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# Highlights From Discourses Published in Volumes 31–40

What is apparent in both the study and the application of research utilization principles and methods is that it is a social process.

With the accumulation of more evidence on research utilization, we need to recognize our theoretical and methodological blind spots and move from taking comfort in the certainties derived from simplistic reductionist approaches to acknowledging the assumptions, biases, and weaknesses that characterize most of our scientific investigations. The uncertainties of research utilization may make us feel overwhelmed by the complexity and messiness of the job; however, other disciplines are beginning to report unintended consequences of successful innovation and the potentially destabilizing impact that "decontextualized" change can have on local communities.

Variously described as an innovation, new idea, new technology, research finding, and, most recently, evidence, that which gets put into practice has to stand up to scrutiny.

It would seem that health care (including nursing) is entering a period of intense activity around research utilization methods and practices. We need to take account of existing research findings but acknowledge the theoretical and methodological blind spots. Our new endeavours must offer us the ability to integrate scientifically derived knowledge with personal experience and patient preferences in ways that are rigorous, holistic, and theoretically coherent.... Having mapped out these areas, we must now move on to embrace the complexities of the wider context and how our relationships within that context influence our ability to respond to innovations. Finally, we must face more fundamental questions, concerning whether we can or should entertain the possibility of workers and clients themselves developing that capacity to decide what innovations should be introduced, how, and for what purpose!

*From* **Research Utilization: Current Issues, Questions, and Debates**
by Alison Kitson (*CJNR* 1999, Vol. 31 N° 1, 13–22)

Without trivializing the continuing impact of severe mental disorders, it is probably fair to say that, because of access to appropriate care, many severely mentally ill adults can now anticipate more satisfying, "normal" lives with reasonable control over their symptoms.

*From* **The Biopsychosocial Perspective in Psychiatric Nursing: Myth or Future Reality?**
by Linda Chafetz and Nicole Ricard (*CJNR* 1999, Vol. 31 N° 2, 17–23)

Although the language becomes cumbersome at times, I have tried to avoid the term "non-pharmacological" when I really mean behavioural and environmental interventions. I try to avoid implying that pharmacological interventions are the gold standard for pain relief and that we must choose one kind of intervention over the other. I have argued that environmental and behavioural strategies provide the foundational substrate for neonatal pain management to which pharmacological therapy is additive or synergistic…

Nevertheless, as much as we pride ourselves on our avoidance of the dualistic mind/body trap, with respect to pain treatment our professional literature reflects the physical/psychological dualism and the pharmacological idolatry in the field of pain.

We must acknowledge that the language of pain, like the experience of pain, has a high degree of plasticity. The terms we use to describe pain will evolve over time to reflect the social and scientific conceptions of cultural groups at any specific point, with acknowledgement of historical ways of thinking. However, we must strive to continually make these conceptions explicit, so that the assumptions will be instructive and not simply a source of bias.

*From* **Relieving Pain: What's in a Name?**
by Linda S. Franck (*CJNR* 2000, Vol. 31 N° 4, 9–16)

During the past 30 years the nature of physicians' directives has changed dramatically, as has medical technology. Much experiential clinical learning in nursing is undescribed because of the social misunderstanding that nurses just "apply" well-established medical knowledge under the direct supervision of doctors. Yet many areas of nursing practice have developed new and uncharted knowledge, of both the delegated and undelegated kind.

Nurses bring a rich experiential wisdom to their thinking. Much of that wisdom is poorly articulated and misunderstood. All three modes of philosophical thinking are needed to do justice to the concerns and goals central to nursing. We need critical powers to evaluate practice, theory, and research. We need creative and edifying philosophies to create an adequate vision for the goals of nursing practice. Finally, we need articulation research and thinking to describe what we know and do not know in our practice.

*From* **Links Between Philosophy, Theory, Practice, and Research**
by Patricia Benner (*CJNR* 2000, Vol. 32 N° 2, 7–13)

Have we arrived in Kansas yet? If the destination of chronic illness research has been an explication of the complexity and richness of chronic illness as experienced over time within social and personal contexts, the answer is no. The constructions of chronic illness to date have provided only a snapshot of the chronic illness experience, because they have limited the breadth and depth of investigations in this field of study. The hope of nurse researchers is that the findings will make a difference to the care and health of those with chronic illness. In order to reach this destination, nurse researchers in the next decade must be prepared to take into account the fluid, contextually based, individual experiences in living with chronic illness. They must be prepared to refrain from assuming that the traditional constructions of chronic illness are representative of the totality of the chronic illness experience. This will require creativity in our methodological strategies, courage in our interpretive claims, and a commitment to more in-depth and multilayered representations of what the complexity of chronic illness entails.

*From* **"Are We in Kansas Yet, Toto?"**
**The Construction of Chronic Illness in Research**
by Barbara L. Paterson (*CJNR* 2000, Vol. 32 N° 3, 11–17)

Nursing's voice must be heard among the voices of social scientists, women, and communities calling for public policy and social action to address violence and abuse. This can happen only if the public is aware that violence is woven into the conceptual fabric of nursing practice. Nursing's presence in the interdisciplinary and intersectoral work that addresses violence must shift from that of supporting cast to leading role.

*From* **A Call to Focus Our**
**"Passion for Substance" on Family Violence**
by Colleen Varcoe and Judith Wuest (*CJNR* 2001, Vol. 32 N° 4, 11–19)

Economics has had the dubious distinction of being termed the "dismal science," and its application in health care has often pitted clinicians against economists in a struggle to lay claim to the mantle of patient advocacy. Practically speaking, economics provides a framework for the allocation of resources, in this case nursing care, among competing ends and the costs, both financial and non-financial, of allocation decisions. The economics question facing nursing is not what the value of nursing care *is* (i.e., costing out nursing services for the sake of determining its costs) but *how* to allocate this valuable resource to best meet the health-care needs of our patients and the population.

*From* **Nursing's Valued Resources:**
**Critical Issues in Economics and Nursing Care**
by Julie Sochalski (*CJNR* 2001, Vol. 33 N° 1, 11–18)

While [commissioned government reports on home care have been] crafted to reflect the notion that home care is for the good of the individual, the documents have as their fundamental precepts a concern with government spending on health; home-care management as a gendered activity, and the expectation that women will take on the role of caregiver; and the ideology of one's individual responsibility for oneself. Furthermore, the home-care discourse is based on deep-seated assumptions about home and family, for example that we all have homes with family and friends close at hand to provide a nurturing environment and that resources are in place (bedding, laundry facilities, etc.) to make home care a reality. In other words, the notion of home care is entrenched in a particular meaning of "home" and constructed from a particular social location: the privileged middle class. Most importantly, it represents an off-loading of responsibility from the state to the individual and "family," even in those instances where "home-care services" are supposedly provided. As I point out elsewhere, the home-care movement must be understood in the context of societal and health-care ideologies that stress individual and family responsibility…and that are enmeshed in the notion that personal misfortunes (as well as personal successes) are *individually* produced.

*From* **The Politics of Home Care: Where Is "Home"?**
by Joan M. Anderson (*CJNR* 2001, Vol. 33 N° 2, 5–10)

Many consider that the continuous cycles of over- and under-supply of health human resources worldwide reflect inadequate projection methods for estimating future requirements for expanding health systems and/or a failure to consider the evidence supplied by labour market trends. HHRP in most countries has been poorly conceptualized, intermittent, uneven in quality, profession-specific in nature, lacking in vision, and lacking in data upon which to base sound decisions. To ensure efficiency and effectiveness, planning activities should be needs-based, responsive to a changing system, and outcomes-directed.

*From* **Where To From Here?**
by Linda O'Brien-Pallas (*CJNR* 2001, Vol. 33 N° 4, 3–14)

The topic of coping covers a vast landscape, but to date it has been investigated like a tourist who has time only for a helicopter excursion and therefore never gets a close-up look at the fauna and flora. Coping researchers have barely penetrated the diverse ways in which people come to terms with the alarms, transitions, and setbacks of life. This is partly owing to the fact that coping has been ill-defined, its measurement has preceded its understanding, and the contingencies affecting the forms it takes are poorly comprehended. In the future, depth should take priority over breadth, and a more dynamic process orientation should replace fruitless study of the relations between isolated bits of coping and the outcomes of interest. Instead of searching for evidence that certain strands of coping have adaptive value, we need to ask how clusters and sequences of coping foster progress towards the goals people strive to attain.

*From* **Coping Research: The Road Ahead**
by Benjamin H. Gottlieb (*CJNR* 2001, Vol. 34 N° 1, 13–27)

Within a relational ethic, we want to give relationship between people primary consideration. We want to acknowledge and give attention to the space between us. Let me take the rather simple hyphen, the hyphen that connects the nurse and the patient as in nurse-patient relationship. When we focus our attention on the relation itself, it might be more useful to move away from the short horizontal line of the hyphen (nurse-patient) and create two vertical lines (nurse | | patient) to give renewed attention to this space. The vertical lines provide a space that stirs us to contemplate the interconnection of human life. Note that the vertical lines (nurse | .. | patient relationship) give more attention to the individuality and separateness of each person in the relationship.

*From* **Ethical Challenges of the 21st Century: Attending to Relations**
by Vangie Bergum (*CJNR* 2002, Vol. 34 N° 2, 9–15)

The real question is: does participation in treatment decision-making at time of diagnosis really improve one's chances of survival?

Why is it so important that we address this question? Because there is an underlying assumption that the answer to the question is "yes."

If important options that could maximize survival are not available in our health-care system, why study patient participation? In more and more cases, there is no real choice — defined as availability of evidence-based interventions — because resources, including nursing resources, are severely limited. In spite of this we create the illusion that there is a choice. Whether this illusion really helps people facing life-threatening illnesses to deal with their disease and treatment remains to be seen.

We have an illusion that we are "in control," but are we really? Ethics and decision-making at the individual level are becoming less relevant as targets of study, while the same topics at the system level are becoming increasingly relevant.

*From* **Ethics and Decision-Making: Lessons From the "Cancer Wars"**
by Lesley F. Degner (*CJNR* 2002, Vol. 34 N° 3, 9–13)

Over the past decade, research has succeeded in clarifying some of the mechanisms that underlie the risk for developing and reinforcing substance abuse. Powerful natural recovery processes have been observed, supporting the use of opportunistic, brief interventions in settings where substance abuse is often encountered, such as the frontline. The nursing professional seems exquisitely positioned to engage in effective yet brief intervention for substance-abuse disorders encountered in such settings.

*From* **Nursing Research and Alcohol Problems: Learning From Recent History?**
by Maurice Dongier and Thomas G. Brown
(*CJNR* 2003, Vol. 35 N° 1, 13–22)

Research has explored and substantiated culture and gender as a determinant of health. Considerably less progress has been made, however, in incorporating this knowledge into the design of health interventions. What is the basis for this omission? Perhaps it is related to culture and gender being considered "non-modifiable" risk factors. Many researchers acknowledge the influence of these factors but believe that little can, or should, be done to modify them.

*From* **Incorporating Culture and Gender Into Multiple Intervention Programs** (Guest Editorial and Discourse)
by Judy Mill and Nancy Edwards (*CJNR* 2003, Vol. 35 N° 2, 9–14)

Are we living at a time when words beginning with the letter "e" are pre-eminent in health-care discourse? Four words in particular come to mind, three of which are *effectiveness, efficacy,* and *efficiency*. On close inspection, these words all have the same Latin root, "effectus." Webster's dictionary provides eight definitions for the noun *effect*, the first being "something that is produced by an agency or cause; result; consequence"… Other definitions connote purpose or intent and the power to produce results. Note that these definitions are neutral or value-free; that is, the "something that is produced" could be either positive or negative, intended or unintended. However, when *effect* is used in the adjectival form, it is no longer neutral but takes on a positive value. In the context of health care, *effective* is applied to something that produces an expected effect under everyday conditions, *efficacious* refers to something capable of achieving a desired end or purpose under ideal conditions (often in the context of randomized clinical trials…), and *efficient* implies skilful accomplishment of a purpose with little waste of effort or resources…

What, then, is nursing care effectiveness?... It is about the power or strength of nursing care to produce intended and desired health outcomes for patients, families, and communities… We need evidence that professional nurses are effective agents in producing desired outcomes through systems of care delivery and processes of care and by their presence and discrete actions or interventions.

*From* **Nursing Care Effectiveness: Here to Stay** (Guest Editorial and Discourse)
by Sandra LeFort (*CJNR* 2003, Vol. 35 Nº 3, 7–16)

Unfortunately, it seems that a reduction in disturbed behaviour has become the preferred outcome for quality of care and health services research in long-term care. Is this good enough?… Much more attention needs to be focused on conceptualizing the quality of daily life and quality of the moment in the cognitively impaired elderly population.

Because of the aging of our population and the resulting increase in the number of people who are cognitively impaired, more people will have parents and grandparents with cognitive impairments and will insist that their lives be lived as fully as possible. Even without this reality, however, I think the opportunity to be creative and to bring innovative approaches to understanding behaviour and to testing different ways of being with and engaging these people will become irresistible to some of our best researchers.

*From* **Making Moments Matter**
by Dorothy Pringle (*CJNR* 2003, Vol. 35 Nº 4, 7–13)

Continuity is a goal to be pursued in primary care. However, policymakers must appreciate the fact that continuity of care means considerably more than simply ensuring that each person is able to register with a family physician. Flexibility of care venue, team continuity, and the use of integrating information technology are all areas of innovation in primary care that offer an opportunity to place current concepts of continuity into a broader policy context.

*From* **Reflections on Continuity in Contemporary Canadian Primary Care**
by Sam Shortt (*CJNR* 2004, Vol. 36 Nº 2, 7–10)

By pressing for the exposure of situated vulnerabilities, I hope to open an inclusive discourse on diversity that sees discrimination and social injustice not as the prerogative of those assigned to certain categories but as germane to all. No one is exempt from the discourse on diversity. Nor is anyone immune to the experience of marginalization, dehumanization, and human suffering.

A postcolonial feminist humanism holds out hope for the opening up of a discursive space for diverse voices, resistances, and praxis that might move us towards inclusivity and social justice.

*From* **The Conundrums of Binary Categories: Critical Inquiry Through the Lens of Postcolonial Feminist Humanism**
by Joan M. Anderson (*CJNR* 2004, Vol. 36 N° 4, 11–16)

Rural health research…has been concerned more with access, regardless of how services are funded, and should offer more opportunities for international exchange. Rural health research means different things to different folks. Those accustomed to thinking about research in terms of randomized clinical trials, or at least in terms of a quasi-experimental design, in which an intervention is assessed for its effect on outcomes, may be surprised to learn of the large body of funded research that makes little or no use of such methods.

In contrast, much of the rural health research currently funded in the United States is undertaken not to discover effective clinical interventions but to discover effective policy interventions. Those who labour in this vineyard have fashioned their research portfolios to address how rural is different, why rural is different, and, in most cases, whether the differences merit a policy intervention.

*From* **Rural Health Research: Building Capacity and Influencing Policy in the United States and Canada**
by David Hartley (*CJNR* 2005, Vol. 37 N° 1, 7–13)

Until recently, palliative care tended to concentrate on the needs of cancer patients and their families, focusing on the terminal stages of a person's life. However, the field is being challenged to provide high-quality care to a wider range of patients, receiving care in a variety of settings, with more complex symptoms and co-morbidities, at earlier stages of their illness.

The attention given to the patient's comfort, complex symptoms, and confusing feelings, as well as difficult family dynamics, is what makes palliative care effective. It is impossible to be an expert palliative care nurse and skim over the patient's concerns, minimize distress, or ignore minor difficulties. Indeed, it is the nurse's detailed attention to the small aspects of a patient's physical, emotional, and spiritual state that makes a difference.

*From* **Directions in Palliative Care Nursing Research: Impeccable Care, Timing, and Complexity**
by Linda J. Kristjanson (*CJNR* 2005, Vol. 37 N° 2, 13–20)

Much remains to be unmasked; we have to make transparent the complexities of these intersections and how they are *played out in everyday life to determine women's health.* We might assume we know what "race" means, but how can we use the concept as an analytic category in trying to comprehend the social determinants of women's health? What are the *processes* by which *race* is played out in everyday life that makes it worthy of mention, and how do these processes intersect with class and gender?

Let me be swift in pointing out that it is not only people of colour who are racialized. The processes of racialization apply to everyone. Or we might assume that people from some "ethnic groups" will go home from hospital to an extended-family situation when, in fact, they may have no one to help them out at home.

Nurses have a social and moral responsibility to conduct research that is inclusive of all of Canada's populations. However, we must conduct this research in ways that do not reproduce racialized categories but that, instead, challenge the categories and assumptions that result in the demeaning of people.

*From* **Reflections on the Social Determinants of Women's Health – Exploring Intersections: Does Racialization Matter?**
by Joan M. Anderson (*CJNR* 2006, Vol. 38 N° 1, 7–14)

What if the forms of research and restoration that we need to do in order to build a safer, more sustainable health system for all are not the forms of science and knowledge initiatives that are consistently rewarded in our academic lives? If nurse researchers have to struggle to get the respect and recognition for their work in citizen science that corresponds to their efforts, will they answer the call for this difficult work in the backcountry of modern health care?

*From* **Field Notes From Research and Restoration in the Backcountry of Modern Health Care**
by Patricia Marck (*CJNR* 2006, Vol. 38 N° 2, 11–23)

In Canada and the United States and all around the world there are glaring disparities in the health of women of colour compared to white women. This reality is well known, as is the reality of interpersonal violence for a large proportion of women. Yet these two intersecting issues are seldom considered together, in spite of the documentation of violent victimization among women of colour and IPV as a risk factor for many conditions.

As health-care interventions for domestic violence are developed and tested…, it is imperative that they be tested specifically among different racial, ethnic, and cultural groups, or we may end up increasing rather than decreasing the health disparities for abused women of colour.

*From* **A Further Celebration of Nursing Research in Violence**
(Guest Editorial and Discourse)
by Jacquelyn C. Campbell and Angela Henderson
(*CJNR* 2006, Vol. 38 Nº 4, 11–26)

If nursing information systems continue to restrict nurses' tasks, there is a risk that nurses will resist using them, as they offer so little support to the more complex functions of knowledge utilization and knowledge development. Since nurses who devote a considerable amount of time to documenting their practice feel increasingly burdened with information management, it seems more appropriate to develop information systems that support nurses in their decision-making and other functions, where timely access to knowledge is crucial.

*From* **Nursing Informatics:**
**Developing Knowledge for Nursing Practice**
by Luc Mathieu (*CJNR* 2007, Vol. 39 Nº 1, 15–19)

Nursing has its own cultural history with respect to pain. It is a history that bears heavily on both the science of pain and the application of that science in everyday practice. As one of the quintessential areas of nursing care, nursing has long been associated with comfort and support for the sick and suffering.

If we apply the virtue script to pain care, we find the widespread idea that the patient is best served by a kind and attentive nurse, one who helps the patient to voice his or her feelings, supports families, and puts energy and sensitivity into determining the meaning of the illness and the pain for the patient. This is the tenet of patient-centred care. Of course all of these principles are central to good practice, but what concerns me is what is missing from this model of excellent nursing. Where is the science?

Pain management is a science, and one in which nurses are key. The virtue script may have served nurses and their patients well in the past, but in the field of pain, as in so many other domains of care, we need to move beyond angels and practise as knowledgeable scientific and compassionate professionals.

*From* **When Caring Is Not Enough:**
**Understanding the Science of Pain**
by Sioban Nelson (*CJNR* 2007, Vol. 39 Nº 2, 9–12)

Place can impact on many of the health risks we are exposed to, the types of disease that confront us, and the health services that are available to us — important factors in the study of population health. The time is right for nurse researchers to consider some of the health implications of geography.

*From* **The Importance of Geography and Health in Nursing Research** (Guest Editorial and Discourse)
by Shirley M. Solberg and Christine Way
(*CJNR* 2007, Vol. 39 Nº 3, 13–18)

Until governments recognize home care as a major component of the health-care system, and until they embrace an integrated continuing care model that incorporates a continuing-relationship approach, the needs of persons with dementia and their family caregivers will remain unmet. As a result, costs to the health-care system will increase, especially if family members are unable to continue in their caregiving role. There is a narrow window of time in which to address these issues. We must act now.

*From* **Looming Dementia Care Crisis: Canada Needs an Integrated Model of Continuing Care Now!**
by Dorothy A. Forbes and Anne Neufeld
(*CJNR* 2008, Vol. 40 Nº 1, 9–16)

Because nursing is a practical profession, there is always room for improvement, which, in turn, should increase its contribution to patient well-being and health. Such a development, however, cannot be supported solely by a research approach that focuses on enhanced understanding of the perceptions and experiences of nurses and patients. There is also a profound need for evaluative and experimental research to enhance knowledge about what works in practice and its impact on patient outcomes — that is, the effectiveness of nursing interventions… In discourse terms, it is time for a shift.

*From* **A Descriptive Feast But an Evaluative Famine: Implementation Research in Nursing**
by Lars Wallin (*CJNR* 2008, Vol. 40 Nº 2, 17–23)

Studies with patients who have become expert in everyday self-care decision-making reveal that they do not achieve that expertise through compliance with recommendations or adherence to standardized approaches. Rather, those who attain expertise figure out at some point along the way that it is their life that will be lived and they must become the ultimate authority on that life.

*From* **Chronic Disease Management: What Is the Concept?**
by Sally Thorne (*CJNR* 2008, Vol. 40 Nº 3, 7–14)

# Landmark Articles
# From Volumes 31–40

# Des articles-jalons
# tirés des volumes 31 à 40