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PRACTICAL VISION AND RESEARCH

THE BORDERLINE STUDENT NURSE

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YEAR III

The questions of editorial policy printed in the May 1971 issue of *Nursing Papers* brought forth two responses. Hoping to find a position to follow on these questions of policy, we are now confronted with two varying viewpoints from respondents. Alas for *Nursing Papers,* but hurrah for nursing; we have found controversial questions which elicit differing values and beliefs! What are your views?

Please note the letter from D. L. Sackett at McMaster University describing the Health Care Evaluation Seminars funded under a National Health Grant. It is unfortunate that this letter could not have been published to allow readers to apply for the November seminar; however, there are other seminars to follow probably in the spring of 1972.

Adapting Social Measurement

I read your article in *Nursing Papers* with interest and was curious about your positive correlation between right and left opinionation. I gather from what you say, it's possible that these are not necessarily organized in such a way that an individual is predominantly left — or right — opinioned? What is the possibility that your new scale isn't sorted in the same way as Rokeach's were?

I would be interested in having a copy of the scale and scoring used, and possibly could try it out on some other groups of students.

Do you expect to identify changes between students at the beginning and end of the baccalaureate program? In which direction?

Pleased to see it written up; keep it going!

Helen Elfert
Assistant Professor
School of Nursing
University of British Columbia
July 1971

The points you raise in respect to the adapted opinionation scale are of much interest to me. From my understanding of Rokeach's scale, I concur with you that individuals, in general, are not characterized by being either right or left opinionated, that opinionation is a single dimension varying in degree or intensity in various people and population groups. The right-left factor reflects where one sets the mid-point, the generally acknowledged modal point of view regarding an issue, by people in general, as determined by judges in preparing the items for the scale. The difficulty of course is finding judges sufficiently similar to the group with which one proposes to use the new scale to determine the modal attitude, and of course the range of views is considerable. In adapting items for a Canadian nurse population the modal points of view to various items were not sufficiently well established in advance to give a scale that is neutral in this respect. I am expecting that modal attitudes will vary by geographical location, social class, sex, level of education, age, religious orientation, and the rural-urban characteristic of an individual's background. Undoubtedly there are other influencing factors too. When we have a broader range of views it may be possible to rebalance the scale on the right-left characteristic to make it neutral.

Considering your second point, the items were sorted by random selection, as were Rokeach's.

I certainly am glad to send the scale on to you. I should be pleased to hear your results if you choose to use it in British Columbia. This would be a useful contribution to what I hope will be an accumulation of norms from various locations.

At the present we are collecting data on incoming baccalaureate students. We plan to do this again when students complete the program. I feel we also should collect data outside nursing from other university students, from age cohorts not in university, from other kinds of nursing students, and practicing nurses. This information would help us to see if our group is select in respect to opinionation. As yet, however, I have not implemented this part of the plan.

As to what do we expect to find, I'm still thinking that students will become less opinionated as they progress through the program. But does it really matter if they are opinionated or not — I cannot say. It is the critical question as I see it, and it needs to be tested through performance clinically.

Ruth C. MacKay
Associate Professor
School of Nursing
Queens University
August 1971

Responses to Problems of Editorial Policy

I cannot help but respond to the suggestion that critiques of research articles or original papers be included. I think it would be both helpful to the reader, and a step in the direction of positive growth for the profession. Possibly it might provide some back-up for you in selecting materials for publication. I should have welcomed such assistance from a critical appraisor in connection with the article of mine you just published.

Further, the publication of position statements appears to me to serve a very useful function, especially when responses are included. Let us hear more from the other disciplines too. So many processes found in nursing are common to other areas, especially the helping professions. Dr. Moore's study should certainly be of interest to nursing.

I noted that *Nursing Papers* is being covered in the routine cataloguing of materials covered by the *International Nursing Index, an* additional aid to anyone searching the literature.

Ruth C. MacKay
Associate Professor
School of Nursing
Queens University
July 1971

In response to your editorial questions in the latest issue of *Nursing Papers,* I am apprehensive about the inclusion of research critiques unless the critiques are kept very, very short which is extremely difficult to do. My preference would be to *have* the reports and critique them myself. A guide for self-critiquing might be very useful. The critique policy you suggest would be very nice but I suspect we can't afford it at this time.

I agree with the policy of the publication of position statements if they cannot be made available to us in any other form. If we cannot afford the space, could a source page list such documents and we could write for a copy?

If there is a policy to publish research reports on nursing from other disciplines, you may be deluged by the "publish or perish" problem among other groups. Personally, I would like to see priority given to work by nurses (who may have graduate degrees in another discipline) rather then providing a forum for the others who should be able to publish in their own periodicals.

By all means include advertising by university schools of nursing and book publishers.

Margaret C. Cahoon
Professor and Chairman of Research
School of Nursing
University of Toronto
July 1971

Health Care Evaluation Seminar

There is growing attention throughout Canada to improving the availability, effectiveness and efficiency of health care services. The Department of National Health and Welfare, the Medical Research Council, and other national and provincial agencies are supporting innovative demonstration programmes in the organization and delivery of health care.

These developments are hampered by the scarcity of personnel capable of evaluating health care programmes. Although fellowship and degree programmes in health care evaluation are expanding, their impact will not be felt for several years. Furthermore, the duration and location of formal training programmes render them inaccessible to many health professionals, administrators and others who are grappling with the day to day operation and evaluation of health care programmes.

In an effort to bridge this gap, and with the support of the National Health Grant, a group of health care evaluators have developed a series of written and audio-visual educational resources encompass-

ing the measurement of health and health care needs, the measurement and evaluation of health care, and the tools and techniques of evaluation, including economic and operations research methods, alternative strategies to evaluation, and suggestions on the organization and financing of an evaluation project.

These educational materials, which have been produced in both Canadian languages, for use across Canada in a series of Health Care Evaluation Seminars, the first of which is to be held the week of November 14-19 at the new Health Sciences Centre at McMaster University in Hamilton, Ontario. These Seminars will be directed to health professionals, administrators, and others concerned with health care evaluation.

Applicants will be asked to submit a health care evaluation proposal, which will serve to focus on their activities during an intensive one-week educational programme which will include continuous access to a learning resources area, individual tutorial sessions, group discussions and seminars, and consultations with experts in health care evaluation. It is anticipated that most of the participants will have developed a detailed evaluation design by the conclusion of the seminar, and in many cases it will be possible to continue the tutorial relationship on a long term basis.

Inquiries and requests for application forms for the Health Care Evaluation Seminar to be held at McMaster University from November 14-19 may be obtained by writing to Mrs. Marjorie Baskin, Seminar Co-ordinator, Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Ontario.

Scholarships and travel awards are available and applicants who are not selected for the November seminar will automatically be reconsidered for the next seminar which is to be held approximately six months subsequently.

D. L. Sackett
Project Director and Host
Department of Clinical Epidemiology
& Biostatistics
McMaster University

PRACTICAL VISION AND RESEARCH

by

JOAN M. GILCHRIST
Assistant Professor,
School for Graduate Nurses,
McGill University

CONTEMPORARY nursing research articles are replete with suggestions relative to the need for, and ways of facilitating, the collaboration of nursing "practitioners" and "researchers" in the conduct of nursing research.[1] This movement can be conceptualized as an attempt to promote some change in the present relationship among nurses which would result in improved nursing practice. Now, the specific types of change sought in dealing with the perceived problem, and the methods employed to achieve these are inexorably linked to the initial interpretation of the problem. This is simply to say that should the rationale behind the need for change be tenuous or based on faulty assumptions, one could question, the validity of the change sought or the efficacy of the methods employed to achieve it or both. In this paper the writer does not take issue with the validity of the change sought: That is, that all nurses be involved in the continuous study of nursing practice. It is rather the way in which the problem to be solved by this change has been interpreted and the methods suggested to achieve this goal which are to be challenged.

Looking first at the nature of the problem. In stating that "practitioners" and "researchers" should be helped to pursue cooperative ventures, one is accepting as fact the idea that nurses are dichotomously distributed between these two roles, or that these are two of a number of mutually exclusive roles assumed by nurses. Practice and research in this model are conceived as "two types of skill" and "two points of view" which must be integrated.

An alliance of practitioners and researchers would, first, reduce something labelled "resistance to change" or "resistance to research" on the part of practitioners and second, permit those who function in the delivery of care to identify the "real" problems for the researcher. It is usually believed that achievement of these goals would enhance the "climate" for research in agencies where nursing is

carried out and would decrease the "theory-practice" gap in the practice of nursing. This gap is said to have been created because the researcher is "theoretical" but "flexible", while the practitioner is "practical" but "rigid".

It is not difficult to hypothesize the origins of this practice-research dichotomy. Nursing as an identifiable occupation began more than a century ago. It has always been conceived as "practical" in the sense that the skills and abilities of the nurse have been directed toward solving the actual and immediate health problems of real people. From practice and tradition one learned nursing and provided nursing services in a "service" setting as opposed to an academic one. Concomitantly, scientists in the university were developing something labelled "scientific method", assumed to be the one valid way of acquiring new knowledge in all fields. Problems were selected for their intellectual or heuristic value and the scientific method was "applied to" these problems to render a solution primarily in an area divorced from the real world.

In spite of the evidence suggesting that all contemporary nursing practice and nursing research cannot be aptly described by these two positions, the dichotomous conception continues. Research in nursing is seen as external to the practice of nursing, as applied to it. Researchers in nursing are perceived as applying the method of research to the solution of nursing problems. Validation of this "common-sense" conception of nursing and nursing research has been achieved not only by the parallel but separate development of each, but also by the medical model of care characterized by its orientation to the application of *a priori* knowledge of disease and cure to patients on a one-to-one basis. These factors have had enormous and far-reaching effects upon the development of both practice and research in nursing and the relationship of one to the other.

One of the ways society uses to distinguish and understand differences in type and nature of expertise is through something labelled role differentiation within some system. In concert with the basic thesis that nursing research and nursing practice are inherently different, if not diametrically opposed, it is not surprising that two mutually exclusive roles for practitioner and researcher have been hypothesized. The hand of the social scientist, whose tentative formulations with respect to role theory have since been turned into dogmas, is much in evidence. Like the creation of "community power structures" and "social class", role theory has become fact in the sense that what were to have been general and tentative theoretical constructs became instrumental in creating different nursing roles as a social fact. Moreover, in the application of some theoretical posi-

tions,role is actually perceived as a determinant of behavior. These notions, assuming at least two conflicting and competing positions with respect to the practice of nursing and the study of nursing situations, do in fact help to create the conflict between practitioners and researchers.

So far we have attempted to identify and to challenge the interpretation of the problem as presently perceived. We have done this by noting the tenuous nature of the assumptions on which the interpretation rests. That is, that these two positions may be simply embodiments of theoretical constructs which may no longer be useful for understanding the behaviors of nurses. It is now possible to understand better the techniques and methods utilized to date to solve the problem, for they are all based upon ones commonly employed to bring about a marriage between or among "recognized" diversities.

Everyone reading this paper will be familiar with most or all of the strategies described below to bring practitioners and researchers together for they have been suggested over the years as being effective supervisory tools. Beginning with the famous "Hawthorne Experiments" in the thirties, industrial relations experts have sought to develop ways of bringing about a new relationship between worker and management. Popularized as the "human relations" approach, each "side" seeks to have the other "side", "understand" his role, "participate" in some finite way in his work, "accept" his goals as different but try to achieve a "common purpose" and "support" him in the quest for solutions to his problems. The operative norms are "group dynamics", and "democratic leadership". This is essentially a social explanation of behavior; the notions that the individual is subjugated to the primary informal group, that success is measured by morale or getting along as opposed to accomplishment, and that the non-planned, non-rational elements of organizational behaviors are the important entities to understand. While some of these methods undoubtedly have merit in helping people work together, the assumption that their purpose is to bring about consensus amidst difference, militates against their potential contribution to organizational and personal achievement. At best they can only be perceived as manipulative devices permitting the innate superiority of one side over the other. They have been largely unsuccessful and will surely continue to be unsuccessful in solving the problem of how to promote the development of nursing practice.

We have come full circle. We are left only with the statement at the beginning: that all nurses be involved in the continuous study of nursing practice to promote its development. Is there an alternative, a more fruitful or meaningful way to interpret the nature of the

problem and the subsequent methods which might be utilized to achieve its solution?

First we must reject unconditionally all former assumptions with respect to the need for collaboration between dichotomous practitioner-researcher roles and the accompanying polarity of practice and research as variables in understanding nursing behaviors. Instead, we will describe our goal in the following fashion: that All nurses need to be involved in nursing practice, which includes the gathering of information about the nature of the care provided and the assessment of outcomes of care for the persons nursed. In this way, new data are supplied which feed into consequent practice. The nurse whose main function is to care for people uses the new knowledge engendered in this dynamic process in the immediate situation to change and improve the care of the individual. There are others who may take these data as instances of particular cases, which when grouped together over time, lead to more general concepts of care. Development of conceptual models is then possible and, with higher level abstraction, these models may be brought together in the formation of a theory or theories of nursing which may then be tested, elaborated and refined. The notion that the practice of all nurses is part of the same process is basic to the thesis to be explored in this paper. Conceived in this way participation in the process of nursing brings all nurses together in the development of the practice of nursing. To use some very old but still novel ideas of Follett, in working together nurses evoke responses from one another relating to how each sees the situation and its important variables.[2] Through interacting on stage they share experiences directly and indirectly and together they search for emergent ideas with respect to future action. This description of the goal is intrinsically different from that of the goal of collaboration. The latter assumes two rather static positions being brought together. The former assumes a dynamic process of involvement.

This process also differs in important ways from the following example of a common exhortation to nurse researchers. "Much of the distance between nurse researchers and practitioners can be lessened when the researcher is interested in studying problems of practice. Then, the knowledge and abilities of both the researcher and the practitioner become relevant to one another. . . At least an occasional contact with patients in the role of a nurse is both stimulating and clarifying."[3] Here the author, still supporting a two role system, is suggesting collaboration through one group moving closer to the other in behaviours: That is, one takes over the other's role upon occasion. As a solution, this comes closer to our suggestion than

other methods, but the two areas of involvement are not perceived as facets of a single process.

But this re-interpretation of the goal has not yet solved the problem. Perhaps the discriminating reader will be saying to herself "Are we really to believe that there are no behavioral differences among nurses with respect to the study of nursing?" If we disparage the idea of such differences emanating from roles and positions, then to what are differences linked?

At the outset it seems that skills, abilities, careers, work orientations, and motivation of nurses are variable. At least they seem to be. But upon what primary dimension do these vary, becomes the question. As an alternative hypothesis to "role" determinism, we would propose that the basic dimension on which behavioral variation occurs crucial to this discussion is the degree to which the individual nurse assumes a critical approach to her own "practical vision". It matters not what position the individual holds but rather to what extent she has the skill, ability, work orientation, and motivation to criticize her own "practical vision". The concept of "practical vision" is one used by Greer to refer to the behavior of man in everyday life situations.[4] We can apply it to everyday nursing situations using Greer's suggestions with respect to its general applicability.

Much of the training and experience of nurses is directed towards a primary interest in the ends of action, with the acceptance of the means as given. This tends to promote behaviors not overly concerned with observing and identifying important facets of nursing situations but rather to carrying out habitual and routine actions. This precludes the development of the inductive reasoning required to generalize from the specific case. When, and only when, the recipe for action fails in some important way, or she faces a completely new situation, is this nurse moved to worry about contingent laws and the larger framework. It is then and only then she asks herself "under what conditions does this work?" This practical vision is usually called "common sense". "It is what every (nurse) knows and nobody bothers to question since it works. It is a universal and conservative mode of behavior in (nursing)."[5] Even when the individual recognizes that some explanation is necessary for an apparent failure of action or to allow for some novel circumstance, knowledge or material to be drawn into her perception of the situation, the scope of the experiments or studies or assessments exployed to provide the explanation are variable. In point of fact most deal with the conceptualization that is relevant to a given narrow set of circumstances only. Because practical vision is universal we tend to use it most of the time. Continuing our adaptation from Greer, instead of a radical

critique of thought, most nurses nurse primarily through the practical vision they have inherited from the nursing culture. This is to say, their "interpretations of (nursing) are judged not by formal logic or rigorous and skeptical inquiry, but by their congruence with the common vocabulary of the (nursing) culture and specifically, the important listeners".[6]

In addition to the above elaboration of practical vision our tentative hypothesis depends for clarity upon some notion of our meaning of "degree". Since all nurses make use of "known" methods and techniques of carrying out nursing action, which according to our definition, preclude skeptical inquiry relative to their use, how do we vary vis-a-vis behaviors pertinent to the study of nursing? It seems unlikely that one could conceive of the ability and motivation of the individual to criticize her practical vision as either present or absent, as a constant at a polar extreme. Rather it is a variable among people on what might be hypothesized as a continuum indicating the extent to which it is done, and indeed along a similar continuum for the same person at different points in time and in different circumstances.

The extent to which the nurse perceives her practical vision as a rigid constraint in a situation bears a direct relationship to the extent to which she will criticize her perception of a situation. The more the common sense approach appears constraining to the nurse the more she will attempt to acquire improved sense data which would allow her to assess and perhaps identify other, and more useful, or appropriate behaviors. In short, she is less accepting of the infallibility of the "known" ways.

But there is another respect in which nursing behaviors vary and which is an essential part of this conceptual model. It was suggested earlier that once criticism is directed by an individual against a practical vision approach to a situation, it may take various forms which can be differentiated on at least one essential dimension, that is, its scope or level of generality. In its simplest sense, the criticism may take the form of the nurse adding a few observations to her repertoire and reassessing her performance in the light of these new observations. She plans and/or adjusts her care of this patient at this point in time. But the criticism in other instances and with other nurses may not stop with this particular assessment and response. It may include an attempt to link the particular data to other data; in other words, to make increased theoretical demands upon the data and compare these to other schemes of abstraction based on valid experience. Through this process of induction new and more general forms are created. Thus, in gathering information about particular

instances of common nursing problems and in subjecting these to some systematic study, the basic underlying variables can be identified and understood to become subsequently the elements of significant bodies of empirically grounded theories of nursing.

But so far we have left ourselves vulnerable to the attack of methodologists who cannot accept this view of research. A defence of the method is the proper subject of another paper, but to anticipate cristicism a short response is in order. Research has usually been conceived in a much more formal guise than that presented here. Formal, at least, in the sense that it requires a preconceived and highly structured plan. In this vein, Dickoff et al. suggest that "both practice and research are modes of openess to empirical realities. . . (but) . . . research tends to be vitiated when not done according to a perconceived plan."[7] It is possible, however, to reject even this sacredly held principle if one is prepared to accept the validity and reliability of research methodology which has as its purpose the generation of theory as opposed to the verification of hypotheses based on pre-existing theory. In generating theory the research plan evolves as the data analysis proceeds. The categories of analysis are discovered by the examination of the data. It involves a "process" of research. "Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research."[8] Moreover, "what is required is a different perspective on the canons derived from vigorous quantitative verification on such issues as sampling, coding, reliability, validity, indicators, frequency distributions, conceptual formulations, construction of hypotheses and the presentation of evidence."[9] Because our major task in nursing at this time is the development of a theory or theories of nursing the methodology presented here appears eminently suited to the task.

The second type of criticism levelled at this mode of research design centers on the suspected subjectivity of the field observation techniques employed. Becker suggests quite the opposite.

> Field observation is less likely than the more controlled method of laboratory experiment and survey interview to allow the researcher to bias the results he gets in directions suggested by his own expectations, beliefs or desires . . . We should take field work data seriously as evidence. . . (because) . . . the people the field worker observes are ordinarily constrained to act as they would behave in his absence by the very social constraints whose effects interest him: he therefore has little chance compared to practitioners of other methods, to influence what they do, for more potent forces are operating. Second, the field worker inevitably, by his continuous presence, gathers much more data and, . . .

makes and can make many more tests of his (tentative) hypotheses than researchers who use more formal methods.[10]

If we conceive of nursing and the study of nursing in this fashion, we are interpreting the problem in a very different light. The problem, instead of being oriented to bringing together two opposites, researchers and practitioners, is directed toward stimulating a particular method of nursing in which practice and the study of that practice are both part of the method itself. They are inseparable.

Reconceptualized, the specific objectives of change necessary to promote concurrent practice and study consists in helping all nurses to subject their practical vision of nursing situations to critical analysis more frequently — on a day-to-day basis — so that they become the nucleus of the data- collecting team. The outcome of this type of "Nursing-as-Process"[11] approach has gains in immediate situations relative to the care of a patient or patients and in the long run as part of an accumulation of the data necessary for the development of nursing theory. Concomitantly, the nurse who has additional skills and abilities in the strictly methodological aspect of the conduct of research may not only acquire data in an identical fashion through participation but may observe others in the practice of nursing and utilize all data collected in these ways as contributions to the analytic process.

Because the objectives now differ from those of our initial formulation of the problem we must also reconsider the methods and techniques to be used to achieve solutions. There is some evidence that students in educational programs within the general system of education are learning "Nursing-as-Process". This approach can effectively eliminate a good deal of the reliance upon practical vision as a determinant of nursing behaviors among persons now being socialized into the profession. But this is insufficient to induce change in and by itself in the immediate future. We must evolve other mechanisms whereby the process can be expedited. In its most idealistic form an organization for the provision of nursing care which includes nurses with a high degree of skill in the assessment and planning of care as key members to work with other nurses directly could have far-reaching effects. In a recent editorial, Notter suggests:

> "The clinical specialist brings a new focus to clinical practice, a substantial knowledge of the specialty, and a commitment to the improvement of patient care through developing and testing theories relevant to that care . . . The development of clinicians prepared to develop not only relevant theories, but also to test these theories empirically, may prove to be one of the best ways to initiate, stimulate, and

carry out clinical research in nursing."[12]

We would agree with this thesis, and in addition, our conception suggests that she work hand in hand with other "non-research" nurses. This person provides complementary skills in supplying analytical and interpretational acumen. The particular organizational position held by this "specialist" is unimportant as long as she has a recognized and accepted place which allows her maximum opportunity to nurse with others, to guide and assist others to be committed to the constant improvement of practice. The relationship among these two types of persons is one of complete sharing of experience through constant interaction and integration of functions. As we suggested earlier this is the crux of the development of emergent ideas among them.

In summary, the development of this kind of program now in as many areas as possible where nursing is provided, increasing the number as skilled people are available, would provide a situation whereby research was automatically built into the action program. Both the nursing behaviors of the personnel and the conceptual schemes evolving therefrom would be in a continual state of adjustment. The continuous monitoring and assessment of nursing behaviors "would allow an increasing specification of theories, increasing understanding of processes and at the same time a closer fit between means and ends, action and goal."[13]

Footnotes

1. See for example: Voda, Anna M.; Butts, Stanley and Gress, Lucille. "On the Process of Involving Nurses in Research," *Nursing Research.* Vol. 20, No. 4, July-August, 1971, p. 302. Dickoff, James; James, Patricia and Wiedenbach, Ernestine. "Theory in a Practice Discipline," *Nursing Research.* Vol. 17, No. 6 Nov.-Dec. 1968.
2. Follett, Mary Parker. "The Psychology of Consent and Participation," in Metcalf, Henry and Urwick, Luther. *Dynamic Administration.* N.Y. Harper and Row, 1940, pp. 210-229.
3. Conant, LucyH. "On Becoming a Nurse Researcher," *Nursing Research.* Vol. 17, No. 1, Jan-Feb. 1968, pp. 70-71.
4. Greer, Scott. *The Logic of Social Inquiry.* Chicago: Aldine Publishing Co. 1969, p. 48.
5. Ibid., p. 51
6. Ibid., p. 49
7. Dickoff, James and James, Patricia. "Researching Researchers Role in Theory Development," *Approaches to Nursing Research and Theory Development: Readings from Nursing Research.* I. p. 38.
8. Glaser, Barney and Strauss, Anselm. *The Discovery of Grounded Theory.* Chicago: Aldine Publishing Co. 1967, p. 6.
9. Ibid., p. 8.
10. Becker, Howard S. *Sociological Work.* Chicago: Aldine Publishing Co., 1970, pp. 42-44.
11. Allen, Moyra and Reidy, Mary. *Learning to Nurse: The First Five Years of the Ryerson Nursing Program.* Registered Nurses Association of Ontario 1971, p. 166.
12. Notter, Lucille E. "Empirical Research in Nursing," Editorial *Nursing Research.* Vol. 20, No. 2, March-April 1971, p. 99.
13. Greer, Scott. op. cit, p 195

THE BORDERLINE STUDENT NURSE

by

MRS. VIVIAN WOOD
Associate Professor, Faculty of Nursing
The University of Western Ontario

DIRECTORS of Nursing Education and their faculties encounter a myriad of problems in teaching student nurses who will upon graduation make a contribution to the profession. These problems are constantly changing, and as soon as yesterday's are solved, new ones present themselves. Where in the past, for example, concern was directed toward involving nursing faculty in matters of curriculum, selection and policy decisions, now focus of attention has shifted toward problems of student participation.[1] Nevertheless there are other broad issues which are *not* a function of the times which nurse educators constantly encounter. One of these is the borderline student nurse.

The borderline student nurse is one who requires extra faculty and administration attention because of unsatisfactory or deteriorating performance in her program. She may, or may not, have been marginal at the time she was selected to enter the program. Recently completed case studies indicate that problems with the borderline student are relatively common and that administrative action is usually influenced by three factors: student selection, evaluation procedures, and educational policies. Design and operation of student personnel systems often do not specifically reflect concern for the borderline student. In such instances students may suffer or excessive amounts of time and effort may be necessary to identify and solve student problems.[2]

These conclusions come from in-depth case studies of students with problems in Ontario and Quebec schools of nursing.* The project was undertaken to ascertain what problem themes are encountered at schools of nursing. The particular schools were asked to identify an important student problem that had arisen in recent

* This project was supported by a research grant from the Richard Ivey Foundation. The author is indebted to Mrs. W. Gerhard for her assistance in categorizing and summarizing the cases.

times. All participating schools of nursing did so on a voluntary basis.

A case study describing each problem and the action taken was prepared. Major themes emerged and were identified in subsequent analysis. More problems than those discussed in this paper were apparent but the three discussed below were common to most of the schools involved.

THE SELECTION PROBLEM

Careful selection of an incoming class is an important and difficult function in a school of nursing. Pressure to admit students who do not meet minimum standards often arises and sometimes has consequences which last throughout the class's entire experience. Educators do not need to be reminded of the problem inherent in selecting a new class. Picking the best from a batch of applications is difficult even when many more applications are received than places are available. In spite of efforts to obtain all the information needed, decisions must be made on inadequate and sometimes misleading data. Grades, for example, may reflect but do not measure motivation. In the end, decisions are made and errors committed. Students who will have problems are accepted; some who would have been satisfactory are not. The objective is to minimize both these errors as their costs are reflected in subsequent demands on the time and effort of teachers, administrators and counselors. The wear and tear on the student and consequent cost of wasted investment in education makes the exercise of caution in student selection mandatory.[3]

For example, Mussallem in her "Study of Nursing Education in Canada," estimated that the direct cost of educating one student for one year in a hospital school ranges from $1,000 to $1,400. She also stated that indirect costs are equal to the direct cost, so that the total ranges between $2,000 and $2,800 per student per year.[4] Subsequent estimates have put the cost per student even higher. These are 1964 figures and undoubtedly understate today's cost.

Withdrawal, or dropout rates for student nurses are costly and not only for economical reasons. Those students who were admitted and later withdrew may have displaced other qualified students who would have graduated satisfactorily. Willett states "the morale of some students or an entire class may be affected by the admission and later withdrawal of students who encounter difficulty within the program."[5] The attrition factor can influence the effectiveness of instruction within a program both in terms of the quality of classroom discussion and the excellence of instruction. Competent faculty

may leave programs which have a high attrition for others with more rewarding teaching environments. The following table shows that attrition rates have been high in Ontario.

Percentage attrition for students admitted in 1965[6]
Classified by type of program

Program	*Percentage Attrition*
4 year	15.7
3 year	26.1
2 + 1	20.3
2 year	15.9

Student A's problems illustrate the costs of poor selection. She was admitted with a Grade XII average of 64.7% at the age of eighteen. The minimum admission standard of her school was an average incoming grade of 66%. Her clinical performance had unsatisfactory aspects from the beginning and she failed three of the first set of examinations. She was seldom accepted by her peers and her relationships with patients were never more than social. With counselling, she improved only temporarily and later was recommended by her teachers to withdraw. Instead she was placed on probation for three months. No noticeable improvement took place and at the end of this time, she was asked to leave. Her stay in the school, at that point, had been sixteen months.

Should student A have been admitted? Clearly, her grades were below the minimum requirement; yet schools must frequently give serious consideration to such students. Circumstances arise where a class will not be filled if such students are not accepted. For example, most selections are made some months before classes begin. In many instances, applicants who more than meet minimum standards are rejected at that time because the class is full

As registration nears, however, some of those accepted withdraw for various reasons. The good applicants, previously rejected, are no longer available and, if a full class is to be achieved, less qualified applicants must be given serious consideration. The school, in effect, must choose between a smaller class than desired, with its unfavourable budget consequences, and students with less-than-desired qualifications. The risk of unsatisfactory consequences thus arises.[7]

If at the time of application, the school knew that a particular applicant would fail or would require much special attention in order to become a borderline graduate, it would obviously not accept her. This knowledge is, of course, unavailable then. In order to reduce these risks, schools utilize second and third selection stages.

Psychological and achievement tests are used often in combination with personal interviews to improve the quality of the selections. Even then, "mistakes" are made. Consider student B.

In student B's case, an exhaustive battery of tests was administered before the decision to admit her was made. The psychologist who administered and analyzed the test results concluded that this student was not a suitable candidate for the nursing program. In her report, the psychologist suggested that student B's limited knowledge of English was a barrier and this, combined with certain personality traits, warranted rejection of her application. She was accepted, however, and as early as three months after admission, faculty recommended that she receive extra help. Her early clinical experience was acceptable but after seven or eight months it deteriorated and became quite unsatisfactory; subsequently many hours were devoted to counselling. The student felt nothing was wrong. After ten months, her work, application, and comprehension were still unsatisfactory and in June she was asked to withdraw.

In this case the applicant was accepted against the advice of the psychologist. How should such advice be used? For the borderline applicant a good rule to consider is that extra information received from tests and interviews should reveal some special attributes to warrant acceptance. High intelligence scores, and evidence of extra strong motivation to nurse, high aptitude for nursing and so forth, are examples of information to be gained from tests and interviews which would encourage acceptance.[8] In the absence of such achievement, acceptance of those who do not meet minimum acceptance criteria should not take place. Student C's case illustrates the point.

Student C entered the school when she was twenty-four years old. She had been a student in another school of nursing previously for eight months but had been dismissed because of failure. In high school she had repeated Grades IX and X. This particular student ranked very low in the Scholastic Aptitude Tests of Ontario. During her first few months she progressed normally. Theoretical grades at that time were 67% and her clinical experience record indicated satisfactory results; however, student C failed paediatrics and was required to write a supplemental examination. In this particular school, students were permitted to write only one supplemental examination per year. Although this student was doing well clinically and was receiving good comments from the patients, she was having to face the fact that if she failed another examination that term, she must withdraw.

Here the additional information obtained by tests did not show any

special attributes to merit acceptance. Even in the part of the program where the student was repeating work taken at a previous school, her performance was marginal.

Admission procedures should ensure that all the information available on an applicant is given systematic and balanced consideration. In the absence of strong positive evidence from interviews or references a grade average marginally above the minimum acceptable should not offset previous failures and low test scores.[9]

No school can expect to be completely successful in their admission decisions. However, a systematic approach to selection will help to reduce problems and to direct the admission officer's attention and effort. One method to consider is a multi-stage admission procedure that could be used to structure the timing and collection of additional information when needed (Figure II). In this procedure tests and interviews would be utilized only for borderline applicants (using grades as criteria). Test results would facilitate further screening. The time consuming and expensive task of interviewing could thus be reserved for applicants still borderline after the previous stages.

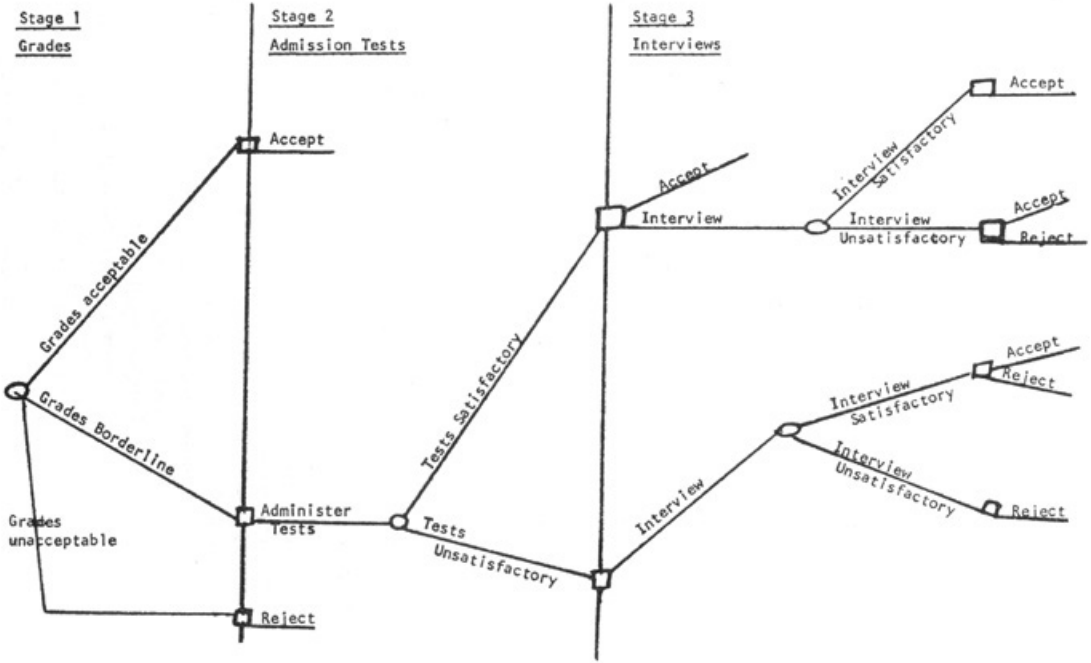
The staged admissions procedure will serve to reduce the time spent on admissions at the cost of extended elapsed time before some cases are resolved. This extended time, however, will be spent on those applications that warrant it. A higher proportion of successes should result.

ASSESSMENT OF STUDENT NURSES

The most frequent concern of nursing schools, school faculty and administrators in this study was the assessment of student nurses. This concern had two major aspects. The first was the use and abuse of the assessment tools utilized in evaluating the clinical performance of student nurses. This one issue occupied large parts of faculty discussion and attention. Problems arose in which evaluations conflicted, were ignored or had not been documented. Often, the evaluation forms themselves made assessment awkward. Some were blank sheets of paper while others were standard rating scales used indiscriminately for every clinical experience. Faculty were unable in these instances to set up assessment tools as they should — with behavioral objectives stated in relation to the objectives to be derived from that particular learning experience.[10]

The second area of controversy was the final assessment of the student nurse. Opinions differed as to the means of determining the overall grades for decision purposes. There are many ways that the final grades can be handled. One is the weighting of the courses taught before grades are averaged together for a final percentage.

Fig. II. A Staged Selection Procedure



For example, a fifteen-hour course should not have the same weighting as a 150-hour course. The latter course should carry more weight in the final event.[11]

Another factor that presented problems was the occurrence of differences between the written evaluation and the verbal report of a particular student's progress. Consider the case of student F. Her performance was described as satisfactory in her evaluation reports. Yet, upon interview with the faculty, several teachers stated she was "slow and immature." No such information had been recorded. It would seem that if teachers found the behavior of students not meeting the behavioral objectives of the programs, then these conclusions should have been written into the record. These discrepancies underlay the difficulties encountered with student assessment.[12]

Student F had become ill with a knee injury, and although her performance had been rated excellent, she was considered a physical risk. Consequently she was permitted to attend classes and excused from her clinical practice while her knee healed. After returning to clinical practice her teachers said her performance was deteriorating but that she needed "watching." Her evaluation reports, however, indicated that she could give "good patient care." After a few months, progress in her clinical performance was noted, but interviews revealed that her teachers still felt the need to "watch" her. In student F's case, subjectivity in assessing her performance and contradictory statements about her performance complicated the task of evaluating her performance and deciding on an appropriate programe for her. In personal interviews, her teachers said that this student's performance was "deteriorating" yet the written analysis of her evaluations in the clinical situation omitted such comments. Several reasons may account for these discrepancies. Perhaps the evaluation tools were too subjective or perhaps the teachers themselves were inadequately prepared in the task of writing assessments.

Also in the case of student A contradictory evaluations impeded analyses and resolutions of performance inadequacies. Her clinical performance had unsatisfactory aspects from the beginning. The verbal statements made by the teachers however, were not always corroborated by their written evaluation. Consequently fifteen months elapsed before consensus was reached and the student was asked to leave the school. There were other examples of contradictions between written and verbal evaluations of clinical performance by faculty. These two elements of assessment — the final grade, and evaluation of clinical experience — were frequently problems to nursing school faculties.

How can one arrive at a realistic and fair final assessment of a

student nurse? Data from the cases indicate that student nurses are sometimes, in fact, short-changed on their final assessment. It would appear that appropriate grades are simply averaged without giving cognizance to the appropriate weighting of the courses.

Consider the case of student F again. She was told she had two supplementals to write as below 65 was considered a failure. Figure III is the chart of this student's final marks.

FIGURE III. Student F.

NURSING PHASE #1 FINAL MARKS		*Class Hours*
Anatomy and Physiology	74	150
Bacteriology	67	30
Chemistry	78	40
History of Nursing	69	20
General Medicine	62	95
Pharmacology	64	51
Nursing Principles and Methods	69	217
General Surgery	65	103
Psychology	69	84
Sociology	85	53

Practical Work — 1st year average — 77 %
Theory 70.2%
First year average — 73.6%

School's Rating Scale

A	88 - 100
B	71 - 87
C	65 - 70
F	Below 65 (Failure)-

Upon close examination, many questions can be raised about the final assessment. How can one justify simple averaging a twenty-hour course with a forty-hour course and a 150-hour course? Weighting of courses would seem to be required here. For example, for every twenty hours of classroom teaching a weighting of one would be given. The twenty-hour course would have a weighting of one; the forty-hour course a weighting of two; and the 150-hour course a weighting of 7.5.

Besides the simple averaging of final marks, consider the marks and courses in which student F failed. In Pharmacology this student received a grade of 64. The passing grade was 65. The pharmacologist, in retrospect, stated that had he known that 65 was the passing

grade, he would have raised student F's mark. Several questions come to mind. Why were the faculty from related disciplines so ill-informed? Second, with a mark as close as 64, surely one could not consider this student as a failure. She could be considered marginal or borderline. Third, what was the class average in Pharmacology? For instance, if student F had received 64 and the class average was 60, then she really did not fail. It would appear that the arbitrary failure mark of 65 was not taken in relation to the class average. The same can be said of the General Medicine grade of 62. What was the class average? All of these things are related and are not to be considered in the abstract.

DECISION-MAKING WITHIN SCHOOLS OF NURSING

Already we have seen the problems of admitting the borderline student. In spite of improved admission procedures, problems of student performance will still arise, however. The decision-making process by which this problem is handled again will affect the effectiveness of teaching within the program. How long do you keep a borderline student in the program, particularly now that we have two-year programs, and at what point do we ask the student to withdraw? Are we really protecting the patient when we keep unsafe students around? Again, studies show that there is room for improvement.

V. V. Murray, in his "Nursing in Ontario," stated:[18]

> In general, among the schools we visited in 1967, the predominant decision-making process within the schools was broadly decentralized with regard to curriculum, while decisions on budget and staffing were more strongly controlled by the director. Like any other organization with overall goals which are occasionally conflicting, impossible to define in operational terms, and whose attainment is difficult to measure unambiguously, our impression was that most schools were characterized by possessing a few cliques and factions representing opposing viewpoints on significant issues. At best, their skirmishes tend to slow down the decision time; and at worst, they substantially harmed the quality of education in the school.

Such slowness tends to aggravate problems. Consider student A, whose clinical performance had unsatisfactory aspects from the beginning. She failed three of her first set of examinations. She had "superficial relationships with her patients" and she was seldom accepted by her peers. Even with counselling, there was no marked improvement, yet she was allowed to continue in the program. Then student A was given three months probation. She was not asked to withdraw until she had been in the school about fifteen months.

Student problems sometimes show where current policy is inappropriate or where no policies exist. Current changes in student attitudes and characteristics are leading to decision problems which previously did not occur. For a given school, past practice (policies) are often not appropriate for these new problems.

A policy that was perhaps too rigid for current problems was evident in the case of student D. She was well recommended, functioned very well in her time within the program (76.6% academic, 83% clinical) and was maintaining her good performance when she became pregnant and was married. At that time she was forced to leave the school because school policy maintains that a student who marries must withdraw. Many schools have revised this policy because of changing social values and the expense of losing an otherwise competent nurse.

In this case, an old rule had, over time, become inappropriate. In such circumstances the school's procedures should permit quick consideration of (a) making an exception or (b) revising the policy to suit changed conditions. There is a tendency for policies to become enshrined as absolute truths when, in fact, the opposite should hold. The pace of change in values, objectives, student sophistication and maturity and so forth promises that the permanence of any student policy is a myth. Clinging unknowingly to obsolete policies extends the tenure of individual problems and frustrates the learning process.

An example of, on one hand, lack of foresight in policy change and, on the other, an offsetting flexible approach occurred in the case of student E.

This student consumed a large amount of medicine for "kicks." The school had not developed a policy governing such behaviour. At first, the reaction of the director was to dismiss the student; however, after further consideration, the student was permitted to remain and a decison about her future delayed until a psychiatrist had examined her. Developing an ad hoc policy to cope with this situation, although successful, cost faculty and administration much time and emotional energy.

In another situation the absence of a quick reaction led to what probably was an unnecessary withdrawal. Student F entered a school of nursing after Grade XII and had been well recommended. During Phase I in the first year, she was rated as satisfactory although some teachers had called her "slow and immature." At that time the policy at this school for promotion from Phase I to Phase II was to review the student's clinical and academic progress, considering a course grade below 65% a failure. Students were permitted two supplemental examinations. This student failed two subjects, and had

achieved 65% in another. She then left for vacation before writing supplementals, and while away, wrote to the school suggesting she might withdraw and requested an interview. Student F felt she would not be able to successfully complete second year. No interview took place and this student withdrew. In this case, inability to identify and counsel borderline performers resulted in the student taking action which was probably not in her, or the school's, best interest.

Good operating policies and procedures serve to protect the student, promote uniform and fair treatment, and reduce the resulting friction and time involved when inappropriate or no policies exist. The school which waits until a problem exists before reviewing policy must analyze and act under time pressures that cannot help the decision process. The risk of poor decisions and generation of poor policies rises substantially.

While accurate forecasting of all problems and prior development of all needed policies are unreasonable expectations, considerable improvement is possible.[14] Systematic and periodic policy appraisal and revision should be built into the school's operating procedures. In this way, faculty and staff have more time to devote to their priority — improving the teaching-learning environment and their teaching techniques. Such a review, combined with a flexible approach to applying policy, could reduce administrative problems and their attendant frustrations.

SUMMARY

Part of the assessment problems encountered in the studies can be related to the schools' operation of their own student personnel systems. Their inherent inadequacies allowed situations to develop that more sensitive arrangements would have anticipated.

It is these situations — assessment and problem identification of the borderline student — that test student personnel systems. What is needed are 1) admission procedures that minimize the probability of accepting students who will not meet requirements, (2) assessment tools which quickly highlight student problems, and (3) policies and procedures which ensure positive action to resolve those problems. We have seen that in situations where inadequacies exist in these systems problems develop which occupy excessive amounts of faculty time and attention. More importantly the teaching-learning environment deteriorates and students suffer when these systems are deficient.

We have indicated some approaches which can be taken to avoid the problems described above. Generally, admissions procedures should spotlight potential borderline students and ensure in-depth consideration of their applications and programs prior to decision.

Assessment techniques should be designed to obtain consistent, unbiased evaluation of student performance. Clinical performance is one area where special care is needed. Because of its nature, objective measurement tools of clinical experience are difficult to develop. The risks of subjective measurement cannot offset the necessity to obtain information on student performance and problems. Thus every effort should be made to get good information. The teacher's sometimes reluctance to put in writing her whole evaluation of the student's performance and potential can be offset by striving to ensure their balanced and objective use.

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