NURSING PAPERS

SPRING 1975

EVALUATING THE CURRICULUM OF A QUEBEC C.E.G.E.P.

QUERIES AND THEORIES:

CLOSING THE EDUCATION-PRACTICE GAP

HOW DOES UNIVERSITY NURSING EDUCATION INFLUENCE PATIENT CARE?

Volume 7, No. 1

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

Nursing Papers is published quarterly by the School of Nursing, McGill University, 3506 University Street, Montreal, P.Q. H3A 2A7, Canada. Faculty in university schools of nursing and nurses with similar concerns are invited to contribute manuscripts, letters and ideas. We are particularly interested in articles assessing problems, posing questions, describing ideas and plans of action in research, education, administration and practice.

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Moyra Allen, *rédacteur en chef*
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Nursing Papers est publié quatre fois l'an par l'école de Nursing de l'Université McGill, 3506 rue Université, Montréal, P.Q. H3A 2A7, Canada. Le personnel enseignant des écoles universitaires de nursing et les infirmières qui ont des intérêts similaires sont invités à soumettre des manuscrits, des lettres et des idées. Nous sommes particulièrement intéressés aux articles dans lesquels des problèmes sont soumis, des questions sont posées, des idées et des plans d'action sont décrits dans les domaines de la recherche, de l'éducation, de l'administration et de la clinique.

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EDITORIAL

The issue of *Nursing Papers* (Summer 1974) devoted to the expanded role of the nurse as described by each university school of nursing was so successful that the Committee on *Nursing Papers* searched for other critical issues of concern to all of us.

In this issue of *Nursing Papers* you will see Mary Reidy's evaluation of a nursing programme. What simpler way to begin an evaluation than to determine the extent to which faculty members understand the theory upon which their curriculum is based:

Can they define the concepts?

Can they trace the relations of these concepts one to the other?

Can they give examples of the theory as it illuminates a patient situation?

Can they give examples of how their teaching of nursing reflects the theory?

These questions force us to think of the theories we ourselves espouse. How would our own faculties respond in such an evaluation?

Would the faculties of the university schools of nursing find it valuable to have an issue of *Nursing Papers* devoted to the nature of the different theories which underlie each of our curricula? Would each faculty be willing to include in their description the process of implementation of the theory in their curriculum and the theory's use in the teaching of nursing?

While the word "theory" may not be used in all faculties, we seek a description of the "rationale", framework", "structure", or "beliefs" regarding the situations with which nursing deals, that is, the ideas which influence nursing' responses to these situations.

We have asked the deans and directors of the schools to advise us immediately of their thoughts on this suggestion.

May we also suggest that summer provides an excellent opportunity for faculty members to write the articles they have been intending to write. I hope we can look forward to an influx of material for publication in the fall. Happy summer!

— Moyra Allen

LETTER

To the editor:

Re: A Canadian Council of Nurse Researchers
Nursing Papers, Fall 1974, Vol. 6, No. 3 p. 7

The questions raised in the above article are timely indeed, and I am accepting the invitation Dr. Cahoon extends as a member of the Task Force, to respond affirmatively to the major questions: Yes, we need one; and, yes, I am interested in A Canadian Council of Nurse Researchers, and I would be willing to assist in any way possible.

She asks with what group such an organization should become associated. I am not sufficiently familiar with the Learned Societies to choose between it and the CNA. However CAUSN would *not* appear to be a suitable organization for the very reason suggested: it excludes those who are not faculty members.

In this same issue of *Nursing Papers* (p. 34) E. Jean M. Hill is asking "How to Relate Education and Service?" This is a genuine and an increasing problem. Miss Hill points out that: "Many nurses in education and service are concerned about the separation between preparation for nursing practice and administration of nursing care services to patients". She asks: "What kind of structure will facilitate pooling resources for the benefit of the patient as well as the future practitioner?" I am suggesting that A Canadian Council of Nurse Researchers which is an inclusive, and not an exclusive, organization, which incorporates nurse researchers from all service institutions and agencies as well as university faculties, could be such a structure. We do not have sufficient leadership and/or research resources in education or service to continue this artificial separation which benefits neither patient nor practitioner.

And, in a very practical way, if nursing doesn't soon "hustle it up" and establish its capabilities and territorial rights, we will find the hospital systems groups have taken over the clinical practice field as well.

Gloria Kay
Co-ordinator of Research Projects
Sunnybrook Medical Centre
Toronto, Ontario

THE USE AND ABUSE OF A CURRICULAR MODEL: AN EVALUATIVE STUDY OF ONE C.E.G.E.P.'s NURSING PROGRAMME IN QUEBEC

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After developing a curriculum based on the adaptation model of Sister C. Roy, and implementing it for several years, the faculty of a C.E.G.E.P. nursing programme asked for assistance in the ongoing evaluation of its curriculum. This paper is derived from the report submitted to the faculty which requested the evaluation.

THE USE OF MODELS

The theory of "Adaptation" as presented by Roy was originally a physiological theory modified to explain psycho-sociological factors and then adapted specifically to nursing (Roy 1970, 1971 and 1972). Roy is in the process of developing a theoretical framework of nursing which begins with the patient and sees the nurse attempting to initiate intervention to promote the patient's adaptation by changing his response potential, helping the patient to attain, if possible, a higher position on the health-illness continuum (Roy 1970).

While Roy conceived of this model primarily as an approach to patient care which holds great potential for nursing intervention, it may be utilized for multiple purposes. As may be seen below, the "Adaptation" theory can be employed as a teaching tool, that is, as a way to organize the content of a curriculum and the materials the students must master, categorized under headings drawn from the theory. As a learning tool, such headings can be given to the student to organize data concerning human behavior, or to understand her own behavior as a basis for self-growth. Further, it can be employed as a professional tool, that is, as a general approach to patient care. The nurse uses the theory not only as a master system for analyzing and organizing nursing knowledge, but also as a guide to direct nursing intervention and basic care. One or more of these functions may operate at the same time, so long as the persons developing or using the model comprehend the differences and the limits of each.

Assuming for the moment that Roy's model is logically integrated, based on empirical evidence, and subject to revision, there is still the problem that any theory which is not based on nursing and the principles of nursing is not necessarily directed towards situations which daily confront the nurse. However, if the theory were integrated with research on nursing, it could provide both foundation and guidelines for developing a viable "nursing" model (Dumas, 1966; Dumas and Johnson, 1972).

Problems of integration and of coordination appear wherever a model is used in the teaching of nursing. Integration problems may stem from the lack of a clear understanding of the theories of practice and the way in which they are related to theories of human behavior. Coordination difficulties stem from the motives, attitudes and values of the practitioners, for it is necessary for the practitioners to be committed to the view that when the nurse performs the sequence of acts under the circumstances spelled out by the model, she achieves an effect which is beneficial to the client.

Problems also arise if guidelines for the application of the model are vague or ambiguous. For example, if the framework, that is, the circumstances under which the model applies, is not clearly understood, or if there are no sanctions attached to the appropriate use of the model, it may be distorted or discarded.

FRAMEWORK FOR A CURRICULUM EVALUATION

Four criteria are identified by Allen (1972) as values which reflect the development and effectiveness of a nursing programme, and these criteria were used to give perspective to the evaluation.

The criterion *relatedness* poses the question: do the individual parts of a curriculum fit together to achieve a common goal, and are the means of achieving this goal or these goals both appropriate and related?

Relevance is concerned with problems such as: are the purposes of a programme relevant to the particular community or country in which it is operating? Are the goals responsive to the environment which supports the nursing programme? Contrast the curriculum which stresses a solution of predictable, known problems with one which explores variable and less known problems.

The third criterion is *accountability*. Is the programme accountable *to* the nursing profession, to society, to the faculty as nurses and as faculty, to the students, and to the college; *for* the goals, the methods and outcomes of a program? A curriculum could be held to be accountable, if the teaching of nursing prevails as a focal point of the nursing programme. It would fail if it were directed solely towards

the preparation for other roles (*i.e.* physician's assistant) or for specialized nursing (*i.e.* obstetrical nurse) and/or for nursing with selected skills and abilities, without the basic scientific approach and knowledge necessary to continued professional inquiry and growth.

The fourth criterion, *uniqueness,* is concerned with the degree to which the goals, activities and operations of a nursing programme "fit" its particular setting. A programme which operates the same way in any setting, or one in which appropriate methods or approach have been developed but are not used, would not possess a high degree of uniqueness.

METHODS AND RESULTS OF THE EVALUATION

In order to draw some conclusions about a curriculum in terms of criteria, questions such as these must be asked: What is the teaching staff doing? What are the problems that arise as they act, what are the sources of these problems? And in order to achieve a higher degree of relatedness, relevancy, accountability and uniqueness, what could they do? These questions provided the frame of reference for information amassed about the curriculum, which included information from individuals and groups, teachers, co-ordinators, students, former students, former teachers, administrators, and committees. The time spent talking with and listening to the staff provided both a "feeling" for nursing at the C.E.G.E.P. and the base lines upon which to build a more structured approach. Much of the available written material, such as aims, objectives, outlines, philosophies etc., was collected and examined.

While all four criteria are important, the greatest emphasis was placed upon *relatedness,* because the curriculum was based on a theoretical model, and because the faculty judged that an evaluation of teaching methods or student performance would be premature.

Three simple instruments were developed and administered. The first was an open-ended questionnaire in which the faculty were asked to describe a situation involving a student nurse in which "adaptation" occurred, and a situation in which "mal-adaptation" occurred. The second was a comprehension test which attempted to evaluate staff knowledge of the model that is basic to their curriculum. The third was a general questionnaire on the application of this model and on the development and application of their curriculum.

Faculty's description of an adaptive situation

Each member of the faculty was asked to describe two situations in which a student nurse played some part; one which involved adaptation, the other non- or mal-adaptation. (The latter became

TABLE 1

CATEGORIZATION BY BEHAVIOR OF ADAPTATION/MAL-ADAPTATION SITUATIONS DESCRIBED BY THE C.E.G.E.P. NURSING FACULTY

Number and type of descriptions

Teaching Group	No.	Adaptive (Positive)			Mal-adaptive (Negative)		
		Nurse Only	Nurse-Patient	Patient Only	Nurse Only	Nurse-Patient	Patient Only
Pediatric	7	1	6	0	1	4	0
Obstetric	7	3	4	0	5	2	0
Psychiatric	5	2	3	0	2	1	0
Basic	5	3	2	0	5	0	0
Medical-Surgical	11*	6	5	4	2	1	6
TOTAL	35	15	20	4	15	8	6

*The number of descriptions of adaptive situations offered by this group exceeds the number of faculty, because four teachers each offered two examples.

practically problematic, in that some faculty felt that mal-adaptation does not exist). The question or request was stated in vague terms in an attempt to avoid influencing the selection of a "situation". A total of 35 staff members responded, describing 39 positive and 30 negative or mal-adapted situations.

The result? First, in these descriptions the word "adaptation" was used in different ways. More than half of the respondents describe situations in which adaptation occurred by modification. In other words, situations were selected in which adaptation denoted the flexibility of the people involved. Another 25 per cent were situations in which accommodation occurred, in that people yielded to a certain degree. A further 30 per cent were situations in which adjustment occurred, that is, something was brought into correspondence with something else or was fitted together. The content of these descriptions, then, varied across the faculty.

In an attempt to elicit their intuitive responses, the faculty were not asked to describe any specific person adapting. Intuitively and immediately, who are the main "actors" in their view of the theory of adaptation? Table 1 is simply a categorization of their descriptive situations, adaptive and mal-adaptive, under three headings:

—*Nurse Only* indicates simple nurse behavior, i.e., a pure situation in the sense that it describes the nurse herself as she reacts to problems and attempts to discover solutions.

—*Nurse-Patient* describes a nurse interacting with a patient, i.e., a situation in which there was a nurse and a patient and the nurse was interacting with the patient by direct intervention or modification of stimuli.

—*Patient Only* refers to simple patient behavior, i.e., a situation in which the patient as an individual changes, or learns, or modifies his behavior.

None of the examples offered, centered on adaptive interaction between nurses or between other members of the medical staff/team.

In her description of the "Adaptation" theory, Roy essentially talks about the patient in terms of stimulus-response, and defines and describes adaptation in terms of the patient and his response potential, his abilities his final resolution. However, of the 39 positive situations here, 15 describe the nurse herself, being flexible, for example) ; 20 describe nurse-patient interaction or intervention, and only four describe the patient himself. On looking at the negative situations, even more of the responses are in terms of nurses not being adaptive, rather than descriptions of nurse-patient interaction. However, there is a small increase in the percentage of simple patient situations. From looking at the content of these behavioral descriptions, it can be seen that the theory of adaptation was used not only to organize curriculum, or to look at patient behavior, but also to explain nurse behavior and to categorize nursing intervention. The model, then, has multiple functions for this faculty.

On the whole, there is little difference between the responses presented by the different groups of the faculty *(i.e.* medical-surgical nursing, obstetrical nursing, etc.) except that the medical-surgical group has described proportionately more simple patient situations. One might speculate on the reason for this. At the beginning of a program, the students themselves are much more concerned about themselves and about being flexible. By the time the students are seniors and have reached the medical-surgical area of their study, they are, perhaps, better able to be outwardly directed and to concentrate upon patient and nurse-patient situations. The responses by the medical-surgical members of the faculty may, in turn, reflect the attitudes and behaviors of the students whom they teach.

It is interesting to note that few of the faculty actually used terminology proper to either a general theory of adaptation, or to Roy's particular modification of this theory. About 26 per cent of the positive descriptions and 14 per cent of the negative ones made use of terminology (of any sort) ; only ten of the 68 examples obtained employed Roy's terminology. However, the responses were without exception explicit descriptions of adaptive behavior which if collected over a long period of time might give empirical support for this promising theory in nursing.

Faculty's comprehension of the model

The second instrument was a test of faculty comprehension. The faculty were asked first to define the basic terms of the model (such as adaptive response, coping mechanism) and then asked to discuss the relationship among these concepts (such as the relation between illness and response potential, or between adaptive response and coping mechanism.) Again, most of the staff responded in terms of a general adaptation theory rather than in Roy's specific language. Such responses could in no way be considered incorrect, but they did tend to highlight the process of interpretation and interpolation which accompanied the utilization of the model.

Twenty-two faculty members responded to the first part of the questionnaire, and most evidenced comprehension of adaptation concepts in a general way, introducing terms such as stress, needs, or problem-solving. Only one advanced incorrect definitions; on the other hand, only one or two used Roy's specific terminology. The exceptions were for the definition of *coping mechanism,* where six used her terms, and for *modes of adaptation,* where fourteen quoted almost verbatim from her publications. It would seem that there are two explanations for this divergence from pattern. While both coping mechanism and modes of adaptation are emphasized in the theory itself, the former is fairly easily understood by the faculty, and the latter poses the greatest problem to them. In their description of the application of the curriculum, it is the concept of modes of adaptation which the faculty believed should be modified, refined or further developed.

In contrast to the general understanding of concepts of adaptation, in their discussion of the relationships among these concepts, faculty members evidenced confusion and vagueness. As many as six gave no response at all, and two gave incorrect ones. The rest answered only in the most general language.

These results do not necessarily indicate that the faculty misunderstand or mis-apply the model, but may indicate instead that there are problems proper to the model itself, in which many of the links among concepts are not shown explicitly or in detail (including the process of mal-adaptation).

Faculty's use of the model

The third instrument consisted of a series of open-ended questions related to the faculty's development and modification of their curriculum based on the "Adaptation" model. The responses were supplemented by written material (objectives, outlines, etc.) and non-structured interviews of staff singly and in groups. In responding to

the questions, the faculty tended to include a great deal of emotive material rather than giving direct and concise responses to the questions. This instrument afforded insights into the ability to meet the three other criteria of this evaluation, relevance, accountability and uniqueness, as well as that of relatedness.

In abstracting data from responses, some general points became obvious. There was less conflict among staff than the staff itself realized. There was more enthusiasm for the curriculum than they realized. There was more willingness to work toward improving the curriculum than they realized. However, there seemed to be problems in communication among them and problems in interpretation of the model.

It would seem that the problems which the faculty face are of two general types. On the one hand, the faculty as a whole felt that the model itself requires elaboration and refinement and that they must themselves achieve a deeper understanding of it. On the other hand, they point to the need for a better system of communication and greater commitment to the application of the model. These problems of choosing, integrating and coordinating a psycho-social model to nursing have been experienced by other programs and noted by previous investigators (Wooldridge *et al.*, 1963).

The student is seen to have difficulty integrating the model with the content of special areas (i.e., pediatrics, etc.) and with the social sciences. The model, rather than automatically facilitating the understanding of such content, seems to confuse by adding another dimension for the students' consideration. However, while there is little emphasis on the student's use of the model as a self-development tool, some students do use it as such, and some do not (as reported by the students themselves in informal discussions and interviews). Further, as the students encountered different teachers in different subject areas, they encountered different approaches toward the model's interpretation and application. Nevertheless, the faculty, on the whole, feels that the students do use it and are certainly much more comfortable with it than are many of the staff. The students, however, will probably continue to experience difficulties internalizing any theory, so long as the faculty find it lacking in credibility. (Kelman, 1965).

What relationships do the faculty see between different subject areas and "Adaptation", how useful do they find the concept? It would seem that the teachers within specific subject areas are frequently seen, by other faculty members, as "loyal" to their subject area and its immediate goals rather than committed to the program as a whole. Faculty with loyalties to their subject areas emphasize

content primarily, and secondarily, that interpretation or part of the adaptation theory which seems most immediately appropriate, rather than building on and developing the theory as students grow and move towards being professionals. Some of the difficulty seems to lie in the faculty's attempting to fit what they see as a well-developed content area, to the theory that is presented from the outside, rather than developing the two together as sequential steps in a well-developed curriculum.

Of those that answered the question concerning the usefulness of this model, two of the faculty indicated its usefulness without qualification; nine that they needed help; eight that it was somewhat useful, but that they as yet had to overcome their personal discomfort in its use; and a final six that they did not know whether or not they found it useful.

Most complain that it does not provide directly a method of patient intervention, and that the actual theory is very complex to present in total to beginning students. The latter is a problem in coordination and integration, central in the development of a curriculum. The former is a problem in the theory itself, which may be resolved by the understanding that this theory *encourages* rather then prohibits the integration of any problem-solving approach. (Orlando, 1972)

While more than half of the staff feels that "gaps" and/or overlap in both content and experience are extremely problematic, few seemed to realize how complex this problem is. On the one hand, as a faculty they did not grasp the paradox of their desire both to avoid "overlap" and to exercise academic freedom. The former is primarily an organizational or technical question, the latter philosophical, and as such a privilege of many faculties (or as is thought by many, the right of all faculties) to read, to discuss and to hold and express differing opinions, and to make one's own decisions concerning matters academic. These faculty members emphasize that they are, and must be, free to state their opinions and to act independently. At the same time, about half of them complain that other faculty members are at fault (because of omissions) for the gaps or overlaps in content. Only a few of the staff realize that in further developing their curriculum they must decide the relationship between a philosophical privilege (or right) and the organizational necessity in reaching the objective of the curriculum and in ensuring the rights of the students, the public and the nursing profession.

It would seem that the faculty has spent a great deal of time writing objectives. These seem to be well written and many of them are in terms of the model. However, they are written in terms of a theoretical definition of that model. As a faculty they have not

systematically collected information on the student as she learns to nurse. As Allen (1972) has mentioned, when a staff focus on objectives as outcome they tend to overlook those outcomes which the student actually achieves, in concurrence with, or in lieu of, the expected objectives. They fail both to gather information on how the student reaches her objectives, or on her usual pattern of nursing, and to identify the influences which impede or support the process of nursing and the process of patient care (and so the process of patient adaptation). The establishment of objectives should be an evolving process in which the staff must participate. As a student moves from one year to another, not only will content and level of complexity of performance change, but also the level of complexity of internalization and utilization of concepts.

DISCUSSION OF RESULTS

The curriculum in terms of the evaluative criteria

These findings may now be considered in terms of the criteria considered earlier. It is in terms of the first of these, "relatedness", that this faculty has perhaps the greatest difficulty. While they have adapted a model which in principle should serve as the common base from which the various parts of their curriculum develop, problems in interpretation, understanding and emphasis at times serve to divide rather than unite their efforts.

They themselves have identified problems with communication and perhaps with commitment. Their responses indicate that these seem to be emotionally charged subjects and want further examination when they are in a clearer frame of mind. At such a time both the size and the solution to these difficulties will assume more realistic proportions. However, considering this and their concern over "gaps" and "overlap", it would seem difficult to rate them too highly on a scale (if one existed) of "relatedness".

Although relevancy, accountability and uniqueness have been discussed in the original report, these criteria are more difficult to assess conclusively, given the nature of this evaluation method and the data amassed during this study. For this reason, they have been omitted from this paper. The staff have chosen a change model for their curriculum, they have requested and participated in an evaluation process, and finally, they are trying to build a curriculum unique to their setting.

The Model and its application

In looking at a model and its application, one asks, "is it logically integrated, based on empirical evidence, and subject to revision?"

This C.E.G.E.P.'s faculty have found some logical problems in the model, particularly in the relationship between concepts. It would seem, in this regard, that the model requires further development. Is it based on empirical evidence? Intuitively, the faculty have been gathering empirical evidence (consider, for example, their ability to generate behavioral examples). They now need to become systematic in gathering this evidence.

Is it subject to revision? There is no doubt that the staff has been revising its curriculum. But toward what, and based on what evidence? Roy's "Adaptation" model is a change model; it allows for continuity; it locates the source of change. (Chin, 1969). It does not, however, define too well the goals of change or the way in which such goals are decided. Further, the actual action of the nurse as a change agent is uncertain unless another theory (such as that of Orlando,1972) is interpolated into that of the model. Also, a way of analyzing the interrelationship of nurse and client is lacking unless a theory such as Peplau's (1952) is introduced.

The model of nursing intervention is not spelled out in detail, and unless a complimentary theory or approach is introduced, a great deal is left to personal interpretation or interpolation. This would appear to be a major weakness in the adaptation of this model to nursing.

In considering the actual application of the model there are questions which the staff have already asked themselves. Does everyone understand it? Has everyone even tried to understand it? Further, there are problems in attitude, motive and commitment. While most are enthusiastic, not everyone feels that this is the best or even an appropriate approach. A few even prefer to ignore the model completely.

The guidelines for application are not clearly spelled out, and individual interpretation on main points leads to confusion and frustration. No sanctions have been identified and/or exercised against members of the group who chose to ignore or harmfully distort the model. Many of the faculty, however, are coming to realize that, in the preparation of the professional, freedom as such must be balanced with other components such as responsibility, commitment, accountability and the rights and needs of the student enrolled in the program.

Conclusion

While a model serves as a heuristic base in the development of a curriculum, the selection and application of a model is a complex and difficult undertaking. Further, the use of a model may entail much

more than the novice can foresee, and require much closer attention to detail than a laissez-faire attitude would permit.

The criteria of relatedness, relevance, accountability and uniqueness seem most appropriate in an evaluation such as this. They permit the amassing of data of various types and from multiple sources, at the same time as they serve as comprehensive and desirable aims for faculty involved in the evaluation process.

This evaluation, as much as any other type, is effective to the extent that it is internalized and acted upon by those involved in the process of being evaluated.

For a faculty which is ready, as this C.E.G.E.P.'s faculty seems to have been, such an evaluation can serve as a catalyst for personal growth and curriculum development through the steps of workshops, discussions, curriculum reorganization, and attempts to amass standardized data on students and their performance.

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QUERY and THEORY

Query: Nurses across Canada are attempting to arrive at a systematic approach to assessing the health of families. What dimensions do you consider within the nursing framework? In other words, how do you structure a family health assessment?

Mona Kravitz
Lecturer
School of Nursing
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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 patients as well as the future practitioner?

E. Jean M. Hill
Dean and Professor
School of Nursing
Queens University

Theory: Taking Jean Hill's use of the term "structure" in the broad sense, I think there are many things we can do to help bridge the gap between education and practice, but there are no panaceas. While this reply is aimed at finding ways and means of making service more real in the education of practitioners and vice-versa, it is based on the assumption that some tension is functional.

In a sense, dealing with the education-nursing gap is like dealing with two siblings: admonishments that they should "get along," help each other, etc., are useless; they will "get along" only if they see that it is to their individual advantage to do so. The theme must be "*functional* interdependence." For example, joint education-service appointments are sometimes regarded as a hope for bridging the

gap. In reality, these are often conflict-ridden situations in which the day to day demands of direct service to patients and staff can overshadow educational priorities; or, if the educational commitments are too inflexible in nature, the "service" which the joint appointee can give may occur primarily at times when it is seen as not really needed. A more realistic approach would seem to lie in the planned seconding of actice practitioners to teaching positions and vice versa. (In one school this is being done on a one-year basis.) This arrangement allows for the complete immersion in the other's boots, yet allows for the preservation of employee benefits; it permits the practitioner and the educator to explore within and contribute to each other's domains, yet it need not threaten basic work preferences.

Another example revolves around the question, "How much say do practitioners *really* have in relation to education?" And vice versa? My opinion is that while service people sit on educational committees, they often have no final vote in policy matters, and curricula suggest that their views are seldom taken seriously, conversely, there are "token" educators on various service committees, but where is the evidence of their impact? Greater results might come if we quit overutilizing the committee structure approach and put more emphasis on shared, concrete *task* accomplishment, on a non-committee basis. For example, there might well be more "functional interdependence" if educators and/or nursing students were to be actively involved in a hospital nursing service audit, evaluating charts along side of service personnel, i.e., taking "their" turns, than by an instructor sitting on a nursing audit committee. Conversely, the examination of a student's Nursing Care Plan skills could well involve the expert opinion and bona fide "vote" of a service person.

Two final examples: There seems to be an abiding hysteria about entrusting students to service personnel, even senior students. At a time when clinical supervision costs are becoming astronomical, could educators not, even on economical (much less the more important pedagogical) grounds, actively pursue a policy of contracting for at least some "service" supervision and teaching of students, and quit clinging so tenaciously for all clinical experiences for all times to the "hovering educational instructor model"? Another example: Within the last few months the National Health Grant research monies policy has been expanded to include provision for money to assist health agencies in developing sound research proposals. How many deans and directors of schools of nursing would see it as their responsibility (much less their opportunity for creating functional interdependence) to enquire of their health agency counterparts if they are

aware of these changes? The sociological literature abounds with evidence to the effect that supplying needed information, not "structure" alone, is an important source of creating interdependence. How much do we in nursing service and education utilize that principle? Too often we are telling each other what is already known, or what one would rather *not* hear, techniques which create animosity, not interdependence.

The above are admittedly limited examples but will perhaps serve to demonstrate the points that multiple approaches are needed *and* at multiple levels of interaction, and that structural arrangements based on tokenism or mere courtesy are not only inadequate but very likely damaging in that they can result in feelings of hopelessness, lack of common cause, and anomie. Only as we are able to design ways of being truly consequential in each other's work do we make substantial headway in closing the gap. And one last point: organizational interdependence is very much like people interdependence. Specific strategies which work for any two organizations, such as a health unit and a school of nursing, may not be meaningful to other such agencies. We focus a lot on the need to individualize patient care; we should keep this in mind when we focus upon strategies for individualizing service-education relationships.

Shirley M. Stinson
Professor, School of Nursing, and
Division of Health Services Administration
The University of Alberta

Theory: Changes in structures both on the part of nursing education and nursing service will be needed if an interdependent relationship which benefits both clients and students is to evolve. On the part of education, changes in curriculum structure may assist in this evolution. To this point in time there has been emphasis on students' learning knowledge and ideas, the content of the discipline. Less emphasis has been given to the process of nursing, or "how nurses nurse", and models which have been employed (such as problem-solving) have not always seemed relevant to educators and practitioners.(1) Models such as problem-solving emphasize some of the processes involved in nursing clients but do not account for other aspects of the process.(2) A process-oriented curriculum, using a comprehensive model of the process of nursing(3) which is acceptable and realistic both to educators and clinicians, can assist students to use the knowledge and ideas pertinent to nursing practice in a manner which makes their own nursing systematic and effective, as well as communicable to other members of the health team. Em-

phasis on process tends to make explicit aspects of nursing (such as priority-setting) which have remained implicit and therefore obscure. In this sense, study of process generates content which becomes part of the knowledge of the discipline. The development of process-oriented curricula therefore benefits clients and practicing nurses as well as students.

A second responsibility of the university in facilitating the evolution towards an interdependent relationship is that of developing research projects which examine clinical nursing, both its processes and its content. Only through establishing a strong body of knowledge concerning clinical nursing can there be increased consensus between nursing service and nursing education. Educators must have the confidence that the knowledge and concepts they are imparting to students are based on sound research findings, and practitioners must be assured that changes in care suggested by students or teachers are based on factual knowledge. The very process of conducting clinical nursing research by faculty members will help to convey their interest and concern for the issues relevant to practitioners, and the findings generated will assist practicing nurses in the provision of thoughtful and scientifically based nursing care.

On the part of nursing service, an important evolution in structure will be towards creating a climate which enhances learning in every clinical area which receives students. Administratively, this may require making nurses accountable for creating and maintaining an atmosphere which tends to enhance student learning. The sense of responsibility towards the learners in our profession needs to be recognized, cultivated and rewarded in the practicing nurse. Educators can reinforce this process of recognition through selection of practising nurses to act as role models for students in experiences which are negotiated between the teacher, the student and the practitioner.

The occurrence of the three structural changes suggested could enhance the bridging of the gap between nursing education and nursing service.

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Lesley Faith Degner
Assistant Professor and Research Associate
School of Nursing
The University of Manitoba

Query: 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 (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?

E. Jean M. Hill
Dean and Professor
School of Nursing
Queens University

Theory: It seems to us that Dr. Hill is asking whether or not any school is assessing the quality or effectiveness of the care provided by graduates of university programs. Her Query might also include a request for information as to whether or not the presence of graduates of university programs in nursing care situations has a positive effect on the work of other nursing personnel in the provision of care.

While such data would indeed be useful it would surprise me if they were available. Studies of positions held and their activities related to these reveal nothing of the effectiveness with which encumbents perform. Indeed, it would seem likely that if it were possible with any degree of reliability and validity to study nursing effectiveness of university graduates, it would be possible to acquire data about the quality of nursing care in general.

Research which I have read devoted to the latter leaves much to be desired primarily in the failure of the researchers to identify suitable dimensions of the concept "quality of care".

I think, however, that Dr. Hill's question is one which is of the utmost importance if it should serve to stimulate good research in this area.

Joan M. Gilchrist
Director
School of Nursing
McGill University

Theory: Currently the University of Calgary School of Nursing is initiating what will be an ongoing study of the effectiveness of its program in achieving the School's educational goals. The study is so designed that assessments will be made by the graduates themselves and by these graduates' employers.

Questions included in the questionnaires to be used in the study seem to bear on Dr. Hill's question. These are:

For the graduate: "Describe briefly what you think is the most significant improvement in nursing practice that you have been able to bring about in your current working situation."

For the graduate's employer: "Describe briefly the most significant contribution this nurse has made to your nursing service."

The School engaged J. Peitchinis to assume responsibility for designing and implementing the study. Assisting her is a committee of faculty members — D. Pechiulis, S. Sethi, N. Sparks, C. Stainton. Questionnaires will be going out to the first class of graduates and their employers the end of February 1975.

Marguerite Schumacher
Professor and Director
School of Nursing
The University of Calgary

Theory: We had circulated a questionnaire to New Brunswick employers of our graduates. It was designed to aid us in curriculum revision, rather than obtain a response to your specific query. There was frequent reference in the replies to 'a high quality of care' but there was no definition of the term, or criteria offered for judgment made.

The employing agencies also referred to the insecurity of the new graduate in her first position, and a reluctance to assume roles of responsibility. Again there was no indication of how soon the graduate was expected to assume such roles, but it was a definite criticism.

We also sent questionnaires to graduates from 1969-1973. Approximately half responded. One question asked how they could have been better prepared to cope more effectively with problems they have encountered. A large percentage asked for more experience and practice in leadership roles (as team leader, head nurse). At present this is not feasible in our program. They do receive the theory and are given an opportunity to understand what is involved in the process of change, and the extent to which they can work with others to bring this about, and eventually make an impact on the community.

There are obviously incongruities between the ideal and the real in this, and since there is the stated need by graduated to take on charge positions very early in their careers, we shall have to look at how we might better prepare them for this

We need to obtain information from graduates which specifically indicates the positions they have held and are holding. This we do not as yet have. This should help us in assessing the impact on nursing care they are making.

Irene Leckie
Professor, Faculty of Nursing,
for Lois E. Graham, Dean
Faculty of Nursing,
The University of New Brunswick

Theory: We wonder whether the question posed by Jean Hill is the right question to be asking, at least at this time. Possibly a more crucial question in terms of accreditation relates to whether the school's instructional programme is consistent with objectives such as preparing for leadership roles and acting as change agents. For instance, there is some evidence (Fagen & Goodwin, 1972) that although many baccalaureate nursing programs "state their intent to prepare the baccalaureate graduate to be a change agent" the curricula do not include learning experiences in change. A further question is that concerned with outcomes, that is, is the programme producing outcomes consistent with such objectives at a performance standard appropriate to a baccalaureate programme.

Certainly we agree that the performance of the graduate reflects upon the philosophy and curriculum of the school and we have carried out follow-up studies of the graduates (Parker, 1968; Parker, 1971; Parker & Humphreys, 1973). The data collected is then considered in relation to other factors in curriculum revision. We feel, however, that in addition to much more precise information about the situation in which the graduate is attempting to function and the many other variables influencing quality of care, definition of both 'influences' and 'quality of patient care' would be necessary.

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Nora I. Parker, Professor and
Academic Coordinator
Kathleen Arpin,
Clinical Coordinator
Faculty of Nursing
University of Toronto

Theory: The School of Nursing, University of Manitoba, has not conducted any official surveys to provide evidence as to the effectiveness of graduates. However, we have collected evidence in an informal way since the inception of the program and this is related to how the graduates of the program are functioning. These include:

1. Graduates have been invited to return each year to discuss how *they* are functioning in the community. This was done through Nursing Education Alumni Meetings where graduates were invited to talk about their activities and through planned programs where graduates were asked to discuss problems they were having in initiating programs and making change. In this way we have been able to be kept informed of the changes and innovations they have been able to institute. Examples of programs instituted include a program out of a hospital Not For Admissions program where the nurse visited women who had elected tubal ligation, before and after the surgery; a T.V. program for elderly to enable them to utilize community resources and to deal specifically with problems with which they need assistance. A great deal of sharing took place in these discussions.

2. Graduates were also invited to return to the School and discuss transition into the work world. These were shared with students in the current program and as a result of these discussions and difficulties graduates identified, a number of changes were made in the leadership course in nursing to create specific critical incidents with which graduates were faced and these were used as case studies to determine ways in which change might be facilitated to overcome inabilities to function to the benefit of the patient, particularly when services to patients were recognized as lacking.

3. An official survey of graduates was made five years after inception of the four year integrated program to determine how many graduates have pursued graduate study and it was found that 6.8% have done so.

4. A survey was also done five years after inception of the program to determine the placement of graduates. A recent survey has indicated a change from the original placement which was largely public health and mental health oriented to a greater inclination to seek employment in institutions and in rural areas as opposed to the earlier selection of urban settings.

5. In 1972 a consultant was brought in to survey the community and other disciplines as well as the nursing profession to determine the satisfaction with the service given by our graduates. It was a unique type of survey in which comparison of the ideal and real situations was asked of those interviewed. As a result of this survey a new curriculum was developed over a two year span of investigation and study of the present curriculum. The recommendations of the consultant were almost entirely incorporated into the new curriculum.

6. An Ad Hoc Committee in Continuing Education was established in 1972 and we are assessing, from the point of view of community nurses of all types of nursing service, what kinds of continuing education, our graduates as well as graduates of other programs require. We now have a Continuing Education Co-Ordinator who works with the Extension Division to design and implement programs in the Community.

7. The only direct solicitation of data from patients is in the form of a National Health Grant study funded on *The Use of Clinical Facilities by Nursing Students in Manitoba.* One form of data collection is in interviews with patients to determine the impact of nursing students on patients while the students are learning in the clinical area. It does not extend beyond the learning experience. A second study is more longtitudinal in nature. It is also a study that has been funded, by the Manitoba Educational Research Council and Manitoba Association of Registered Nurses, and is a study of the *Characteristics of Nursing Students Related to Potential for the Success in Nursing.* While students are being assessed through psychological testing and development of typologies of characteristics of students in the varied types of programs in nursing, the plan is to eventually request of patients their opinions of the success of the students who exhibit the characteristics which teachers and the literature indicate students should exhibit. The study is still at the stage of developing the typologies of characteristics related to success.

8. We are able to keep informed and make distinct efforts to do so informally concerning those kinds of changes in which our students are involved. Students who have graduated feel free to share with faculty their needs and concerns and thus we feel fairly well informed

about the activities and particularly the innovations in nursing care, in which students are involved.

We will be instituting a new curriculum in 1975 and it is our plan to use the Stake Evaluation Model in the program which is a broad approach to evaluation and includes survey of those served by graduates. In addition we look forward to the accreditation process which C.A.U.S.N. is initiating and will participate fully in that process.

Helen Glass,
Director, School of Nursing
The University of Manitoba

Theory: Ms. McClure has asked me to respond to Jean M. Hill's Query.

According to Professor P. A. Field, "The only follow-up study of the graduates of the four-year program that has been done to date is a follow-up one year after graduation. An item analysis of difficulties they encountered in the work situation has been undertaken. A paired questionnaire has been sent to the graduate and to the person who normally evaluates her. A rating on thirty items related to nursing assessment, intervention, and evaluation; communication skills; self-development; and leadership is completed. Both the graduate and the employer indicate where on the scale they feel the point of safe practice lies and also where the graduate is functioning. A comparison with performance levels of graduates from other schools was not undertaken."

Professor K. Dier, reporting on research related to the evaluation of graduates of the Northern Nurse Program (Nurse Practitioners), states "A tool for evaluation of graduates of the Nurse Practitioner Program is now being developed under the direction of Dr. Clark Hazlett, Associate Professor, (Educational Psychologist) Health Services Administration, as a separate project funded by the Federal Government. This is to be based on the bank of Behavioral Objectives that have been validated over the past two years by the five universities (Toronto, Sherbrooke, Manitoba, Alberta, and London, Ontario) involved in these Medical Services sponsored programs.

"The measuring instruments now being tested include objective-type written examinations as well as practical examinations in the areas of physical assessment, history-taking, and surgical techniques. The evaluation guide will be completed by the Spring of 1975 for the use of Medical Services. If implemented, this would

involve selecting a random sample of graduates from the five Nurse Practitioner Programs across the country. Observer(s) will then be sent to the Outpost Stations in which the nurses are employed, and, using the evaluation tool, attempt to determine if the graduates are in fact using the knowledge and skills as set down in the objectives for the Nurse Practitioner Program.

"It should be pointed out that this evaluation will not necessarily measure the quality of patient care, but it should measure quite accurately how effectively this person is operating clinically, which of course should have a bearing on services received. This project does not attempt to measure attitudes."

It should be noted that, while the preceding studies are definitely relevant to the follow-up of graduates of the respective programs, they do not actually evaluate in what way university education in nursing influences the quality of patient care. While many positive observations have been made by employers about the performances of the graduates of our two- and four-year bachelor of nursing science programme, they are of a subjective nature and not based on findings from rigorously conducted research studies.

Helen Niskala,
Associate Professor and
Coordinator, Undergraduate Programs
School of Nursing
The University of Alberta

Theory: Our Faculty has not undertaken any activity oriented towards a scientific follow-up of the effectiveness of our graduates in the area of nursing practice chosen by them. Many employers have expressed their appreciation of the quality of care given by our graduates, but, as mentioned already, these appreciations were not the result of any scientific evaluation.

Nevertheless, some papers written by students or groups of students have shown that some nursing approaches made by university-educated nurses are really scientific, totally different from the usual nursing approaches. In a manner, this research has shown that university education does provide evidence of effectiveness.

Jeannine Baudry
Assistant to the Dean
Coordinator of the Baccalaureate
Degree Program
Faculty of Nursing
University of Montreal

Theory: We have done nothing in a formal way to gather data and to show how and what way university education in nursing influences the quality of patient care. The only thing that we know is the readiness with which our graduates are accepted by employers, indeed, sometimes deliberately sought, and the feedback that is provided informally by employers.

We did have a student who located, with a small sample, the study done by Nora Parker of U. of T. graduates regarding their satisfaction with their educational program, difficulties, etc. encountered in the first employment position, and subsequent work and educational experience. The results were very similar to the Toronto results.

I shall be interested in knowing whether others are engaged in any data collection.

Dorothy J. Kergin
Associate Dean of
Health Sciences (Nursing)
School of Nursing
McMaster University

Theory: We have done some follow-up of graduates in the past, but not to determine their effectiveness as "agents of change" and as to leadership in nursing practice.

I believe this needs to be done so that other health professionals, the public and ourselves will have the facts as to whether there are differences in the practice of baccalaureate and diploma registered nurses.

Margaret D. McLean
Director, School of Nursing
Memorial University of Newfoundland

Theory: I'm sorry to say we are doing nothing about gathering data to demonstrate that University nursing education improves the quality of patient care.

It needs to be done and I will see if we can get any kind of study underway.

Muriel Uprichard
Professor and Director
School of Nursing
The University of
British Columbia

Theory: We have not to this point attempted to gather data to determine how and in what way university education in nursing influences the quality of patient care. However, we have talked about the need to initiate such a project and we believe that by 1975 a sufficient number of our basic degree students will have completed the program that such a project will be important and meaningful.

We are not expecting to have an appropriate instrument ready until possibly January, 1975 at the earliest. Should the study materialize, I should be happy to communicate with you further on its results.

Sister M. Simone Roach
Chairman
Department of Nursing
St. Francis Xavier University

Theory: I am sure Dr. Hill's question will catch many of us unprepared, as it did us. We have not undertaken any studies to show how university education in nursing influences the quality of patient care. I can only hope others may have.

I look forward to reading the responses to this Query.

M. Marguerite Muise
Coordinator, Nursing Program
Mount Saint Vincent University

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