of much if not most of the synthesizing of groups such as the Cochrane Collaboration, but are they always the best evidence in nursing practice? Grouping evidence into two broad categories,

research evidence and non-research evidence, serves to highlight the major distinction between research utilization and evidence-based practice. Research utilization is concerned with research evidence only, and is therefore actually a sub-set, albeit a critical one, of evidence-based practice. Evidence-based practice includes, or ought to include, the entire gamut of evidence. Such a conceptualization makes apparent the importance of, and concomitant difficulties of, identifying and valuing an evidential structure in the profession.

### *Research Evidence*

Research evidence can be categorized as evidence from research syntheses and evidence from individual studies. If we consider the former, currently the products that might be used by clinicians can take at least four forms:

- *Cochrane Database of Systematic Reviews (CDSR)*, a sub-set of the Cochrane Library
- *Agency for Health Care Policy and Research (AHCPR)* guidelines in the United States (AHCPR is in fact a combination of research synthesis and consensus panel or expert opinion)
- *Systematic Research Effectiveness Overviews* such as those conducted by the Quality of Nursing Worklife Research Unit (now known as the Nursing Effectiveness, Utilization and Outcomes Research Unit — NEUORU), University of Toronto, and the Hamilton-Wentworth Public Health Unit/McMaster University, and those conducted by a number of professional associations such as nursing's in partnership with the Alberta Heritage Foundation for Medical Research (AHFMR)
- the familiar *narrative literature review*, found, for example, in the *Annual Review of Nursing Research*. While probably still the most common form of synthesis, this is rapidly being replaced by more explicitly rigorous and systematic approaches.

The Cochrane Collaboration does not yet have a large orientation to nursing syntheses. However, an example of synthesized research evidence from Cochrane that is highly relevant for nursing is the systematic review of labour support in which Hodnett (1994) reports that support during labour results in shorter labour, decreased use of intra-partum analgesia/anaesthesia, fewer forceps or vacuum-extraction deliveries, fewer cesarean sections, and decreased likelihood of newborns having a 5-minute Apgar of less than 7 (Hodnett, 1994, 1996).

These are startling outcomes when we consider that the labour-support interventions considered bear a remarkable resemblance to basic obstetrical nursing interventions — fundamentals of practice in *oldspcak*. One wonders what other outcomes, in other populations and other circumstances, might be positively affected by similarly basic nursing interventions.

**Individual studies.** Individual research studies are commonly classified as: (a) RCTs; (b) non-randomized clinical trials; (c) cohort, case-control, and descriptive studies; and (d) qualitative studies. While there are a number of variations on this general classification, they all imply a similar hierarchy, in which the highest value is placed on RCTs, the lowest on descriptive and qualitative studies. Sometimes we very much need evidence from controlled trials, and if it is not available we have to make do with less-controlled studies. Other times, however, the nature of the clinical problem we are experiencing may be better informed by studies that use other methods. Qualitative studies using methods like grounded theory or ethnoscience may be the best way to understand, for example, the ways in which nurses touch their patients. However, if we want to establish that touch as a therapeutic intervention effects some outcome, such as relaxation, blood pressure, or sleep, we seek evidence from clinical trials.

### ***Non-Research Evidence***

It is the non-research kind of evidence that presents nursing with the most difficulty. There can be little doubt that this kind of evidence is equally important to us, and to our patients and clients, but it is not easy to categorize, quantify, or rank. As we have seen, it comes in at least three forms — colleagues, experience/clinical acumen, and clinical judgement. Clinical judgement and clinical experience are particularly important forms of evidence that we know relatively little about. Earlier studies such as those by Benner (1984) and Pyles and Stern (1983) gave us insights into these realms, but these areas have received little or no attention in the EBN discourse. What are their elements? How do we measure them? How can we best acquire and keep them? How do we/can we deploy them with deliberation? We do know, as reflected in the findings described earlier, that they are commonly used by clinicians. We also know that we must be cautious about experience as a kind of evidence: we have notoriously selective recall and will often remember recent interventions and/or interventions with either an unusually good or unusually bad outcome. There may be other

kinds and sources of evidence, and these may well be a mixture of research and non-research evidence. Additionally, it is clear that nursing education is a blend of many of Carper's (1978) forms of nursing knowledge. However, what we may not have attended to as rigorously as the *content* in nursing curricula is acquiring the skill sets and critical-thinking capacities necessary to not only locate and understand information, but also to be able to judge the appropriate match between evidential sources and the contextual demands of clinical encounters.

### *What Is the Best Available Evidence?*

Is there a best kind of evidence? When considering scientific evidence in medicine, conventional wisdom has often identified the following structure as the preferred one: (a) meta-analyses of RCTs; (b) individual RCTs, especially if they are large; (c) less controlled and descriptive studies and sometimes the dramatic results of uncontrolled studies; and, finally, if we have to, we rely on, (d) expert opinion and consensus conferences. This is not a bad hierarchy as far as it goes, and as long as we add to it some of our own conventional wisdom and common sense. For example, to conventional wisdom we need to add individual and aggregated qualitative research studies such as are beginning to be described in the literature (Estabrooks, Field, & Morse, 1994; Jensen & Allen, 1994; Sandelowski, Docherty, & Emden, 1997).

We also need to learn how to integrate non-research sources of evidence, such as clinical experience and clinical judgement, into an evidential structure. Nursing does not yet have confident answers to the question "What is the best available evidence?" Nor is there necessarily one correct answer. The practice context is complex, people are complex, and clinicians are complex. The best evidence will most probably come in different forms, in different situations and contexts — and knowing how to decipher this complexity, how to match situation and context with appropriate evidence requirements, will perhaps be the most important requirement of the 21st-century practising nurse. However, given the continuing explosion of knowledge and our rapidly increasing access to information through on-line searching, on-line databases such as *Cochrane* and *DARE*, new journals like *Evidence-Based Nursing*, emerging centres for EBN, and everyday professional and public access to the Internet, one thing is clear: we have no choice but to find and use the best evidence available.

## Conclusions

Will evidence-based nursing practice make practice more perfect? Do we recognize *good practice* when it happens? Probably not always, but there is not a legitimate, bona fide clinician who does not know when she or he is practising well. Clinicians are acutely aware that what they do can and does make a difference, that their ignorance sometimes costs lives, that most health professionals, be they nurses, physicians, physiotherapists, or others, just want to do the best job they can and make some small difference. They want to save lives; ease suffering; provide physical, emotional, and spiritual comfort; improve health; prevent disease and injury; and promote healthier lifestyles — but they do not always know how to do these things. Used prudently, EBN can help us shed some of our ignorance and, *at the very least*, help us to *do no harm*.

EBN can help us do these things, but only if we develop a clear and meaningful conception of EBN. When we mean research utilization we should say research utilization. We should understand that its precise meaning is narrower than EBN's, but while its meaning is narrower, and while it is a term not often used outside of nursing, it is a clear term. We should not abandon it in favour of terms like *research transfer* or *uptake*, which, while more prevalent, are less meaningful for nursing. Research utilization carries with it the implication that behaviours must change for it to exist, and those behaviours must remain in a dynamic state for it to persist.

Kitson (1997, p. 38) says it is a bold step for nursing to sign on to an evidence-based clinical agenda. Assuming we do sign on (and we have already begun to), if we let EBN go beyond what our collective common sense tells us, and let it develop into an ideology, it will not serve us well. Anderson (1997) cautions his colleagues in psychiatry to embrace but not be bewitched by EBM. The same advice could apply to nursing. Anderson points out that the assumptions inherent in the EBM movement may not be valid. For example, evidence is not transparent or value-free; decision-making does not necessarily involve a weighing of the evidence; evidence-based decisions may not be taken in the face of political and other pressures (p. 226). No doubt there are other assumptions. There are, as Kitson points out, explicit and implicit *rules* in the evidence-based movement. There are clearly, as Kenny (1997) and Johnson and Ratner (1997) argue, questions about whether good science is enough for good practice.

The synthesis and dissemination of knowledge for nursing practice is a politicized growth industry. If research-based practice, and its new companion, EBN, are to move us closer to more perfect practice, we will have to be ever vigilant, not forgetting that we exist because we are a practice discipline sanctioned by a society with expectations. One of those expectations is that we will use sound evidence, the best available evidence, to practise as well as we can with the intent of making it *better* in some way for the patient or client. Our primary motivation in studying, promoting, and doing EBN must be focused squarely on the health of the public. A focus on EBN cannot, in the case of organized nursing, be traded as membership dues to either the academy or the professions, nor, in the individual case, be bartered like a career horse. To do so at least neglects and at worst violates what I believe is a sacred covenant, one in which, in exchange for society's promise to remunerate, support, and value us, we also make a promise:

...to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966, p. 15)

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# The Unanswered Challenges in Measuring Quality of Life

J. Ivan Williams

The measurement of health status and quality of life is a major challenge facing health researchers. The task is to locate individuals within life space and show how health-related events impact on their life space. The specific quest is for measures sensitive to changes in health status/quality of life that can be attributed to health problems and interventions. Pharmaceutical companies must demonstrate, to the agencies responsible for approving drugs, the impact of their products on the quantity and quality of life. Researchers need responsive, sensible instruments for assessing the efficacy and effectiveness of interventions in randomized controlled trials and clinical studies. Providers, managers, and policy-makers need to know the cost-effectiveness of interventions and programs. Outcomes information systems are introducing measures into managed care in the United States, for purposes of both management and marketing. National organizations in the United States, such as the National Council for Quality Assurance and the Foundation of Accountability, are requiring report cards for managing care that include assessments of outcome.

The creation, adaptation, and testing of measures has been a growth industry in Europe and North America over the past 20 years, as evidenced in publications, presentations at conferences, peer-reviewed grants, industry funding, graduate theses, seminars, workshops, consulting activities, and the commercialization of specific products. International collaborations and networks of providers are being formed to create new measures. Researchers and commercial enterprises compete for their share of the academic and private markets.

One might wonder about the state of the quest for measures. There is general agreement that health should be conceptualized in terms of physical, mental, and social well-being, rather than just the absence of disease (World Health Organization, 1958). There is further agreement that quality-of-life assessments should include measures of general health status, disease-specific measures, and measures of patient pref-

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erences. Spilker's (1996) edited work covers 215 measures. Bowling (1995, 1997) and McDowell and Newell (1996) offer thoughtful guides to the use of the more established measures. An entire journal, *Quality of Life Research*, is dedicated to the subject and several major journals have published special issues on it. My bookshelves hold more than 30 volumes related to the measurement of health status and quality of life, and my holdings are by no means exhaustive.

The range of measures reflects four basic strategies in creating them: psychometric methods, clinimetric methods, deriving utilities, and Rasch modelling. In the absence of objective criteria for health status/quality of life, researchers have adapted items from existing measures and created items to reflect theoretical domains and concepts of interest. Psychometric methods are used for reducing the number of items, identifying the factors or facets of the underlying structure of the responses, and testing the internal consistency of the responses. The measures are correlated with pre-existing measures to establish construct validity. Clinimetricians select items based on occurrences of symptoms and problems reported as important by providers and patients, or in other studies. The items are specific to the disease and interventions of interest, and they are gauged on clinical criteria. The selection and weighting of the final items are based in part on the declarations of importance. Validity is determined by how well the measures predict clinical outcomes. Researchers, working from concepts of economics and decision theory, derive utilities for given health states based on patient preferences. Typically, the methods produce a single value for each health state, ranging between 0.0 for death and 1.0 for perfect health. The standard gamble is the "cardinal method," as it is theoretically tied to the axiomatic theory of Von Neuman and Morgenstern (Drummond, O'Brien, Stoddart, & Torrance, 1997). Other measures are based on time-tradeoff methods, multi-attribute theory, and rating scales. Researchers employing the Rasch model for item-response theory focus on the scoring of responses of items, so the items can be weighted to reflect degree of health and quality and the respondents can be rated and scored on the underlying dimension of interest.

Brock (1995) summarizes the current state of the quest as follows: "While that literature provides little in the way of well-developed, philosophical accounts of the quality of life or of a good life, it is a rich body of analysis, data, and experience on which philosophical accounts of a good life can draw." While there is reference to the World Health Organization dimensions, researchers focus on the physical and mental dimensions of health, giving nominal attention to social dimensions.

There are attempts to broaden the definition and domains or attributes, such as the WHO Quality of Life Instrument (Szabo, 1996), and to recast the items accordingly, but this is a fledgling international collaboration. If we knew the dimensions of life, we could begin to focus on the precision with which location and motion might be measured.

Random error in the measurement of key endpoints increases the size and costs of studies (Fleiss, 1986) and the difficulty in using the results to make key decisions in clinical policy and management of individuals (Nunnally, 1978). While authors have defined the uses of the measures and have set stringent standards for the reliability and validity of responsiveness, most researchers ignore these and cite instead the standards of 25 years ago, for the initial development of measures (Kane & Kane, 1981; McDowell & Jenkinson, 1996; McHorney & Tarlov, 1995; Williams & Naylor, 1992; Wright & Feinstein, 1992).

Responsiveness is the Achilles' heel of measurement. A measure is responsive if it mirrors the status of individuals over time, whether it changes or not. It is difficult to identify true change and no change from random fluctuations in scores. I think this is so for two reasons. First, we drift in life; our points of view change subtly as we move through our experiences. Summary assessments of functioning, activities, moods, and feelings over the previous week or month may well shift from one time to another without assessment being either "wrong" or "unreliable." Second, as we encounter significant health events, our perspective or frame of reference may well shift. Even though a hip or knee may not work as well after total joint replacement as the normal joint, an individual can alter expectations for performance and redefine health status and quality of life accordingly. Qualitative researchers may have to provide quantitative researchers with directions as to how to reconstruct their concepts and methods (Kessler & Mroczek, 1996).

A reformulation of the theory and concepts of health status and quality of life is required, and the theory and concepts should stem from an idea of the good life. The advance of strategies and tools is contingent upon new ideas being in place rather than the constant production of new tools for old concepts. This is what the quest for quality of life should be about.

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# **The Developing Family: How Is It Doing with Nurturing Young Children?**

**Kathryn E. Barnard**

## **Parental Disengagement**

Every time I visit a culture or country different from my own I gain a new perspective on families and children. One theme I have observed in Asian cultures is the caregiving of the infant and young child by other family members. In China the maternal grandmother cares for the new baby as well as for the young parents; often the families live together. In Taiwan it is customary for the paternal grandmother to help with the newborn. In France there is a well-developed system of day nurseries supported by the government.

In both Canada and the United States it has been customary for parents to do the caregiving of infants and toddlers. I therefore find it interesting to read studies about the mother's perceptions of her experience both working and mothering. I detect a shift in our two countries as the care of young children becomes less exclusively the responsibility of parents. David Hamburg made the assertion, while President of the Carnegie Foundation in the 1980s, that the United States is experiencing an epidemic of parental disengagement. He suggested that post-industrial society has found a non-adaptive solution for child care, expecting the family to bear full responsibility; the society, including government and private corporations, has not assumed its share of responsibility in helping families care for children, while at the same time it has created work demands on the family for regulating the economy. In the United States over 60% of women are back in the work force by the time their infant is 1 year of age. As a society we are removing caregiving as a priority from the family agenda by employing the parents, yet government/business provides little assistance for the care of children. This is an issue that must be addressed by both scholars in human development and policy makers in human service delivery.

In fact we have much to learn from scholars in other countries about their strategies for early child care and their observations of child

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outcomes. International nursing congresses could be the focus of rich exchange concerning the issues of early family life and child care.

### **The Changing Roles of Parents**

Several researchers have studied the role expectations of parents and the influences of parents' own well-being on their ability to parent (Killien, 1998; Lederman & Miller, 1998; Solchany, 1998; Walker, Flescher, & Heaman, 1998). Their work reflects the many changes that are occurring in early parenting, precipitated by the factors of more working mothers, more child-care involvement by fathers, more cultural heterogeneity within the population, and more unmarried women with children. Parenting of young children is changing; mothers are no longer the only primary caregivers. Solchany's research focuses on becoming a family by adoption, a topic largely neglected in the study of family formation.

Demonstrating the biological basis of behaviour is another important avenue of early family research. Humenick, Hill, Thompson, and Hart (1998), for example, examined the sodium content of breast milk and its relationship to breastfeeding. This research strategy informs while at the same time adds to the credibility of health and behavioural practices, leading to increased understanding of phenomena and increased recognition of the issue by biologically oriented scientists.

Often the complex and comprehensive perspective that nursing embraces forces us to use small sample sizes. Edwards, Sims-Jones, and Breithaupt's (1998) epidemiological design using a large sample to examine trends of maternal smoking and choice of infant-feeding methods might, however, be an indication that we have "come of age." Questions surrounding the feeding of young infants represent a vital issue in early development. The evidence that the most natural form of infant feeding — breastfeeding — is better for the child's growth and development suggests that health-care providers understand more fully the biological and lifestyle factors that influence breastfeeding success.

### **Important Questions for Nursing Science**

Today nursing science uses a variety of designs and methodologies, ranging from large quantitative studies to theory-generating qualitative ones. This is a positive indicator of its developmental maturity. However, the reporting of nursing research today puts greater emphasis on the questions and the answers than it did in the past, when typically we were preoccupied with design and methods. This change in

emphasis in publishing study results is important, because as a practice-related discipline we must apply our scientific findings. It is on the answers to practice-related questions that nursing science must focus.

### **New Questions Concerning Caregiving Environments**

A critical issue facing society today concerns the care of the youngest children. Who is providing the care? What are the consequences of non-parental early care? History can be informative, but most historical accounts of early child care date from times of extreme stress, when countries were facing war and famine. As we approach the year 2000 we have an opportunity to study early caregiving informed by child-development and family research. We presently know more than we ever have in recorded history about optimal environments for promoting the health and well-being of children. We have the new challenges of the information age and the global village as the contexts in which children will become adults. We know that early development can be promoted in emotionally supportive environments both within and outside the immediate family context. Human potential is a critical issue; change is constant, and children must be prepared to cope with changing environments. I submit that by studying children under optimal conditions we can discover new levels of human development, where mind, body, and soul are integrated more fully than they have ever been. We need to learn how the potential of human genetic phenotypes can be achieved by conditions of rearing. We can examine the limits of developmental potential given our increasing capacity to nurture the individual differences of each child.

### **Expanding Our Knowledge Base of Caregiving Environments**

What do we know about the early caring environment? How can the caregiving environment be studied and measured? Recent methodological advances have brought us tools to measure the early environment. My own research has developed several instruments for observing and coding parent/caregiver behaviour and child responses in feeding and teaching contexts (Barnard et al., 1989; Sumner & Spietz, 1994). Our accumulated data demonstrate the predictive value of parent-child interaction in the first 2 years of life (Barnard, 1994; Morisset, 1994). The parent's performance as a social partner is a strong predictor of the child's language and cognitive development. Parents' scores on the Nursing Child Assessment Satellite Training (NCAST) Parent-Child Interaction Scales during the first 2 years predict the child's IQ. Knowing the parent's influence on the child's micro envi-

ronment is both important and interesting, but the changes in early parenting necessitate more studies on non-parental caregiver/child interaction. We need to understand how the child's complementary caregiving partnerships predict competencies. Nursing scholarship and research have been focused on the nuclear family; we now need to broaden our lens — the young child is no longer primarily in the care of parents.

Recent attention to early brain development and outcomes in animal and human studies (Shore, 1997) also highlights the need for intensified study of infant and toddler caregiving. As the society collaborates with parents on early child care, we need to answer several questions: What is the appropriate environment for the developing child? What does the brain need to develop well? What type and number of emotional connections does the young child require? What role do temperament and self-regulation play in developmental processes? We have the ability to bring to early child care knowledge and resources that have never before been available. We can truly test the ultimate nurturing of human potential.

As the society becomes more involved in and more responsible for the care of young children, we need to collectively establish and implement standards of caregiving. The process is beginning. Recently published daycare guidelines (American Public Health Association & American Academy of Pediatrics, 1992) speak to brain development and the social-emotional needs of young children. The document calls for activities in the child-care facility (centre- or home-based) that offer young children opportunities to develop personal and affectionate relationships with a small number of caregivers; experiences coping with separation and loss of their parent caregivers for large parts of the day; experiences communicating in the language of their family; and play opportunities that help reduce anxiety, resolve conflicts, and adapt to reality, and that combine the inner and outer worlds. These guidelines have their foundation in theories and empirical evidence of child-development research, demonstrating the practical application of research in caring for children.

### **The Best of Times and the Worst of Times**

While for many families and children early childhood is the best of times, for some children early development is the worst of times. In my research partnership with an Early Head Start program, we are finding that mothers whose relationship past has been troublesome, and who are even as new mothers struggling with relationship issues, are often

emotionally unavailable to their infants. Their unresolved losses and trauma bring great emotional distress and conflict, manifesting as post-traumatic stress symptoms. How do we deal with such a parent? How can a mother possibly nurture a child unless she is freed from her own anxiety, terror, and despair? Parent-support and education intervention strategies with unavailable caregivers are ineffective in helping the parent recover fast enough to meet the needs of a child on a rapid developmental timetable (Barnard, 1998; Barnard & Morisset, 1995; Barnard, Morisset, & Spieker, 1993). These parents are unfortunately providing environments in which the child experiences rejection, fear, and despair. In later years such children often exhibit the depression and aggression so epidemic and troublesome in our human family (Karr-Morse & Wiley, 1997). As members of the scientific community we have an obligation not only to study the context of family and child well-being, but also to serve as advocates for changing the conditions of family formation and function in relation to child care. I encourage your participation in the research on early child-rearing and also in redefining society's responsibility to the care of children.

The final challenge I would bring to you is the need for a better understanding of social-emotional development. An overwhelming issue for many parents is the management of their own adult emotional states. The rates of family conflict and domestic violence are a major issue in families at all social-economic levels. The development of emotional expression and emotional regulation in the young family is an important area for future research. The nurturing of the emotional system, while a complex process, has been studied only superficially. Many alarming national statistics demonstrate an increasing amount of aggression expressed by both children and adults in schools and in the community at large. This increased aggression fuels violent acts within families and communities.

The role of the early environment in developing the cortical feedback systems to regulate the aggression is emerging as one of the major issues in neuroscience. My challenge to nursing colleagues is to increase our attention to this critical area of human function, in the hope that nursing science will bring new insights into this dimension of human functioning — the formation of compassionate and caring relationships with one another.

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# Call for Papers

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## *International Nursing*

December 1999 (vol. 31, no. 3)

There are diversities as well as similarities in the practice of nursing around the world, and there is increasing international collaboration designed to improve nursing globally. This issue will focus on the ways in which various countries are dealing with the issues, challenges, and problems in nursing. Its purpose is to publish studies relating to policy and planning, education, working conditions or the work environment, and the clinical practice of nursing. Topics include: policy formulation and planning, including situational analyses of requirements and supply; aspects of education such as assessments of the quantity and quality of programs, applicant pool, recruitment, follow-up of graduates, and evaluation of faculty; and staffing patterns such as mix of professional and non-professional staff, recruitment and retention strategies, and ways in which clinical nursing services are being provided. Of interest are theoretical, research, or evaluative papers that advance our knowledge of nursing across cultures and societies. Of particular interest are studies that cut across two or more countries or that are the result of international collaboration.

**Guest Editor: Dr. Susan French**

**Submission Deadline: April 30, 1999**

## *Alternative Treatment and Symptom Management*

March 2000 (vol. 31, no. 4)

The implementation of alternative treatment and symptom management is rapidly increasing and is of interest to nurses across the full spectrum of patient populations and conditions. This issue will focus on novel or non-traditional treatments and management of symptoms within the realm of nursing practice. Of particular interest are studies from a nursing-science perspective that address but are not limited to the symptoms of pain, fatigue, stress, anxiety, fear, and depression. We hope to publish the latest research as well as papers that describe the development or validation of theoretical or conceptual perspectives. Priority will be given to papers that deal with the evaluation and implementation of alternative treatments and management of symptoms in vulnerable populations, such as infants and children, the elderly, and individuals with cognitive, developmental, or communication disabilities, and the effect of this management on the individual, the family, and society.

**Guest Editor: Dr. Bonnie Stevens**

**Submission Deadline: July 15, 1999**

Please send manuscripts to: The Editor, *Canadian Journal of Nursing Research*  
McGill University School of Nursing, 3506 University Street  
Montreal, QC H3A 2A7 Canada

# Appel de soumission d'articles

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## *Les sciences infirmières sur la scène internationale*

Décembre 1999 (vol. 31, no 3)

Il existe des diversités tout comme des similitudes au sein la profession, partout dans le monde, et les collaborations internationales conçues pour améliorer la pratique à l'échelle mondiale se font de plus en plus nombreuses. Ce numéro sera consacré aux approches mises en place dans différents pays pour gérer les questions, les défis et les problèmes qui se présentent à la profession. L'objectif est de publier des recherches qui se penchent sur les politiques et la planification, l'éducation, les conditions ou les milieux de travail, ainsi que la pratique clinique. Entre autres, ce numéro traite des sujets suivants : la formulation et la planification des politiques, y compris l'analyse de situation en ce qui a trait à l'offre et à la demande; les aspects de l'éducation tels que l'évaluation de la quantité et de la qualité des programmes, le bassin étudiants-postulants, le recrutement, le suivi des diplômés et l'évaluation de facultés; ainsi que les tendances en matière de composition du personnel, comme par exemple les équipes composées de professionnels et de non-professionnels, les stratégies de recrutement et de fidélisation, et les méthodes utilisées pour prodiguer les services en milieu clinique. Nous vous invitons à soumettre des articles théoriques, évaluatifs et de recherche qui nous permettront d'approfondir nos connaissances de la profession, exercée dans le cadre d'autres cultures et sociétés. Également, seront privilégiés les écrits dont le contenu traite de deux pays ou plus où qui sont le fruit d'une collaboration internationale.

**Collaboration spéciale: Susan French, inf., Ph.D.**

**Date limite pour les soumissions: le 30 avril 1999**

## *Traitements alternatifs et gestion de symptômes*

Mars 2000 (vol. 31, no 4)

La mise en place de traitements alternatifs et de pratiques de gestion de symptômes est un phénomène en pleine croissance qui constitue un intérêt pour les infirmières œuvrant dans toutes les conditions et auprès de toutes les catégories de patients. Ce numéro se penchera sur la question des traitements nouveaux ou non traditionnels ainsi que la gestion de symptômes au sein de la pratique infirmière. Revêtant un intérêt particulier sont les études effectuées à partir d'une perspective en sciences infirmières traitant des symptômes de douleur, de fatigue, de stress, d'anxiété, de peur et de dépression, sans toutefois s'y limiter. Nous souhaitons publier des recherches de fine pointe ainsi que des articles qui décrivent le développement ou la validation de points de vue théoriques ou conceptuels. La priorité sera accordée aux articles qui traitent de l'évaluation et de la mise en place de traitements alternatifs et de pratiques de gestion de symptômes au sein de populations vulnérables, tels les nourissons et les enfants, les aînés et les individus handicapés sur le plan du fonctionnement cognitif, du développement ou de la communication, et l'effet de cette gestion sur l'individu, la famille et la société.

**Collaboration spéciale: Bonnie Stevens, inf., Ph.D.**

**Date limite pour les soumissions: le 15 juillet 1999**

Prière d'envoyer les manuscrits à: La rédactrice en chef,

*Revue canadienne de recherche en sciences infirmières,*

École des sciences infirmières de l'Université McGill, 3506, rue University,  
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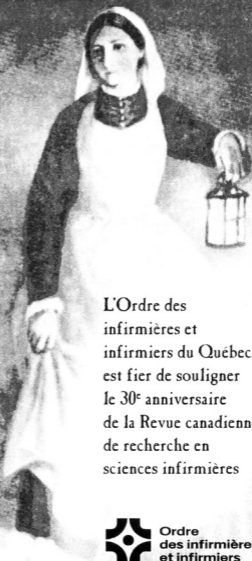


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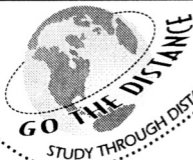
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