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CLINICAL NURSING RESEARCH

OPENING DOORS: CREATIVITY IN NURSING

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NURSING PAPERS TODAY

THREE FIRSTS have been achieved in this issue of Nursing Papers. We received one letter-to-the-editor in response to Joan Gilchrist's article on "Profession or Union". This letter plus Miss Gilchrist's reply provide us with the beginnings of a dialogue. If you would like to pursue these ideas further, we would be pleased to hear from you. This crucial topic of how the nursing profession can negotiate for the development of nursing services within the whole field of community health and, at the same time, expand the function of nursing to the full practitioner role to which it aspires provides a dimension to the problem which requires immediate study and consideration. A second letter-to-the-editor invites response to the Recommendation on the Preparation of Public Health Nurses formulated by the Canadian Public Health Association. This is an issue worthy of some debate and I think you will find Elizabeth Logan's reply a provocative one.

We are pleased to announce as the third accomplishment that the main content of this issue of Nursing Papers has been provided by the School of Nursing of the University of British Columbia. Floris E. King, Ph.D., Associate Professor and Coordinator of the Graduate Program, forwarded an article on creativity. Helen Moogk Elfert, M.A., late of McGill and now in Vancouver, kindly developed some ideas she had presented at the Research Session of the last CNA General Meeting in Saskatoon into a paper on clinical nursing research. We hope that other university schools might like to follow a similar path and plan an issue of Nursing Papers for a future publication.

Following the appeal for financial assistance described in the November 1969 issue, we received the sum of $475.70. I would like to thank the few university schools of nursing who provided such generous support as well as the many individuals and groups who contributed. Our situation at present is as follows:

Expenses for 1130 copies, November issue, 1969	$550.00
Received — individual, group and school contributions	475.70
Balance owing	74.30
Balance owing from April issue, 1969	$392.15
Total Balance Owing	$466.45

We have been asked repeatedly to provide for individual subscription to Nursing Papers. You will find an application form for this purpose in the front of this issue. Please complete and forward with your cheque as soon as possible.

We approached the Lippincott Company of Philadelphia for financial backing for Nursing Papers at least until it was well established as a journal to express the views of university schools of nursing in Canada. Although we did not receive a written reply to our request, the verbal message, although congratulatory, indicated that the company did not wish to expand in this direction at present. The Lippincott Company probably wonders at our capability to produce research articles in nursing comparable to those in other nursing journals. However, we are off to a good start and with your support in bringing research projects and potential reports and articles to our attention, Nursing Papers should expand and become well established within a year or two.

M. A.

LETTERS TO THE EDITOR

"PROFESSION OR UNION"

IF I MAY, I would like to comment on Miss Gilchrist's article "Profession or Union", in the latest issue of Nursing Papers.

It does not appear to me that the professional status of nursing provides a basis of solidarity amongst the members. There seems more evidence to support the idea that the professional status of nursing is rather questionable. I'd pose these two factors as the basis for an argument against using our "professional organization" for bargaining and negotiations.

As Miss Gilchrist has pointed out, economic remuneration will accrue to nurses relative to the social economic situation with or without formal negotiations. Fringe benefits are relative to the individual work situation. We might benefit then from the approach taken by the teachers at Ryerson Institute of Technology.

Negotiations are carried out by representatives of a group of employees in the organization. They act not as members of a union or a professional organization but rather of a group concerned with continuously providing the highest quality of service within that organization. This has proved effective for the teachers at Ryerson. Perhaps it could do the same for us.

Helen Carter, BN, RN, Toronto

I am pleased to have the opportunity to respond to Helen Carter's letter.

I applaud Miss Carter's suggestion on two points: First, the restriction of the bargaining unit to that of individual work organizations with their particular goals, strengths, weaknesses and internal relationships; and secondly, that negotiations and bargaining be focused upon those things relative to the provision of "the highest quality of service within that organization". The fact that there is no necessary connection between the two and that present employer-employee contracts within the specific organization are systematically focused not upon quality of service but upon typical labour-management considerations should not theoretically inhibit us from eventually pursuing that outcome. One may ask: What better way to accomplish high quality service than through a con-

sideration of needs of individuals working together formulating their own ideals and ideas through the system of relationships which create the effective structure of that organization alone? Moreover, "bigness" as a characteristic feature of contemporary social institutions (including bargaining units) is being challenged by a very idealistic and a very vocal segment of our society who are working toward the more individualistic and less standardized and bureaucratized system.

Yet, having said this, I still do not feel committed to the course of action suggested by Miss Carter. My primary reason for rejecting the proposal is that as an occupational group, if not profession, we have not yet identified that for which we wish to bargain. It is hardly necessary to point out that all the nursing leaders in the hundreds of Canadian hospitals, agencies, and schools in which nursing is practised are hardly au fait with either the health needs of the community they serve or the ways in which nursing can best make its contribution in a system of rapidly-changing roles. Nor do they have the knowledge or opportunity to determine what these should be. We have only to refer to what many nurses in positions such as nursing consultant, director of nursing, association executive, university faculty, and the like are saying and doing, to recognize that our spokesmen have often used little imagination and are hampered by traditional relationships between nurses and others when attempting to participate in formulating crucial alternatives and choosing among them. Our representations have often been hesitant, inadequate in scope, and not based upon nursing research data which would promote a credible and expert judgment in nursing matters. Thus, before individual organizations could evolve a system of useful and productive negotiations, it is necessary to "start at the top" and embark upon a heavy round of serious scientific study, formal and informal discussions, presentation of briefs, participation in lobbies, conferences and meetings, and so on with top personnel of government, with administrators and with other professional groups with a view to establishing a realistic, viable, and meaningful place for nurses and nursing within health services. Now is the time for our traditional place is surely under attack. It seems absolutely clear that with success in this area, bargaining units per se would be an anachronism and the nature of labour-management relations would more closely approximate modern social needs.

If, however, we remain concerned with the here-and-now, the short run needs of nurses and nursing while the above rhetoric

takes place, then I still do not believe that bargaining in the individual organization is a useful answer for the majority of nurses. Let us recognize that the example provided is not representative of our employment situation. In the instance of schools and universities where nurses are hired primarily as teachers, they derive the benefits (and the disadvantages, I might add) acquired through three or more decades of labour-management negotiation between teachers and employers. Their status and position in the organization is more relevant to that of another discipline. Most nurses are employed solely as nurses by large organizations, themselves situated within larger structures and all ultimately financed by large governments. Historically, the monopolistic tendencies of employers and their ability to make unilateral decisions and to effectively regulate competition for members of an occupational group, has been counteracted and eroded only by an equally large bargaining unit. Where small individual bargaining units have been most effective, useful and attractive is when the availability of large, impersonal and highly bureaucratized alternatives exist for both sides and provide countervailing powers. Caught in a web which demands negotiation the value of more decentralized bargaining becomes evident. In our own case both sides might then focus upon the attainment of a situation in which good nursing care becomes possible, is rewarded for its own sake, and is dictated by the needs of the public it serves rather than the institution in which it is practised or the people who practise it.

Whether nursing has ever, or has now, achieved "professional" status appears to me completely irrelevant, a red herring. What is important is that if nursing wishes to survive, and it will only if it is prepared to make a contribution which others deem useful and necessary, it must decide with others what the nature of this contribution is to be. All nurses have a stake in making this decision whether we are judged to be a profession or an occupational group. By using the professional association as a base from which to structure a unified approach to the problems of nursing, we do not imply that this association is at present a basis of solidarity, but rather that it could readily become so if we really think we have a skill and an expertise which we can pursue for the benefit of others. — *Joan M. Gilchrist, M. Sc. (A), R.N., Montreal.*

REPLY TO CPHA

A report on Recruitment of Public Health Personnel was considered by the Executive Council of the Canadian Public Health Asso-

ciation in May 1969. A number of recommendations on the training of public health nurses were forwarded to our School by E.S.O. Smith, M.Sc., M.B., D.P.H., C.R.C.P.(C), Chairman of the Committee on Recruitment. Mr. Smith invited comment with particular reference to Recommendation 5.1:

> That a course leading to the certificate or diploma in public health nursing be provided by at least one University School of Nursing in each province.

A copy of the response from our school follows. Many university schools as well as the CCUSN have been asked to reply to the CPHA's recommendations on the training of public health nurses. This question is a vital issue representing as it does the larger problem of the preparation of nurse practitioners for the present and future health services of Canada. I know we have all given much thought to this issue; it is now time to take a stand. With this idea in mind , I hope that you will read our answer and make yours available also, so that we may consider more closely the views of our schools on such matters.

Response to Recommendation 5.1

Although health knowledge is available, the people of Canada have not been receiving the health services they need. Now there is a marked shift in health care from the hospital to the home, the community clinic or the ambulatory service in the hospital. Therefore all nurses must be prepared to work in the community setting, at different levels. This in fact, is happening and has led to the discontinuance of the diploma course in public health nursing.

We concur with the recommendation that at least 25% of nurses (all nurses) have a bachelor's degree. The remaining 75% then can be graduates of basic diploma schools. These two kinds of nurses along with nurses aids, if placed in effective working relationship can provide the nursing service for the community. The vital consideration is effective utilization.

Changes in nursing education may appear to come too slowly. This seems to be partly due to a reluctance to give up old patterns and a tendency to retain a picture of the public health nurse from the past. Basic diploma schools of nursing in many instances are now preparing graduates who can provide first level nursing in any part of the community. Some public health agencies have already reported this to be successful. These agencies are setting up brief but carefully focused orientation programs for the graduates and find that they function quite effectively. It must be remembered that diploma courses in public health and other areas were original-

ly established to make up the deficiencies of the basic program. As these deficiencies of preparation cease to exist, the public health course as such is upgraded and incorporated into the degree program.

The bachelors degree course aims to prepare the nurse who is au fait with the changing health needs of the community, skilled in working with individuals and in organizing nursing services. University prepared nurses are needed in institutions (e.g. hospitals) as well as other community agencies. They are the ones who will move into the supervisory and organizing positions and direct the utilization of nursing services as a part of the total health service in the community. They are also prepared to evaluate nursing care and work for improvement. It must be remembered that these graduates are often inexperienced. They need to start at the first level and work their way along according to their abilities. On their way up, they can do a great deal towards the development of nursing service given a system which will support them.

Nurses as any other professionals need opportunities for constant review and revision of their functions and skills. We certainly agree that the university has some responsibility in providing this opportunity in the form of short courses, etc. In addition, there must be opportunity for all nurses to increase or develop special skills, — the diploma graduate in the college system and the university graduate in the university. The university can also make available courses which will allow the practising nurse to study on a part-time basis. It must be recognized that part-time study has limitations.

As we look back over university programs in Canada, evidence appears of an unmistakeable reluctance for nurses to seek university preparation. This situation stems from the attitudes of employers, other professionals, and nurses themselves and undoubtedly some failure of university programs to remain sensitive to nursing service needs. It is therefore imperative for all schools of nursing and health agencies to plan together so that all their activities are coordinated within the health team. Then there is more hope of increasing the 5% of nurses in Canada with university preparation to the 25% that is recommended, and thus move closer to our aims for nursing service in the community.

Elizabeth Logan, M.N., R.N.,
Director, School for Graduate Nurses,
McGill University

CLINICAL NURSING RESEARCH

HELEN MOOGK ELFERT, M.A., R.N.
University of British Columbia

THE BULK of nursing research in the past has been concerned with the study of the people doing nursing and the bureaucratic systems within which nursing takes place. Gradually the realization has grown that what is needed is more study of the process of nursing itself. This includes a study of what individuals are like in health and illness and how they respond to the stress of illness, changes in their way of life, and modifications of family structure. It includes as well an appraisal of nursing action in its attempt to modify these stresses and help individuals move toward health.[1]

Clinical nursing research is the way in which nurse-researchers study these processes trying to build a theoretical framework on which to base nursing actions. There are many difficulties involved in identifying problems for study and in planning this research. In this paper a look will be taken at specific problems in carrying out clinical nursing research.

These problems can be broadly grouped into two classes —

1) Problems related to the fact that the researcher is also a nurse, and
2) Problems related to the setting in which the research is carried out.

The nurse doing research is subject to all the difficulties inherent in field research in any area. Her view may be biased and distorted by her previous experience, her expectations of what she will find and her lack of objectivity. These problems must be largely attacked in the research design by building in safe-guards so that the researcher cannot, even unconsciously, manipulate the data to fit her expectations. It is an all too common human failing to see the evidence which supports our hypotheses, yet fail to see the contradictory evidence.

The nurse as researcher is generally subject to role-conflict: she

is often in a position in which she finds herself exposed to demands which seem contradictory and incompatible. Conant has expressed the belief that the successful study of nursing practice will be done by nurse practitioners who also do research.[2] While agreeing with the value of linking research to practice, one must look objectively at the nurse who is involved. How often students of research in nursing have expressed difficulty in carrying out their research tasks, when in the course of these, they see needs of patients which are not being met. Picture the nurse-researcher who has set herself the task of collecting detailed observations of children in a selected hospital setting; since she is not invisible and the fact that she is a nurse is known, she may be subjected to demands from the busy staff to help out, to watch some piece of equipment or to watch a patient. She has further ambivalence within herself when she sees a distressed child; the nurse part of her wants to pick him up and soothe him. It is difficult for nurses to differentiate the nursing process itself from the study of this process, and the nurse-researcher is frequently in conflict with herself, as well as having difficulty in interpreting her role to her nursing colleagues.

Nursing research can be carried out in any setting in which nursing is practised. In most cases this involves some sort of bureaucratic structure, whether hospital, clinic or other agency. In order to obtain permission to do research, it must be shown that the study is possible within the organizational structure, that it will not disrupt services, that it will not involve unanticipated cost to the agency, and that the welfare of patients will be safeguarded. This means that the research design, including measuring tools must be presented to administrative personnel. The response to a request to use an agency for research varies, depending on pre-existing beliefs of administrators, as well as the skill of the researcher in presenting her case. There are administrators who automatically turn down requests to do clinical nursing research, usually on the ground that they cannot allow outsiders to interfere with patient care. There are, fortunately, more and more administrators who are receptive to research proposals, and who will assess these individually and try to help in implementing them. It is the researcher's responsibility to show that her study can be done within the setting, and it is helpful if she can also show that the study will be of benefit to the organization in the provision of new ideas or information.

There may be specific conflicts with doctors in defining limits of nursing research and action. These may be gradually lessened

as nurses more clearly define their sphere of action. The problem will be resolved, not so much by writing and arguing, as by the actions of educated, thoughtful nurse practitioners in their day-to-day interaction with other members of the health team.

To move from the institutional level to the specific area in which research is done, we must look at the subject of clinical nursing research, the patient, or more frequently the nurse and patient together. There is often conflict about how much to tell the subjects of research about what is being studied. Obviously, data can be distorted if the subjects know exactly what is being looked for, and nurses can become quite sensitive in figuring out what the researcher wants. Saying that you are interested in how long it takes for call bells to be answered is certain to alter the way nurses answer them. And it is hard to imagine beginning an interview with a patient by saying, "I'm trying to find out what patients are like who've been labelled 'uncooperative' by nurses". At the other extreme it would be hypothetically possible to collect data with subjects totally unaware, but there are considerable ethical problems in hidden cameras and tape-recorders or even in assuming another role while collecting data.

How this difficulty is solved will depend on the particular problem being studied and the researcher herself. The rights of patients must be protected and the good will and cooperation of the nursing staff is usually essential.

For some kinds of information, patients may distort their answers in a deliberate attempt to be good or to please the nursing staff. They may be unwilling to express their ideas about the care they are receiving while they are still in hospital — there may be considerable divergence in reports of nursing care given while in hospital and those given after discharge. More sophisticated patients may identify the purpose of particular tools and try to supply information they feel fits the researcher's expectations.

Within the clinical setting there are also what might be called interaction effects: How much does the presence of the researcher affect what is being observed? Clinical nursing research can likely never be "pure" in the sense that laboratory study can be. What is happening at a particular moment is dependent on many factors within and outside the present situation. It is the aim of research design to control for or minimize the effect of the many variables present. This leads to the question of how clinical research is developed and how the findings will finally be used to develop a body of nursing knowledge.

It has been said that every event which occurs is unique. It is also quite apparent that no two patients are identical in every way. At the same time, advancement in nursing knowledge is dependent on identifying patterns of behavior, so that we can make predictions of what care patients may need, or of how they may respond to a particular experience.

Many skilled nurses operate largely on what they call intuition. They can say, with considerable assurance, that a patient looks better, or worse, today. It is often hard to translate this intuitive feeling into objective terms. Much nursing action is based on feelings, previous experience, trial and error, and habit. This largely non-rational decision-making process has provided some excellent nursing care, but also makes it likely that there will be much poor nursing care. Operating largely on feelings leads nurses to categorize patients as "good", "cooperative", "difficult", "confused", and to apply nursing in stereotyped ways.

Nursing research aims to show more effective ways of doing nursing, to help in educating better practitioners and to make more rational demands and decisions about what nursing care patients need. The most basic research question is: If this action is taken will it be of benefit to the patient? Benefit may broadly include any progression toward health — he feels better or more comfortable, he recovers more quickly, he is subjected to less stress, his anxiety is less. A major problem in clinical research is the development of ways of measuring effects of nursing actions.

At this time, when clinical nursing research is really in its infancy, much exploratory study is needed. The researcher needs to immerse herself in the study of clinical material, to watch day to day behavior of patients and nurses, to collect detailed descriptions of what is said, of facial expressions and posture, body movement, responses to events surrounding and occurring to patients. For this the researcher needs clear vision, time and knowledge of the pitfalls of observation. Time is a crucial factor because she cannot begin to see recurrent themes or patterns until she has seen a fairly large number of patients. Insights come as the researcher studies and reviews her observations, and discovers that some events occur repeatedly. These recurring patterns lead to questions of "why" and "what is happening", which lead to further observation to see if what has been discovered also occurs in other similar situations. Eventually, this sort of exploration may lead to formulation of hypotheses, statements of expected relationships between events which can be tested experimentally.[3]

The nurse-researcher may well use theories from other disciplines, for example the social sciences, to try to understand and explain things she has discovered. Her background of study in other fields gives her added insight into the meaning of what she sees and does. But basically, a body of nursing knowledge will be developed by nurses studying nursing. As this knowledge increases and becomes organized, we will have a much more precise and predictable way of transmitting nursing knowledge and skills to students as they learn to become practitioners.

The final beneficiary of this knowledge must be the patient. As we learn to understand better what he is like, what he is experiencing in illness, what his behavior may mean, and can identify changes from day to day, we are in a better position to plan care which is appropriate for him in terms of his immediate and future needs. Because patients are individuals, nursing care can never be stereotyped or the same for everyone, but increased knowledge helps us to select ways of acting which are likely to be useful, and to assess the patients' responses to our actions and to modify the plan of care as needed.

Possibly one of the greatest problems in clinical nursing research is transmitting findings and incorporating them in practice. Much research ends in the journal in which it is published. The solution will lie in better preparation of nurse-practitioners and in having more researchers who are intimately involved in the provision of nursing care. As Conant says, "only those who remain linked to clinical practice are likely to study problems in nursing practice and develop theories of practice".[2]

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OPENING DOORS
CREATIVITY IN NURSING

FLORIS E. KING, Ph.D., R.N.
University of British Columbia

THE PRACTICE of nursing is a continual challenge to the imagination. Creative imagination plays a vital part in the development of all professions. It is the *sine qua non* of scientific and technological achievement.

Today, the word creativity is "part of a growing resistance to the tyranny of the formula, a new respect for individuality, a dawning recognition of the potentialities of the liberated mind".[1] There is need for freedom of thought and inquiry if this unpredictable, capricious, open, independent, zealous, synthesizing process of creativity is to flourish.

Creativity may be defined as the ability to bring a new or different perspective or approach to a situation, the ability to perceive a new way of organizing an existing situation, and the ability to see a new and deeper order or unity in the end product. Creativity defined in this manner receives considerable support in the current literature relating to creativity.

Some Background Literature.

Rogers defines the creative process as the "emergence in action of a novel relational product".[2] The individual is able to bring forth this product through the intermeshing of his own uniqueness with the materials, people, events and circumstances of his own life.

Bronowski,[3] in writing the lead article for the September, 1958 issue of *Scientific American,* defines creativity as the product of a single mind which perceives a deep new unity in disorder. This unity results from the discovery of unexpected likenesses within the diverse. Scofield, similarly, sees creativity as the "idiosyncratic perception of intellectual relationships"[4] between two or more stimuli which the individual has never before experienced.

Guilford,[5] at the University of Southern California, was the first

to envision creativity as a continuum and a dimension of the personality that had many components. The following factors of creativity were extracted: synthesis, associational fluency, ideational fluency, originality, adaptive flexibility, spontaneous flexibility, redefinition and sensitivity to problems.

The work of Guilford and his associates served as the basis for most of the work that has attempted to utilize tests for the purposes of identifying the creative person, or the person possessing creative talent. Leaders who have pioneered research on creativity in the educational setting are Getzels and Jackson at the University of Chicago, and Torrance at the University of Minnesota.

Getzels and Jackson[6] adapted some of the Guilford tasks of creative thinking for use with children. Studies have been conducted comparing intelligence levels and creativity levels of various groups, as well as differences in career aspirations of the highly intelligent individuals as compared to highly creative individuals. The authors found a low correlation between high intelligence and creative ability with the creative group selecting more unusual and numerous occupational choices than did the highly intelligent group.

Torrance, as Getzels and Jackson, began his work in the area of creativity in education by adapting some of the tasks devised by Guilford for use with children as well as with adults. However, Torrance developed complex tasks, which were models of the creative process as a whole. Individuals were then scored on various types of creative thinking factors involved.

Wallace[7] used some tests from the Minnesota Tests of Creative Thinking to investigate the relationship of creative thinking to high sales productivity and to customer service. He found that salespeople employed in creative departments (e.g. ladies dresses) were found to have significantly higher mean scores of creative thinking than did salespeople working in non-creative departments (e.g. notions and candies).

Research on creative thinking and its relation to nursing has been limited. Dr. Ann M. Hart did her doctoral dissertation in 1962 "to determine in what manner creative thinking was related to nursing performance."[8] Her findings indicated that the creative factors of spontaneous flexibility, originality and elaboration are significantly associated with nursing performance; that the verbal ability of nurses is not significantly associated with nursing performance; and that the quantity of ideas does not tend to contribute to a high level of nursing care practices.

It would seem that the nurse has a great opportunity to utilize

some aspects of creativity in patient care. The nurse, by meeting the needs of the individual patient through a meaningful nursing diagnosis, would be manifesting an ongoing aspect of creativity. The individualized nature of the nurse-patient relationship would also seem to provide further opportunity to approach each patient in a creative manner. Of course, the educational setting provides an excellent setting to foster creativity.

Perhaps one of the greatest challenges today in the nursing profession is to provide a setting to stimulate and nourish the development of individual creativity.

The Creative Setting

There are degrees of creativity. Many could achieve fairly impressive levels under favourable circumstances.

Creativity requires mastery of the subject area in which work is to be done, but as the limited review of the literature indicated — there is something more than sheer mastery. Creativity is an individual phenomenon — the climate to foster creativity is necessarily that which nurtures overall individual growth and development.

Only three special groupings of characteristics of the creative setting will be mentioned here: hope and encouragement, freedom and richness of ideas, and finally effort and guidance.

Hope and Encouragement. Even though Thomas Carlyle was right in saying, "a certain amount of opposition is a great help to a man," creativity is so delicate a flower that praise tends to make it bloom, while discouragement often nips it in the bud. The discouragement that hurts creativity the most is that which comes from those whom we regard most highly. Consequently, it is essential to have a setting which encourages ideation, one which even welcomes mistakes. The very essence of creativity is to keep on trying and trying, harder and harder — and that is almost too much to expect of human nature without an expression of encouragement.

Basic to expression of encouragement is the acceptance of the individual for his own worth. Today, in much of the literature, there is a search for meaning — "a rebirth of faith and confidence in the human person."[9] Groups, organizations and societies are important, but they can be only as creative and productive as the individuals comprising their structure. Consequently by fostering encouragement and instilling hope in the individual one can help provide the climate for creativity.

Freedom and Richness of Ideas. A setting rich in ideas is vital to the development of creativity. Freedom to change directions, shift strategies, try new experiences, develop new systems of thoughts and patterns helps to evolve more ideas — an augmenting type of experience. The creative person is noted for remarkable zeal or drive. He is wholly absorbed in his work. This energy is not only intense but sustained. The individual must be free to fulfill this drive which permits all kinds of combinations and recombinations of experience with a minimum of rigidity.

Effort and Guidance. Effort - concentration - tends to make association of ideas more fruitful. James Ward, English psychologist and philosopher, stressed how association can be enriched by selective attention. The more persistent our interest is, said he, the more we can profit from association.[10]

It takes hard work to be creative. Not everyone is willing to put the effort into thinking, trying, feeling, relating. Through guidance, efforts can be channelled and assisted.

The nursing profession not only has the opportunity to provide the creative setting — it has the responsibility. It must open the door to creativity. This door may be opened through hope and encouragement, freedom and richness of ideas, and, effort and guidance. In order to open doors for others, doors must also be open for us — it is that simple.

In Revelations 3:8 — "Behold! I have set before thee an open door, and no man can shut it."

Footnotes

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