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PERSPECTIVES EN NURSING

Special Issue on Curricular Ideas

Numéro Spécial: Les bases de programme

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Volume 7, Number 4 — Moyra Allen, *Editor*
Winter 1975-76 — Vivian Geeza, *Managing Editor*

Nursing Papers/Perspectives en Nursing 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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NURSING PAPERS/PERSPECTIVES EN NURSING
Volume 7, Numéro 4 — Moyra Allen, *rédacteur en chef*
Hiver 1975-76 — Vivian Geeza, *directeur*

La revue *Nursing Papers/Perspectives en Nursing* est publiée 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 nous intéressons plus particulièrement aux articles faisant état de problèmes, qui soulèvent des questions ou qui soumettrent des idées et des programmes d'action en recherche, éducation, administration et pratique.

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EDITORIAL

In preparing for this special issue, we invited the twenty-two university schools of nursing to describe the philosophical and theoretical basis for their curricula. With the seven papers that follow, we are dealing with approximately one-third of the schools in Canada. There are similarities in these papers, both in what the schools chose to write about and in the nature of the content they included. However, there are also differences and undoubtedly, one has some idea in studying the seven that there are varying degrees of wholeness and logic in the presentations. One might say, using the criteria of our

Committee on Accreditation of the Canadian Association of University Schools of Nursing, that there are differences in the extent to which these papers reflect the criteria of *relevance, relatedness, accountability* and *uniqueness.* However, the most critical criterion here from the viewpoint of clarity of meaning and the reader's comprehension is that of *relatedness,* the extent to which the parts of the paper relate to each other or fit together for a common purpose or goal.

During the coming year there is opportunity for classes in teaching and curriculum as well as faculty to analyze these first position papers and to respond to them in *Nursing Papers.* We hope that other schools will study these statements and then provide a second series of position papers on the theoretical basis of their curricula for an issue of *Nursing Papers* in 1977.

We noticed recently that *Nursing Research,* that long-established journal published by the AJN, launched a question and answer column in September-October 1975 called "Research Q and A". I wonder if they are experiencing the same difficulty we do with ours? Since launching the "Query and Theory" column in Spring, 1974 we have received over a hundred offers of assistance in replying, but only a half-dozen questions. We have all kinds of faculty members who have the answers, the *Theory* side, but no faculty to ask questions, the Query side. Yes, forever, NURSES!

—*Moyra Allen*

EDITORIAL

En vue de ce numéro spécial, nous avons invité les vingt-deux écoles universitaires de nursing à nous décrire l'aspect philosophique et théorique de leurs programmes. Les sept articles qui suivent représentent environ un tiers des écoles du Canada. Certaines similitudes apparaissent dans ces articles, en ce qui concerne leur contenu et l'objet de ce contenu. Néanmoins, on y trouve aussi quelques différences et il est indubitable pour quiconque étudie ces sept articles que la logique et l'intégrité de chacun diffèrent à des degrés divers. On pourrait même dire, en reprenant les critères de notre comité d'accréditation de l'Association canadienne des écoles universitaires de nursing que ces articles diffèrent quant aux critères de *pertinence, connexité, responsabilité* et *unicité.* Toutefois, le critère essentiel ici, du point de vue de la clarté du sens et pour la compréhension du lecteur, est celui de la connexité des idées, c'est dire la façon dont s'agencent les différentes parties du texte dans un objectif commun.

Au cours de l'année à venir, professeurs, étudiants et éducateurs auront la possibilité d'analyser ces premiers articles et de leur répondre dans Nursing Papers/*Perspectives en Nursing*. Nous espérons que d'autres écoles étudieront ces critiques et nous fourniront une deuxième série d'articles de fond sur les aspects théoriques de leurs programmes, articles qui seront publiés dans *Perspectives en Nursing* en 1977.

Nous avons remarqué, il y a peu de temps, que *Nursing Research,* journal établi de longue date et publié par l'AJN, a lancé une rubrique de questions/réponses "Research Q and A" dans son numéro de septembre-octobre 1975. Je me demande si cette publication rencontre les mêmes difficultés que nous. Depuis le lancement de notre rubrique *Query and Theory* au printemps 1974, nous avons reçu plus de cent offres de réponses; contre une demi-douzaine de questions seulement. Tous les membres de notre corps enseignant peuvent nous fournir les réponses, le côté *Théorie,* mais nous n'avons personne pour poser des questions, le côté "on veut savoir". INFIRMIERS, INFIRMIERES, remuez votre matière grise!

— *Moyra Allen*

LETTER

To the Editor:

The article by Lindstrom (1975), "Holistic Nursing: A Basis for Curriculum" prompts several major concerns. These concerns, in turn, suggest some of the recurring dilemmas of nursing and nursing education.

Attridge (1974), in discussing the bandwagon approach to behavioral objectives, notes "It is typical of nursing education, and indeed a very human characteristic, that when we find a valuable and useful idea, approach or tool, we overuse it. We seem to suspend critical judgment; we try to make it fit every circumstance or make every circumstance fit it. No where is this so evident as in curriculum planning in schools of nursing". Is the current use of "conceptual frameworks" another illustration of this approach, with a framework developed for one nursing programme being 'made to fit' another programme without due thought as to whether it is consistent with the philosophy and objectives of the latter? The assertions that "the theory of holistic nursing provides a philosophy of nursing which can be easily carried from the beginning of the course to the end" prompted this question. Surely a philosophy of nursing, explicit or

implicit, guided the selection of Levine's conservation principles as the basis or framework for the curriculum rather than the reverse.

A closely related concern can be expressed in the question of whether, in the current enthusiasm for adopting conceptual frameworks, sufficient groundwork is being done. Are the basic sources ever consulted or do we adapt an adaptation of a theory or model relying only on secondary sources and interpretations? Since the theories used as the basis for developing conceptual frameworks for nursing curricula have been developed in other disciplines and for other purposes, it seems that it would be helpful to study the basic sources rather than adaptations of those sources. In relation to groundwork, the definition and understanding of the basic concepts of the model is critical (Reidy, 1975). Even more crucial is agreed upon definition and differentiation of terms such as concept, principle, conceptual framework and theory.

Nora Parker
Professor
University of Toronto
Faculty of Nursing.

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A PROCESS OF CURRICULUM ANALYSIS

JOAN CROOK*
Associate Professor, School of Nursing
McMaster University

The changing needs of society for nursing personnel, an enlarging student body, and the establishment of a medical school at McMaster University led the faculty of the School of Nursing to critically review the curriculum design of the undergraduate nursing programme. While major changes were initiated in 1971, the process of curriculum analysis and change continues today. From the time that the process of curriculum change began, the structure within which the programme operates has become more complex. Changes have occurred in the university's administrative organization; a Faculty of Health Sciences has been established which encompasses both medicine and nursing; two new educational programmes have been established, in which nurse faculty members have major roles: and there have been a number of changes in the faculty complement that has the major responsibility for the B.Sc.N. programme. This changing group of faculty has continued to meet the challenge. The reader can appreciate the spirit of the programme if he/she accepts modification and change as the only constant; a standard of excellence as the major goal.

There were four major areas that required an organizational structure to support a dynamic, changing curriculum. Task Groups composed of nursing faculty, other health science faculty, students, clinical service personnel, and research associates were established to perform the following functions:

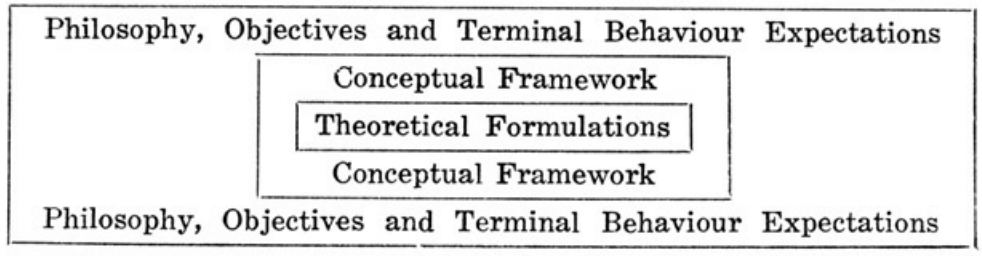
1) Curriculum monitoring — Programme Task Group
2) Resource allocation — Resources Task Group
3) Long-term planning — Goals Task Group
4) Monitoring of standards — Evaluation Task Group

These task groups report to the policy-making body of the programme, the Undergraduate Nursing Education Committee. Recommendations and educational issues or concerns are then carried to the Health Science Education Committee.

One of the assumptions has been, and continues to be, that a well-designed curriculum is necessary if students are to develop the

*The author was assisted in the writing of the paper by members of the Goals Task Group and Operations Group.

Figure 1: Model From National League for Nursing



variety of professional skills required for creative nursing practice. It has fallen to the Goals Task Group to analyse the conceptual framework that gives structure to the curriculum and reflects the educational goals. The National League for Nursing model in Figure 1 has provided a framework within which to critique and analyse the curriculum(1).

PHILOSOPHY

The philosophy of the undergraduate programme and statements on the goals and purposes of the university and the Faculty of Health Sciences were examined to extrapolate congruent and conflicting beliefs. This examination was used to promote dialogue amongst faculty and also provided the impetus to the Health Sciences Education Committee to work toward developing a more formal statement of a philosophy for Health Sciences that would reflect the interface relationships among health sciences educational programmes.

Issues from the critical analysis of the stated philosophy included:

1. Should we be providing students with more educational, service and research opportunities that promote the development of collaborative relationships with other professionals? It is obvious that an individual programme cannot meet this goal in isolation.

2. Does the philosophy articulate an active response to the new directions of health care delivery suggested by recently published government reports, such as the Boudreau (2), Mustard (3), and Lalonde (4) Reports? The implications of these reports regarding regionalization, environment, human biology, life style, primary care, and expanded role skills should be reflected in a curriculum designed to prepare nurses to function in a changing society.

TERMINAL OBJECTIVES

A programme needs a clear view of an end product or goal. An analysis of the ten terminal objectives of our programme was undertaken to determine whether they reflect the desired characteristics

of a B.Sc.N. graduate. In summary, it was agreed that the programme aims to graduate a nurse who

- recognizes that learning is a life-long process for which the individual has primary responsibility;
- consistently uses a problem-solving process when faced with professional nursing problems, i.e. has an analytical "research mindedness" rather than a prescriptive approach to patient problems; and
- possesses human relationships and technical skills necessary to practice effectively and competently (5).

Examination of the stated programme objectives raised the following questions:

1. How are these objectives operationalized within the curriculum?
2. Are they congruent with our present beliefs and practice?
3. Do they reflect the present and future needs of the health care system?

CONCEPTS AND THEORIES

The faculty made certain assumptions when examining the conceptual framework of the curriculum:

1. Integration occurs within the mind of each student. A curriculum can help the process through the selection and organization of concepts, theories, content, courses, and learning experiences.

2. Nursing has a unique body of knowledge and function, but this body of knowledge is interdependent with, enhanced and influenced by other resources. We, therefore, take an eclectic approach to the use of theoretical formulations to explain and predict human behaviour and nursing practice. These formulations derive from the arts, biological, behavioural and nursing sciences.

3. Faculty function to facilitate students' independent learning through encouraging open-ended exploratory use of knowledge and skills, and exposing students to real and simulated situations in which the knowledge and skills can be used. Problem-based learning is fostered.

4. An identification and understanding of the issues that are presently facing us as nurses and educators is a necessary prerequisite for directing actions toward constructive solutions. This implies exploring our "sacred cows", questioning previously unquestioned assumptions.

5. It is important to re-examine the often ambiguous meanings and applications which are given to such terms as nursing process, concepts and theories.

Figure 2

Major concepts	Subconcepts	Theoretical Formulations
Health	Health-illness continuum Health maintenance Health promotion	Systems theory Adaptation theory Stress theory
Nursing	Nurse-patient relationship Health team Nursing team leadership	Communication theory Nurse patient relationship theory Role theory
Man	Bio-psycho-social-sexual being Growth and development	Systems theory Need theory Developmental theory
Society	Family Community Nation	Health Care delivery system Epidemiological theory
Teaching-Learning	Self-directed learning Self-evaluation Change	Change theory Group theory Problem-solving methodology

Using the model for curriculum analysis, the Goals Task Group compiled the major concepts over the four years. The sub-concepts compiled were numerous, as were the theoretical formulations. A sample of the application of the model is tabulated in Figure 2.

The group had difficulty identifying and extrapolating the development of the sub-concepts vertically in any one year and horizontally throughout the four years. The reasons for this difficulty are most likely obvious to anyone in education. For example, while a curriculum has both a structure and process, it is not a static entity. New faculty bring new ideas and interpretations to a curriculum design and internal and external influences and pressures require response and plans for modification.

The effort, nevertheless, raised several issues that faculty and students must appraise:

- Semantic ambiguities regarding the terms faculty use;
- The anxiety and confusion for both faculty and students regarding the different theoretical approaches used in the identification and solution of nursing problems; and
- The level of competency in ambulatory and expanded role skills expected of graduates.

Faculty now face the issue of attempting to strike a balance between the ambulatory and expanded role skills and the acute "critical care" skills necessary for competent practice in the variety of settings in which graduates function.

While the Goals Task Group has been giving direction to faculty and students in the examination of the curriculum, other faculty/student groups and individuals have been focusing on other issues and tasks, including:

- Preparing a follow-up study of graduates and their employers to evaluate the effectiveness of the programme and to assess its relevance to community and professional needs;
- Exploring ways of providing more opportunity for students to enroll part-time or achieve advanced standing;
- Looking towards developing a general admission policy for all Health Science programmes;
- Joining with a number of science and medical departments in an examination of the basic science component of the curriculum;
- Participating in the development and administration of a series of workshops for the Faculty of Health Sciences on teaching methods and orientation;
- Completing a comparative study of the effectiveness of different teaching methods; and
- Working with the Faculty in the School of Medicine on the expansion of interprofessional learning opportunities.

Other tasks will be generated within the programme as new needs are perceived, and in response to changes within the health care system. Others will occur because of the position of the School within the Faculty of Health Sciences. It is acknowledged that changes should be preceded by a rigorous, intellectual re-evaluation of where we are and where we have been.

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Faculty Positions

Dalhousie University

1. Professor or Associate Professor of Nursing to coordinate the Master's Program in association with the Director of the School. It is expected that the candidate would have completed a doctorate, and have had clinical, nursing education and research experience. The appointment includes teaching in the graduate and undergraduate programs, and provides opportunity for research.

2. Because a number of our faculty will be leaving to pursue further education at the end of this academic year, there wil be positions available for qualified faculty. We are especially interested in candidates with preparation in **mental health and psychiatric nursing,** and in **community health nursing.**

Interesting developments for the future make Dalhousie School of Nursing a challenging place in which to contribute to nursing education and to further one's own professional goals.

— New and modern quarters for the School are planned.

— Our masters program is now in its first year.

— Some research projects are getting underway and Dr. Margaret Scott Wright from Edinburgh, well known in Canada and internationally, will be our new Director.

Applications, with curriculum vitae, should be sent to Muriel E. Small, Director, School of Nursing, Dalhousie University.

"Pouvez-vous décrire la nature des différentes théories qui sous-tendent votre curriculum?

JEANNE REYNOLDS
Doyen de la Faculté de Nursing
Université de Montréal

Cette question de fond pose le problème du mode d'évolution de nos programmes d'études, tout comme notre conception des termes théorie, nature, modèle en nursing.

Le problème sera traité de la façon suivante: très bref rappel du début du baccalauréat à l'Institut Marguerite d'Youville, intégré à la Faculté de Nursing depuis 1967; identification de la nature des theories qui sous-tendaient le curriculum et qui le sous-tendent actuellement; utilisation d'un modèle nursing afin de mieux identifier les activités nursing pour mieux servir au sein d'un équipe multidisciplinaire.

Le progmamme du baccalauréat en nursing offert aux infirmières dès 1934, par l'Institut Marguerite d'Youville, était sous-tendu par des théories dont la nature s'enracinait dans les humanités et les sciences tant naturelles que sociales. Mais la nature même des ces théories plongeait ses racines dans une conception humano-chrétienne de l'homme, donc de sa nature et de sa destinée.

L'analyse des objectifs des cours et de leur contenu, tout comme l'ensemble des programmes offerts démontrent clairement que ce baccalauréat en nursing fut toujours sous-tendu par des théories dont la nature était nettement axée, tel qu'affirmé, sur une philosophie humano-chrétienne.

Le cours de base (1962), offert aux jeunes du secondaire (4 ans) et, aujourd'hui, à la population du CEGEP général, option sciences de la santé (3 ans), fut conçu et réalisé dans le même esprit et dans la même conception du nursing avec, en plus, l'accent marqué sur une formation scientifique plus poussée. Cette population était destinée, dans l'esprit des fondateurs, à former des infirmières de chevet (généralistes cliniciennes) plus compétentes, capables de devenir des agents de changements en vue d'améliorer la qualité des soins aux malades.

Ce programme fut et est influencé, du moins en partie, par les écrits de Virginia Henderson (1), concernant les besoins fondamentaux des malades et basés sur les principes fondamentaux des soins infirmiers.

Au niveau de la maîtrise en nursing, le curriculum est sous-tendu par les théoriciens qui rejoignent la spécialité concernée. Le cours sur les Théories et modèles en nursing permet à l'étudiant de choisir un modèle compatible avec sa conception personnelle du nursing et d'en expérimenter l'application.

Il faut reconnaître que les professeurs possédant une maîtrise ont largement contribué à développer nos programmes de spécialités, de façon à ce que ces spécialités tant dans les domaines de l'éducation, de l'administration que de la clinique, contribuent à l'amélioration des soins infirmiers et, conséquemment, à l'amélioration du niveau de santé de la population.

Un groupe de professeurs du premier cycle a élaboré, il y a quelques années, un instrument (démarche nursing) pour aider les étudiants à recueillir, de façon systématique, leurs données auprès des clients, et ceci en s'inspirant du *Nursing History* de Gainesville pour appliquer la conception de Virginia Henderson aux soins des malades. Mais, fait à noter, au même moment, les blocs de cours ainsi que les stages continuaient à être organisés autour des spécialités médicales traditionelles: pédiatrie, obstétrique, etc. Le résultat ne pouvait être autre que l'accent conservé sur le modèle médical au détriment d'un modèle nursing.

Depuis environ trois ans, une prise de conscience plus aigue de cette anomalie a permis aux professeurs d'aller de l'avant dans cette ligne de pensée qui conduira à l'implantation d'un modèle nursing et, conséquemment, à la réforme du curriculum, en accord avec le modèle choisi. Actuellement, la majorité des professeurs se rendent compte de la nécessité de l'utilisation d'un modèle nursing comme indispensable à l'apprentissage du nursing, afin de mieux identifier le rôle de l'infirmière dans un équipe multidisciplinaire. De cette façon, on peut "démontrer" que l'infirmière poursuit un but autre que celui du médecin, ou de tout autre travailleur de la santé, conçoit le client autrement que ne le fait le médecin et, forcément, assume un rôle distinct de celui du médecin (2). Procéder ainsi ne nie aucunement la nécessité d'une collaboration entière entre le corps médical et le nursing mais, au contraire, en assume la complémentarité. Conséquemment, la mission sociale de la discipline nursing serait identifiée, clarifiée et reconnue, tant par chacun des professionnels de la santé que de la clientèle servie, puisque l'interdépendance tant préconisée par les théoriciens des équipes multidisciplinaires en santé présuppose logiquement une automonie, une indépendance, une existence en soi pour chacune des disciplines de la santé.

Dans un article intitulé "Un modèle conceptuel: à quoi bon" (3) l'auteur fait clairement ressortir la différence entre modèle, philosophie et théorie. Il s'exprime ainsi:

> Un modèle est une image mentale, une invention de l'esprit, une conceptualisation, une façon de voir . . . et découle d'une théorie ou est fondé sur une théorie. Une philosophie est aussi une "façon de voir" des choses, mais elle se situe à un niveau d'abstraction plus élévé que celui du modèle . . .
> Une théorie est aussi une conceptualisation ou une invention de l'esprit; une théorie se situe cependant plus haut qu'un modèle dans l'échelle des abstractions . . .

L'auteur poursuit en nous rappelant que "ni une théorie, ni un modèle ne sont la réalité . . ." puisque "la théorie représente la substance de la réalité" tandis que "le modèle en représente la structure". L'auteur fournit ensuite les éléments essentiels qui constituent un modèle conceptuel. Et c'est à partir de chacun de ces éléments qu'il faut en arriver, avec l'utilisation d'un modèle nursing, à ce qui était dit précédemment: distinction entre le but poursuivi par l'infirmière et par le médecin, entre rôle de l'infirmière et rôle du médecin ou autres travailleurs de la santé.

Notre programme du premier cycle est actuellement en révision. Une étude sérieuse est en cours et aboutira certainement au choix d'un modèle à expérimenter, ce qui appellera de soi une réorganisation des cours et des stages.

Il semble possible, à la lumière des données qui précèdent, de conclure en affirmant qu'actuellement plusieurs théories sous-tendent notre curriculum et que la nature des ces théories est surtout d'ordre bio-psycho-social, que des efforts se poursuivent et s'intensifient en vue d'en arriver à l'utilisation d'un modèle nursing pour l'apprentissage de l'art et de la science nursing. Il nous semble désirable que l'application de ce modèle reflète et concrétise les grands principes d'ordre philosophique et scientifique sur lesquels doit reposer notre curriculum et qui révéleront à la fois notre conception de l'homme (vie et mort), de l'éducation et du nursing.

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THE B.Sc. (N) CURRICULUM AT McGILL

MARGARET HOOTON
Chairman, Curriculum Committee
Associate Professor, School of Nursing
McGill University

Curriculum study is a continuous and probably inexhaustible process, with revision occurring as new ideas emerge. Five years ago there was a major change in the curriculum of the basic programme as part of a new overall approach to education in Quebec. Since that time on-going assessment has resulted in further adaptations and refinement, but the basic propositions and theory have remained constant. This paper will describe the general framework within which the curriculum is developed, indicate the theory underlying its structure, and discuss the most salient features which are an integral part of the teaching learning process.

The faculty holds a firm conviction that a curriculum needs to be relevant and accountable to critical sectors of society in which the school is situated. The university, the profession and the wider community thus play major roles in determining the structure of the curriculum. The university influences it through a belief in a liberal education which prepares the individual with the potential for leadership. Conjointly with the school itself, and within the guidelines stipulated by the government, the university sets standards and criteria for admission of students. Within the professional context it supports an approach to learning which involves questioning, experimenting and searching for knowledge — an approach with a far broader scope than is immediately relevant to the practice of the professon. A broad approach is imperative if graduates are to respond to and influence the health of people in a society which is continually changing and which continually challenges men's ability to adapt to their environment.

To meet the health needs emerging in today's complex society a decentralized and restructured health care system is required. Equally important is the need for a redefinition and realignment of the roles of professionals within the system. The nursing graduate of the university is expected to have the skill and knowledge to actively explore the development of new health roles and to assume broader responsibility in the delivery of health care. These basic premises serve as guidelines as the faculty develops a specific curriculum framework which reflects and articulates the school's philosophy of nursing and learning.

We believe that nursing is a process which is theoretically grounded in practice. The major thrust of the curriculum has as its focus the student and her experiences with patients as well as her relationships with teachers, peers and related health team members. Consequently, the student learns how to use the processes of science in her exploration of a patient situation and in the development of a nursing response. She learns through experiences with individuals, families and groups of patients in a variety of settings in the community. While it is important with whom and where the student learns, we also feel it is critical to attend to how she studies and grows herself.

Using scientific inquiry and knowledge from the biological and social sciences, the student involves herself in assessing the health status of individuals and families and examining their health behaviour and its determinants. Implicit in this approach is the notion that the plan of care evolves from data gathered in the patient situation, and that its effectiveness is evaluated in terms of the patient's response to it. To perform in this manner the student needs to acquire observation and interactional skills as well as a personal awareness and understanding of her own values, motivations and behaviour.

Surrounding the student-patient dyad there are many complementary and supportive resource people who promote and enhance learning. Experiences with peers, teachers, nurses and other health personnel help the student learn how to utilize, relate to and collaborate with others in a mutually beneficial way.

Throughout the three years selected courses from other disciplines are sequenced so as to be relevant and related to the dimension of nursing being learned at any point in the curriculum. Within the nursing courses the student's experiences with patients and significant others are ordered to vary the nature and extent to which they interact and are interdependent. Basically this means varying the nature of the patient population. When number of individuals, age, and phase of illness are altered it follows that the student's experiences, setting and involvement with other health team members also change. The guidance implicit in the ordering of these variables assists the student in her efforts to build a body of nursing knowledge. This, then, is the context within which the teaching-learning process progresses.

FIRST YEAR

In the first year many of the essential components of learning to nurse are introduced; this means that the student has contact and experiences with patients almost as soon as she begins her studies. The teacher chooses individual patients and settings to allow the

student to attend to the patient but also to herself and others in the setting. To facilitate the use of the patient as a data source the student is helped to develop her observation and interaction skills within a nursing framework.

Initially the student views this approach with skepticism, preferring to be given "bits" of content. But gradually, in conferences, the student learns how to share her observations and feelings with peers and to ask questions of the content of the discussion. The teacher assists the student to determine the relevance of her observations and interpret them in terms of health behaviour and needs. At the same time she also helps the student to become aware of her own values and attitudes and to begin examining how they influence her own perceptions.

As the student progresses in her ability to collect data, relate to patients and value the approach to learning, the teacher chooses patients whose health problems have a more distinct medical focus. Through her experiences with these patients, the student continues to develop those skills to which she already has had exposure and adds those that promote rest, comfort, healing, and relief of pain. At this phase of her learning she is helped to examine her data in relation to the biological and social sciences so as to make a beginning health assessment. From her expanding data base the student is helped to determine what is relevant and unique to the individual as as basis for the planning of his nursing care and to attend to his responses as a means of evaluating its effectiveness. Concomitantly the teacher helps the students group their data to arrive at some ideas regarding the commonalities of patients' physiological and psychological responses and the relationship to the pattern of medical management. Simultaneously, her peers and teachers are helping each student examine what she as an individual brings to the nursing situation.

Throughout the first year the student is in a milieu which encourages her to observe and interact with other members of the health team. Initially the student observes their behaviour and learns how to approach them to acquire information. The teacher supports the student in these endeavours but helps her alter her behaviour so that she learns how to share patient information and offer suggestions for patient care. Emphasis is placed on developing a relationship with the nurses more than with other members of the team.

SECOND YEAR

During the first part of the second year the student continues to work mainly with individual patients, but involvement with other

members of the family begins to be more vital. The focus for this part of the programme is on the development of nursing knowledge as it pertains to the individual with a long-term illness. While the student is helped to develop and expand the skills she has previously used, additional skills needed to make a more comprehensive physical and mental health assessment are now included. As a result the student is able to amass considerably more data.

Through actively sharing experiences in group conferences the student is helped to examine her data in terms of behavioural change in the patient, becomes aware of the impact of illness on the individual and his family, and begins to understand the various ways this is managed. As she critically analyzes her assessment, she is helped to appreciate the complexity of the patient situation and to identify relevant and influential factors operating therein. She is encouraged to look at a number of patients to identify similarities and differences in patients' perception, responses and nursing interventions.

The plans of care which the student develops and implements are examined for comprehensiveness, relevance and effectiveness. With help from her classmates she considers alternatives in analysis and action, and experiments with strategies they have found beneficial. In these experiences the student is learning to use her interpersonal skills in a therapeutic way. Conferences must therefore be designed to help the student explore her own feelings and reactions, to help her become more aware of her own behaviour and her impact on the nurse-patient relationship.

At this point in the curriculum the focus becomes much more family- and group-oriented. Towards the end of the second year experiences are chosen with families who are in different phases of the child-bearing cycle and with families whose integrity is being threatened by the illness of a young child. The student adds to her core of nursing skills those pertinent to assessing the newborn and the growth and development of the child. Her knowledge of individual growth and development, and of phases of family development support the grounding of the information the student is gathering at this time. Through these experiences the student is helped to identify behavioural changes during the critical phases of establishing and maintaining the family unit. She is helped to expand her knowledge relative to the impact illness has on individuals and to acquire an appreciation of the part play has in the total development of the child. Moreover, through the exploration of health practices the student is helped to become aware of the influential role the family's values and beliefs have upon their behaviour.

In conferences the assessments, plans of care and outcomes are critically examined to determine their comprehensiveness, relevance and usefulness in meeting individual and family needs. Considerable time is also devoted to helping the students examine and explore their own feelings and responses because the very nature of the experience challenges many of their values and attitudes. This awareness of self in relation to others has been developed throughout the year by means of more frequent and discriminating utilization of the students' peers and other health team members. Consequently, their reliance on the teacher as a discussant, initiator and facilitator has been decreasing while their reliance on other members of the health team has been increasing. This process leads to the students becoming much more active participants in the total team.

THIRD YEAR

The third year of the programme involves the student in experiences which support an intensive study of health and illness behaviour of families and groups of patients. For the first part of the year the student functions as a primary worker within the context of the family in both home and community clinic settings. To maximize the learning opportunities and acquire a complete and comprehensive assessment of family dynamics, perceptions and health status, emphasis is placed on the refinement and extension of those skills which are an integral part of the functioning of a primary care worker.

In discussions with other nursing personnel, members of the health team and peers, the student generates from her data some general ideas regarding family health behaviour and health problems. Through her explorations, the student becomes cognizant of the intimate relationship between the individual, family and community; by means of an epidemiological approach, the teacher helps the students order their data to identify variables which are associated and which may be mutually influential in terms of health and illness behaviour. At the same time the teacher helps the student learn why, when and from whom additional assessments of the same nursing situation are needed.

As she pursues these activities the student becomes more active with extended family members, social workers and agencies which provide social and welfare services in the community. This involvement requires that the student assume a more collaborative role in the health team. However, it also exposes her to many ideas and behaviours which may conflict with her own expectations, desires and values. Through discussions the student is helped to deal with her

own feelings and abilities and to adapt to or accept situations realistically.

The final part of the programme involves the student in experiences which support her learning how to participate as a member of the nursing team in delivering care to a group of patients. As a quasi-staff member the student refines those skills necessary to assess the health and illness behaviour of the specific group of patients with whom she is working and to specifically develop interpersonal skills as they apply to group behaviour. In nursing conferences the student learns how to lead discussions, initiate plans of care and share her own ideas regarding patient care. At the same time the student is helped to differentiate between individual patient and group needs with a view to determining nursing care priorities. This sociological approach helps the student examine her data so as to reveal some generalizations regarding patient needs and behaviour. Different patterns of nursing care which exist in various settings are studied with the aim of identifying their critical determinants as well as assessing the outcomes relative to patient care.

As the student finds herself preparing for graduation she is motivated to explore its meaning to herself as a person and as a member of a profession. The development of nursing as a profession is examined within a societal and historical perspective. This exploration reveals to the student some of the issues which have been critical in determining the profession's continued development and the role it plays in influencing the delivery of health care. Accordingly the student is involved in trying to evolve for herself an expectation of professional nursing behaviour which she can articulate.

On completion of the three years it is our contention that the graduate has formulated a comprehensive understanding of health behaviour as it is significant to man and society. She has acquired those skills which allow her to use herself and her knowledge in making a comprehensive health assessment and to effectively provide nursing care. Equally important, the graduate has scientifically built a body of nursing knowledge and has acquired those learning skills which will allow her to continue to add to that base. Furthermore, she has developed a commitment to total health care of the individual, family and community and has the ability to identify, utilize and negotiate for those skills and knowledge which complement and supplement her own.

CURRICULUM OF THE BASIC BACCALAUREATE DEGREE PROGRAM AT DALHOUSIE - MOUNT SAINT VINCENT

HATTIE SHEA and MARGUERITE MUISE*

The curriculum of the baccalaureate program in Nursing at Dalhousie University was instituted in 1968 and was modeled after the curriculum of the University of California at San Francisco (1). An intensive review of the curriculum was done in 1974-75. This review indicated that many adaptations have been made between 1968-1975. It is the purpose of this paper to describe the curriculum in operation during the 1975-76 academic year.

The curriculum is an integrated one built around four major concepts: Man, Health-Illness Continuum, Society, and Nursing — Practice and Process. Each of these concepts is emphasized in every year of the program, and appropriate sub-concepts are introduced to provide breadth and depth to the content.

Man as a holistic being is introduced in Year I as a member of a family and a member of a community. Normal growth and development of and within a healthy family is the area of content concentration. The concept of stress is introduced late in the year. Students visit individuals and families for the purpose of developing skills of assessment and communication. There are also visits to nursery schools and public schools to observe and assess growth and development. Process recordings are used as a learning/evaluation tool. Basic nursing skills such as vital signs, bathing, bedmaking, and feeding are learned in the skills laboratory and then are practiced in a variety of clinical settings — pediatric care, obstetric area, acute care facility and/or long term care institutions. Concurrent courses this year include chemistry, anatomy and physiology, and one Arts and Science elective.

In Year II the concept of stress is fully developed in the context of developmental and situational crisis. Specific stressors in the first category include pregnancy and parenthood. Experience in assessment and communication is provided by visits to families. Prenatal contact with labor and delivery follow-through and post natal visits is an example of interaction with a client and family

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experiencing a developmental crisis. In the area of situational crisis the illness concept is introduced as a reaction to stress — specifically, invasion and trauma. Man's internal environment is believed to be coping adequately; therefore, illness or disruptions studied in this year tend to be short term problems caused by external stressors. Manual skills such as injections, isolation, sterile technique, pre and post operative care are learned in the skills laboratory and are practiced as necessary interventions in any clinical area through which the student rotates. Process recordings, nursing history, and nursing care plans are learning/evaluation tools used in Year II. Chemistry, microbiology, developmental psychology, and one Arts and Science elective are also studied this year.

Year III continues the concept of illness in a framework of chronicity and rehabilitation. It considers Man as he reacts to internal stressors while the external environment remains stable. Specific stressors this year are metabolic, congenital, psychosocial, and degenerative. Clinical practice is planned to focus on clients and families with long term problems as might be found in chronic care facilities and in the home. Teaching tools and skills are basically the same as for Year II. Supporting courses are math (statistics), and two and one half Arts and Science electives.

Year IV completes the move from simple to complex by studying Man as he reacts to both internal and external environmental maladjustments. Complex health problems are examined within the framework of the community at large. Clinical experience is available in all types of settings. Brevity and accuracy are the hallmarks of the nursing care plans developed in Year IV predicated on the philosophy of Mayer (2). Students in Year IV also study research and current issues in nursing. Assessment of community needs in the Atlantic region indicate a need for basic courses in teaching and administration at the baccalaureate level. These are provided in the final year, and the student elects one or the other. Efforts are made to coordinate information in all nursing courses in this year so that reinforcement rather than repetition of content and concepts occurs.

In the statement of philosophy of the Baccalaureate Program in Nursing is the following definition of Nursing on which is built the nursing content:

> Nursing is a process of action, reaction, interaction and transaction, whereby nurses assist individuals of any age and socio-economic group to meet their basic needs in performing activities of daily living and to cope with health and illness at some particular point in the life cycle. (3)

Nursing process is the methodology of practice accepted by the faculty and emphasized at all levels of the program. The problem-solving component is introduced early in first year and continues in depth and scope during subsequent years, culminating in the use of the Claus-Bailey decision-making model (4) in year IV. Planned nursing intervention and evaluation of interventions are begun in first year and continue at a progressively more complex level in the succeeding years. Some specific theories taught in relation to nursing process within this identified conceptual construct are: communication, development, need, change, learning, management, systems, role, stress, adaptation, crisis, and decision-making.

The curriculum at Dalhousie-Mount Saint Vincent is currently undergoing evaluation and revision. Attempts are being made to isolate the conceptual matrix so that a clearly defined framework can be developed. Integration defined by Torres as ". . . blending the nursing content in such a way that the parts or specialties are no longer distinguishable" (5) is the ultimate goal, and this kind of integration fits naturally into a conceptual framework. At present much of the content from the specialty areas is presented as individual (and identifiable) segments in the curriculum mosaic. The aim of the current revision is to have the segments so blended that what one sees is the whole picture and not the parts.

In summary, the Dalhousie-Mount Saint Vincent curriculum of the basic baccalaureate program is focused on Man as an individual in a family and a society at a given place on the health-illness continuum. The aim of nursing is the manipulation of Man's environment in order that he may attain and maintain his optimal level of health as he performs his activities of daily living. The process of assessment, planning, intervention, and evaluation forms the basis for nursing practice. Current revision is underway to further identify and relate the concepts in this program to formulate a conceptual framework.

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A FRAMEWORK FOR THE NURSING CURRICULUM AT ST. FRANCIS XAVIER UNIVERSITY

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HISTORICAL BACKGROUND

Nursing education began at St. Francis Xavier University in September, 1926, with the purpose, as quoted from the university calendar of that year, "to afford a broader education than is given by a School of Nursing alone, and to equip nurses who desire to fit themselves for teaching and supervision in Schools of Nursing and for public health nursing service." It is interesting to note that the nursing "entity" at the university at the time was called the *Department of Nursing and Health.* The School of Nursing referred to was the diploma program at St. Martha's School of Nursing. However, as the program developed, the degree was offered to graduates of other diploma schools.

While there were revisions and changes during the first forty years, the degree given was a *Bachelor of Science in Nursing* with emphasis on the physical-biological sciences and teaching. Most of the early students were preparing themselves for teaching positions in diploma schools of nursing. In the late forties and fifties, an attempt was made to strengthen the clinical content for students preparing for clinical instruction. The present four year basic program leading to a Bachelor of Science in Nursing was introduced in 1966. We have a present enrolment of 90-100 students with a present maximum capacity of 120.

PHILOSOPHICAL AND CONCEPTUAL OVERVIEW

Figure 1 represents the curriculum model and shows the basic concepts — Person, Health, Human Condition — as three interlocking circles. Superimposed on these three circles is an inverted triangle signifying the human life continuum from conception through and beyond death. Development of each of these concepts constitutes the rationale for the existence of nursing with its gradual evolution from a human response of primitive man to his brother in need, to an organized occupation, to profession.

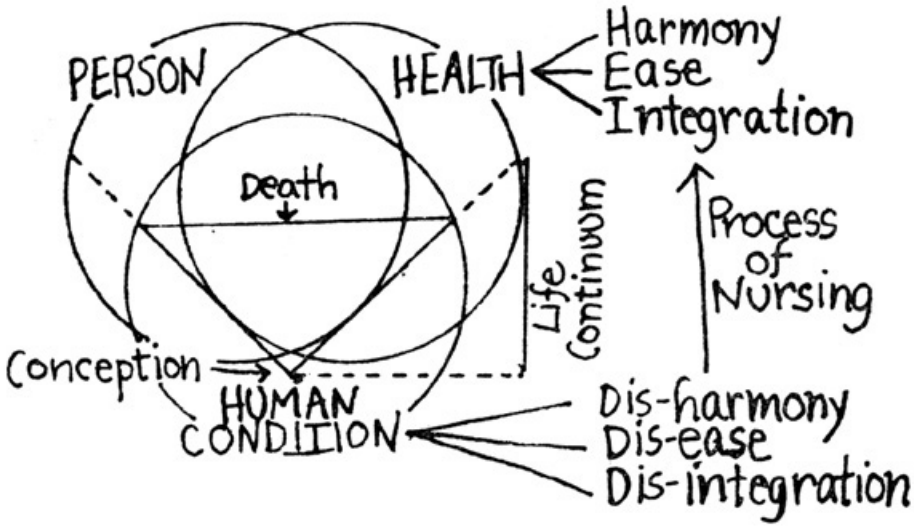
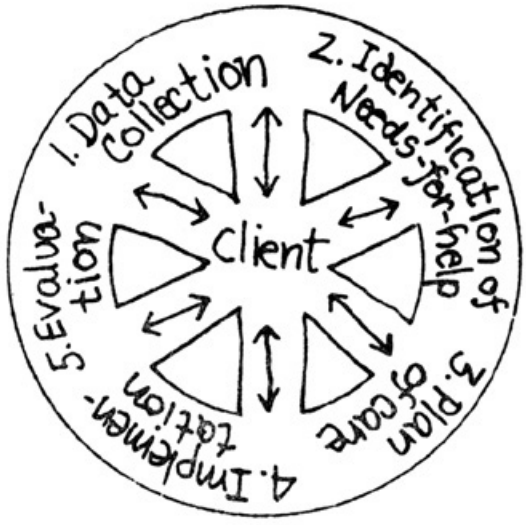


Figure 1. Curriculum Conceptual Model



GENERAL-PROFESSIONAL CURRICULUM COMPONENTS
PHILOSOPHY OF NURSING AND NURSING EDUCATION

The hub of this wheel represents the client, which can be a person, a family, or a community. The rim represents a systematic approach to health needs; the spokes, interpersonal dynamic.

Figure 2. Process of Nursing

Year 1.	Focus: Personal Health Courses: Nursing Component, Biology, Psychology, Philosophy-Theology.
Year II.	Focus: Personal, Family, Community Health Courses: Nursing Component, Biology, Nutrition, Developmental Psychology.
Year III.	Focus: Personal, Family, Situational Crises Courses: Nursing Component, Sociology of the Family, Christian Approaches to Human Sexuality, Elective.
Year IV.	Focus: Personal Family Situational Crises Courses: Nursing Component, Research, two Electives.

Figure 3. Focus and Course Sequence

We believe that persons come to nursing because they have a desire and motivation to establish a helping relationship with people and, in the context of this helping relationship, nursing as a personal service is practiced.

The curriculum, which is said to be *value-oriented,* is developed from a philosophical statement encompassing Judeo-Christian beliefs and values. The core value is *Person,* the core concept *Human Health,* the core problem the need of persons, families and communities to achieve that "state of ease, harmony and integration" which is the essence of our working definition of health. Nursing exists because, in the experiential human condition, persons, families and communities do not enjoy perfect harmony, ease and integration but, in various and sundry ways, experience dis-ease, dis-harmony, dis-integration. The nursing profession has evolved because *caring persons* have experienced the need to assist persons, families, communities in their search for health, to help them identify and avoid threats to health, to cope with disability, and to prepare for the inevitable human experience of death.

The major goal of the curriculum is to assist the student to become a *professionally caring person* by acquiring the cognitive, affective, and psychomotor skills subsumed under what we designate as the *Process of Nursing.* The key elements of this process are represented in Figure 2.

COURSE SEQUENCE AND ARRANGEMENT

Selection of courses and sequence of focus from first to fourth years have been the result of a carefully thought out and deliberate choice. Figure 3 gives an overview of the central focus and requirements in each year. Skills pertinent to the process of nursing are introduced in the first year and developed as the program progresses. In the first year, the student learns specific aspects of data

collection — health history-taking with the appropriate interpersonal component — with application to her healthy peer group or others, e.g. members of family or relatives. In the second year these and additional process skills are applied to the family and different age groups in the community. The student learns to identify and describe the health needs, problems and programs of a given community. In the third and fourth years, the process is extended to persons and families experiencing situational crises. The process of nursing is enhanced in the fourth year by offerings in research methodology which include the carrying out of an actual study, identification of clinical nursing problems, and review of selected clinical studies already done in nursing.

It is to be noted that the nursing curriculum is not composed of nursing courses and "something else." The four year program constitutes a blend of general and professional courses which are selected to assist the student to experience something of what the various disciplines have to contribute to an understanding of man's personhood, his development, aspirations, needs and problems. The nursing curriculum hopefully provides an experience which engenders, in the words of John Henry Newman, "a general culture of mind which is the best aid to professional and scientific study" (1)

EDUCATION AND LEARNING

It has been noted above that the nursing curriculum at St. Francis Xavier University is value-oriented. A word of clarification is in order. It would seem obvious that there is no such thing as a valueless curriculum. To say that one does not teach or talk about values is already stating a value position. By saying that our curriculum is value-oriented, we mean that we deliberately strive to explore meanings of such expressions and concepts as "the dignity of the human person", "human life", "human health", etc. and to encourage a climate of reflection and study conducive to conscious choices on the part of faculty and students.

We believe that the aim of the educative process is to impart meanings and to enable the student to comprehend values. We believe that education cannot impose values but that it should broaden the student's field of options and encourage self-investment in that which the student grasps as meaningful. We believe that the student learns what she lives, i.e. thinks, feels, accepts. Therefore, a learning environment which facilitates reflection and where the student is encouraged to search, explore and analyze is regarded as important.

When we identified Person as the core value in the curriculum, we were thinking not only of the person as client but of the person

as student as well. Hopefully, the learning experiences assist the student to grow towards maturity as a professionally caring person. We hope that the student is assisted in this process by learning to esteem and care for herself and also by the caring she experiences in her relationships with peers and concerned and caring faculty.

SUMMARY

It is doubtful whether we can say at this point that we have a curriculum which is grounded *in* or *on* a theory using the latter in its scientific sense. However, the elements of a theory or theories are clearly there and hopefully operative. Presentation of the theory for adequate testing is another task. The elements of the theory presently in the stage of development are as follows:

- The human person is made to God's image and likeness. (Judeo-Christian Image Theology)
- The human person's ultimate purpose bears a relationship to the above belief which cannot be tested in the empirical sense but is seen in the domain of faith (e.g. life and health transcend death).
- The human person, as a body-soul unity, cannot be defined but his meaning can be explored through his history, his present experience, the needs that move him to act, and Judeo-Christian revelation.
- The human person seeks inner harmony, ease and integration (health).
- Within the human condition — the natural habitat of man — man does not experience complete harmony, ease and integration but varying degrees of dis-harmony, dis-ease, dis-integration (the problems of pain, suffering, death).
- Intrinsic to the human person, as revealed by earliest records of primitive man down through the centuries, are the need and capacity for caring.
- The professional practice of nursing has evolved from man's primitive human response to man in need, to an organized occupation, to a profession with caring as the consistent and unifying variable.
- Individuals choose nursing primarily because they have the desire to help others.
- The professional practice of nursing is the process of *professional caring.*
- Caring becomes professional when this natural, human quality is nurtured and developed to serve in creative and effective ways through learned skills — cognitive, affective, psychomotor.

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DEVELOPING A CONCEPTUAL FRAMEWORK

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"If core curriculum is not clear in theory it is difficult to develop it in practice."**

In 1968, the University of Toronto Faculty of Nursing introduced a curriculum having as its major premise the notion of a central core of nursing (Wilson, 1973). At that time core was defined as "that body of nursing knowledge and skills which can be applied in any nursing situation" (Wilson, 1973). This approach to nursing was reflected in a curriculum structure which focused on *nursing* and its practice rather than on the different clinical divisions.

As the curriculum was implemented it became apparent that the general approach was workable, that there were particular areas of strength, such as the teaching and research threads, but that the major component, the assessing, planning, giving, and evaluating thread was presenting difficulties. Faculty were expressing concerns in a variety of ways. Among the problems identified were the following: Core content was topical rather than consisting of key concepts which were pervasive throughout the four years; and various definitions and interpretations of core were serving as guides to the teaching of nursing. As a result of these two major difficulties the notion of a central core of nursing with clinical application was never quite perfected.

Ausubel (1968) holds that the question of how knowledge can be transmitted in such a form that it can be retained and applied in clinical problem solving over long periods of time is a central problem of medical education. To facilitate retention and transfer, Ausubel suggests that the basic organizing concepts of a given discipline should be identified and used as the basis of the curriculum. In nursing as in medicine, it seems that transfer would be enhanced if

*The authors would like to acknowledge the contributions of other faculty members in the development of the conceptual framework, as it has been a total faculty effort.

**M. J. Wilson, "An overview of the New Basic Curriculum." *Nursing Papers*, 1973, 5(1), 5-14. This issue comprises a detailed description of the curriculum of the University of Toronto Faculty of Nursing.

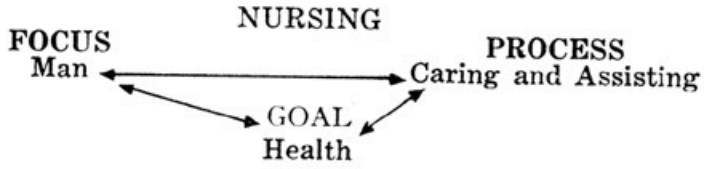

Figure 1

such central concepts and related principles constituted the major components of curriculum content and directed problem solving in clinical practice. There is, indeed, evidence that transfer obtained through the application of generalizations or principles learned in one situation to a second situation is faciliated (Haselrud & Meyers, 1958; Hendrikson & Schroeder, 1941; Judd, 1908; Overing & Travers, 1966). Such a cognitive view of transfer (Ausubel, 1968; Bruner, 1965) is consistent with the philosophy of the University of Toronto Faculty of Nursing.

A review of the expectations (Wilson, 1973) for each year assisted in isolating the problem more precisely. It was agreed that although content and process were well defined in other threads, this was not so with the thread of assessing, planning, giving, and evaluating care. It was also agreed that there was, in fact, a need for a framework of concepts which would constitute the main elements of core content for the curriculum. Once this consensus had been reached the faculty set about to develop a conceptual framework which would be consistent with the philosophy of, and the assumptions regarding nursing (the assumptions developed when the curriculum was undergoing revision were reviewed and, where necessary, amended).

Since to begin work it was necessary to have a common frame of reference, the initial step was the definition of essential terms. Three critical terms, among those selected, were core, concept, and principle. These were defined as follows:

Core — Key concepts and principles relevant to all nursing.

Concept — an abstraction categorizing events or objects according to their criterial attributes.

Principle — a statement relating two or more concepts which has wide applicability as a result of testing.

Using the elements of a conceptual framework as outlined by Conley (1973) the focus, process and goal of nursing were identified. The relationship between man (the focus), caring and assisting (the process) and health (the goal) are illustrated in Figure 1.

Table I: Concepts, Assumptions and Implications for Nursing

Key Concepts	Assumptions about Man	Implications for Nursing	Basic Assumptions Regarding Nursing
1. Wholeness	Is a whole composed of parts, but is more than and different from the sum of the parts.	Man's response always reflects his unitary and unique nature.	Nursing is concerned with the total individual, but it is recognized that at various times the focus may be on particular aspects of the individual or his environment.
2. Cognitive — affective	Is a cognitive — affective being. Has a belief system. Makes judgments and decisions.	Thought and feeling are reflected in each response.	The patient has a right to participate in planning and carrying out his own care.
3. Life process	Man develops sequentially from birth to death.	Potential for development is always present.	The practice of nursing involves caring for individuals, families and groups and assisting them to achieve health. This process includes restoration to or promotion of health, prevention of disease and deformity, care and rehabilitation of the sick and support of the dying.
4. Life style	Previous man-environment interactions influence subsequent pattern and organization.	Man has a characteristic manner in which he conducts his existence.	The nurse's capacity to understand and work with others is affected by her attitudes, her understandings of herself, and the realization that all behaviour is meaningful.
5. Reciprocal interaction Change Energy	Is in reciprocal interaction with environment. Is always changing. Is an energy field.	Man has a complementary relationship with people and events.	Nursing is concerned with the response to individuals, families or groups to people and events.
6. Pattern & Organization	Maintains pattern and organization amid change.	Man sometimes needs assistance in dealing with threats to his integrity.	A problem solving approach is used in assisting man to deal with threats to his integrity.

It was felt that the goal of the process of caring for and assisting man, should also be clearly defined. Health therefore was defined as "a relative state in which the individual maintains optimum pattern and organization amid constant change." As with other definitions for this framework, the definition of health is not intended to and could not stand alone (as, for example, the W.H.O. definition of health). It, along with the key concepts, assumptions and so on, must be viewed in the context of the total.

The next step was to isolate from among those already included in the nursing courses, those over-riding concepts and related assumptions regarding the focus of nursing — man. These would constitute the framework of the nursing content and along with the implications for nursing and some key assumptions regarding nursing are shown in Table I. Beliefs regarding nursing which flow from our philosophy will shape the further extension and development of the framework.

To illustrate both the process by which concepts were identified and how they will direct teaching, practice and research, we have selected the concept "cognitive-affective".

As staff searched for a concept which would convey the knowing, reasoning and feeling attributes of man, terms such as rationality, emotionality, spirituality, perception and thinking were examined. In the end, 'Cognitive Affective' was chosen as a concept which would be inclusive of our meaning for all of these terms. The related assumptions for this concept, and the implications for nursing were then developed.

The theoretical content, its clinical application and teaching strategies used will need to reflect the notion that man makes judgments and decisions and therefore, has the capacity to collaborate in his care. His choices regarding health and his care will be affected by his belief system, his feelings and his perceptions of the total situation.

In the area of research this particular concept should generate inquiry into how to enlist man's involvement in attaining optimal health, as opposed to an approach which emphasizes compliance.

The philosophy of the Faculty of Nursing is basic to both the undergraduate and graduate programmes, therefore, the notion of core is not considered to be unique to the basic curriculum. The first step in implementation of core as now conceived has in fact been taken in the graduate programme. Objectives and related content for each of the key concepts have been developed, and in the coming academic year students from the three clinical speciality areas will be meeting

together with faculty for core classes. The objectives for and the content to be presented in the core classes is outlined in Table II. This application of core will provide a means of evaluating the framework.

In the undergraduate programme work is continuing in relation to delineating the sub-concepts and progressively differentiating these in terms of specificity (Ausubel, 1968). Such refinement will be a continuing process as the model evolves. As Bevis (1973) has indicated "the theoretical framework becomes a dynamic document, not carved in marble, but always tentative and provisional". As it evolves, its usefulness will be constantly assessed. "Formulating a theoretical framework is merely an intellectual exercise if it is not used as a source for deriving criteria for content, teaching methods,

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Table II: Objectives and Related Content for each Key Concept

Objectives	Suggested Content
WHOLENESS	
1. Analyzes the concept of wholeness.	Concepts of wholeness and uniqueness.
	Scale of observation.
2. Understands the unitary and unique nature of man.	Barriers to perceiving wholeness.
3. Synthesizes the data regarding the parts of man that comprise this unity.	
PATTERN AND ORGANIZATION	
1. Understands the cyclical nature of man's patterns (e.g. diurnal, biochemical, etc.)	Conceptions of pattern and organization related to man. Examination of particulars versus examination of wholeness.
2. Understands that man maintains pattern and organization amid change (homeokinesis).	Perspectives of time.
3. Understands that the structure and function of man has pattern.	Diurnal rhythms. Biochemical rhythms.
4. Recognizes that different scale of observation is needed when examining a pattern than the particulars within a pattern.	
5. Assesses an individual's unique pattern.	
6. Plans nursing interventions which will promote organization in repatterning.	

Table II (continued)

COGNITIVE — AFFECTIVE	
1. Understands the cognitive-affective components of man and their relationship.	Interaction between thought and feeling. Man's belief systems (ethical, cultural and moral values) and implications for nursing.
2. Comprehends the principle that the cognitive-affective characteristic of man is a crucial factor in promoting care.	Definition of health as high-level wellness. Potential modifiers of health. Meaning of health to the individual — perception of health and man's participation in his care (choice). Lalonde's health field concept and related ideas.
3. Values scholarly and scientific methods as an inherent part of professional identity.	Inquiry methods — problem solving. Use of scientific evidence in implementing care.
LIFE PROCESS and LIFE STYLE	
1. Evaluates the sequential development of man from conception through death in order to plan nursing intervention.	Developmental process of individuals, families and communities (including genetics). Crisis. Loss (including integrity, body image, death).
2. Recognizes that the life process of the species as well as that of the individual is influenced by multiple factors (e.g. technological advances; population mobility).	Societal changes that influence the life process (including health care legislation).
3. Recognizes that an individual at any given moment is the expression of the total events that have occurred in his life process.	Man as part of all that he has met — implications of this to nursing care. Quality of care. Effect of life experiences — life style.
4. Understands the developing complexity in the repertoire of man/-environment interactions.	
5. Facilitates the potentialities for constructive change in the individual's life process.	Theories of change and their implications for nursing.
RECIPROCAL INTERACTION, CHANGE AND ENERGY	
1. Analyzes the concepts of change and energy as inherent in interaction.	Concepts of change, of energy and of interaction. Adaptation theories — assimilation and accommodation. Open systems — dyads, triads and mass.
2. Evaluates interaction in complex groups.	Groups process concepts (conflict, power, status).
3. Recognizes the uniqueness of individuals and of groups in any interaction.	Communication.

evaluation methods, and human relationships", (Bevis, 1973). As a University school of nursing we would include 'research' in this list; the degree to which the framework stimulates and guides research will also be a criterion of its usefulness.

Authors' postscript

As the article indicates, refinement of the conceptual framework is a continuing process. As work has continued, the overlap between the definition of health, and assumption relating to pattern and organization has been noted. Our work is presently focused on this and other problem areas.

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CURRICULAR THEORIES FOR NURSING AS PROCESS

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The University of Windsor, School of Nursing has just completed a curricular revision for its four year generic and three year post-diploma programmes. The integrated programmes are designed to provide the graduate with the skills required by the baccalaureate nurse to assume the responsibility and functions of a nurse practitioner in both primary and secondary care settings with the emphasis on optimal health of individuals, families and communities. The revised four year programme will be implemented in September, 1976; the post-diploma programme in September, 1977.

After an intensive search of the literature, the faculty and students of the School of Nursing adopted Em. O. Bevis' *Curriculum Building in Nursing: A Process* as its curricular revision model. This model through a process or systems approach allows for the generation of a nursing curriculum with a theoretical base.

Briefly, Bevis identifies curriculum building as a process. Process is defined as the core phenomenon of all man's activities and has three characteristics. The first characteristic, the inherent purpose or subjective aim, is what the process accomplishes. The second characteristic, organization, is the series of actions or operations that accomplish the given aim. The third characteristic, infinite creativity, is on-going innovation progressing, advancing or changing in time.

The purpose of curriculum building as a process is to provide learning experiences that will enable students to develop nursing behaviours that promote the greatest possible health for every individual in society. The organization of the curriculum building process is its theoretical framework, that is, the conceptualization and articulation of theories, phenomena and variables relevant to a university's nursing educational system. The infinite creativity of curriculum building is curriculum vivification. Curriculum vivification is the creation of a holistic curriculum through the translation of the theoretical framework into a dynamic curricular design.

The School of Nursing's adopted theoretical framework is comprised of structural and cognitive components. The four structural

components describe the perimeters or context of the School of Nursing. The first component identifies the present and projected societal health problems our graduates will encounter in their nursing practice. The second describes the unique educational environment in which the School of Nursing exists. The third and fourth components document current faculty characteristics and present and projected student characteristics. These are the givens.

The two cognitive components of our theoretical framework are nursing and learning. Theories of nursing and learning have been studied and adopted by the faculty to serve as the theory underlying our revised curriculum. The curricular theory will be discussed separately.

Bevis' theory of nursing was accepted by the faculty and students due to its comprehensiveness and scope for nursing practice. The theory states:

> Nursing is a process; its purpose is to promote optimal health through protective, nurtrative and generative activities. These activities are carried out within the intrapersonal system, the interpersonal system and community system.

It should be noted that this theory of nursing is a synthesis of eclectically combined theories. Related theory from the natural, social and medical sciences, as well as humanities and nursing comprise the basis of the nursing theory.

The purpose of the process of nursing is the highest possible level of health or self actualization for each individual. Inherent in this purpose is Martha Rogers' concept of the unitary man and H. L. Dunn's concept of health and disease as levels of wellness whereby a nurse protectively, nurtratively and generatively, in collaboration with individuals, families, groups and communities strives to achieve, maintain or restore health.

Systems theory, more specifically systems analysis, has been employed to identify three desired nursing behaviours that promote high-level wellness, optimal health. These three kinds of nursing behaviours: protective, nurtrative and generative behaviours have been adopted from Leavell and Clark. The behaviours are not sequential but can occur simultaneously or separately.

Protective nursing behaviours are nursing measures that maintain and promote health. Nurtrative behaviours are nursing measures that are therapeutic, curative and comfortive, while generative behaviours are nursing measures that are innovative, productive and/or rehabilitative.

The second characteristic of nursing as a process is its organization, that is, an analysis of activities or subsystems necessary to achieve optimal health or self actualization. Three subsystems have been identified: the intrapersonal systems, the interpersonal systems and the community systems.

The intrapersonal system, man as a single unit, is the target of desired nursing behaviours that promote optimal functioning of all internal biochemical and life processes, all biological growth process and individual personality formation.

The second system, the interpersonal, entails those nursing activities that promote optimal functioning of two or more people to include the nurse and client, other health professionals, the client-family and surrogate families.

The community system, a group of people having common organization and mutual interest, is the target of nursing behaviours that promote optimal functioning of communities. Nurses engage in activities which involve working with health care systems, governmental agencies and citizens groups.

Finally, the third characteristic of nursing as a process is its innovation or creativity. Theories have been selected from various fields of study resulting in a synthesis of life processes which, when utilized in nursing practice, promote optimal health for the individual, family and/or community. The creative element of nursing as a process consists of six innovative subsystems or processes.

The stress-adaptation process is based on Engel's view of stress and strain. Nursing's responsibility is to prevent stress, promote adaptation and care for patients exhibiting strain.

A second process, the decision-making process, has been adopted from McDonald's problem solving theory. Problem solving is the key process in the innovative component of nursing.

The communicating process has been synthesized from Ruesch's general theory of communication. This process includes communication for the intrapersonal, interpersonal and community systems which the nurse utilizes as an individual, professional and a citizen.

Learning as a process has been based on propositions derived from associationism and Gestalt-field theories. Learning promotes self actualization through the utilization of the environment to fulfill individuals' needs at any given time.

The human development process has been adapted from J. C. Powell's human development model. This model had been generated from theories of Erikson, Havighurst, Maslow, Carlton and Piaget. Developmental status influences nursing care because health-wellness

and nursing care encourage or inhibit development as it moves through progressive stages.

The change process is a process of organizational structure and management and a process of adaptation and problem solving. Change propositions have been drawn from Bennis. Nurses through participation and collaboration need to respond to health care delivery system needs with a deliberate change in methods of coping with health problems.

The theories underlying learning, the second cognitive component of the theoretical framework, will be identified. Two theories comprise the synthesized learning process: associationism and Gestalt-field theory. The Yale Learning theory of behaviourists states that learning behaviours are results of a drive or need to attain a goal or solve a problem. Gestalt-field theory maintains that learning is a matter of understanding relationships within a total field or area.

It should be kept in mind that such an eclectic approach to learning allowed the School of Nursing to choose from both schools of thought rather than select one theory or the other.

Upon completion of the theoretical framework, the faculty and students began curriculum vivification with the selection of a curricular model. The nursing process was selected as a model that would enable learning activities relevant to identified societal health problems and appropriate to student needs to be organized by process.

The nursing process as a curricular model is supported by an organizational content model in which core nursing courses for all levels of the programme are levelled and contain information input courses and simulated practice activity and clinical practicum. Students will use the nursing process in all clinical experiences with individuals, families and communities in both primary and secondary care settings.

At this time, the School of Nursing faculty is developing individual courses for implementation and evaluation.

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