NURSING PAPERS

FALL 1974

A PHENOMENOLOGY OF NURSING

INTEGRATING DEVELOPMENTAL RETARDATION INTO THE NURSING CURRICULUM

A CANADIAN COUNCIL OF NURSE RESEARCHERS

THIRD NATIONAL CONFERENCE ON RESEARCH IN NURSING

Volume 6, No. 3

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Moyra Allen, *Editor*
Vivian Geeza, *Managing Editor*

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Moyra Allen, *rédacteur en chef*
Vivian Geeza, *rédacteur gérant*

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Editorial

For three years, *Nursing Papers*' "ambassadors" have met during the annual C.A.U.S.N. meetings. These meetings enable members of the editorial board to offer and receive ideas and suggestions for *Nursing Papers*. Our June meeting in Toronto dealt with several topics which we would like to share with our readers.

Our greatest concern was to encourage the writing of more articles. Schools which in the past have taken on the responsibility of an entire issue, indicated this commitment often provided impetus for members to start writing. Another means found valuable by some faculties to assist members unsure of their writing ability, was to obtain part-time editorial help from persons on their campuses.

In discussing ideas for future issues, many interesting themes were suggested such as accreditation, evaluation of students, etc. Some ambassadors felt the area of nursing care has been under-represented in papers submitted. We would note that a new alternative to the submission of full articles is the column *Query and Theory,* an ideal forum for readers wishing to pose a question on teaching, research or nursing care for our panel of experts across Canada.

The news that all members of the Western Region will now subscribe to *Nursing Papers* as part of their C.A.U.S.N. dues was indeed gratifying. Equally heartening are indications that articles from this journal are appearing more frequently on student bibliographies, and that more schools have made articles the foci for faculty discussions.

There seemed to be some confusion about student contributions to *Nursing Papers*. The journal does have a policy of not accepting articles written by students; however, we welcome questions and comments from all our readers in the *Query and Theory* column as well as among the letters to the editor.

Our meeting was brief, but we feel much was accomplished. We hope that those of you on nursing faculties in Canada continue to approach your ambassadors with suggestions or questions for *Nursing Papers* in order to help this journal best meet the needs of us all.

THIRD NATIONAL CONFERENCE ON RESEARCH IN NURSING

AMY E. GRIFFIN
Professor, Faculty of Nursing
The University of Western Ontario

The Third National Conference on Research in Nursing was held May 21-23, 1974 in Toronto. It was sponsored by the School of Nursing, McMaster University and by the Faculties of Nursing, University of Toronto and The University of Western Ontario. It was funded under National Health Grant No. 613-1015-72. The Planning Committee comprised: Dr. Margaret Cahoon (Chairman) and Dr. Helen Carpenter, University of Toronto; Dr. Ruth MacKay and Mrs. May Yoshida, McMaster University; Miss Sheila Creeggan and Dr. Amy Griffin, The University of Western Ontario. Mrs. Marion Barter functioned as Program Co-ordinator and Sister Jeanne Forest as Translator. Dr. John Godden and Mr. Robert Randall, of Medi-Edit Limited, Toronto, assisted the Planning Committee in preparation of the pre-conference kit, conference materials and published precedings.

The theme of the Conference was Decision-Making in Nursing Research. The objectives were as follows:

General Objectives — to enable each participant to:

(1) Share knowledge, skills and attitudes about the research process and about on-going research activities.

(2) Analyze those determinants which influence the making of decisions in nursing research.

Specific Objectives — to enable each participant to:

(1) Identify those decisions which influence the development of a research proposal.

(2) Develop the ability to appraise critically the decisions in a proposal.

(3) Propose solutions to specific problems arising out of the use of human volunteers.

(4) Explore some design decisions in interdisciplinary investigations.

(5) Analyze the outcomes of decisions which influence research design:

   (a) the sampling plan

   (b) identification and measurement of variables

   (c) collection of data

   (d) analysis of design

(6) Identify potential sources of consultation and other sources in funding and research design, including statistics.

(7) Consider the decisions made in writing and publishing research reports.

It was recognized that individuals attending the Conference would vary in their interests and research expertise, that each would bring to the Conference the potential of a unique contribution and would take from the formal program and the informal contacts what best met their individual needs. These factors influenced the devisement of a varied program.

Dr. J. D. Hamilton, Vice-Provost, University of Toronto, opened the Conference. Miss Marjorie Simpson, B.A., S.R.N., O.B.E.* delivered the keynote address, titled "Quest for Excellence." She delineated the ways in which research can contribute to excellence in nursing, emphasized the needed relationship between the nurse researcher and the nurse practitioner, discussed factors to be considered in the quest for excellence in research and criteria for its assessment, contrasted the contribution and stage of development of descriptive and experimental research in nursing, considered needed attributes of nurse researchers and referred to certain ethical considerations. Her concluding statement emphasized the need for nursing research and interdisciplinary research conferences but warned that these need to promote provocative controversy rather than destructive strife.

Dr. Helen Carpenter was the dinner speaker the second evening. Her topic was "The Power of an Idea." In this she outlined the approach to a development of research in nursing in Britain which she observed while on sabbatical leave. She paid tribute to Miss Simpson for her creative, zealous and productive efforts in its promotion.

Additional special guest speakers and their areas of consideration were as follows:

Professor Horace Krever, The University of Western Ontario — Access to Patients and Other Human Subjects.

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*Miss Simpson has recently retired from the position of Nursing Officer (Research), Department of Health and Social Security, England.

Dr. W. Harding LeRiche, University of Toronto — Proposals as Viewed by an Independent Researcher.

Dr. John Godden, Medi-Edit Limited — Writing and Publishing the Report.

The format for the majority of the program comprised the highlighting of research projects by individual nurse researchers involved in their design and implementation followed by plenary or small group sessions. These projects were at varying stages of development and completion. They were selected from approximately fifty submitted to the Planning Committee by nurse researchers in various education and service agencies for their relevance to the following areas of decision-making in nursing and for interdisciplinary research: development of a proposal, appraisal of a proposal, designing a study, collecting data, analysis of data. The pre-conference kit had included descriptions of all studies considered at the conference so that participants could come to the conference with a frame of reference for each study, speakers could selectively focus their brief presentations and the audience could direct comments and questions to specific areas within the context of each total project. Following is a list of the projects discussed and the investigators involved in their conduct:

M. Allen and M. B. Kravitz — Design to Evaluate Model of Nursing Across Primary Care Settings — A Comparative Systems Approach

R. Coombs — Development and Implementation of the Nurse Clinician Role.

R. Cunningham — An Analysis of the Supervisory Process in Middlesex - London Health Unit.

L. Degner — The Life-Prolonging Dilemma: Its Impact on Patients, Families and Health Practitioners.

K. G. DeMarsh, A. J. (Nancy) Anderson and P. E. Poole — Effects of a Specific In-Service Education Program for Registered Nurses on Patient Welfare and Hospital Operation.

S. MacPherson, S. French and V. Marshall — Evaluation of a Psychosocial Program Being Implemented in a General Hospital.

H. Glass — Use of Clinical Facilities by Nursing Students in the Province of Manitoba.

C. Gow and J. J. Williams — A Survey to Determine the Perceptions of Death and Dying Among Community Health Nurses and Hospital Nurses at the Staff Level.

L. Levesque — Evaluation of the Effects of a Preoperative Teaching Program on Patients for Elective Surgery.

R. C. MacKay, E. R. McNeely and H. W. Beatie — Interaction of Health Professionals With Patients With Peripheral Vascular Disease.

M. Phillips and L. Turner — Patient's Perceptions of Selected Feelings of Nurses and Nurse's Self-Disclosure.

K. vonSchilling — Early Evidence of Maternal Attachment.

Dean Joan M. Gilchrist, McGill University, summarized the Conference at the close of the final session. An evaluation questionnaire was completed by 87% of the participants. Responses were reassuring in terms of meeting the general objectives of the Conference, with an anticipated indication of somewhat less success in meeting all the specific objectives for all participants. Respondents underlined their sincere interest and feeling of freedom to comment frankly by incorporating many helpful, specific and forthright suggestions for themes, programming and conduct for possible future conferences. One respondent made the following particularly heart-warming comment:

> "I do not think the values of this Conference is reflected in or can be assessed by those Specific Objectives. It was an extremely worthwhile and well planned conference and offered more than these objectives indicate."

Two respondents voiced the feeling of many when they said, "I was pleased to see young researchers in action" and "Keep the young ones coming".

It is anticipated that the next conference may be held in the "Golden West." Dr. Shirley Stinson, University of Alberta has already conferred with Dr. Margaret Cahoon to gain the benefit of her Planning Committee's experience and to consider feedback from participants. It is understood that plans for the Fourth National Conference on Research in Nursing were at least in the embryo stage within a few weeks of the conference herein reported. There is firm widespread confirmation that Canadian nurse researchers are earnestly seeking the kind of mutual sharing and learning which such conferences promote and facilitate.

A CANADIAN COUNCIL OF NURSE RESEARCHERS

MARGARET C. CAHOON
Professor, Faculty of Nursing
University of Toronto

At the post-conference meeting of the Colloquium on Nursing Research in Montreal on March 30, 1973, it was suggested that the third conference be planned for 1974 rather than 1975. At this point the question was raised as to whether there would be enough studies underway within a year to warrant this. The Planning Committee for The Third National Conference on Research in Nursing has found over eighty projects, in which nurses are project directors, principal investigators or co-investigators, ranging from those being planned to those recently completed.

Assuming that there are often gaps between projects, there must be well over one hundred Canadian nurses involved in research. A few Canadian nurses have demonstrated involvement in more than one investigation in this period yet most carry heavy teaching or service responsibilities, and very few are able to devote full-time to research.

Although the foundations of research in nursing in Canada have been built by university faculty members, there appears to be an increasing number of nurse researchers employed in service institutions, community health agencies, government, professional and other associations. Some of the latter very new appointments are for full-time research activities. Although the majority are located in or near the major health science centres, some appear to be relatively isolated from other health researchers.

Possibly a few of the Canadian nurse researchers belong to the Council of Nurse Researchers of the American Nurses' Association. It was organized in 1972 to advance research in nursing and the exchange of ideas among its members and associates. It is restricted to those who have earned a master's or higher degree and are engaged in the conduct of research, guiding graduate students in research, or serving as consultants in research. It is responsible to The Commission on Nursing Research of the American Nurses' Association.

Are we ready to organize a Canadian Council of Nurse Researchers? Do we need an organization to provide clearing house functions on a national basis? Are we able to keep informed about on-going research as well as completed research? Do we need further opportunities for better communication? To what extent have we been able to plan for collaboration? Do we need opportunities to synthesize the outcomes of the many small, often isolated studies that could be brought together to identify gaps for which investigation is required? What access do we have to short, intensive, educational opportunities to extend and deepen our knowledge about new facets of research methodology? Do we need a framework for promoting scientific sessions, conferences, colloquia and special interest groups?

If we are ready to organize a Canadian Council of Nurse Researchers, should it be associated with the Canadian Nurses' Association, the Canadian Association of University Schools of Nursing (which does not include those who are not faculty members), or The Learned Societies? An advantage of the latter would be that ultimately a group could emerge, on a similar basis to the Canadian Association for Studies in Education, as the Canadian Association for Studies in the Health Sciences.

This proposal aroused such interest that a special session was timetabled at eight-thirty before the regular program of the third day. A Task Force was appointed to pursue this development: Dr. Moyra Allen, Dr. Margaret C. Cahoon, Professor H. Elfert, Dr. M. Josephine Flaherty, Dr. Margaret R. Francis, Dr. Amy E. Griffin and Dr. Shirley Stinson. The members of this Task Force would like to hear from you about your interest in A Canadian Council of Nurse Researchers.

A PHENOMENOLOGY OF NURSING

JOYCE SCHROEDER MacQUEEN

"So the doctor put me on a special diet and told me not to eat anything with fibers in it — of course, being a nurse you know all about that."

"I'll tell you, that was one really nice nurse, she used to sit down and have a cigarette with us in the evening."

"What kind of a nurse is she anyway? She can't even give me an aspirin without calling the doctor."

"Well, in my opinion, they're just trying to make little doctors out of them."

Do some of these conversation snatches sound familiar to you? Do you know of twenty more that could be added to the list to show how little the general public and even allied medical professions know about what nursing is? Do you and your fellow nurse agree on what nursing is?

It seems to this writer that the confusion in the minds of the public about what they may legitimately expect from nurses is a reflection of the confusion in the minds of nurses themselves about what nursing is. This type of confusion is commonly called an 'identity crisis'. Because of changes occurring in society as a whole as well as in medical services and education, the role of the nurse is no longer clearly defined. Nurses are asked to perform skills that previously belonged solely in the domain of the physician and in turn are delegating 'nursing' tasks to auxiliary personnel. This makes it difficult to know what 'nursing' is. Nurses in all areas are involved in this identity crisis but we will use as an illustration the nurse who graduated from a three year hospital diploma school of nursing. This nurse is desperate right now to know what nursing is. Below her in the hierarchical scheme are auxiliary nursing personnel who are taking over more and more of the traditional nursing functions. Above her in the hierarchy are the 'university nurses' who take the top positions and leave the diploma nurse little room for promotion. Besides this squeeze from above and below the traditional diploma nurse sees graduates of the newer two year schools of nursing as a further threat to her status because their presence implies that her education was inferior. In this changing pattern of nursing and nursing education, the traditional diploma nurse needs very badly to know what nursing is.

Nurse educators also are desperate to know what nursing is since this constitutes the major philosophic basis of any nursing education

program. If you do not know what nursing is, how can you teach people to become nurses? With the current attempt both to improve and in some instances to shorten the period of formal education, it is crucial for the nurse educator to know what nursing is so that essentials will not be overlooked in the multitude of changes.

When we talk about what nursing is, we mean what is its essence, what is it that makes nursing what it is? The essence of nursing is its "indispensable quality."(1) Thus the importance of knowing the essence of nursing is obvious. The educator must be absolutely certain that the student learns this indispensable quality and the practicing nurse must be certain that this is not delegated to some other group, leaving nursing a hollow sham.

Having considered the confusion about what nursing is and the importance of knowing the essence of nursing, how do we actually go about discovering this? By what method can one find the essence of nursing?

The subjective method has been used to obtain knowledge of the essence of nursing. Catharine Barnett's article, "This, to Me, is Nursing"(2) is an excellent example of this method. The author describes in depth one nurse-patient relationship and shows from this, in a very inspiring way, what nursing means to her. This is valuable but it tells us only what nursing is to one person and not what the indispensable quality of all nursing is.

The quantitative method is considered by many to be the most objective method of arriving at knowledge. Nursing studies using this method record such things as one nurse's activity for one day and the number of minutes spent at each task. There is something very precise and satisfying in having this kind of knowledge and it is the kind of knowledge required in some instances. But knowing all the things nurses do and how long they spend at each task does not tell us what the essence of nursing is because many of these tasks may also be carried out by other personnel. In other words, the essence of nursing must tell us what is uniquely nursing and must apply to any nursing situation.

There is a third, less well known method of arriving at knowledge, the phenomenological. The phenomenological method is a qualitative rather than a quantitative analysis. After a brief description of the phenomenological method, a phenomenology of nursing will be presented.

WHAT IS PHENOMENOLOGY?(3)

In phenomenology, by looking carefully at the *qualities* of experience, one arrives at knowledge about the essence of that experience.

If we want to know the essence of a thing, we must discover its unique *quality,* and thus phenomenology is a qualitative analysis. Phenomenology is a method of careful observation and description to determine what are the qualities of the experience. In order to understand this better we will use nursing observations as an analogy. Careful observation is a method that nurses use in order to gain knowledge of their patients. In order to be a skilled observer the nurse must have a certain amount of knowledge of the subject and at the same time must, in a sense, temporarily set aside her knowledge and past experience so that she will not see something that is not there because she expects it to be there and so that she will not miss something that is there because she was not expecting it. In phenomenology, by looking carefully at the qualities of experience, one arrives at knowledge about the essence of that experience. In order to do a phenomenology of nursing, one must have knowledge of the subject (for example, be a nurse). But one must also consciously 'put off' one's ideas and prejudices about nursing in order to describe the situation *as it is.*

To carry the analogy further, a nursing observation is both subjective and objective. It is subjective because it is what the nurse sees but it is also objective in that others may verify the observation. Phenomenology claims this kind of objectivity. A phenomenological analysis gives us certitude in that anyone following the method will arrive at the same results unless an error is made (just as in a nursing observation, or in physics or mathematics).

So far then, we know that a phenomenological analysis is a description of the qualities of experience and that the knowledge thus gained is objective and verifiable. One further point is necessary. We have said that essence means the indispensable quality of a thing. A phenomenological analysis of nursing will be based on one situation but it must fit all nursing situations if it truly describes the essence of nursing.

One might ask how this differs from Catharine Barnett's description of one nursing experience. Her description makes no attempt to state only qualities that are universal to nursing or that refer only to nursing. In a phenomenology of nursing, the description must apply to all nursing experiences and must delineate what belongs to nursing alone. Thus, a phenomenological analysis is *inclusive* in that it describes all nursing experiences but it is also *exclusive* in that it eliminates all that is not nursing.

A phenomenology of nursing, therefore, is a pure description of a nursing experience. In this kind of observation, everything that is not uniquely nursing is ignored and everything that is nursing *must* be included. The result, therefore, is that this description will fit every

instance of nursing. In other words, this description then gives us the essence of nursing.

In order to do this we begin by emptying our minds and attempting to become fine points of observation. We describe what we observe and then analyse this description to see if it fits all cases or if there are unnecessary parts to be stripped away. In this way we hope to arrive at the core or essence of nursing.

A PHENOMENOLOGY OF NURSING

When I turn my mental glance to a nursing situation my first response is to list and categorize the things I see the nurse doing. In other words, I find myself doing a behavioral analysis rather than a phenomenological. Nurses have, it seems to me, a predisposition to describe overt action and quantity because of their traditional role as 'doers'. However, when I analyze this list of nursing activities, I find that it does not tell me what nursing is because the activities may all be done by people other than nurses.

So I admit my error and turn my mental glance again to the nursing situation. Now I see that the nurse is always inter-acting with someone. The nurse never functions in an isolated situation; to nurse means to be involved with persons. At first glance there seem to be a number of different persons important to the nursing situation — other nurses, doctors, the patient. On closer observation, I find that the only necessary person other than the nurse, is the patient. One may nurse whether there are other nurses or not; one may nurse whether there is a doctor or not; one cannot nurse if there is no patient. So far then, we have established two things. We have seen that nurses are always involved in relationships with people. We have reduced this down further to say that the only relationship that is present in all nursing situations is the nurse-patient relationship.

Let us see now if we can reduce this to get closer still to the core or essence of nursing. Is there some quality in the nurse-patient relationship that is essential to nursing? In order to analyze this we will look at both poles of the relationship, the patient aspect and the nurse aspect. Then we will attempt to look at the nurse-patient relationship as a whole to see what the essential quality of that relationship is.

The Patient Aspect of the Nurse-Patient Relationship

In order to analyze this nurse-patient relationship, we will look first at the patient aspect of the relationship. We see, first of all, that the patient views himself either as an object or a person.(4) (I will give examples of this, shortly.) The patient who views himself as an object in the relationship obviously sees the nurse as an object as well.

On the other hand, the patient who views himself as a person may see the nurse as a person too. Further, I see that the situation in which these are occurring may be one of two things: it may be an emergency situation or it will not be an emergency. Diagram 1 attempts to clarify this.

DIAGRAM I

THE PATIENT ASPECT OF THE NURSE-PATIENT RELATIONSHIP

	Emergency Situation	Non-Emergency Situation
The patient who sees himself as an *object*	(a)	(b) usual response (b_2) response due to environment
The patient who sees himself as a *person*	(c)	(d)

Let us look at the first situation in Diagram I, the patient who sees himself as an object. When I look at the relationship in this situation I see one of two things. The situation may be an emergency. For example, the patient may be hemorrhaging. In this situation he sees himself as an object requiring immediate treatment and sees the nurse as an object to give that treatment (Diagram I a). Secondly, the situation may not be an emergency and the patient still sees himself as an object ("I am the vice-president of Bland Corporation." "You are the nurse.") In other words, some patients normally respond as objects in a relationship (Diagram 1 b_1). But I see other patients in the same situation reacting as objects because the particular environment has made them into 'patients' or 'numbers' (Room 204 bed 3), or diseases (the appendectomy in there) (Diagram I b_2).

To summarize this section on the patient aspect of the nurse-patient relationship, the patient sees himself as either an object or a person depending on the situation. If the situation is an emergency or perceived by the patient as an emergency, he is most likely to respond as an object. If the situation is not an emergency he may respond as an

object because that is habitual with him or he may respond as an object because the particular situation forces this role on him. At other times the patient will respond as a person.

The Nurse Aspect of the Nurse-Patient Relationship

Now let us analyze the other pole of the relationship,, that of the nurse. What are the particular qualities of this aspect of the relationship? I turn my mind's eye to the nurse in the nurse-patient relationship and see here two ways in which the nurse perceives herself in the relationship depending on the context. The nurse may see herself as an object or the nurse may see herself as a person. The context may be either an emergency or a non-emergency. Diagram II is an attempt to illustrate the nurse aspect of the nurse-patient relationship. I see three types of emergency: situation (a), a physiological emergency (example: the patient is hemorrhaging); situation (c), a 'patient' emergency where the patient perceives the situation as an emergency ("I need to get out of bed right now"); situation (a_2), a 'nursing' emergency where the nurse perceives a situation as an emergency ("I've got ten patients to look after. This isn't the Royal York, you know!").

DIAGRAM II

THE NURSE ASPECT OF THE NURSE-PATIENT RELATIONSHIP

	Emergency Situation		Non-Emergency Situation
The nurse who sees herself as an *object*	(a) Physio-logical Emergency	(a_2) Nursing Emergency	(b)
The nurse who sees herself as a *person*	(c) Patient Emergency		(d)

Let us view the situations in Diagram II separately. In (a) where a physiological emergency exists the nurse need only respond as an object. The nursing objective here is to relieve the emergency situation as quickly and effectively as possible and responding as an object is all that is absolutely necessary of the nurse.

Diagram II (a_2) we have called a nursing emergency. Here the nurse perceives herself in a situation where she is forced to respond as an object. This is an inappropriate response on the part of the nurse because it ignores the nurse-patient relationship which we have found to be the essence of nursing and concentrates on the nurse. For the same reason, the case of (b) is also an inappropriate response on the part of the nurse.

In situation (c) where the patient views himself in an emergency, the nurse responds to relieve the situation and responds as a person.

Let us step outside our phenomenological analysis for a moment to illustrate this section. Many nurses in hospital emergency departments see themselves as needing to act only in psysiological emergencies (a). However, many patients coming into the department not in the physiological emergency category but in patient emergency (c) are not responded to by the emergency staff or are responded to as objects. According to our analysis so far, these people, though processed through the emergency department by nurses, are *not nursed.*

To summarize this section of our analysis: The nurse-patient relationship for the nurse means responding as a person to a person except in a physiological emergency where it is adequate temporarily to respond as an object. For the nurse to respond as an object in any other situation is inappropriate, i.e. is not nursing.

The Nurse-Patient Relationship Viewed as a Whole

So far in our analysis we have seen that the nurse-patient relationship is the essence of nursing. But we must describe the qualities of the relationship more precisely in order to distinguish the nurse-patient relationship from, let us say, the social worker-client relationship. In order to do this we have focused on the patient aspect of the relationship and the nurse aspect of the relationship. Now it is necessary in our phenomenological analysis to view the relationship as a whole; to see what actually is this relationship between the nurse and the patient. The essence of nursing is the nurse-patient relationship. What is the essence of the nurse-patient relationship?

In looking at the nurse-patient relationship we notice that it depends on two things: the reality of the situation and how each perceives it. In other words there is a situation in which certain objective things are happening. There is also the patient's interpretation of what is happening and the nurse's interpretation of what is happening. Let us diagram the situation of a physiological emergency (Diagram III.)

Each individual's perception of the situation is important because he expects the other to respond in a particular way. We can see that

it is important for the nurse to recognize the difference between an emergency and a non-emergency. In other words, her perception must fit fairly closely to the reality of the situation. This requires specialized knowledge of medical situations and skill. However, in viewing

DIAGRAM III
THE NURSE-PATIENT RELATIONSHIP
IN A PHYSIOLOGICAL EMERGENCY SITUATION

	Patient Perceives Emergency	Patient Perceives Non-Emergency
Nurse Perceives Emergency	(a)	(b)
Nurse Perceives Non-Emergency	(c)	(d)

the relationship we see that it is equally important for the nurse to recognize the patient's perception of the situation. This requires specialized knowledge and skill in relationships.

We have diagrammed the nurse-patient relationship in a physiological emergency situation, now let us diagram a very ordinary nursing situation (Diagram IV). Let us examine closely situation (c) in Diagram IV. The patient perceives the situation as an emergency, "I'm supposed to have my dressing changed at ten o'clock!". The nurse does not perceive this as an emergency considering her other tasks and says "He's a demanding patient." What are the possibilities open to the nurse in this situation?

1) She may do nothing and the patient will not be nursed even though the dressing eventually is changed. (Remember, the basis of our analysis here is that other persons may change dressings but the essence of nursing is the nurse-patient relationship).

2) The nurse may teach the patient her own perception of the situation, "I am too busy." Again we see that this is not nursing. There is no nurse-patient relationship in this situation, only an object

DIAGRAM IV

THE NURSE-PATIENT RELATIONSHIP
IN A COMMON NURSING SITUATION
REALITY OF SITUATION: BURN WOUND DRESSING
TO BE CHANGED TWICE DAILY

	Patient Perceives Emergency	Patient Perceives Non-Emergency
Nurse Perceives Emergency	(a)	(b)
Nurse Perceives Non-Emergency	(c)	(d)

requiring specific attention and an object doing that particular thing. This is a one-sided response since the nurse's perception of the situation is the only relevant part of the relationship.

3) The nurse may understand and deal with the patient's perception. This situation is the reverse of 2). This is still a one-sided response, only in this situation the patient's perception dominates the relationship.

Let us step outside our analysis for a moment to apply this to situations we know. Most students who enter nursing do so with a sincere desire to help people. At the beginning of her career, therefore, the nurse chooses alternative 3). She attempts to understand and deal with the patient's perception of the situation. The patient's response is, "She's a wonderful nurse. She really cares about me." But at some point, the nurse's energy gives out. As a student her patient assignment is such that alternative 3) is a possibility. As a graduate, it may at times be physically impossible. The nurse, therefore, is forced to take either alternative 1) or 2). She may continue to see 3) as an ideal and feel guilt and dissatisfaction with her role. The patient continues to feel that he is not nursed.

By eliminating these three situations as not describing the quality of the nurse-patient relationship we are saying that it is not a relation-

ship in which one person is dominant over another, it is a person-person relationship.

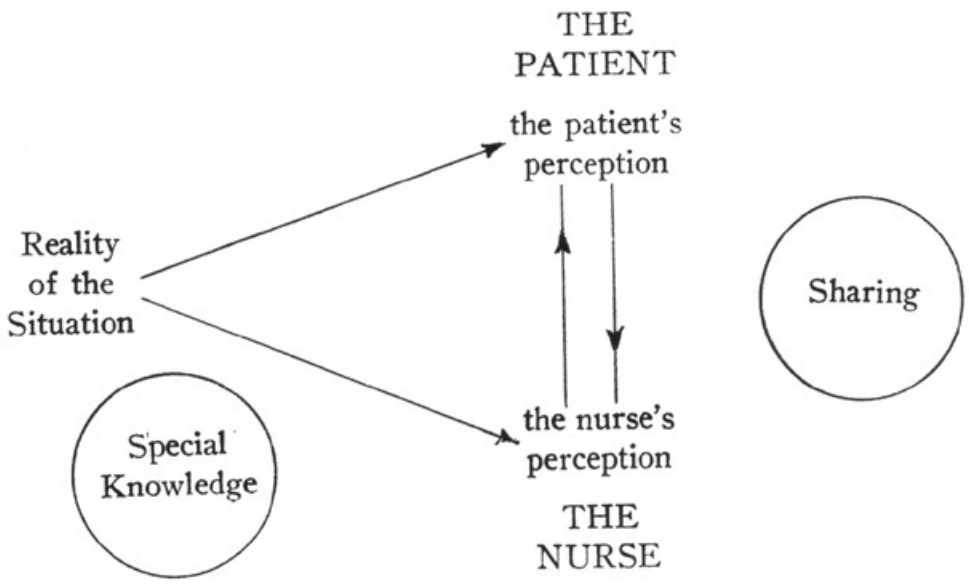
Having eliminated these situations in our phenomenology, fortunately, we do see another alternative:

4) Each person in the relationship recognizes the other's perception. This situation is a true person-person relationship in that there is two-way communication. We see here that the patient has a role to play as well as the nurse; that he shares the responsibility.

We see then the quality of the nurse-patient relationship: that there is sharing of perspectives and that the nurse must have special knowledge. Diagram V is an attempt to illustrate these factors.

DIAGRAM V

THE QUALITY OF THE NURSE-PATIENT RELATIONSHIP



We stated at the beginning that, in order to be true, this analysis of one nursing experience must fit all nursing experiences. We find that the nurse-patient relationship as described through our analysis holds true for all situations, for example, such wide spread situations as a healthy person in the community or an ill person in hospital. Further, we see nothing else that is common to all nursing experiences. In our analysis, therefore, we have discovered the essence of nursing. The essence of nursing is the nurse-patient relationship; the essence of the nurse-patient relationship is that there is sharing of perspectives and that the nurse has special knowledge. This implies an important educational role for the nurse. Also, we see in the end that

there are no objects at all, only people who see themselves in different ways in different situations.

The exciting thing about the phenomenological method is that one does not know the results at the beginning. The findings are not a foregone conclusion and one truly 'discovers' something that one did not know previously. Of course the results of the analysis have been suggested by others(5) but to my knowledge no one has undertaken to arrive at this phenomenologically. Their conclusions, in a sense, corroborate the findings of this analysis, while the analysis presented here, as far as it is free from error, lends certitude to our knowledge that the essence of nursing is the nurse-patient relationship and the essence of that relationship is sharing between nurse and patient and the special knowledge of the nurse(6).

Notes

1. *Pocket Oxford Dictionary.*
2. Catharine Barnett, "This, to ME, is Nursing," *Nursing Outlook,* Feb. 1960, pp. 72-75.
3. Those interested in a more thorough examination of phenomenology are referred to the bibliography. The purpose here is to give the nurse reader a general background in phenomenology to understand the phenomenology of nursing when it is presented. I am deeply indebted to my husband for his assistance with the phenomenology.
4. An object is defineable solely in terms of its function or limited role, whereas a person is a *total being* not merely defined by his role.
5. It is interesting to read Dorothy M. Smith's article, "A Nurse and a Patient" in the light of this analysis. (*Nursing Outlook,* Feb. 1960, p.68-72.)
6. We will not take the phenomenology further here. But we might want sometime to discover the unique quality of that sharing and of the special knowledge.

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THREE RESPONSES TO "A PHENOMENOLOGY OF NURSING"

While there are many thought provoking ideas in this paper, I will limit my discussion to one, the problem of definition by exclusion vs. inclusion. The notion that one can define the essence of nursing implies that there is a universal quality in the multiplicity of people and activities called nursing. Mrs. MacQueen finds this to be the relationship between nurse and patient. I would suggest that this is a circular definition in that it is meaningless until you spell out what is "nurse" and what is "patient". Otherwise the definition would equally fit the relationship of social worker-client or patient-child or teacher-pupil.

Apart from this, in role definition something is surely lost by eliminating all activities which might be done by someone else. I believe one could logically demonstrate that everything nurses do is also done in some context by non-nurses, be they aides, or volunteers, or mothers, or neighbours or other health professionals or whatever. Would this prove that nursing does not exist? Logical proof of this non-existence would not convince either nurses doing nursing or patients being nursed.

I suggest that definition of nursing hinges not so much on searching for what is uniquely nursing, as in describing nursing as it occurs in many situations. It is likely that the definition would involve two aspects: the process of nursing, and the range of problems to which the nursing process is applied. The nursing process has been widely discussed and is essentially assessment-planning-caring-evaluating. The range of problems to which this is applied varies with changes in education, society and the health care delivery system.

I suggest that the definition of nursing should be by inclusion, to define the scope of nursing in its many facets, rather than by exclusion, searching for its elusive essence.

Helen Elfert,
School of Nursing,
Assistant Professor,
University of British Columbia

In responding to this paper, I feel it is important and essential to comment on several assumptions that appear in the introduction of the paper. I presume the assumptions stated are attitudinal and as such, form the authors' basis for the argument of the utilization of the phenomenological method to describe the essence of nursing.

First, the "identity crisis" of nursing is of a complex nature not easily understood in a single context such as educational preparation. A complete discussion would include sociological phenomena relevant to the status of women and the traditional role women have played in society since time began. Further discussion would suggest that the traditional role of women in nursing has impeded if not arrested the political aspects of development of the nurse and her awareness of potential and self-ability to be a highly influential agent in affecting a better quality of health care for those in her charge.

Second, I wonder at the statement, "The traditional diploma nurse sees graduates of the newer two year schools of nursing as a further threat to her status because their presence implies that her education was inferior". In my opinion, any educational preparation of three or five or ten or twenty years ago was indeed inferior, if some effort to maintain or improve ones level of competency is not a continuing process in ones professional life. In this context, the impact of technical change alone for some people can be a devastating emotional experience, while for others, those who adjust more readily to change, it is of minor importance or a welcome improvement. Accommodating oneself to progress and change is not accomplished through resistance but through a concerted effort to search out knowledge and methodology that allows adjustment and continued personal growth.

I believe the author of the paper titled, "A Phenomenology of Nursing", was searching and I appreciate her intent. There can be no question that the essence of nursing lies in the ability of the nurse to interact personally, positively, and therapeutically with those in her care. I find no reason to question her role as a facilitator and reinforcer of growth and learning in the care of her community, nor would I deny her competence or technical ability. Therefore, I disagree with the author and her statement that we do not know what nursing is. On the contrary, we know what it is. Our problem is not one of being unaware, it is one of being wary; to have knowledge, to have independent and decisive thought, to have competence, to have the ability to plan and risk change for the betterment of care and to have expression in a personal and a professional capacity.

In this paper the phenomenological method is attempted by the author to describe the essence of nursing, that is the nurse-patient relationship, and then to describe the essence of the nurse-patient relationship. I have already stated that as a reader, I can quickly respond by stating this is not a discovery, but rather a known finding previously and adequately described by many a nursing person. In fact, I would venture to say any nurse who has had a personal thera-

peutic relationship with someone in her care does not need to utilize the phenomenological method to tell her what the essence of nursing is. However, I do applaud the author for bringing a new dimension of thought to our attention as I do think any attempt to define nursing should not be thwarted.

Although I find writings by Husserl and interpretations of his writings extremely interesting, I do wonder why a framework of phenomenology was used for this paper, in view of the fact that the method is not well accepted nor is phenomenology a well explained philosophy. Also, I am struck by the rather simple application of a very complex set of philosophical beliefs. Further, I find the application of phenomenology to nursing in this paper an incomplete argument. For example, if the true phenomenological method is used there should be no question regarding that which is described and that which is discovered and yet the author sets out to describe a known belief and reveals no new discovery, nor does she exclude situations that are not nursing as she purports to do in respect to describing the essence of nursing.

The introduction of models in the article unfortunately clarifies very little of the method for the reader and as such are not useful.

The note by the author indicating that readers might want to become familiar with the philosophy in order to understand the application of the method to nursing is misleading as a good deal of study must go on to really interest the application of the method.

Jean Innes
Associate Professor, Community Nursing,
College of Nursing,
University of Saskatchewan

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Trying to discover the essence of nursing is like chasing the famed Scarlet Pimpernel. We seek it here, there and everywhere but it is still "dem'd elusive" (Orczy 1964). In her Phenomenology of Nursing, the author clearly describes the essence of a therapeutic relationship. However it is not evident that such a relationship is unique to nursing. A relationship, a sharing within that relationship and the particular knowledge held by a therapist are basic elements in the helping process no matter which health profession we choose to examine (Purtilo, 1973).

Although it was not the author's intent, her focus on this common structural component forces us to re-examine a trend we cannot afford to ignore, and offers us a new prospect for continued study. Along with our need and desire for a clear definition of nursing we must realize that in view of the current fusion of roles among health professionals and the inter-disciplinary path which nursing is now treading, we have to learn to live within less precisely defined role structures. This awareness should lead us to invest more of our energies into the examination of common goals and ways of collaborating more effectively with our colleagues in other health disciplines. Preoccupation with our own uniqueness narrows our vision and discourages professional growth.

Ms. MacQueen has presented us with an effective means for the continued investigation of these problems. Qualitative methods are most appropriate to the study of social phenomena in their natural setting and are supported by the work of Glaser et al. and Quint. Also by clarifying ideas and describing essential relationships, the author has carried out two of the specific aims of phenomenology (Farber, 1966). By so doing she has illustrated the usefulness of the phenomenological approach to the study of nursing problems.

Further development of the phenomenology might include observation of nursing in a variety of settings, other health professionals in encounters with their clients, and a study of nurses participating collaboratively with other health disciplines in the provision of care.

A broad data base such as this would help to provide practical solutions with which to dispel the confusion many nurses are currently experiencing.

Elizabeth Finch
Lecturer, Psychiatric Nursing,
University of Ottawa

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INTEGRATING DEVELOPMENTAL RETARDATION INTO THE NURSING CURRICULUM

RUTH ELLIOTT AND NANCY P. FORBES*

A continuing responsibility of the nurse has been to care for the developmentally retarded child and the family. This service has taken place in the hospital, in a community setting and in the home, wherever health care and supervision have been needed. The ability of the nurse to understand the particular problems of these patients and to provide for a successful intervention depended largely upon his or her own ingenuity. Rarely was there any organized program to assist her in acquiring the appropriate skills and knowledge nor was there any systematic evaluation or follow-up of her activities in this specialized area.

Identifying The Problem

The pediatric nursing faculty at the University of British Columbia has felt very strongly that a more methodical approach to the organization and teaching of content relating to developmental retardation was needed. Such a program would benefit not only the student in her approach to the nursing care and guidance of these children and their families, but would also benefit the individuals directly.

The CELDIC Report (1970) indicates that retarded children comprise 3 per cent of the school age population and for many of these children there are limited, if any, special facilities for their care, supervision and follow-up. The faculty also recognized that after graduation many nurses are in a position to influence decisions about the kind of care patients receive; therefore it was important that their university program include an in-depth study of the long term care of the mentally retarded child. We had been working to develop teaching "models" for our pediatric nursing content, and felt that "developmental retardation" could typify our model for illustrating a "long-term condition" with a "community problem" emphasis. (Taba, 1962).

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* At the time this article was written, Ms. Elliott was head of pediatric nursing, School of Nursing, University of British Columbia. Ms. Forbes has held positions as lecturer and as consultant in mental retardation to the School of Nursing, University of British Columbia.

Theoretical Framework

One generally accepted educational principle is that real life experiences, coupled with a theoretical backdrop, provide the best learning laboratory for people. (Commission on Educational Planning, 1972) Students integrate knowledge best when involved directly in the situation which they are expected to learn about and/or influence. Involvement in the actual situation gives students the opportunity of feeling, thinking, questioning and implementing some new ideas gained from formal instruction or independent study. (Dewey, 1963; Tanruther, 1967).

Postman and Weingartner state that the critical content of any learning experience is the method or process through which the learning occurs. While nursing education, perhaps in an attempt to achieve academic respectability, has tended to pull away from the clinical setting to a more formal learning environment, it is becoming more evident that direct patient care has much to offer the student as a place for integration of knowledge.

Our curriculum innovation was based on the premise that to learn about the retarded person, one needed to work with and interact with retarded people.

In the fall of 1968, we decided to devote two weeks of the 9-week pediatric nursing experience to the study of and practice with the developmentally retarded person. We were fortunate in having a part-time faculty member working with us who was financed by a grant from the British Columbia Mental Retardation Institute, (B.C.M.R.I.) and who had advanced preparation and experience working with retarded persons. The B.C.M.R.I. was a 5-year project funded by federal and provincial grants for the purpose of creating and expanding professional curricula and preparation in the area of service for the retarded.

Laying the Groundwork

The following fundamental questions were considered.

1. Could the students be provided with an experience that would successfully alter some of their pre-existing, negative attitudes about developmental retardation?
2. Could we teach some interventions that would help the student in her encounters with the retarded person and the family?
3. Could we show the student the love, patience and understanding possessed by individuals who successfully work with the developmentally retarded?

4. Could we demonstrate the power of a team approach to working with the developmentally retarded which would show the broad range of training and expertise such groups may bring to the problem?
5. Could we foster in the student the optimism and the necessary skills to work for improving the acceptability of the retarded in the community and increasing the opportunities and alternative life styles available to the retarded?
6. Could we successfully help students utilize their knowledge of normal growth and development to intervene appropriately with the child and the family?

"Yes" answers to these questions essentially were our aims for the program, bearing in mind that the University of British Columbia baccalaureate program is designed to prepare the new graduate to be a generalist and to practice at a first level position in a variety of health agencies. Our goal was not, therefore, to educate a developmental retardation specialist but to provide a broadly based experience with wide applicability.

The Setting

In New Westminster, British Columbia we are fortunate in having the Woodlands' School for the retarded with a client population of 1200 persons. It was here that we have been able to provide student learning experiences that we felt would fulfill the objectives of our educational program. Students from other educational programs in nursing as well as from other disciplines, receive experience at the Woodlands' School so the staff has become accustomed to being involved in the education of students from various backgrounds.

The Content

It was decided that a minimum of two weeks of the nine week pediatric experience were needed to familiarize the student with the mental retardation content, to involve her directly with the children to identify and deal with preconceived negative attitudes towards the retarded person, and to adjust to a new educational setting. It was felt that the student would require time to try out and evaluate some of the interventions which she was learning.

Our nursing students had encountered children with developmental problems and behaviour disorders during their pediatric nursing experience in the general hospital setting. In their final year, as participating students in Child Health Conferences, in conjunction with local public health departments, they were expected to utilize

a wide base of developmental knowledge in counselling parents and in assessing children. We felt it imperative that they be conversant with developmental theory and principles, able to identify real or potential developmental problems and to utilize appropriate nursing skills.

The program relied quite heavily on teaching by members of the staff of the Woodlands' School in a variety of departments: nursing, social service, psychology, medicine, education, recreation. Representatives from these departments presented material pertinent to their own specialties and related it to the on-going program of development for the children. Seminars were conducted by the nursing faculty member associated with the B.C.M.R.I., the in-service Coordinator of Nursing at the Woodlands' School, and the pediatric nursing faculty. These seminars were held daily and dealt with topics needing clarification, elaboration or with attitudinal concerns the students presented. They were held either informally over a bag lunch or scheduled into the program. Ongoing supervision was a regular part of the learning experience and included direct feedback, anticipatory guidance, clarification and highlighting of behaviours demonstrated, and suggested interventions. At least one faculty member was directly involved with the students and available to them at all times during the experience. Students were taught to assess the developmental levels and behavioural manifestations of the children prior to arriving at an individualized plan for care.

Selected nursing interventions, based on theories of growth and development and knowledge of behavioural change with anticipated outcomes formulated the theoretical framework for nursing action.

While the first week of the two week experience was devoted largely to lectures and discussions, the students were introduced to the children who were participating in a ward activity training program which included training in visual, auditory and motor skills. It was the student's responsibility to select one, two, or three children upon which to focus for an in-depth study of behaviour.

During the second week the students were to observe, participate in and evaluate the children's behaviour and progress in the training program. It was here that the student worked with the children in the areas of self-care activities — feeding, dressing, toileting, teeth-brushing, washing, etc.

The students found it useful to observe the individual children for whom she was responsible as well as to see them in a broader context interacting with the other children whose special needs and problems deserved consideration as well. They observed the problems faced

daily by the staff in the training of the children as well as solutions for dealing with these problems. The realities of institutional care for the retarded were recognized and proposed alternatives were explored in seminar discussions.

Most of the students had an opportunity to observe families and their children in the Out-Patient's Department who were being considered for admission to the institution, or who were offered guidance and supervision for the home care of their retarded child. Determining the role of the Public Health Nurse in developmental retardation was an important aspect of the experience.

A major role of the instructor was to help the student to narrow her range of observation and concentrate on one or two children at a time. This was so that she could learn at close range the behavioural manifestations of the child and to intervene by attempting to change inappropriate behaviours and to encourage those behaviours considered socially acceptable, such as feeding, dressing, toileting, etc.

The students also felt it was important for them to be a part of the on-going ward situation. They requested a chance to begin the day at 7 o'clock, when the rest of the staff came on duty. The faculty recognized this as an important factor in the student's development of her relationships with colleagues and her professional self-image. The experience of being with the children over a longer period of time allowed the students to understand more fully the role of parents and staff who work with these children on a day to day basis.

Assessing the Results

Evaluation is an important part of curriculum development and we kept this in mind as we proceeded with our curriculum innovation. (Tyler, 1967). The evaluation was based on our aims and objectives for the program and we decided to use a variety of measuring methods in the evaluation process. The students were examined by test questions incorporated into their final pediatric nursing exam. They were also observed as they related to and worked with the children under their care. Daily seminars gave students the opportunity to examine issues pertinent to retardation and to display their breadth of reading and application of knowledge. Most of the students expressed a change in attitude about retarded people.

> I can understand that if the retarded individual is given training and helped to develop to his potential he can live in the community and function, even if it is in a very limited capacity, as a member of that community.

> In dealing with these children — I am beginning to fully appreciate what can and should be done to help these kids develop their full potential.
>
> By training retardates for jobs they can successfully manage in the community they are helped towards a fuller life as a functioning member of society.

As important as it was for the student to narrow her focus for her learning, it was also important to encourage the student to widen her perspective to view the total picture of the problem of developmental retardation, as it affects the individual, the family and the community. The students appreciated a diversity of activity which included field trips to other agencies who provide various services for the retarded.

Although geography, curriculum restrictions and other factors helped to determine the content and development of this part of the program, it was not intended that this nursing problem be confined to one part of the total educational program.

The faculty involved in the process found it a valuable learning experience to be involved from the beginning in an innovative approach to pediatric nursing. Once the program was established, the B.C.M.R.I. member began phasing out her involvement in order to ensure continued integration through permanent curriculum and faculty planning.

We are satisfied that we have recognized and developed a most important aspect of our curriculum. But more important than curriculum change is the contribution to the overall preparation of the nurse and to improved service to the developmentally retarded and their families.

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QUERY AND THEORY

HOW DOES UNIVERSITY NURSING EDUCATION AFFECT PATIENT CARE?

The following question was submitted by E. Jean M. Hill:

Nursing educators enthusiastically promote the notion that graduates of university programmes in nursing should be "agents of change", make an impact on the community and be prepared for leadership roles within nursing practice. It is suggested further that accrediting procedures should require follow-up studies of graduates which provide evidences of the effectiveness of graduates as a criterion for accreditation (in, Joan L. Green, "Accreditation in Nursing Education: New Trends and Responsibilities", *Nursing Forum,* XIII, 1, 1974).

Are any Schools in Canada gathering data to show how and in what way university education in nursing influences the quality of patient care?

FOCUSING NURSING CARE ON FAMILY HEALTH

The responses that follow were received in response to Moyra Allen's query in the Spring, 1974 issue:

"There's no need for me to visit that family. It doesn't have any problems." In my experience nursing within a pediatric practice and a community health center, I have heard many nurses and nursing students conclude that because they have not identified a "health problem" in a family, the family would not benefit from nursing care. What is our criteria for determining health problems? Why do we devote so much nursing energy to problem-seeking? Let us devote more energy to identifying and describing health and factors which lead to health, and to counselling about healthful ways of living.

Nurses are in an ideal position to undertake research about the constituents of health because of the nature of our work. We can learn about health by observing the health states of our patients. With guidance we could collect information from patients to identify states of bodily health, personal happiness, social functioning, and interpersonal relations, and factors which augment and impede such states. Our patient experiences provide us with opportunities to apply and test principles of health maintenance.

If nurses are going to counsel families about healthful behaviour we obviously need to know more about health. We have been advising families regarding what we have thought were healthful ways of

living and patients have been receptive to nurses assuming the role of health counsellor. How much of what we have been advising is based on scientifically proven fact? We emphasize such virtues as moderation of activities, for instance "healthy" balance between work and leisure. What do we know about the effects of intellectual effort, physical labor, and inactivity on our health? How does solitude or companionship affect our health? Nurses often encourage their patients to socialize. On what basis do we give such advice? How does the density of population in which we live affect our health? We need to know more about this if we are going to counsel our patients, whether they live in cities or isolated areas. How do families cope and how do they learn to cope with factors infringing on their health? We could learn a lot about health from our patients.

Once we know more about what to teach, we need to know more about how to effectively teach constructive health habits. This would necessitate motivational studies. How can we motivate the public to preserve their health? It is obvious research is necessary when such a behaviour as smoking remains popular in spite of evidence that smoking is injurious to health.

The health professions, particularly nursing, have the responsibility of investigating what health is, how we achieve and maintain it, and what mitigates against it.

— Linda Kingsbury
Lecturer
School of Nursing
McGill University

Les questions posées sous le thème "Health behavior, nursing practice and nursing research" me paraissent d'une extrême importance. Quoiqu'apparemment simples, elles nécessitent des réponses complexes. De prime abord, nous sommes tentés de répondre par l'affirmative, mais très tôt nous sommes conduits à des implications au niveau de l'essence même du nursing et de son orientation future.

Il est relativement facile d'accepter les prémisses énoncées: la majorité des individus et des familles au Canada ne bénéficient pas de services de soin global (comprehensive health care) et continu et de relance à la suite d'une maladie ou de toute autre situation de crise. Les raisons de cet état de choses sont multiples. Je ne traiterai ici que de deux aspects de cette problématique et je tenterai de répondre à chacune des questions principales, à la suite des commentaires spécifiques à chaque aspect.

Une première difficulté déjà mentionnée vient de notre incapacité de définir la santé de façon suffisamment opérationnelle pour pouvoir décrire et observer ses éléments systématiquement. L'histoire met en parallèle l'évolution de la définition de la santé et le développement de modes de dispensation de soins, d'abord des services centrés sur le traitement de la maladie, puis sur la prévention de la maladie et enfin, plus près de nous, des modèles de systèmes de soins découlant d'une conception plus globale de la santé.(1) On tend maintenant à accepter que la santé est plus qu'une condition ou un état, mais bien un mode de vie, un ensemble de comportements que l'individu adopte face aux situations stressantes qui forment la trame de toute existence. Selon Selye, l'essentiel n'est pas d'éviter ou de réduire le stress mais bien de savoir vivre avec le stress.

Parmi les infirmières, les hygiénistes se sont toujours préoccupées du domaine de la santé. Depuis quelques décennies, elles ont donné des services à des groupes de familles dans le but non seulement de prévenir la maladie mais aussi de "promouvoir la santé". Pourquoi faut-il aujourd'hui se demander si les infirmières doivent entreprendre l'étude systématique de la santé comme phénomène familial quand elles ont jusqu'à présent tenu le rôle de promoteur de la santé auprès de la famille? Il est évident que les infirmières ont fonctionné dans le même cadre de référence que leurs collègues dans les professions de la santé qui étaient aussi aux prises avec l'urgence de la situation, avec des problèmes de définitions, etc. Il est aussi fort probable que plusieurs d'entre elles ont acquis un bagage imposant de connaissances sur des phénomènes variés relatifs à la santé. Toutefois, elle n'ont pu, pour différentes raisons, dépasser le niveau purement empirique de leur expérience. Elles n'ont donc pas formulé de propositions précises au sujet du comportement humain en matière de santé, plus précisément du comportement des mères qui sont les premières à façonner non seulement les habitudes de santé des enfants mais aussi leurs patterns de réactions à la maladie.

Il est intéressant de noter dans les revues scientifiques que, depuis quelques années, certains chercheurs en sciences humaines étudient la santé dans divers contextes à travers des cadres de référence variés, tels le rôle, l'apprentissage, les attitudes, le processus de socialisation, etc.; parmi eux, des infirmières ont entrepris des recherches sur certains aspects de la santé comme phénomène familial. Un livre récent par une mère infirmière décrit la croissance et le développement des mères et présente du concept de la mère une vue bien différente de celle des auteurs (la plupart masculins) qui ont jusqu'ici conditionné les infirmières, quelques générations de mères et (inévitablement) de

familles à accepter des théories sur le sujet, qui pourraient bien un jour s'avérer des mythes(2).

Si les infirmières prennent au sérieux le rôle qu'elles se donnent de satisfaire les besoins de santé des individus, des familles et de la communauté, il m'apparaît indispensable qu'elles entreprennent des études systématiques sur les relations entre certains facteurs biologiques, psycho-sociologiques et écologiques qui influencent le développement de comportements sanitaires. Seulement alors, pourront-elles comprendre dans toute sa dimension ce que sont les "besoins", la "santé" et la "communauté" et développer des stratégies de soin qui appartiennent plus à une théorie prescriptive qu'à l'artisanat. Cette conception nous conduit au thème "soin global" qui fait le sujet du deuxième aspect de cet exposé.

Dans cette problématique, deux propositions sont sous-entendues: (1) le soin global peut améliorer la santé de la population et (2) les infirmières peuvent donner ce type de soin. La même difficulté que précédemment se présente. Le terme soin global veut dire bien des choses pour bien des gens. La plupart des rapports d'expérience de soin global omettent de décrire et de quantifier cette variable indépendante. Après une étude dans le but d'arriver à une définition compréhensive du terme, Haggerty conclut que:

> the elements of comprehensive care include continuity; coordination; family orientation; combined preventive and curative care; and concern for psychological, social, educational, recreational and economic factors delivered by personnel, often in team fashion, with responsibility for the whole area of health of an individual or family and with an additional factor of reaching all in the community(3).

Selon Lewis(4), on n'est pas encore parvenu a démontré de façon évidente qu'un soin global est plus efficace qu'un soin "non-global". De plus, il n'est pas certain que la population veuille nécessairement d'un soin global. Dans les études rapportées par le même auteur, la plupart des groupes de clients consultés sur le sujet accordent la priorité aux services d'urgence et aux soins accessibles vingt-quatre heures par jour. Est-il utopique de proposer que le soin global sera efficace quand l'individu (ou la famille) coordonnera lui-même ses soins de façon à atteindre les objectifs de santé qu'il se sera fixés? Quel professionnel de la santé est apte à donner le type de soins défini par Haggarty? Il semble que les programmes de soin global ont été appliqués par des équipes composées de professionnels de disciplines variées surtout formés dans un modèle médical. Si le nursing est orienté vers les besoins de santé des gens, les infirmières ne devraient-elles pas être formées, dès le premier instant de leur forma-

tion, à concevoir la maladie comme une situation de crise au cours de laquelle l'individu fait un apprentissage intensif lors de sa marche vers la santé?

Compte tenu des idées émises précédemment, de mon expérience en évaluation de soins et après bien des considérations sur le développement des systèmes de soins et l'organisation de la main d'oeuvre sanitaire, j'en suis venue à croire que c'est seulement dans le cadre de projets pilotes (démonstrations), dans lesquels les infirmières pourront planifier et contrôler les soins qu'elles désirent donner, qu'elles auront l'occasion de démontrer l'impact de leurs services sur la santé de la population. Je ne crois toutefois pas qu'elles pourront arriver au succès sans s'assurer que quatre conditions sont réalisées: (1) des services de nursing adéquats par des infirmières habilitées à dispenser ce type de soins; (2) la collaboration d'autres professionnels de la santé ds les premiers instants du projet; (3) la participation réelle et constante des citoyens; (4) le support soutenu des gouvernements. L'entreprise est de taille et l'enjeu pourrait bien être la survie du nursing.

Références

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— Marie F. Thibaudeau
Professeur adjoint
Faculté de Nursing
Université de Montréal

HOW TO RELATE EDUCATION AND SERVICE?

E. Jean M. Hill has sent the following question:

Query: Many nurses in education and in service are concerned about the separation between preparation for nursing practice and administration of nursing care services to patients. During an early developmental period independence seems necessary, however, both education and service now appear to be sufficiently mature for an interdependent relationship to develop. One question of first importance is how should we manage this relationship without repeating the

handicaps of the past; what kind of structure will facilitate pooling resources for the benefit of the patient as well as the future practitioner?

POST-OPERATIVE CARE

The following suggestion for post-operative care was submitted in response to a query by Irma Riley in the Spring, 1974 issue:

1. Motivate the patient. A surprising amount of energy becomes available to do the things we consider important. During pre-operative teaching, discuss with the patient and his family the rationale for and advantages of early ambulation. Warn him that it will be uncomfortable and tiring, but describe how he will be assisted.

2. Organize nursing care so the patient has opportunity for uninterrupted rest. This is seldom a problem for the experienced staff nurse but is a challenge for the nursing student. The instructor is often busy supervising other students with procedures and fails to observe that the post-operative patient has had some three hours of well-meant but tiring attention from the student nurse. Students do need help in planning so that such things as checking IV, dressing, drainage tubes, taking the vital signs, and irrigating levine tubes are not spread over several trips and many minutes. Obviously rest periods should be provided after meals and strenuous procedures The bottom of the bed can be changed by another nurse while the patient is up.

3. Make the procedure itself as energy-conserving as possible. Roll the bed into high Fowler's position. Swing feet down and body up in one motion. Two nurses provide both emotional and physical security. It can frighten the incapacitated patient to see one small nurse attempting to support him. When feasible, walk the patient to the bathroom, as it increases motivation to have a useful destination.

Arlene Aish
Associate Professor
School of Nursing
Queen's University