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

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Vivian Geeza, *rédacteur gérant*

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CONTENTS

THE ARTICLES IN THIS ISSUE WERE WRITTEN BY MEMBERS OF THE FACULTY OF NURSING OF THE UNIVERSITY OF WESTERN ONTARIO

Editorial

EXCHANGE AND CRITICAL APPRAISAL OF IDEAS: A PROFESSIONAL IMPERATIVE

"Suffer yourselves to be blamed, imprisoned, condemned; suffer yourselves to be hanged; but publish your opinions. It is not a right, it is a duty."

M. JOSEPHINE FLAHERTY
Dean, Faculty of Nursing
The University of Western Ontario

Nursing Papers represents the realisation of a dream of a small but dedicated and persistent group of nurse-scholars at McGill University. Their dream was the creation of a forum through which nurses in Canadian universities could expose their thoughts to the scrutiny of their colleagues and thus generate exchange and critical appraisal of ideas about nursing practice, nursing education and nursing research. Monetary contributions from CAUSN, the School of Nursing and the Alumnae Association at McGill and the contributions of subscribers together with countless hours of volunteer work by Moyra Allen and her colleagues and by nurse-authors across the country have maintained *Nursing Papers* as a viable academic journal. In the Preface to his *Dictionary of the English Language,* Samuel Johnson noted that "The chief glory of every people arises from its authors." *Nursing Papers* can be regarded as a medium through which Canadian nurses can exercise their responsibility to publish their opinions.

Through demonstrated and recognised competence and productivity in intellectual arenas and through the pursuit of excellence in nursing practice, nurse-teacher-scholars have earned membership in the scientific community. As members of that community, nurse-teachers in universities should delight in reason and the beauty of logic and be curious about the nature of man and the world about him. Such people are driven to "find new means to explore the unknown and to design and try out new devices and novel approaches to make such explorations. . . . [they derive] satisfaction from reexamining and reaffirming the theories of their predecessors"(1).

Universities attempt to recruit teachers whose intellects and talents for abstract thinking allow them to derive conceptual order and meaning from the discoveries of the past and whose vision leads them to ask the questions and to express the ideas that set new directions for scholarly inquiry(2).

It is because of the small but increasing number of scholars in nursing that the profession's commitment to scientific inquiry is growing and developing. There is no doubt that advancements "in science and the development of new technologies are inextricably intertwined with the values placed on scholarly inquiry by influential people, and on their eagerness to have new knowledge used for improving circumstances and practices in any human enterprise"(3). It has been suggested that "research as the inquiry spirit is to be spread up and down the nursing ranks and not reserved for a nursing elite"(4).

The challenge to nurse teachers then is to demonstrate to students the practice of critical thought, which, if real,is ongoing and not merely episodic. Critical thought is "thought that is more than merely descriptive of what is — in several senses. Critical thought includes the capacity to: 1) be articulately opposed to what happens to be the case, 2) see and devise possibilities not yet existent, 3) invent in the light of what is a means to produce the desired reality"(5). Such thought allows the thinker to look upon the so-called *real* or *given* as matter to be shaped in conformity with imagination. It permits "the imaginative leap that transforms an undifferentiated given into a pattern of reason"(6).

The discovery of penicillin is an example of such an imaginative leap. "Many bacteriologists had seen that cultures of microbes are spoiled when exposed to molds, but all they concluded was that molds must be kept out of such cultures. It took a stroke of genius to see the medicinal promise of the basic observation"(7).

University teachers who are intellectually and practically engaged in curriculum development and implementation cannot help but be engaged constantly in critical appraisal of what they are doing. Their work involves definition of objectives, specification of the conditions under which those objectives can be met and subsequently, location, or if necessary, creation of those conditions, provision of appropriate learning experiences for students, rigorous evaluation of the results of those experiences and implementation of modifications where indicated. They must inquire constantly to remain in touch with the worlds of nursing theory and nursing practice upon which their curricula are based.

One of the major problems facing educators in all fields today is the necessity for teachers to use training and experience obtained in the past to prepare candidates in the present to function in the future, in a world the character of which is virtually unknown. For nursing education, this is not new; the sweeping changes which are taking place in all of the health professions — the result of advancements in

knowledge and unprecedented technical impact — have made obsolescence of professional nursing practice almost as worrisome a problem as is the obsolescence of machines. Nurses are living in an age which demands almost instant reaction and action in response to ever-changing situations and problems. As a profession, nursing is not intimidated by this state of affairs. No longer do nurses feel obliged to carry the burden of omniscience that has plagued so many professions. Rather, nursing's hallmark is conspicuous effort to develop stategies to deal with almost instant obsolescence of knowledge. Such effort requires a commitment to research which encompasses "all systematic inquiry designed for the purpose of advancing knowledge"(8).

Canadian nursing in the seventies has committed itself to the development of conceptual models for nursing practice and the implementation of nursing education programmes which are based on these models. Nurses are examining their practice and declaring themselves accountable for that practice. Nurse educators are examining educational programmes for relevance to the real world of nursing, for internal consistency and its relationship to the process of learning and for concept validity or the extent to which the learning experiences which define curricula permit the achievement of programme objectives.

The nurse-teachers at the University of Western Ontario are no exception. Faculty members are examining their beliefs and values, developing a conceptual model for nursing practice, building curricula which are based on that model and reviewing educational practices and learner outcomes with a critical eye. Perhaps, to a greater extent than ever before, these teachers are "thinking out loud" in the presence of their peers in order to expose their ideas — at all stages of development — to the scrutiny and critical thought of their fellows.

In the pages that follow, some of the ideas and activities of nurse-teachers at Western are presented for appraisal by nursing colleagues. There is no overall theme; rather, from the multitude of problem areas under discussion in their own Faculty, these teachers have selected only a few on which to comment and reflect. Some are not new; some represent novel approaches to familiar problems; some are speculations which are still in the developmental stage and some provide more questions than answers.

Lillian Bramwell considers the transition from nursing education to nursing practice and speculates upon the idea of marketing nursing education. Janice Given points to issues and problems for the nurse-educator in relation to professional socialization. Jean Forrest con-

siders the use of the contract with the patient as a means of determining the limits of a relationship and as a tool for the educator.

Carolyn Roberts points to some interesting implications from the findings of an evaluation by parents of a tonsillectomy and adenoidectomy follow-through experience for students in paediatric nursing while Janet Pfisterer looks at the learning needs of cardiac patients. Hattie Shea shares her perceptions of the teacher as practitioner as did Diana Gendron in an earlier volume of this journal(9).

The authors invite comment, criticism and discussion through which they hope to develop their ideas further and/or to modify the direction of their inquiry.

NOTES

1. Rozella Schlotfeldt, "Rearch in Nursing and Research Training for Nurses: Retrospect and Prospect," *Nursing Research,* Vol. 24, No. 3 (May-June, 1975), p. 177.
2. *Ibid.*
3. *Ibid.*, p. 178
4. James Dickoff, Patricia James and Joyce Semradek, "8-4 Research. Part I: A Stance for Nursing Research — Tenacity or Inquiry," *Nursing Research,* Vol. 24, No. 2 (March-April, 1975), p. 88.
5. *Ibid.*, p. 85.
6. *Ibid.*
7. Hans Selye. *Adventures of the Mind.* New York: Alfred A. Knopf, 1959.
8. Schlotfeldt, *op. cit.*, p. 177.
9. Diana Gendron, "An Experience Taking Patient Assignments While in the Teacher Role," *Nursing Papers,* Vol. 6. No. 4 (Winter 1974-75), pp. 5-10.

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THE NURSING EDUCATOR AS FACILITATOR OF TRANSITION FROM EDUCATION TO PRACTICE

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Nurses perceive in varying degrees a discrepancy between nursing education and nursing practice. It may be argued that, if we are educating for a practice discipline, we should adopt a functional approach by preparing nurses who are capable of fitting smoothly into the present health care system. In other words, why perpetuate the discrepancy between nursing education and nursing practice? Kramer's (1974) answer is that educators have a responsibility for equipping nurses to cope with a constantly changing society. If change in the health care system is to mean improvement then:

> It is not enough to teach nurse aspirants the specific behaviors and facts needed to nurse in the system of today; we must equip them with the tools needed to nurse in the future. (Kramer, 1974:27)

The assumption is that process learning of an encompassing nature (the tools) will at least partially equip the practising nurse of the future to manage change.

Loomis (1974:48) states her position emphatically when she asserts:

> I would speculate that professional nursing must change dramatically within the next ten to fifteen years or be relegated to the history of contributing peoples who became historically extinct. The social handwriting is on the wall, and health care has attained the status of a civil right. If the nurse is unable to meet society's needs, then most assuredly she will be replaced by someone who can.

This paper adopts the premise that it is essential to prepare nurses capable of responding to the continually evolving health care needs of society and individuals. At the same time, we must educate nurses to assume a functional role within the present health care system. Initially the article focuses on Kramer's (1974) Anticipatory Socialization Theory, and Raths, Harmin, and Simon's (1966) Values Theory as examples of two approaches that the nurse educator may use to assist the beginning nurse to reconcile values perpetuated by the learning environment with those underlying activities in the nursing practice setting. Strategies to encourage acceptance of the new graduates by the health care agencies will also be discussed. The

above intervention will increase the beginning nurse's potential for a successful transition from the world of school to the world of work.

NURSE-ORIENTED APPROACH

The discrepancy between a previously-learned approach to patient care and institutional expectations, as perceived by the new nurse, results in her experiencing some degree of "reality shock" which is defined as:

> . . . the startling discovery and reaction to the discovery that school-bred values conflict with work-world values. In some instances, reaction to the disparity between expectations and reality is so strong that the individual literally cannot persevere in the situation. (Kramer, 1974:4)

If the individual cannot cope then she opts out of the situation and perhaps out of a nursing career.

Attrition from the practice of nursing as a result of reality shock is a waste of nursing manpower and is a detriment to nursing if one assumes that those who were unable to compromise their professional values under bureaucratic pressure may have had potential as change agents had they been able to ride out the storm.

One solution to this problem is Anticipatory Socialization, a strategy proposed by Kramer (1974), which is built upon the proposition that if the neophyte nurse will inevitably encounter discrepancies between nursing education and nursing practice, then she should be subjected to these discrepancies during the learning experience when she has support and guidance enabling her to prepare her defenses — a form of immunization against reality shock. The theoretical framework of Anticipatory Socialization has as its basis the following propositions:

1. Some degree of professional-bureaucratic conflict is inevitable, but conflict is not necessarily bad.
2. Growth-producing conflict resolution behavior can be facilitated by exposing students to conflict situations early in their educational careers.
3. Skills of interpersonal competence can be enhanced through controlled and manageable exposure to conflicts while in school as opposed to the overwhelming confrontation after graduation.
4. Development of strategies or lines of action can be facilitated through exposure to an outside reference group to which students can anticipatorily socialize themselves. In this way students would be stimulated to learn and model adaptive conflict-resolution behavior.
5. Pre-exposure to the anticipated process of reality shock, its signs and symptoms, and possible resolution channels would help to decrease the discomfort of the ensuing shock situation and assist in making this a self-discovery and growth-producing experience.
6. Deliberate attacks on cherished professional values and provision of refutational defenses with opportunity for practice of same

would help to safeguard these highly vulnerable beliefs. If beliefs are safeguarded for at least an initial period of the new work experience, the likelihood of their being operationalized will increase (Kramer, 1974:45).

The program described by Kramer equips the new graduate with knowledge of what to expect and ability to cope with situations as they occur. It would seem that an important requisite for the teacher is an adequate and objective view of the amount and kind of conflict that exists between nursing education and nursing practice. A naive group of teachers could provide little insight for a naive group of students.

Kramer's sixth proposition states if values are safeguarded, there is greater probability the values will be acted upon. If values are to endure and serve as a guide to action, they should be operating at the conscious level. The practising nurse who can identify the values upon which she bases her nursing actions, will not readily abdicate them without careful analysis of the situation; therefore, to reinforce and enhance the Anticipatory Socialization process I propose that nurse educators also use teaching strategies that encourage value formation and clarification.

The first step to be taken in planning a learning experience that will encourage value formation is to define the intended learner outcomes in terms of affective objectives. An optimum terminal outcome to be achieved in the educational setting would probably be at the level of "organization into a total philosophy" (Bloom, Hastings and Madaus, 1971:229) which would require the learner to integrate and reconcile a set of values into a unified whole The terminal objective would be to develop a personal philosophy of nursing that would guide nursing practice.

The teacher then plans a learning experience to achieve stated affective objectives. This procedure can be based upon the processes of valuing which are as follows:

Choosing: (1) freely
(2) from alternatives
(3) after thoughtful consideration of the consequences of each alternative
Prizing: (4) cherishing, being happy with the choice
(5) willing to affirm the choice publicly
Acting: (6) doing something with the choice
(7) repeatedly in some pattern of life
(Raths, *et al.*, 1966:30).

Encouraging value formation by use of the valuing processes is based upon the belief that:

> . . . human beings hold the possibility of being thoughtful and wise and that the most appropriate values will come when per-

sons use their intelligence freely and reflectively to define their relationships with each other and with an ever-changing world) (Raths, *et al.*, 1966:39).

It would would be difficult to implement such a process unless one accepted the above belief.

Value formation and clarification requires personal, active involvement of the student. This can be achieved by several methods, for example: discussing issues and dilemmas in small group settings (Kramer, 1974; Kohlberg, 1973); role-playing conflict situations that are personally relevant (Raths, et al., 1966; Stanford and Roark, 1974); using "you" questions to help students find personal meaning in subject matter (Stanford and Roark, 1974); and using the clarifying response (Raths, *et al.*, 1966). The nurse educator can, with imagination and planning, adapt these and other approaches to nursing education programs.

The ultimate test of whether the values established in the learning environment can be implemented and serve as a guide to nursing action occurs after the nurse leaves the educational setting for the practice setting.

I would view then, one aspect of preparing the nurse to function effectively in the practice setting as a combination of developing a value system and testing, revising, and reinforcing that value system through a program analogous to Kramer's (1974). Such a venture is not sufficient to insure a successful integration of learning with practice. Successful implies that the nurse is accepted by the health care institution without abdicating her value system in order to achieve this status.

INSTITUTION-ORIENTED APPROACH

When manufacturers prepare a car for the marketplace they design a vehicle that is functional, attractive, and different. Their task is not accomplished, however, until the car is purchased by consumers. This goal they achieve by creating acceptance of and then desire for their vehicle through extensive exposure of their product via advertising. Is there a lesson in this process for nurse educators?

There are several possible ways to encourage acceptance of our nursing graduates by health care institutions. One is to write about our nursing education programs, describing explicitly their philosophical bases, the terminal goals, and the learning experience required to achieve the goals. The articles should be addressed to practising nurses and should therefore be submitted to journals that are read by this group. Another way is to seek opportunities for participation in continuing and inservice education for nurses. Such activities

can possess a dual purpose of providing a service to the nursing community and keeping it informed about the learning experiences of nursing students. In addition, contact with individuals who are responsible for patient care can give educators valuable input for ongoing program revisions. Mutual give-and-take between nursing education and nursing practice has potential for improving both areas.

Additional strategies exist for assisting with the transition from student to nurse; however, they may extend beyond our area of accountability. Contact with health care agencies helps the educator identify institutions that have value orientations similar to those of the educational setting. One may speculate that the more similar the value orientation, the smoother the transition from nursing education to nursing practice. If so, the issue then becomes, does our responsibility for assisting with this transition extend to influencing the new nurse's choice of the setting in which she elects to practise? Should we encourage several students to apply for positions in the same setting so they form a source of mutual support? How would such activities by educators be perceived by students and health care institutions? The analogy of car manufacture and marketing may or may not fit, depending upon one's perspective.

In summary, the complex problem of how to facilitate the move from nursing education to nursing practice has several possible solutions. Perhaps the answer lies in a combination of solutions. We, as nursing educators, have a responsibility to the learner and the health care institution for planning and implementing strategies that will assist beginning nurses to make an effective transition to nursing practice.

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THE NURSE EDUCATOR AND PROFESSIONAL SOCIALIZATION: ISSUES AND PROBLEMS

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Professional education in nursing comprises two elements:

(1) the study of the knowledge and skills requisite to the practice of nursing;

(2) the development of a professional self-concept, a set of attitudes, values, and behaviours that guides interactions with clients, colleagues, and members of other professions and paraprofessions.

Responsibility for both aspects of professional education is a concern of nurse educators who not only plan learning experiences for students, in classroom and clinical settings but also serve as role models of professional behaviour and orientation that nurse aspirants may emulate. Although there is a plethora of information regarding the educator's functions in the instructive process, there is a decided lack of literature concerning the role of the teacher in the professional socialization process. This paper examines several issues related to the role of the nurse educator as an agent of professional socialization.

One important issue is the nature of the process. In an examination of the tasks performed by educators in professional schools, Wilson identifies three major areas of responsibility (Wilson, 1962:17-28). First, teachers direct students in their learning of the specific knowledge and skills necessary to develop expertise and competence in a set of clearly-defined tasks. Second, the educator provides the neophyte with the circumscribed standards and ethical code designed to regulate actions with clients. Finally, the educator assists the aspiring practitioner to work out an orientation to both the professional group and other professions. This set of orientations, which includes career commitment and involvement, is difficult to delimit and evaluate effectively. Wilson argues that periods of formal teacher education generally equip educators to handle the defined tasks of instructional activity but that little attention is given to preparation for the diffuse and divergent responsibilities that form part of professional socialization and educators often perform this portion of their teaching role with less than adequate skill or knowledge.

In addition to adequate preparation, nurse educators face two further conflicts with regard to their roles as socialization agents. The

first concerns role definition. Becoming a nurse educator requires a change in orientation from that of direct service to the consumer of health care to a role where such service is rendered indirectly through the student. The nurse educators' clients are not those seeking health care, but students who wish to become nursing practitioners, a situation that can lead to a conflict of priorities for the nurse educator. Do nurse educators consider themselves nurses, educators, or nurse educators? Does the priority interest of the nurse educator become the needs of the consumer of health care or the needs of the student? Can one who is concerned with educational standards effectively model the practitioner's role to students? Does the teacher's concern become nursing or educational standards? All of these issues can contribute to an ill-defined role definition for the teacher and influence the types of behaviour modelled to students.

A second source of conflict for nurse educators may be the lack of viable reference groups in the education setting. In an examination of reference group theory in relation to adequate role performance (Kemper, 1968:31-44), Kemper identifies three types of reference groups that an individual takes into consideration in selecting an appropriate behaviour pattern:

(1) the normative group, which provides the individual with norms and prescriptions to guide behaviour;

(2) the comparison group, which provides role models through which the individual may assess the adequacy of his own performance, find legitimation for his actions and behaviours, and stimulus for change or behaviour modification actions;

(3) the audience group, which provides sources of support and motivation for higher levels of achievement.

For nurse educators, normative standards are supplied by reference groups within nursing and within the specific employing agency. Audience groups are provided by colleagues in the work setting or by students. However, nurse educators may lack a comparison group. Most teaching tasks are performed in isolation. Except for team teaching situations, nurse educators may have little opportunity to assess the adequacy of their role performance or learn new behaviour patterns through role model identification with other nurse educators. If colleagues do visit class or clinical areas, it is usually on invitation or for evaluative purposes.

A non-definitive comparison group can be especially problematic for the beginning teacher. Studies of the difficulties encountered by beginning teachers report that they form their expectations about teaching from their own early experiences with educators as students, their teacher training experiences, and from supportive and emulative

experiences with their new colleagues in the work setting (Musgrave and Taylor, 1969:9). If no comparative group exists, the new teacher relies heavily on imitation of teachers encountered during his or her own basic nursing education program.

> It is noteworthy that the same teachers who found it easy to describe their former teachers had difficulty in describing colleagues of outstanding competence; their reply frequently contained the phrase, "we never see each other at work." (Lortie in Etzionni, 1969:27).

Such a system is not only non-supportive of new teachers but also hinders the adoption of new behaviour patterns. In a changing system teachers need reinforcement from their contemporary colleagues and not reliance on role models that they may have encountered under a more traditional nursing education system.

Nurse educators, then, face some dilemmas in their roles as professional socializers. One such quandry is the indeterminancy of comparative reference groups; others are the problems of role definition and lack of preparation for socialization tasks. The recent changes in the structure and emphasis of basic nursing education have deemphasized the traditional socializing patterns that were prevalent in nursing such as the heavy reliance on ritual and symbols, the isolating factors of residence-life and an education system separate from the mainstream of general education, and the continual requirement of exchanging service for education that resulted in prolonged periods of contact with clients and graduate nurses. These changes have resulted in a change in the nurse educator's role as a professional socializer as he or she has become a dominant force in the student nurse's life. Is it not time to assist nurse educators to become more aware of their roles as professional exemplaires for nurse aspirants?

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THE CONTRACT AND NURSING PRACTICE

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The contract is a dynamic tool that can be utilized to determine the limits of a relationship between the participants. In this paper, the two participants are designated as follows: (1) the nurse — the one offering to help and (2) the patient or family — the one asking for help. If the contract is used appropriately and both participants clearly understand its terms, then it becomes an effective tool because it encourages joint participation.

The helping relationship has the distinct feature of being a dynamic interaction between two or more participants. It is not a product of circumstances or a mechanical registration of impressions by the participants. It is a shared process, once initiated, that has a cumulative effect with each additional interaction. In order for the nurse to interact with patients, a process must occur. Faith in the nursing process without constant examination is dangerous. We have seen how much of our present perplexity and confusion in nursing practice develops from rigidity of approaches. Tempered by experience and reflection, I am, above all, desirous of making better sense of our approach to nursing practice, of taking on new approaches which either modify, substantiate the old or introduce the new. To act and institute are of little use, unless we clearly understand why we should do so.

This article attempts to stimulate interest in examining the tool of the contract. The goal is its use by nurses in a variety of settings. To do so seems appropriate in the light of critical assessment of the differing needs of the consumer of nursing. Although people have differing ideas, there is growing evidence in our society that the consumer of health services is more selective as to how and by whom his personal health services are to be provided. The contract permits the patient to exercise his right to choice and self-determination. When the patient decides to use an agency for help and care, he is exercising this right. This is also the real beginning of the contract. It is a conscious agreement on the part of the patient to work in a proposed manner towards a goal. Menninger (1964) suggests the contract should spell out carefully and clearly the goals of patient and practitioner as well as clarify the circumstances of participation.

If this contract is to be an effective tool, how is it to be used? And what are the benefits to nurse and to patient? Additional questions that must be posed to assess the merits of the contract are:

(1) What is actually being contracted?
(2) Who is the patient?
(3) What are the goals?
(4) Does the patient clearly understand the goals?
(5) What is the time length of the contract?
(6) Can the goals be reached in the determined time length?
(7) Has the contract been so established that this can be done?
(8) What is the intent of the helping relationship?
(9) Can the nurse cope with rejection or withdrawal on the part of the patient?

This writer believes the contract has potential merit as a continuing integral part of the helping relationship as practiced by nurses. Other professional workers have found it worthy of consideration in their practice (Maluccio and Marlow, 1974:28).

DEFINING THE CONTRACT

The *Oxford Dictionary* defines contract as an agreement between parties or as a accepted promise to do or forbear. Therefore, a contract is a promise or a group of promises, recognized as a responsibility of both participants. It is really a partnership established to deal with a situation that needs consideration, such as the urgent concerns and responsibilities of both participants.

The nursing contract is an agreement that is verbal or written, simple or in detail, formal or informal. It is between the nursing team or its representative and the individual patient or family. Contracts may be informal agreement between a community nurse and a volunteer committee that sponsors special services for children. Contracts may be very specific. The following are specific examples of use of the contract:

(1) to establish a trust relationship to help the patient work on his identified problems
(2) to establish performance requirements by the patient in carrying out activities of daily living
(3) to establish reasonable conduct of behavior
(4) to establish goals for the patient's care
(5) to participate in the established goals
(6) to assess progress in the patient's care on a continuous basis.

Lack of understanding about the contract and its application to nursing practice are factors that need clarification for effective implementation. While the use of the contract has been gaining acceptance in psychiatric and community nursing (Mayers, 1972:232), it is in the beginning stage of use in other areas of nursing. It is this writer's belief that it can be used effectively in all areas of nursing.

A nurse-patient dialogue occurs when the two participants meet in any setting to discuss the concerns and care of the patient. By so doing, an opportunity is provided for the nurse to negotiate with the patient as to the responsibilities of both to achieve satisfactory care. As their mutual goals are determined and the purposes of their association are clarified, a significant component of the contract is established.

One of the first requirements of the contract is to ask the patient his perception of the purpose for the interview. Unless this is done, interviews can terminate without the participant's ever understanding what the interview is all about. There must also be agreement as to the purpose and the ending of these interviews. The use of jargon should be shunned as clarity of terms avoids confusion and permits a better opportunity to carry out the contract (Evans, 1971:114).

COMPONENTS OF THE CONTRACT

Consideration must now be directed to the components of the contract. In this writer's opinion, eight aspects of the contract merit consideration. Some samples of contracts are first given whereby the where and when of the interviews as well as other limits are established (Parsons, 1972:19). The contract should be recorded on the patient 's chart or record. It must be simplistic and clearly spelled out for both participants and recorded in this manner:

> Arranged contract with patient. It was mutually agreed to meet on Monday, Wednesday and Friday at 11:30 a.m. for one-half hour for six weeks to discuss the patient's concerns. Stipulated that contract required the verbal participation of both participants.
>
> Patient agreed to meet at 9 a.m. daily for fifteen minutes for one week to discuss his increasing responsibilities for his self care (activities of daily living). Two members of the nursing team will alternate this responsibility and arrange to meet with him at this time.
>
> Mother agreed that nursing visits in the home should be made every two weeks for one hour for three months to discuss her difficulties with her hyperactive child. This will permit the mother opportunity to implement the discussed goals as well as a chance to increase her confidence.

FREQUENCY, LENGTH AND PLACE OF THE INTERVIEW

Concern about the frequency, length and place of the interview is often expressed in the beginning stages of the helping relationship. Leaving the patient with unresolved conflicts results in many feel-

ings in both participants. The contract allows the nurse to arrange with the patient the details of the interviews so that future interviews can be directed to the resolution of these conflicts. The patient is reminded of the time limitation about ten minutes before the conclusion of the interview to permit preparation for ending the interview (Burgess and Lazare, 1973:14).

There is a wide range of need for the frequency of interviews from acute care to long-term care. In the acute situation, it is suggested interviews may be required several times daily. As the patient improves, the interviews can then be scheduled daily or less frequently. In the crisis situations in the community setting, it is suggested interviews may be required daily, every other day or twice weekly. As the crisis recedes, interviews can then be scheduled weekly or bi-monthly. For the long-term situation, weekly, bi-monthly or monthly interviews would be the appropriate frequency.

The length of the interview must be determined by the ability of the patient and nurse to be comfortable in this face-to-face interview. For example, in the long-term situation, an hour is usually appropriate. For the acute or crisis situation, varying lengths are appropriate. The range can be from fifteen minutes to one hour.

The place can be in the setting of a hospital, an office, clinic or a home. With the exception of psychiatric nursing (Davis and Woodcock, 1971:26), there is limited documented evidence of use in the hospital setting. Bowden has demonstrated the contractual approach in the care of severely burned patients (Bowden, 1972:67).

In the office or clinic setting, the nurse uses the appointment method but a stated time period is rarely included. The home visit, as used by the community nurse, lends itself to be determined on a contractual basis. The community nurse usually asks families to make return home visits but rarely arranges the return visit on an appointment basis for a stated time period.

PARTICIPATION

The concept of the contract focuses on the joint participation of patient and nurse (Maluccio and Marlow, 1974:31). The contract encourages the patient to be an active participant rather than to assume the nurse will "do for him". The right of the individual, as previously stated, to determine and participant in his own health care needs clearly has significance in participation.

MUTUALITY OF AGREEMENT

Agreement between the nurse and patient is required regarding the basis and direction of their interaction. This implies that goals

and tasks must be determined for the direction and dimension of the helping relationship (Maluccio and Marlow, 1974:30). The experience of mutuality is a critical element in learning to trust. Trust is an important component of the helping relationship.

ACCOUNTABILITY

The participants have a responsibility to each other to try to achieve the mutually determined goals. The contract does make them aware of their promises (Maluccio and Marlow, 1974:32). The accountability of the patient must be assessed and discussed. Failure to do so could be a factor in withdrawal from the interviews. The decreased responsiveness of the patient helps the nurse recognize this withdrawal and to negotiate or institute more effective nursing measures within the terms of the contract.

FLEXIBILITY

For the tool to be dynamic, flexibility in the use of the contract must be possible. To protect against rigidity, there should be opportunities to renegotiate so that the present contract can be altered if indicated (Maluccio and Marlow, 1974:34). Conversely, too much flexibility could sabotage the contract and provide opportunities for withdrawal. A reasonable flexibility must be established by the participants. Short-term contracts that can be renegotiated are probably the best way to handle this situation.

COLLABORATION WITH THE TEAM

The most important function of the team is to provide and maintain an atmosphere which encourages the initiation and development of contracts. The team shares equally in the terms of the agreement. For the beginning and any later negotiations the participants should consider the goals still to be achieved (Davis and Woodcock 1971:26). Frequent assessment should be done and shared with other members of the term who are involved in the patient's care. Meaningful collaboration can be an advantage to the nurse in her contractual relationship.

BENEFITS TO THE NURSE

By helping the patient cope and participate in aspects of his care, the nurse will gain from the use of the contractual approach. Instituting a contract with the patient helps both participants to establish possible short-termg oals. This will enable both participants to reduce their anxiety and to develop trust. An approach that is consistent will lessen concerns for the outcomes of nursing intervention (Bowden, 1972:71).

APPLICATION IN NURSING PRACTICE

There is limited documented evidence of the application of this tool and its relevancy. Davis and Woodcock state that it is "one way of working with the patient according to his frame of reference" (Davis and Woodcock, 1971:27).

This writer has had six years of experience with nursing students using the contract in their clinical practice assignments. The fourth-year baccalaureate students arrange all of their interviews by contract with their psychiatric patients in either the hospital, clinic or community setting. At the first meeting, the contract is spelled out explicitly. The student and client determine frequency, length and place of meeting. The length of the interview is often the greatest concern for the student. Fifteen minutes, a half-hour or an hour seem to be a very long time to "talk" to someone, to "help" someone and not to use "the laying on of hands." The patient is also anxious at meeting a new person and a "student". Constant faculty support is needed to help students see their own professional assets, that is therapeutic use of self, communication skills and psychotherapeutic strategies. Because students come to us in their final year from the acute care setting, their focus has been on the "doing" skills and the communication skill is often neglected in the face of many urgent life-saving measures.

Now the student is forced, by the nature of the assignment, to be therapeutic and to use communication skills. How then, does the contract improve these skills?

It sets limits for student and patient. The student can refer back to the contract or restate the contract when acting out or disruptive behaviors occur on the part of the patients. To date, we have used only verbal contracts and have found this to be appropriate for student learning experience. The following are situations when the student can use the contract to further the helping relationship:

> The patient who walks out during the interview learns the student remained until the agreed time was over and left a message for the time of next visit as stated in the contract.
>
> The patient who repeatedly asks: "Why did you come to see me?" receives the answer, "It is part of the contract that we decided upon together."
>
> The patient who absents himself from the interview is reminded by messages that the student came and will return as agreed in the contract.
>
> The patient who engages himself in another activity such as ping-pong and gives every indication of continuing the game is re-

minded of his agreement. He has agreed to participate in the interview. The student remains in the setting for the agreed time period.

The patient who leaves the setting just as the student arrives is reminded by the student of the contract. She states her intention to carry out her part of the contract.

The patient who speaks to faculty in the clinical setting about the student is reminded by the faculty of the contract.

Working on a consultant basis with five public health agencies for a three-year period, this writer has been focusing on the use of this tool for nurses who seem to be experiencing difficulties with the complex families. To date, this writer has insufficient empirical data to support its use in this area. However, some significant comments from nurses and their experiences with the contract have been received. As an example, one nurse commented, "I have had my first uninterrupted holiday in six years." Living and working in the same small town, she was delighted that one of her patients did not call her during three-week annual vacation. The nurse was amazed at this result from a patient who often telephoned weekly or even more frequently. Another nurse commented that she was constantly being interrupted at the school by a mother of three pre-school children. The nurse correctly made a nursing diagnosis of an anxious mother. She established a contract of weekly home visits for a six-week period. No further interruptions occurred in the school setting. This nurse was delighted with the changed behavior.

USE OF THE TOOL

From the depth of six years' nursing experience with the contract, this writer is convinced it is an effective tool for use in nursing practice. The contract offers another approach for nurses to use. It provides the nurse with an opportunity to rearrange and consider, to see clues, new chains of cause and effect and in the final sense, it promotes professional growth.

Although at first use, it may be rather threatening, the rewards are visible. It provides understanding of the responsibilities of both of the participants in the helping relationship. If there are difficulties in the contract as first established, then opportunity for renegotiation is possible. And, finally the contract permits the nurse to state the service which she can provide to the consumer for his care, recovery and maintenance.

This consideration of the contract is far from adequately reviewed with respect to every clinical situation and is based on this writer's

personal experience. The points raised in this consideration may seem trivial but do allow for clearer understanding of the use of this tool in nursing practice. It is this writer's personal belief that it adds another approach to the helping relationship and merits use by the nurse in her practice.

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PARENTAL EVALUATION OF A T&A FOLLOW-THROUGH PROGRAM

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The follow-through clinical experience as a vehicle through which faculty and students can meet clinical educational objectives is not a new one. The essence of the experience consists of student-client interaction before, during and following an anticipated health care intervention in which the student plays an active role. The concept of follow-through clinical experiences evolved as one answer to the diminishing acute care setting client population in the face of increased enrolments in all of the health care educational facilities. Further, the stucture of this type of clinical learning experience fosters the kinds of nursing behaviors associated with the baccalaureate nurse. It is within this contex that the Tonsillectomy and Adnoidectomy (T&A) follow-through program was planned as a component of the pediatric nursing clinical experience. The purpose of soliciting parental evaluation of the program was two-fold: to determine the value of the program to participant families; to elicit strengths and weaknesses in current course and curricular design.

It is the purpose of this paper to present the parameters of the program, parental perceptions of the competencies of the student nurse and the implications of client evaluation of student performance for curricular development.

THE PROGRAM

All patients who met the following criteria were selected from the practices of participating otolaryngologists:

— residency in the city proper, to facilitate student visiting
— admission to a pediatric acute care setting
— the surgery was booked for any of three specified days during the week, over the academic year
— the anticipated hospital stay was two nights.

While the most common procedure was the T&A, it may have been any procedure on any child which met the above criteria such as a myringotomy or septoplasty.

The program consisted of four phases. The first of these was a home visit involving the student, child and family some three or four days prior to admission to the hospital. The specific behavioral objectives of this visit centred around the establishment of rapport with the child and family and preparing both child and parents for the

hospitalization experience and post-operative home care. The second contact was made at the time of admission with specific learning objectives concerned with facilitating the admission of the child and orientating the child and parents to the hospital environment. During the third phase, the student spent the operative day with the child. The objectives focused on nursing behavior preparatory to imminent surgery, the provision of post-operative nursing care in both the recovery room and on the unit, as well as an observation experience in the operating room. Finally, a home visit was made about one week post-operatively to ascertain the recovery status of the child and to terminate the relationship.

The total number of participant families was restricted to 39, the enrolment of the class for which the experience was planned. The 41 children involved ranged in age from 2.5 to 14 years. Following one explanatory contact with the family by a faculty member, the student assumed responsibility for all subsequent phases of the experience. The theoretical premises, procedural routines and behaviors to be achieved relevant to this practicum were presented to the students prior to the first visit.

PARENTAL EVALUATION QUESTIONNAIRE

The questionnaire was sent to each of the homes from 2 to 15 weeks following the last visit. Parents did not have prior knowledge that they would be asked to fill out a questionnaire. A covering letter indicated that the anonymity of the respondent was desired, that the student's grade would not be affected by the ratings, and that the purpose of the questionnaire was the improvement of the experience for other children and their families.

The questionnaire consisted of 18 statements to be rated on a 5 point scale ranging from excellent (A) through average (C) to very poor (E). Of the 18 statements, 14 related directly to student behavior.

The statements were organized sequentially relative to the four phases of the experience but designed to elicit parental perceptions of the knowledge (5), affective skills (5) and technical competencies (4) of the student. A distinction was made between the student's ability to enact a helping relationship with the parents and with the child (7 statements relating to each).

RESULTS

Eighty percent of the questionnaires were returned. The responses were heavily skewed to the excellent (A) rating, with a response mean of 75.9% across the fourteen items falling in that category.

Hence, the perception of excellence was used to assess relative strengths of student competencies in relation to cognitive, affective and technical abilities; skills relating to helping behaviors directed towards parents and towards the child; the four phases of the experience.

The percentage of parents who rated student performance as excellent on the cognitive, affective and technical competencies was 71.10%, 78.52% and 78.70% respectively.

On the parent/child dimension, the percentage of respondents rating student behavior as excellent relative to helping behavior directed towards parents was 75.66%, and the child, 76.18%.

A comparative summary of the perceptions as excellent of the competencies on each of the parent/child dimensions is presented below.

PERCENTAGE OF PARENTS PERCEIVING STUDENT BEHAVIOR AS EXCELLENT RELATIVE TO DIRECTION AND KINDS OF SKILLS

	Cognitive	Affective	Technical
Directed towards parents	71.29	81.48	81.48
Directed towards child	70.37	76.54	77.77

The parents' rating of excellence in terms of student helpfulness during the four phases of the experience is shown below. Further, the mean percentage for parental ratings of excellence on those student activities which occurred in the hospital was 73.28% as opposed to 78.51% for those which occurred in the home.

PERCENTAGE OF PARENTS PERCEIVING STUDENT BEHAVIOR AS EXCELLENT RELATIVE TO EACH OF FOUR CONTACTS

Pre-operative (home)	Pre-operative (hospital)	Operative day	Post-operative (home)
75.55	68.79	77.77	81.48

DISCUSSION

The questionnaire elicited some interesting directions in the parents' perceptions of student helpfulness throughout the planned hospitalization of their children. More parents rated students as high in their technical skills and supportive role than in their knowledge base as expressed through the teaching function. Parents perceived that students were of greater help to them than to their children. This help was greatest in the home setting and least during the admission of the child to the hospital. With the exception of the admission phase, the parents saw the students as increasingly helpful as the experience progressed.

While parental ratings of the students are necessarily influenced by uncontrolled variables, the direction of their perceptions raises

some interesting questions about the experiential emphasis within the curriculum, the inter-relatedness of facets of the students' learning and the resultant relative student competencies in nursing behaviors.

In terms of curricular and course design, the discrepancy between perceived helpfulness at home and in the hospitals may well reflect greater experiental focus in home care. More specifically, it may reflect the fact that the admission of this child is the student's first experience in the T&A unit. Or, it may reflect the parents' greater sense of control and comfort in the home. That is the admission procedure, as the irrevocable commitment of the child to surgery, may be the most stressful phase of the experience for the parents, student or both.

In a course that is ostensibly child-centred, it was interesting that parents felt students offered more to them than to their children. This perception begs a number of questions because it speaks to a fundamental philosophy of child nursing. Does it reflect curricular stress on adult-centred nursing or perhaps, family-oriented nursing? Could it be an expression by the respondent of a greater awareness of his own needs as a parent, or, perhaps an unwillingness to acknowledge skills in another perceived as a travesty on the parental role?

Parents rated more students as excellent in technical competencies than in cognitive competencies. Those of us who teach in baccalaureate education are apt to be surprised. Statements such as: "The student knew what to do for my child," relative to the operative day, were categorized as technical. "The student could answer my questions," typifies the statements relevant to cognition. These statements subsumed a teaching function. Hence, the lower rating on cognition may reflect a greater deficit in the teaching role than in cognition *per se*. On the other hand, it may reflect congruence between the student's and parent's understanding of the surgical procedures and hospital routines but a greater capacity for the student to act in that context.

There is an omnipresent need for evaluation of educational experiences designed to prepare students to meet client needs in their nursing practice. Client evaluation of services provided is a sorely neglected source of data on the relevance of our educational goals to the needs of the public and the effectiveness of the curricular designs we use to achieve these. It offers a dimension to the evaluative process which can augment those tools commonly used to assess the achievement of educational goals. The instrument described needs considerable revision if it is to answer more questions than it raises. It represents a beginning effort to tap yet another credible source about the validity of our efforts as educators.

PRACTISING TEACHERS: A MEANS OF LESSENING THE COGNITIVE DISSONANCE OF THE NEOPHYTE NURSE

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New graduates of nursing suffer cognitive dissonance in the work situation. Much has been written about the conflict which develops in the neophyte nurse when she is employed to give nursing care according to the dictates of the hiring institution, rather than the idealistic nursing care she was taught to give. Kramer has studied this phenomenon extensively and reported the findings in her book *Reality Shock* (1974). A question comes immediately to mind: why are these two kinds of nursing care so disparate?

One of the leading theories is that the goal system in health care institutions favours a bureaucratic structure. (Dilworth, 1963; Georgopolis, 1966). Bureaucratic organizations tend to favor a rigid rule system. Statements made by the diarists in Kramer's study (1974:32) validate the bureaucratic vs. professional value system conflicts in the neophyte nurse. One would hope that a problem area so well documented for such a long time would have reached some degree of resolution. Perhaps all facets of the problem area have not been thoroughly explored.

The influence of the teacher of nurses is an example of a factor which might contribute to the non-resolution of the bureaucratic vs. professional conflict. It is doubtful that any teacher of nursing entered a school of nursing with the specific intent of becoming a teacher. Were they "pushed" or "pulled" into graduate school because of their own cognitive dissonance regarding the care they were allowed to give? Do they find it more pleasant to avoid the shift work, rigid hours and low salaries imposed by institutions? Whatever the reasons which guided them into the university setting, those reasons are now an integral part of their value system and are likely to be evident in their behavior as teachers. When nurses become involved in the education of students, what are they, nurses or teachers? To whom does their chief concern belong, the student or the patient? Do they attempt to improve their expertise in teaching or in nursing? These questions are of critical importance, particularly to those who teach clinical nursing. They reflect the role conflict inherent in the teaching and supervision of students in the clinical area not only to the teacher but to the student and nursing service personnel as well.

Nursing is many things, including the utilization of cognitive, affective, and connative skills for the promotion and maintenance of health. Expertise in the performance of these skills requires practice. It is highly possible that students and service personnel wonder whether teachers are capable of performing those skills which are part of the practice of nursing. The credibility of nursing teachers must be in doubt as the years without practice begin to mount.

Nursing has attempted to insure teacher credibility primarily in two ways. One method is to appoint teaching faculty jointly with the service agency so that responsibility for patient care and for student education is vested in the same person (Dilworth, 1963:50). This is the method used in medical education and it deserves consideration for nursing education. The fact that this potential solution has been around for a long time and is not widely used makes one wonder if the basic philosophy of teaching institutions and service institutions is such that this method is untenable. The second approach receiving wide acceptance is the appointment to teaching positions only to persons who have had a specified period of clinical experience. This requirement assures an experienced clinician as a beginning teacher, but what happens to the clinical expertise over her tenure as a teacher? With each successive year of teaching without practice, the credibility gap widens.

Kramer describes an experimental teaching strategy utilizing an instructor-model (1972:65). Role-modelling as a teaching method can take a variety of forms ranging from joint appointments to specialized teaching units in which faculty actually participate in patient care.

A slightly different approach has been tried by some faculty members at The University of Western Ontario. Arrangements have been made between the Dean of Nursing and the administrative heads of various service agencies for faculty to practice nursing in their area of clinical specialty. The times available for faculty are usually during the summer. Faculty are not freed from university commitments during this time, nor are they reimbursed by the institution in which they work. Not all faculty participate in this program. The number of days, hours, length of time and type of patient assignment is arranged by the individual faculty member. The benefits of these endeavors are as varied as the individual faculty members, but some commonalities can be identified:

(1) the teacher is more comfortable in her nursing practice
(2) the teacher is accepted as a "nurse" by the service personnel

(3) teachers are no longer considered outsiders and students are more likely to become "our" students instead of "your" students

(4) teachers are once again compelled to consider the bureaucratic vs. professional value system.

Williamson states that faculty are responsible for socializing students and that their ability to do so is dependent on their own values and norms (1972:364). With time available for faculty to practice in an institutional setting, perhaps more teachers will be able to resolve their own bureaucratic-professional conflict. A better understanding of the problems encountered in a health care facility should help the teacher to prepare the student for he reality of the wark world.

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LEARNING NEEDS OF THE CARDIAC PATIENT BEING DISCHARGED FROM HOSPITAL AS SEEN BY THE PATIENT, HIS DOCTOR, AND HIS NURSE

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For many members of the health team, the following incidents will be familiar: a patient with angina is discharged from hospital with the instructions to "take it easy"; a man with a peptic ulcer receives his diet sheet a few minutes before leaving hospital. On the premise that a common factor in these situations is the lack of communication among the patient, doctor, and nurse, this study was undertaken to identify the learning needs of the patient being discharged from hospital as perceived by each of these three persons. "Learning need" was defined as

> . . . the identification or expression of the difference between what the learner knows, how he feels and what he can do at the present time, and what he should learn in order to progress toward individually desirable and attainable health goals. (Wallace, 1960:8).

A review of the literature would seem to indicate that teaching patients in preparation for their discharge from hospital is beneficial (Cole and Emmanuel, 1971:959; Boyek, 1972-42; Royle, 1973:25) but that there is a lack of such teaching (Monteiro, 1964:29; Redman, 1972:10; Palm, 1971:678). Part of the problem would appear to lie in the communication about the patient's learning needs and in the opinions about who should meet these needs (Redman, 1972:10; Nordwich, 1970:124-125).

The Study

The sample consisted of the first ten cardiac patients who, after a given day, were admitted to a general medical ward, either directly or from the coronary care unit. Their primary problem was one or any number of the following: angina, myocardial infarction, congestive heart failure and valve stenosis or insufficiency. All of the patients were discharged to their homes. There were four females and six males with ages ranging from 31-75 years. Length of hospitalization varied from three to thirty days.

Open-ended questionnaires were completed by the patient, his doctor and his nurse at the point of discharge. On the fifth day at

home, each patient completed a second brief questionnaire. These were returned by mail to the investigator. All questionnaires were completed by the interns and nurses. Seven of the ten patients filled in the first questionnaire, and eight of the ten patients returned the second one.

Findings

Several of the significant findings were:

1. With one exception, agreement among doctors', nurses' and patients' responses about the patient's learning needs never exceeded 50 per cent.
2. One of the five problems encountered by patients at home had been listed by a doctor and one by a nurse as being an area in which teaching was required.
3. Two of seven patients reported unmet needs for information at discharge. Each of two more patients had one unanswered question within the first five days at home.
4. For seven patients, doctors identified twenty-three areas and nurses listed sixteen areas in which teaching was required. These seven patients perceived teaching as having been done in eleven areas.
5. Of the five nurses responding to the question, all five saw the nurse as teaching. Five out of ten doctors saw her as being involved in this.
6. One out of seven patients perceived the nurse as having taught him.

Conclusions

Because of an unavoidable delay in initiating the study, several problems were encountered during the data collection phase which had to be carried out during the Christmas holiday season. This, coupled with the limited numbers of questionnaires which were returned, makes any conclusions very tentative.

1. The amount of agreement among the patients', doctors' and nurses' responses about the patient's learning needs seems rather low, indicating some lack of communication in this area.
2. The fact that four out of seven patients had unmet needs for information tentatively suggests a need for a more thorough assessment.
3. It appears that patients see their doctors as teachers much more frequently than their nurses. Is this due to the content provided by nurses, the way in which it is provided, or the expectation of the patient concerning the nurse's role?

4. Nurses seem to see themselves as teachers to a greater extent than do doctors.

Recommendations.

Several recommendations were made on the basis of the findings and conclusions.

1. A need for more communication between nurses and doctors with regard to their patients' learning needs at discharge might be partially met if discharge orders were more frequently completed at least one day before the patient goes home. The doctor and nurse might record, on a special form in the chart, the teaching that has been done and perhaps any which remains to be done.
2. The possibility of having a number at the hospital which the patient could call during the first days at home might be studied.
3. Health education departments might be established within hospitals and programs set up for teaching patients in the first weeks after discharge from hospital.
4. Improved communication between medical and nursing staff about content to be taught to patients and responsibility for this teaching might be facilitated by increasing the emphasis on this in shared undergraduate medical and nursing education. Joint discussion among health team members in the clinical setting with regard to the learning needs of individual patients, and who is to meet them, would seem desirable.

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