NURSING PAPERS
PERSPECTIVES EN NURSING

Development of Nursing Theory:
Doctoral Programs: Criticisms, Problems,
Beliefs, Solutions

Nursing as a Design Process

Nursing Papers/Perspectives en Nursing
Cumulative Index 1969-78

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LETTRE AUX REPRESENTANTES DES REGIONS ET DE LA REDACTION

Bonjour,

Cette lettre se situe dans le cadre de l'Editorial du Vol. 10, No. 2 et amorce une suite à l'exergue en page 31 du même numéro.

Comme chacune de vous, j'exerce la même importante fonction pour *Perspectives en Nursing* et je souhaite échanger certains points de vue et expériences. En effet, je suis de plus en plus consciente qu'une action vigoureuse et synergique de notre part est fondamentale à l'atteinte de nos buts en matière d'érudition et de recherche en sciences infirmières.

Pour ma part, l'hiver dernier, je mettais en oeuvre en milieu francophone, une campagne progressive et à plusieurs volets. Je me limiterai ici à un seul aspect c'est-à-dire un sondage exploratoire sous forme de mini-questionnaire. Il avait pour but de recueillir des opinions sur les sujets suivants: connaissance et utilisation de la revue, possibilité de la promouvoir, identification de problèmes brûlants et controversés, demandes de thèmes pour numéros complets, jalons d'articles, moyens d'encourager les universitaires francophones à écrire plus d'articles de calibre pour la revue, etc.

J'ai accompagné ce questionnaire d'une lettre, d'un coupon d'abonnement, et de plusieurs renseignements tels que: reférence au Vol. 8, No. 4 élaboré par l'Université de Montréal, l'attestation de RADAR (répertoire analytique d'articles de revues du Québec) et autres.

Le tout fut adressé à des groupes tant à l'intérieur qu'à l'extérieur de l'Université. Dans notre Faculté, il s'agit des administrateurs, professeurs et chercheurs, de nos étudiants de maîtrise ainsi que de nos étudiants au baccalauréat en deuxième et troisième année. En dehors, ce sont nos diplômés de deuxième cycle, les diplômés de premier cycle des deux dernières promotions, les coordonnatrices(eurs) des départements de techniques infirmières dans les CEGEP francophones, des cliniciennes spécialistes, des directrices(eurs) de soins infirmiers d'hôpitaux universitaires, etc.

A partir de septembre, je compte communiquer avec d'autres groupes d'infirmières(ers) ainsi qu'avec des organismes et des milieux extra-hospitaliers de distribution de soins. Quelques contacts prometteurs sont déjà établis à ce sujet.

Jusqu'à maintenant, dans l'ensemble, les résultats sont bien stimulants. En effet, je dégage graduellement les lignes d'intérêt de nombreux lecteurs de ma région, entre autres, le besoin d'augmenter

la proportion d'articles en recherche clinique. Je connais mieux certains aspects de questions controversées telles que les niveaux de formation et de responsabilités. Je bénéficie également de suggestions comme celle d'un numéro complet pour l'Année de l'Enfant. Un article est déjà remis au comité de révision et quelques autres sont en voie d'élaboration. Une directrice d'hôpital a même exprimé le voeu de me rencontrer relativement aux recherches en cours dans son milieu. Enfin, un autre résultat et *non le moindre* consiste en l'augmentation très notable du nombre d'abonnements.

Je me sens donc bien encouragés à poursuivre ma démarche. A mon avis, cette tentative jointe à chacune des vôtres fait partie d'un processus d'enracinement nécessaire à la floraison de l'écriture scientifique et de l'érudition pour notre discipline dans nos régions respectives.

Je profite de l'occasion pour vous remercier — ou votre porte-parole — des échanges agréables et fructueux à Saskatoon, lors de la dernière réunion de l'A.C.E.U.N.

N'hésitez pas à m'écrire si vous désirez tenter une expérience de ce genre et si vous avez des questions. N'hésitez pas non plus à me faire part de vos commentaires découlant de cette lettre ou de vos propres modalités d'action. J'en profiterai certainement.

Bon succès dans toutes vos activités pour *Perspectives en Nursing!*

Julienne Provost, professeur agrégé
Représentante de la région du Québec
et de l'Université de Montréal

Merci publiquement à toutes les personnes qui ont appuyé *Perspectives en Nursing/Nursing Papers* par des réponses à mon mini-questionnaire, abonnements, articles, demandes d'information, suggestions pertinentes ou toute autre forme de collaboration.

A plus tard, pour d'autres détails.

LETTER TO THE REGIONAL REPRENTATIVES AND AMBASSADORS

Bonjour!

This letter is the follow-up to the notice on page 31 of Volume 10 no. 2. Since I, as regional representative for *Nursing Papers/Perspectives en Nursing,* fulfill the same important function as you, I would like to share some of my experiences with you. I have become more and more conscious of the need for strong, joint action on our part in order to meet our goals in nursing scholarship.

Last winter I launched a multi-faceted campaign in the French-speaking nursing community. Our work included a mini-questionnaire on the following topics: knowledge and use of the journal, promotion possibilities, identification of burning and controversial issues, suggestions for articles, means of encouraging French-speaking university nurses to write more scholarly articles, etc. A letter and subscription coupon were included along with other information such as reference to Vol. 8, no. 4, the issue sponsored by the l'Université de Montréal; and the acclamation *Nursing Papers-Perspectives en Nursing* received in *RADAR* (répertoire analytique d'articles de revues du Québec).

The package was mailed to groups inside and outside the University. In our Faculty, administrators, teachers, researchers, masters students and second and third year baccalaureate students received the mailing. Outside groups included graduates from our Baccalaureate (last two classes) and Masters programs, the French CEGEP's coordinators of departments for technical nursing, clinical specialists, and directors of nursing in university hospitals.

Starting in September, I plan to contact other groups of nurses, organizations and health agencies functioning outside hospitals. I have already made some encouraging contacts.

The results of the first phase of the campaign have been stimulating. I have begun to identify the main interests of many readers in my region: for example, the need to increase the proportion of articles on clinical research has become clear; I now have a better sense of controversial issues — levels of preparation and practice; I have received suggestions such as devoting an issue to the Year of the Child (one article has already been sent to the reviewers, and other articles on this topic are in progress). A director of a hospital nursing service has asked to discuss research in her milieu. Another important result of this campaign is the increase in subscriptions.

I feel encouraged to keep this campaign going. In my opinion, this effort, joined with each of yours, is part of the "grounding" process necessary to the development of nursing scholarship.

I would like to take this opportunity to thank you, or your spokesmar, for our pleasant and fruitful meeting in Saskatoon during the last CAUSN meeting. Please don't hesitate to write if you wish to initiate an effort similar to the one I have described above. I will be happy to supply more detailed information if needed. We would appreciate your sharing any experiences you have had in your area, as well as any comments you might like to make on this letter.

Julienne Provost

DEVELOPMENT OF NURSING THEORY:

DOCTORAL PROGRAMS: CRITICISMS, PROBLEMS, BELIEFS, SOLUTIONS

by

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With the total lack of Canadian doctoral programs in nursing how will development of nursing theory progress in Canada? To find a perspective from which to explore this question I have chosen a philosophical model(1) which views the concerns of any particular profession as a series of criticisms, problems, beliefs, and solutions which have sequential changes in pattern over time. I have added to the original model a subsection entitled "Background to the Problem" which will be inserted directly after the Problem Statement. Five series of criticisms, problems, beliefs and solutions will be presented.

SERIES I

Criticisms: A certain percentage of nurses who take doctorates in other disciplines do not return to nursing (Pitel and Vian, 1975, p. 348). In Canada only 60% of the employed nurses with earned doctoral degrees are known to be working in the field of nursing (Zilm, LaRose and Stinson, 1979, p. 65). Moreover the nurses who do return to nursing have to go through a "resocialization process" and adapt to the "necessary value shifts" (American Nurses Association, 1974, p. 1) between the discipline selected for doctoral study and the discipline of nursing.

Problem: "Shall we continue a pluralist approach to doctoral education for nurses (American Nurses Association, 1974, p. 1)?"

Background to the problem: The evolution of doctoral programs *for* nurses as opposed to *in* nursing started with the Ed.D. which accounted for 60% of the degrees awarded to nurses in the 1950s (Pitel and Vian, 1975, p. 342). In the 1960s and 1970s the Ph.D. became the most frequently awarded degree to nurses and "coincided with the development in the 1950s of the American predoctoral fellowship programs and, in the early 1960s, of the Nurse-Scientist Training Program of the Division of Nursing of the U.S. Public Health Service (Pitel and Vian, 1975, p. 342)." There had always been the opportunity for a nurse to pursue a doctorate in any discipline for which she could meet its program's entrance require-

1 The author is particularly indebted to Stephanie G. Edgerton, Ph.D., Head of the Division of Historical and Philosophic Foundations, New York University for the formulation of this model which Dr. Edgerton originated to examine a profession's concerns.

ments. However, the latter two programs were organized in the 1950s and 1960s to foster research training of nurses specifically in the sciences most closely related to nursing. The rationale was to create a cadre of scholars who, after having achieved a philosophical style of approaching and developing the science of an established discipline could make the conceptual leap and attempt to do the same for the emerging science of nursing.

BELIEFS:

Belief #1 "Nursing is a (discipline) and as such contains a body of scientific knowledge which requires constant exploration and revision. The broad conceptualization of this knowledge is that it deals with the human being as a whole person in constant interaction with his environment throughout the entire life cycle (Calendar, Division of Nursing, New York, University, 1978, p. 14; Crowley and Donaldson, 1978; Leininger, 1976a, p. 8)."

Belief #2 Scholars and researchers in nursing can only be prepared "in doctoral programs that have as their core the critical and creative study of the science of nursing and not that of other disciplines. The elaboration of nursing's theoretical system is dependent on this foundation (Calendar, Division of Nursing, New York University, 1978, p. 14)."

Belief #3 Any discipline needs the most advanced degree "in its own field of study if it is to maximize its potential contribution to society (Doctoral Education in Nursing, Canadian Association University Schools, 1978, p. 1)."

Belief #4 "There is a definite trend toward acquisition of doctorates in nursing rather than in a non-nursing discipline (Leininger, 1976a, p. 22)."

Belief #5 Some "deans of schools of nursing (will seek and employ) nurses with a nursing doctorate rather than a doctorate degree in a cognate discipline (Leininger, 1976a, p. 22)."

Solution: From the 1962 outset of the American federally funded "nurse-scientist" programs in related disciplines, the plan was to phase out most of these programs "in preference for doctoral programs which grant degrees in nursing (Leininger, 1976b, p. 204)." In 1976 an extension of the United States' National Research Award Act, although retaining the format for training nurses primarily in basic science departments, allowed "a few (out of 35) institutional awards" for doctoral preparation in nursing "in graduate departments in well-qualified schools of nursing (National Research Council, (NRC) Committee Report, 1978, pp. 128-9, 141)."

Twenty American doctoral programs in nursing exist (*AJN*, 1978, p. 1290); 12 offer the doctor of philosophy in nursing; 7 offer the

professional doctor of nursing science and one offers the doctor of education. Twenty-nine more American universities have doctoral programs in nursing in various stages of approval or planning so it is estimated that at least 50 doctoral programs in nursing will exist in the U.S. by the year 2000 (*AJN,* 1978, p. 1290).

Although the nursing profession in both Canada and the United States has moved towards consensus that nurses should seek doctoral preparation in the discipline of nursing, if theory development in nursing is to occur another series of criticisms, problems, beliefs, and solutions are on the horizon.

SERIES II

Criticism: The same problems faced by the nursing profession in the adage "A nurses is a nurse is a nurse" is evident in the adage "A doctorally prepared nurse is a doctorally prepared nurse is a doctorally prepared nurse."

Problem: How does the nursing profession differentiate among the various types of doctoral preparation in nursing so that its members may select a doctoral program congruent with their individual career goals?

Background to the Problem: Three types of professional doctorates have been identified in nursing. Schlotfeldt (1975, 1978) and Newman (1975) have proposed a doctoral program for nurses as a first professional degree. This Doctor of Nursing (N.D.) degree will prepare its graduates for entry into professional practice, not for careers in either university teaching or research. The first N.D. curriculum commences in September 1979 at Case Western Research University *(Nursing Outlook,* 1978, p. 413). Schlotfeldt (1978) envisions this type of nursing doctorate as a post-baccalaureate program. That is, the program will be for non-adolescent, mature students, who would come liberally educated, have a degree to attest to their ability to survive in academia, and presumably, evince a commitment to nursing as a life-time professional career. This N.D. degree would be analagous to the M.D. (Doctor of Medicine) or the D.D.S. (Doctor of Dental Surgery) and its product would be addressed as 'Doctor.' Schlotfeldt (1978, p. 306) contends such a title would be beneficial as the current discrepancy would be resolved between the nature of the education of students in the other health disciplines and that of the current generic baccalaureate nursing graduate. Newman (1975) writes: "I challenge anyone to deny that the difference in title conveys a difference in status (p. 705)."

Two other types of professional doctorates for nurses are well established. Both these degrees often are built upon baccalaureate and/

or masters degrees in nursing. The first of these is the Doctor of Nursing Science (D.N.Sc. or D.N.S.) degree which was first established at the University of California in 1964 (Leininger, 1976b, p. 206). By 1978, five other American universities offered this degree (NLN, 1978) and at least one more university commenced such a doctoral nursing program in 1978 (Downs, 1978). It has been contended that this type of professional doctorate is "the highest university award given in [a] field in recognition of completion of academic *preparation for practice* and other professional activities (Association of Graduate Schools (AGS), 1966)." From this perspective the D.N.S. label connotes an expert practitioner who would be more likely to be found as discerning utilizer, in the service setting, of research findings from her own or others' theoretical formulations than as an academician. That is, he/she might be expected to seek employment in service agencies, or as a cross-appointment between a service agency and a university where, as a clinical faculty member, she/he would be an exemplary role model for undergraduate and graduate students.

An allied contention is that "while persons with a professional doctorate may provide the necessary clinical teaching . . . most cannot meet the academic requirements for research and scholarly contributions expected of graduate faculty members in major research-oriented universities (Cleland, 1976, p. 632)." Undoubtedly, the nurse faculty member will have to meet the same university-wide criteria for appointment to the graduate faculty as a person in any other field. Cleland also points up that it is significant that the professional doctorate is awarded by the university, not the university's graduate school (Cleland, 1976, p. 631).

Few Canadians have sought the D.N.S. degree. Currently one Canadian holds such a degree; four others are currently enrolled in D.S.N. programs (Zilm, LaRose and Stinson, 1979, p. 65).

The second type of doctoral degree that was often built upon undergraduate and/or graduate nursing degrees is the Doctor of Education (Ed.D.) degree where "the doctorate level focuses on scholarship and research, but . . . (in an) applied aspect . . . (Downs, 1978, p. 59).

Prior to 1960 the Ed.D. was the most frequently awarded doctoral degree to nurses (Pitel and Vian, 1975, p. 342). It is understandable that nurses during and prior to the 1950s "would pursue doctoral degrees in education since the focus of the profession at that time was on teaching and curriculum development . . . (Pitel and Vian,

1975, p. 343; Gortner and Nahm, 1977, p. 18). Undoubtedly all disciplines need teachers with the capability to transmit knowledge to their students. However, it is believed that the award of the Doctor of Philosophy (Ph.D.) degree "usually implies appropriate preparation for teaching (AGS, 1966)." Nevertheless, the onus is on the new holder of the Ph.D. degree in a university setting to seek peer, administrative, and student evaluation and to take the readily available tool courses in Colleges of Education during their probationary years in order to ensure that they will be rated, when evaluated by tenure criteria, as skillful transmitters of knowledge for their disciplines.

The report of the U.S. N.R.C. Committee (1978) studying the needs for research personnel "called for a significant reorientation of the program of fellowship support" away from such fields as education and administration and emphasized training should be in research (p. 129). Only one of the twenty American universities listed in 1978 as offering doctoral programs for nurses continues to offer an Ed.D. program (AJN, 1978, p. 1290). Eighteen percent (15) of Canadian nurses with earned doctoral programs are known to hold such a degree, but only three percent (2) of those enrolled in doctoral programs are currently seeking such a degree (Zilm, LaRose, and Stinson, 1979, p. 65).

In distinction from its definition of a professional doctorate AGS (1966) defined the Ph.D. as "the mark of the highest academic achievement in preparation for creative scholarship and research." A Ph.D. degree is designed to allow the student to think creatively about the emerging science germane to a particular discipline and to explore and to test theoretical models. Formal research training is incorporated throughout the Ph.D. program and the graduate is expected to be able to conduct meaningful research independently and to discover new knowledge throughout his/her career.

The Ph.D. degree has assets for those who wish a career in academia. "Institutions of higher learning were at one time far more tolerant than they are today of accepting and granting promotion and tenure to nurse faculty with lesser educational preparation than members of other disciplines (Downs, 1978, p. 57)." Whether the holder of a professional doctorate has in fact any less preparation is not the point; it is what the label of D.N.S. may connote to appointment and granting agencies' members holding Ph.D.s that is at issue. If one's career goal includes a desire for primary responsibility in a graduate nursing program, the Ph.D. or comparable academic qualification and proven ability to conduct original research in a discipline

are essential, particularly for those who plan to guide doctoral students' research (Chater, 1976, p. 90).

The Ph.D. degree in nursing was first offered in 1934 at New York University (Leininger, 1976b, p. 206). No other Ph.D. nursing program was established until 1970 (Leininger, 1976b, p. 206). In 1978, however, of the twenty United States doctoral programs offered for nurses, the majority (12) were of this type. Seventy-two percent (59) of Canadian nurses with earned doctorates have a Ph.D. (most of these not in nursing; 86 percent (63) of Canadian nurses currently working on doctoral studies are seeking the Ph.D. degree (Zilm, LaRose, and Stinson, 1979, p. 65).

Beliefs:

Belief #1 The N.D. (Doctor of Nursing) will be used to designate a post-baccalaureate nursing degree for entry level professional practice (Schlotfeldt, 1978, p. 302).

Belief #2 The D.S.N. and D.N.Sc. are practice-oriented professional degrees (Cleland, 1976, p. 632; Leininger, 1976b, p. 206; Schlotfeldt, 1978, p. 302).

Belief #3 The Ph.D. is a research-oriented degree (Cleland, 1976, p. 633; Leininger, 1976b, p. 206; Schlotfeldt, 1978, p. 302).

Belief #4 The number of different symbols used to designate nurse-doctorates should be kept to as few as possible and the distinction between them should be as clear as possible (Downs, 1978, p. 59; Kroepsch, 1968, p. 7).

Although the second and third beliefs cited above seem to attest to distinctive attributes of different types of doctoral programs a word of caution is in order. In 1968 Kroepsch predicted "that eventually we shall have a variety of doctorates in nursing in which the similarities among and between them will not be reflected in their titles (p. 7)." For instance, the D.N.S. program at the University of California at San Francisco does not have a clinical practicum but does have a strong emphasis on theoretical formulation, whereas the Ph.D. program in nursing at Wayne State University includes a clinical practicum.

Kroepsch has suggested one should ask several questions before he draws conclusions about a particular doctoral graduate: "Peering over his Ben Franklin glasses, he asks, "and from what university (is your degree)? and in what field? and under whom did you write your thesis?" Then this scholar makes his own judgment as to the quality of the man's formal intellectual experience, and thereupon assigns him to a rather specific spot in his personal academic pecking order. (p. 3)."

Solution: Prospective nurse doctoral students and those members of the nursing profession who urge students to undertake doctoral study should be fully versed in the attributes of any particular program. A personal visit to the university, interviews with potential doctoral faculty, and perusal of that program's graduates' publications as evidence of their research productivity would seem appropriate. By this means it should be possible to align the prospective nursing student's career goals(s) with the appropriate type of doctoral program and to avoid the "hollow promise of a professional future (Downs, 1978, p. 60)" that is inimical to the distinctive attributes of a particular program(s). The third series of criticisms, problem, beliefs and solution arises about the nurse product of any particular doctoral program.

SERIES III

Criticism: "The primary concern, however, remains the failure of nurses qualified in research to continue to pursue research activities in and related to nursing (Pitel and Vian, 1975, p. 35)." Only if such activities are pursued will there be theory development in nursing.

Problem: "How may nurse researchers be better prepared to pursue research projects beyond their doctoral dissertations (Chapman, 1971, p. 2)?"

Background to the Problem:

In the United States earlier surveys of federally funded nursing research, 1955 to 1968, and of American Nurses' Foundation research grants, 1955 to 1970, demonstrated that not very much nursing research was being done by nurses with earned doctorates (Abdellah, 1970a; 1970b; 1970c; *Directory of Nurses with Earned Doctorates,* 1969, 1970, 1971; Taylor, 1970). Only approximately one quarter of the research funded by these two main sources during the fifteen year period 1955 to 1970 was conducted by nurses with doctoral preparation.

In the 1978 Canadian *Survey of University Faculty, Funding of Research Project 1973-1978* (which admittedly excludes any nurse-doctorates in Canada outside of these faculties) a similarly dismal picture is found. Only 11 percent (8/73) of the individuals listed as senior investigators were doctorally prepared nurses. Yet there are eighty-two nurses with earned doctorates in Canada (Zilm, LaRose and Stinson, 1979, p. 64) and in 1973 seventeen of these persons were employed in these same universities (Zur-Muehlen, 1978, p. 59).

Pitel and Vian (1975) in gathering information on 1020 nurses (in 1978 there are over 1800) (AJN, 1978, p. 1160) with earned

doctorates for the 1973 *International Directory of Nurses with Doctoral Degrees* specifically collected data on these nurse-doctorates' research activities. Only 3.5 percent classified their primary position as researcher (Pitel and Vian, 1975, p. 350). Less than half (43 percent) were currently engaged in research and only 31.5 percent perceived research as a major responsibility of their present position (Pitel and Vian, 1975, p. 350). The most telling statistic, however, was that in the previous five years 20.8 percent had not been engaged in any type of research (Pitel and Vian, 1975, p. 350). The problem is not unique to nursing. One study, "indicated that only 15 percent of people who held doctorates ever published anything beyond their dissertation (Neuman, 1976, p. 66)."

One reason for the lack of postdoctoral nursing research may be suggested in Pitel and Vian's (1975, p. 350) data. The dissimilarity they found between the highest frequency dissertation topic and current research interest was, in their view, "astonishing." Whereas the top ranking dissertation topic was nursing-education-curriculum the top-ranking current research interest was nursing clinical studies which had ranked 21st as a category for dissertation topics.

Downs (1976, p. 375) suggests that the criticism related to the lack of evidence that graduates of doctoral programs for nurses pursue research activities following graduation may apply to a lesser degree to the graduates of doctoral programs in nursing. She surveyed 81 graduates of one doctoral program in nursing between 1964 and 1974. Of the sixty-eight respondents 50 percent had completed research or had research underway since graduation (Downs, 1976, p. 376). Since 54 percent had graduated within three years and 83 percent within six years she believes "we have come to the threshold of developing a core of nurses who are motivated to undertake the paintaking pursuit of knowledge . . . . The data suggest that we have been overly hasty in drawing gloomy conclusions about the fruitfulness of doctoral preparation . . . (Downs, p. 377)."

Beliefs:

Belief #1 Research specialization cannot be separated from substantive theory (Kerlinger, 1968).

Belief #2 Students provide unproductive service when they learn the wrong things (Naegele, 1966, p. 22).

Solution: If nurses undertake doctoral study in nursing the likelihood that they will undertake postdoctoral research to test and develop nursing theory is maximized. It is the belief of this author that nursing has a theoretical body of knowledge to study at the doctoral level, that its members who are potential developers of theory

will make appropriate career choices, and that products of doctoral programs in nursing will pursue postdoctoral research. When one returns to the original question posed in this paper — "With the total lack of Canadian doctoral programs in nursing how will development of nursing theory progress in Canada?" another series of criticisms, problems, beliefs, and solution still are apparent.

SERIES IV

Criticism: Canadian nursing has a scarcity of individuals now within it who have the preparation thought to be ideal for the development and testing of nursing theory.

Problem: How can the Canadian nursing profession increase the number of developers of nursing theory?

Background to the Problem:

If one assumes the doctorally prepared nurse would have the best potential for being the developer of nursing theory one is looking to less than 1 percent of the employed nurses in both Canada (*Nursing in Canada,* 1976) and the United States (Pitel and Vian, 1975, p. 342). Although the focus of this paper is limited to the need for theorticians and researchers in nursing there are many other important roles for nurses that are believed to require doctoral preparation (U.S. DHEW, 1976, pp. 101-104).

At the 1975 National Conference on Nursing Research, Huguette LaBelle, then Principal Nursing Officer, Health and Welfare Canada, pointed out that Canadian doctoral programs in nursing were long overdue. In the past 46 percent of Canadian nurses have obtained their doctoral degrees from American universities and 38 percent of Canadian nurses currently working on doctoral studies are studying in the United States (Zilm, LaRose and Stinson, 1979, p. 65). This avenue is becoming less and less available to Canadian nurses as equally well qualified Americans are vying for the small number of available places in American doctoral programs.

No Canadian nurse, as of Pitel and Vian's 1975 (p. 349) international survey of nurse-doctorates, who had taken advantage of the opportunity for doctoral study in the U.S. was reported to have remained there. In fact at that time three American nurse-doctorates were employed in Canada. However, in 1978, seven former Canadian nurses were known to have accepted employment outside of Canada after earning their doctorates (Larsen, 1978).

In 1979, four simultaneously occurring conditions have brought the problem of theory development in nursing in Canada to crisis proportions. They are: (1) a moratorium on development of new graduate programs in Canada; (2) the surplus of qualified American

nurses seeking admission to the U.S. doctoral programs for nurses; (3) the devaluation of the Canadian dollar in the U.S. economy for the few Canadian nurses who are accepted into American programs and (4) the political climate which makes it extremely difficult for Canadian universities to add American nurses with doctoral preparation to their small (47) (Zilm, LaRose, and Stinson, 1979, p. 64) cadre of doctoral prepared faculty and researchers. For example, whereas in 1977-78 Ontario universities were able to recruit 121 full-time professors from abroad, in 1978-79 the number dropped to 73 (*The University of Toronto Bulletin,* 1979, p. 1).

A moratorium on new graduate programs is in effect in institutions of higher learning at a time "when nursing should increase its capabilities to solve critical problems related to health care delivery . . . (and) when a number of nurses are ready and interested to pursue doctoral programs in nursing (Leininger, 1976b, p. 203)." In the United States during 1976 the two largest producers of nurse-doctorates, Teachers College, Columbia University and New York University admitted no new doctoral nursing students in order to maintain quality in the face of increasing enrollments for the same number of faculty (Downs, 1978, p. 57). When the new D.S.N. program at the University of Pennsylvania was announced, 150 inquiries were received within two months (Downs, 1978, p. 57). For 1978 the estimated vacancies in the United States for positions for doctorally prepared nurses were 8,741 (Leininger, 1976b, p. 209). If even a quarter of the U.S. masters programs' graduates plan to enter doctoral programs to fulfil such vacancies, there will be in the U.S. a "Crisis by demand (Leininger, 1976b, p. 208)" for doctoral programs for nurses. Canadian will have to look elsewhere.

Beliefs:

Belief #1 Canada can no longer expect the United States to prepare all of its nurses who wish to pursue a doctorate in nursing.

Belief #2 Nursing must take the initiative for the planning of doctoral programs in nursing in Canada.

Solution: A small group of persons qualified to prepare a green paper on doctoral preparation in nursing *in* Canada were appointed by the Canadian Nurses Association Board of Directors (CNA, Annual Meeting Program: Report of Special Committee on Nursing Research, 1978, p. 23). The mechanism used was the creation of a Task Force from the Canadian Association of University Schools of Nursing, (CAUSN). After discussion at the National CAUSN meeting in October 1978, CAUSN's position on *Doctoral Education in Nursing* (1978) was presented to the Kellogg National Seminar

on Doctoral Education for Canadian Nurses in November, 1978. Clarification of the type and nature of the degree advocated by the Canadian University Schools of Nursing — the Ph.D. — has thus been accomplished but action towards implementation of Ph.D. programs in nursing is the theme of the last series of criticisms, problem, beliefs, and solutions to be offered.

SERIES V

Criticisms: Over a decade ago Kaspar Naegele in looking at the future of Canadian nursing voiced the following criticism: "Canadian (nursing leaders) should lay down their curious reluctance to lead themselves, take a look at what they have to work with, and move onward (Naegele, 1966)."

Problem: When will Canadian nursing come of age and accept responsibility itself for establishing Canadian doctoral programs in nursing.

Background to the Problem:

In 1971 Matarazzo, chairman of a medical psychology department, at a conference entitled *Future Directions of Doctoral Education for Nurses,* indicated that a nursing faculty with five to ten members with a Ph.D., all of whom are productive, several of whom have research underway, and some of whom are nationally visible, would "more than constitute a critical mass for a Ph.D. in nursing . . . (pp. 90-91)." In December 1978 two Canadian universities had five nursing faculty with doctoral preparation *(CAUSN Newsletter,* 1979, p. 3). Moreover, such a degree he said would be fully as robust as 50 percent of current Ph.D. degrees in other disciplines (p. 91). The United States nurses took him at his word. Of the eleven new and proposed Ph.D. in nursing programs as of March 1, 1976, two programs were planned with five doctoral faculty, one with ten, and two with twelve which was the medium number of faculty initiating such programs (Leininger, 1976b, p. 207).

Funding for doctoral programs in nursing is another challenge to be met. "Most doctoral students at Canadian universities have been supported by federal and provincial government fellowships, by teaching or research assistantships and scholarships from universities, or by student loans (von Zur-Muehlen, 1978, p. 67-68)." It is "in the universities' interest to expand doctoral enrolment (p. 67)." Until such income to universities is self-sustaining initial support from granting agencies may have to be sought to ensure doctoral faculty positions during the mounting of a Ph.D. program.

Certainly no university or external administrative body will or should approve a doctoral program in nursing of less quality than

that of other disciplines' Ph.D. programs. In the United States institutions that "presented evidence of strong graduate departments in nursing . . . (Bourgeois, 1975, p. 185)" were the ones awarded grants for doctoral nursing programs.

Beliefs:

Belief #1 The decision to develop or not develop a doctoral program "must be based primarily upon *existing* resources...." (Cleland, 1976, p. 631).

Belief #2 There are Canadian funding sources available for doctoral programs and students.

Solution: Canadian university schools of nursing need to prepare for doctoral programs in nursing by strengthening the base upon which such programs will be built, that is, their undergraduate and, particularly their graduate programs. In 1976-77 in the United States in the schools of nursing with doctoral programs or with pending doctoral programs in nursing, master degree programs' enrolments ranged from fifty-nine to 698. (NRC, Committee Report, 1978, p. 350). In December 1978 two Canadian faculties had master degree enrolments of sixty and sixty-one respectively, but only the latter concurrently had five doctorally prepared faculty (*CAUSN Newsletter,* 1979, p. 3).

Doctoral education is expensive. However, "it is also an investment — an in vestment that pays dividends in new knowledge that eventually — and sometimes rather quickly — improves the economic, health, social, and cultural components of our society (Kroepsch, 1968, p. 6)." Canadian nursing faculties need to be cognizant of every possible source of funding and to tenanciously extract funds from such sources for the mounting of doctoral programs in nursing.

And, finally, nurse faculty of Canadian universities need to stop procrastinating the instigation of Canadian doctoral programs in nursing, and work with their existing faculty resources. The time for Canadian input into development of nursing theory is NOW.

RESUME

Etant donné l'absence totale de programmes de doctorat en soins infirmiers au Canada, quel sera le sort de la théorie du nursing dans notre pays?

Cet article s'appuie sur un modèle philosophique selon lequel les préoccupations de toute profession sont envisagées sous la forme d'une série de critiques, de problèmes, d'opinions et de solutions qui connaissent des changements au niveau des schèmes séquentiels au fil des années. A l'aide de ce modèle, nous avons examiné cinq problèmes:

1. Devons-nous poursuivre la formation pluridisciplinaire au niveau du doctorat en nursing?
2. Comment les milieux concernés distinguent-ils les différents types de formation de troisième cycle en soins infirmiers, pour des infirmières, de sorte que celles-ci puissent choisir un programme de doctorat conforme à leurs objectifs professionnels?
3. Comment peut-on former des chercheurs en nursing qui seront en mesure de poursuivre leurs recherches au-delà de leur thèse de doctorat?
4. Comment les milieux professionnels en nursing au Canada peuvent-ils augmenter le nombre de théoriciens du nursing?
5. Quand le nursing canadien deviendra-t-il suffisamment mûr pour prendre ses responsabilités et mettre sur pied ses propres programmes de doctorat?

Chaque question a été soulevée sous la forme d'un problème après qu'une série de critiques eut été formulée dans des revues professionnelles. Ces critiques sont présentées avant chaque problème respectif. Le contexte de chaque problème fait l'objet d'une discussion, tandis que sont présentées les opinions actuelles relevées dans les revues professionnelles/sur chaque question ainsi que des solutions possibles.

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NURSING AS A DESIGN PROCESS

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INTRODUCTION

Professional nursing is a complex activity which deals with the level of health or well-being of individuals or groups of individuals. Nurses may focus on different client groups and/or types of client needs. However, in order to provide safe, adequate care, the nurse must take into consideration all the health needs of her client, and of those persons affected both by the client's needs and by the intervention intended to assist the client to meet these needs.

THE HUMAN SYSTEM: FOCUS OF NURSING INTERVENTION

Traditionally, nursing has dealt with a person or a group of persons as the focus of its interventions. In some instances, however, the individual, families, or communities, provide the major focus of nursing interventions. However, the individual has traditionally been the smallest unit of consideration for nursing care. Different subsystems of the individual, influencing and influenced by the total person's level of wellness, may require attention, but they remain within the framework of a *part within the total system* under consideration.

Therefore, from a general systems approach, the focal systems of nursing intervention may be considered to be:

A. the individual
B. the family
C. the community.

Any one of these may be chosen as a target for nursing assessment and intervention, the others remaining as background considerations. The nurse in the intensive care unit may focus on individuals as the unit of her interventions. The patients' families use less of her attention in the acute phase of the individual's illness. The family forces which influences and will influence the individual's level of health and ability to recover are considered in her interventions, but remain less salient during a period of immediate survival crisis. Similarly, the community forces which influenced and will influence the individual's and the family's response to, and growth through, the illness episode are considered after the immediate crisis has passed.

THE PURPOSE FOR CONSIDERING THE SYSTEM: THE GOALS OF NURSING INTERVENTION

A systems approach, however, requires a reason for selecting the system for consideration (Hanchett, 1979, pp. 14-15). The goal of nursing is that of increasing the level of health of human systems.

The reason for a specific nursing intervention is defined by the health need presented by the human client system. Health, or growth needs, of human systems can be considered according to Maslow's hierarchy of needs (Maslow, 1943). These needs are not mutually exclusive, rather they are in interaction with each other, and include:

1) survival
2) safety
3) self-esteem
4) belonging and love
5) self-actualization

Nursing as a professional activity deals with these needs according to the priorities presented by the patient or client of its services.

THE MATRIX: THE FOCUS AND GOALS OF NURSING INTERVENTIONS

Nurses focus on different levels or "sizes" of human systems, and different levels or types of needs presented by these systems. Therefore, nursing interventions are more appropriately considered from a matrix point of view than by a single, linear concept. It may be because of this that our problems in defining and interpreting nursing activities have been so difficult. There are a variety of both system sizes and system needs which nurses deal with. All of them are valid and all are delineated by both the level of human system considered and the needs presented by the specific individual or group under consideration.

The matrix, or focus of nursing intervention, then, can be considered to be as follows:

Figure 1. Matrix of Nursing Intervention: The Basis for the Nursing Design Process.

Human System Size	Needs Presented for Assessment and Intervention				
	1. Survival	2. Safety	3. Self-Esteem	4. Belonging and Love	5. Self-Actualization
A. Individual					
B. Family					
C. Community					

Any individual nurse may select one or more areas of this matrix as her own area of specialization, and seek out both educational and work settings in which she is most likely to be dealing with certain human systems with certain general areas of need.

The nurse in an intensive, acute care setting is likely to have individuals with survival needs as her primary focus. The nurse in a home health care agency tends to focus on individuals and families with less acute survival needs. The nurse in administration of a community health agency or involved with political action is most likely to consider communities with different levels of needs. She may focus on survival level needs, such as industrial hazards or she may choose to work toward the establishment of day care programs designed to facilitate the self-actualization of children and their families.

FLESHING OUT THE MATRIX: INTERACTIONS BETWEEN SPECIFIC LEVELS OF HUMAN SYSTEMS

In any systems approach, as in reality, the interactions between the individual "parts" or "components" of a system are as important as the components themselves. So too, in nursing, the interactions between the various levels of human systems which have been selected for attention are as important as the "parts" of the system itself. Interactions between individuals and their families, interactions between families and their community, and interactions between individuals and communities are relevant to the well-being of each of these systems, and therefore appropriate considerations for professional nursing activity. A more complete matrix of nursing interventions would then appear as shown in Figure 2.

Figure 2. Matrix of Nursing Activities, Including Interactions Between Levels of Human Systems Sizes.

Human System Size and Interactions	Needs Presented for Assessment and Intervention				
	1. Survival	2. Safety	3. Self-Esteem	4. Belonging & Love	5. Self-Actualization
A. Individual					
A-B Individual-Family Interaction					
B. Family					
B-C Family Community Interaction					
C. Community					
A-C Individual-Community Interaction					

Examples of nursing interventions aimed at specific interactions within the matrix are as follows:

INDIVIDUAL-FAMILY INTERACTION (A-B).

The need to maintain the integrity of the individual-family interaction is dealt with by nurses in acute care settings according to anticipated and presented health needs.

Belonging and Love (4). The need for continued relationship between parent and child is recognized by nurses working in pediatrics units. This is especially important during those development stages of the child when separation from the parent is most detrimental to the child. This need is considered both in terms of the child in the institution, and the siblings who are at home, in order to assist the parent in planning visiting time.

Self-actualization (5). The need for growth of the relationship between husband and wife via the shared experience of childbirth was recognized by nurses who worked toward gaining the acceptance to the husband's presence in the delivery room. However, these nurses often say "It depends." It depends upon the level of health of each of the individuals, the level of health of their relationship, and an assessment of the individual situation presented by each couple and the anticipated difficulty of the birth.

FAMILY-COMMUNITY INTERACTIONS (B-C).

The relationship between family and community is considered and facilitated by nurses according to the following needs:

Survival needs of families (1). Referrals for welfare assistance, food stamps or other basic formal community services are made.

Self-esteem needs of families (2). Parents are assisted to resist or to change negative playground cultures which evaluate children, parents, and parenting according to specific developmental tasks rather than the unique qualities and achievements of each child.

Need for families to belong (4). Families are helped to integrate into the community by identifying resources and groups with interests similar to their own.

INDIVIDUAL-COMMUNITY RELATIONSHIP (A-C)

Individual-community relationships are a focus for those nursing interventions which deal with a variety of needs such as:

Survival and safety (1-2). The establishment of a program of meals on wheels provides for the survival and safety needs of the individual, and for the self-esteem and altruistic needs of the community.

Safety (2). Community-level programs regarding communicable disease control are aimed to prevent the individual community

member from contracting the disease, and to prevent the community from being a source of disease for its members.

Belonging (4). Identifying retired people within a community who wish to volunteer in a day-care program provides for the older people's needs to belong (4) and to be of service to others (5), as well as providing a mechanism for giving children a positive image of aging. The children also derive a sense of the history of their community through the older people's stories and experience.

THE DESIGN: PATTERNING SPECIFIC INTERVENTIONS FOR SPECIFIC SYSTEMS

In order to appropriately meet the human needs presented for each nursing intervention, the professional nurse must (Mauksch, 1972):

1) take all needs (or problems, or nursing diagnoses) into consideration
2) determine the relative priorities for each
3) identify the resources available to meet these needs
4) design a means of intervention which includes as many of these components as possible, according to their relative priorities.

EXAMPLES OF THE DESIGN PROCESS

1. *The Patient with an Acute Survival Need.*

The design of nursing activities for the patient in the emergency room who requires immediate resusitation includes many levels of system size and types of real and/or potential need.

Individual survival need would present the first priority. Specific measures should be those required for resusitation, monitoring the effects of resusitation, and anticipating needs for revised resusitation measures.

Family: Self-esteem needs. A rapid assessment of the family's need for, and the presence of, available support systems within their own group, and a "mini-assessment" of the family's need for immediate outside support would be done. Respect for the family's need for ongoing information, regarding the success of the resusitation measures, would result in a rapid assignment of someone to monitor and provide these services as necessary.

Individual-family interaction: safety. Maintenance of the integrity of the individual-family "relatedness" would be facilitated by keeping the family informed of the patient's progress, as above, and by allowing the family to be with the patient as soon as possible after the resusitation measures.

2. *The Patient with a Colostomy*

The elements of design considered in doing a dressing change for a patient with a colostomy include many factors. The first priority

in changing the dressing of a patient with a colostomy falls within the area of safety and includes factors such as assessing the level of healing by cleaning the area, and promoting comfort by cleaning and removing the soiled dressing.

The next level, and of equal or greater valence, would be those components designed to promote "healing" of the patient's damaged self-esteem and body image caused by the colostomy. These components of design include removing the soiled dressing, touching and non-verbally communicating acceptance of the patient, and assessing the patient's reaction to the dressing change and to the colostomy.

Promotion and protection of the patient-family interaction would require consideration of measures designed to preserve or promote the patient's self-esteem, and consequent ability to interact with his family, soliciting information regarding the family's response to the effects of the surgery, facilitating and reinforcing the family's positive responses to the patient; and providing information to reduce the family members' negative responses to the patient.

The components of the activity designed to deal with the family would include soliciting information from the patient about the individual within the family. This would depend upon the patient's own level of need and ability to focus off the immediate trauma.

Information regarding community support systems for the family during the period immediately following the patient's hospitalization is designed to facilitate family-community interaction appropriate to the family's need.

Providing information to the patient or family regarding sources of care for the patient during the period following the hospitalization (V.O.N., etc.) and during hospitalization and post-hospitalization periods (ostomy club) are designed to the level of both individual need, and individual-community interaction.

3. *The Patient with Terminal Illness*

A bath for a patient with an advanced terminal illness provides another example of the complexities of the nursing design process.

The patient's safety from additional infection, trauma, and pain are considered along with methods for minimizing the amount of effort he must expend for simple functions for the maintenance of life. The relationship between the patient and his family may, however, provide the priority of the highest valence — and the major developmental task for patient and family alike might be that of re-establishing, or clarifyiing their relationships with each other (Hine, 1977). The actual level of priorities of each of these factors will depend upon the needs of the specific patient and family. The impact of the impending death upon the family is certainly considered by

the nurse, who will, once again, assess their own strengths and support systems, and intervene if she and they feel that these are not sufficient to deal with their needs at the time. Death, as a developmental crisis, provides an opportunity to resolve many previously unresolved issues for the patient, his/her family, and their relationship with each other; and, while difficult, may be the source of dissatisfaction or satisfaction and future growth depending upon the use which is made of this opportunity. The intimacy of touch that, is provided by the bathing process often allows for greater openness of verbal communication with the conscious patient and may provide additional pressure toward verbalization of his concerns regarding significant, unresolved issues.

THE THIRD DIMENSION: TIME

In order to consider the elements of design needed to facilitate the level of wellness of the person(s) under consideration, the nurse must take in to account the element of time. What forces from the past have been carried into the present and are part of the individual, family or community "now"? What future growth needs and resources must be considered to intervene appropriately in the present?

For example, what needs and resources of the individual with an amputation are relevant to that person's current values and patterns of activity? How will these affect his current and future concept of himself and his ability to carry a positive self-concept into future dealings with his family and community? What does he see as the things he would most like to achieve in life? What care is needed to maintain his own internal and external resources so that he can meet those developmental needs? Extending the matrix to identify growth needs and resources from the past into the present and the future is equally necessary to design appropriate nursing care.

SUMMARY AND SUGGESTIONS FOR FUTURE USE

Each specific nursing intervention is an intricate design process based upon the individual's present and future levels of wellness, weighted by the most immediate need presented, and tailored to meet the valence of each level of need as expressed by the individual, family or community for whom the intervention is carried out (Alexander, 1964).

The value of professional nursing, I believe, can only be documented as we become more aware of this design process. Nursing process and problem-oriented approaches can only work for documentation, audit and nursing investigation, if they are somehow brought into congruence with the complexities of professional practice. The value of the problem-oriented approach for nursing may be

precisely that the components of design are made consciously available to the nurse (Gane, 1972).

It would be very time consuming to record every component of design for every nursing intervention performed. Rather, an initial pattern of need might be determined at the initiation of contact with the client. At this time a "goal pattern" might be projected along with the anticipated date for its achievement. The original pattern of need could then be re-evaluated periodically. The changes in levels of need presented would both update the accuracy of the initial assessment, and document the success of the nursing interventions performed (Hanchett & Johnson, 1967).

RESUME

Les activités professionnelles de nursing sont un processus de conception complexe dans lequel il faut tenir compte (A) de la personne, (B) de la famille et (C) de la collectivité ainsi que du niveau des soins selon le(s) système(s) étudié(s). Le système étudié et son interaction avec d'autres systèmes représentent un aspect de la matrice conceptuelle (Fig. 2). Le niveau des besoins (1) survie, (2) sûreté (3) respect de soi, (4) sentiment d'appartenance et amour et (5) réalisation de soi présente dans le second élément de la matrice. Enfin la dimension temps, les besoins du client dans le contexte présent et ses besoins futurs anticipés doivent être considérés dans le cadre du processus de conception complexe qu'est l'activité professionelle de l'infirmière. Plusieurs exemples des éléments considérés au cours de différentes interventions infirmières sont donnés.

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CUMULATIVE INDEX TO NURSING PAPERS/ PERSPECTIVES EN NURSING

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NOTES

The following index lists all of the authors and titles of articles that have appeared in *Nursing Papers/Perspectives en Nursing* since the first issue in 1969.

The index is organized in strict alphabetical order with the exception of articles (the, a, an, le la, etc.). Thus a title such as "The family practice nurse in Newfoundland" will be found under "F." The numbers following each entry refer to volume, issue, page and year of publication respectively. "Responses" appear only in the title index and are listed with the article.

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L'index qui suit donne une liste des auteurs et des titres des articles publiés dans *Perspectives en Nursing/Nursing Papers* depuis le premier numéro paru en 1969.

Cet index est agencé par ordre alphabétique, sauf en ce qui concerne les articles définis et indéfinis (un, une, le, la, etc.). Ainsi l'on trouvera l'article intitulé "L'enseignement de la recherche à la maîtrise" sous la lettre "e." Les chiffres qui suivent chaque notice ont trait au volume, au numéro, à la page et à l'année de publication respectivement. Les répliques n'apparaissent que dans l'index des titres et sont classées avec l'article qu'elles concernent.

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Position available July 1, 1980 to teach MEDICAL-SURGICAL NURSING.

Experience in clinical specialty and classroom is required. Work is with senior students in a baccalaureate program. Applicants should be able to qualify for rank of Assistant or Associate Professor. Master's degree essential. Salary commensurate with educational preparation and experience.

Send curriculum vitae and names of three referees to:

Miss I. Leckie, Dean
Faculty of Nursing
University of New Brunswick
P.O. Box 4400
Fredericton, N.B. E3B 5A3

McGILL UNIVERSITY
SCHOOL OF NURSING

GRADUATE PROGRAM IN NURSING
MASTER OF SCIENCE (APPLIED)

This program has been designed to prepare clinicians and researchers for the expanding function of nursing in our rapidly developing health care services.

Options available:

Option A: Clinical Nursing Practice

Option B: Research in Nursing and Health Care

Graduates will be prepared to incorporate either option within careers in the teaching of nursing or the development and management of nursing service.

Admission requirements

Either a Baccalaureate degree in Nursing comparable to B.Sc.(N) or B.N. from McGill; or a Baccalaureate degree comparable to B.A. or B.Sc. offered at McGill.

Length of program

Two years for those with nursing degrees
Three years for those with non-nursing degrees

Language of study: English

Further information from:

Director, School of Nursing
Master's Program
3506 University Street
Montreal, P.Q. H3A 2A7