# *NURSING PAPERS*
# *PERSPECTIVES EN NURSING*

Tailoring Nursing Education Programs to Meet the Nature of Community Needs

Orientations du Programme de Baccalaureat

**Volume 11, no 1**

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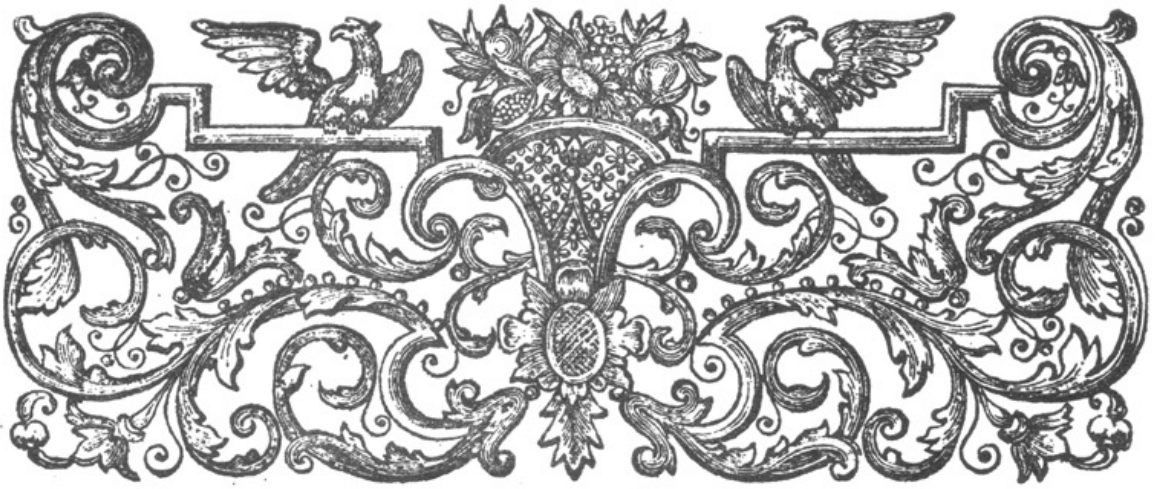
Patient/Professional Interaction and its Relationship to Patients' Psychological Distress and Frequent Use of Health Services

Learning to Observe

**Volume 11, no 2**



# NURSING PAPERS
# PERSPECTIVES EN NURSING

*Nursing Papers/Perspectives en nursing* is published quarterly by the School of Nursing, McGill University, 3506 University Street, Montreal, P.Q. H3A 2A7, Canada. We invite articles related to nurses and nursing particularly those which assess problems, pose questions, describe ideas and plans of action in research, education, administration and practice.

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NURSING PAPERS
PERSPECTIVES EN NURSING
Volume 11, no 1

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# EDITORIAL

## Does Anyone Out There Practice?

An analysis of the titles listed in the Cumulative Index published in the Winter, 1978 issue of *Nursing Papers* reveals that the first ten volumes included seventy-one articles related to nursing education and thirty-two related to clinical practice. Of the clinical articles, ten discussed "the extended role of the nurse," and most others were theoretical discussions of nursing practice rather than actual application of theory or research to "real" clinical situations. Why is there such a scarcity of articles which discuss patients or clients, analyse nursing practices, or report the results of clinical research? Is it because no one out there is practicing nursing?

I believe there is a serious need for a significant increase in the number of articles which present a scholarly analysis of issues relating directly to clinical practice. If nursing is to survive and advance as a discipline, we must continue to develop logical — not intuitive — means of assisting clients to meet their needs. Advances in knowledge and technology permit a considerably more scientific approach to understanding individuals and families and to developing rational approaches to meet their health needs. But is that really happening? Are our clinical practices based on the results of research in the physical and psychosocial sciences or nursing care? Can we support our actions with a scholarly defense? The only way to ensure that we are not left to "invent our own wheels" is to publish the results of our research or to present discussions of approaches and problems in nursing care. We *must* communicate with each other.

Does the huge ratio of education to basic clinical articles mean that the nursing authors in Canada are far more comfortable with educational than with clinical issues? Does it mean that these authors — mainly university faculty members — are more concerned about nursing education than nursing practice? Is it a reflection of the fact that only 7% of Canadian nurses with doctoral degrees have nursing as their "major discipline"?[1] Or — does it mean that we, as faculty, are so far removed from the "real world" that we do not see the issues of practice that need to be addressed? If the latter is the answer — how do we maintain credibility with our students or within either the academic or nursing community?

It is true that this journal provided the first vehicle in Canada for in-depth discussion of issues related to university nursing education.

However, it is time to move on and to place similar efforts on advancing the state of knowledge about clinical practices.

So — if anyone out there practices nursing —

Where are you?

What are you doing?

What are your problems?

What are your ideas and solutions?

The Winter 1978 issue of *Nursing Papers* carried a letter from Julienne Provost, Regional Representative, which indicated "the need to increase the proportion of articles on clinical research" (p. 88). I urge you to submit articles relating to clinical practice which describe new insights into reactions of individuals and families, or new approaches to care. Communicate the results of your pilot studies and research projects. It is only from such a body of literature that we will be able to make sufficiently rapid gains in our understanding of our patients or clients, and the development of realistic clinical practices.

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[1] Larson, J. B., and Stinson, S. Interim data analysis: Some beginning Manpower statistics. In *Ph.D. (Nursing)*, Glennis Zelm, Odile Larose, Shirley Stinson (eds). Ottawa, Canadian Nurses Association, 1979, p. 65.

# EDITORIAL

**Cliniciennes, manifestez-vous . . . .**

En analysant les titres figurant à la table récapitulative parue dans le numéro de l'hiver 1978 de *Perspectives en Nursing,* on s'aperçoit que les dix premiers numéros de cette revue présentaient soixante-et-onze articles consacrés à l'enseignement des sciences infirmières et trente-deux à la clinique. Parmi ces derniers, dix exposaient "le rôle élargi de l'infirmière" et la plupart des autres étaient des exposés théoriques sur la pratique du nursing au lieu de l'application de la théorie ou de la recherche à des situations cliniques "réelles." A quoi peut-on attribuer cette pénurie d'articles traitant des clients ou des bénéficiaires, analysant les pratiques en soins infirmiers ou décrivant les résultats des recherches cliniques? Serait-ce qu'il n'y a personne qui "mette vraiment la main à la pâte?"

A mon avis, il est impératif d'augmenter considérablement le nombre d'articles qui présentent une analyse savante des problèmes relevant directement de la clinique. Si l'on veut que le nursing survive et progresse en tant que discipline, on doit continuer à concevoir des moyens logiques (et non intuitifs) pour aider les clients à faire face à leurs besoins. Les progrès de la science et de la technologie nous permettent d'adopter une approche nettement plus scientifique pour comprendre les personnes et les familles ainsi que mettre au point des méthodes rationnelles visant à répondre à leurs besoins en matière de santé. Mais est-ce là ce qui se passe dans la réalité? La clinique est-elle fondée sur les résultats de recherches menées en sciences physiques et psychosociales ou en sciences infirmières? Pouvons-nous justifier nos actions en présentant une défense scientifique? La seule façon de nous assurer de ne pas avoir à réinventer la roue consiste a publier les résultats de nos recherches ou a présenter des exposés sur les méthodes et les problèmes de soins infirmiers. En un mot, nous *devons* communiquer entre nous.

Est-ce que la proportion élevée d'articles consacrés à l'enseignement des sciences infirmières par rapport aux articles cliniques de base signifie que les auteurs dans la discipline au Canada sont davantage en mesure de traiter de problèmes didactiques que de problèmes cliniques? Cela veut-il dire que ces auteurs qui sont pour la plupart des enseignants universitaires, se préoccupent davantage de l'enseignement que de la pratique des sciences infirmières? Doit-on y voir un reflet du fait que sur le nombre d'infirmières canadiennes qui possèdent un doctorat, 7% seulement sont docteurs en nursing.[1] Ou bien

faut-il en conclure qu'en notre qualité d'enseignants, nous sommes si éloignés de la "réalité" que nous ignorons les problèmes pratiques du nursing qui méritent toute notre attention? Si c'est le cas, comment arriverons-nous à conserver une certaine crédibilité tant auprès de nos étudiants qu'au sein du monde universitaire ou infirmier?

Il est vrai que cette revue a été la première tribune canadienne où l'oi a débattu en profondeur des problèmes liés à l'enseignement du nursing au niveau universitaire. Toutefois, il est grand temps d'aller de l'avant et de déployer autant d'efforts pour faire progresser l'état des connaissances sur les pratiques cliniques.

Si donc il se trouve des cliniciennes parmi vous, répondez à ces questions:

Où êtes-vous?

Que faites-vous?

A quels problèmes vous heurtez-vous?

Quelles idées et quelles solutions nous proposez-vous?

Le numéro d'hiver 1978 de *Perspectives en Nursing* a publié la lettre de Julienne Provost, représentante de la région du Québec qui soulignait "le besoin d'augmenter la proportion d'articles consacrés aux recherches cliniques" (p. 86). Je vous invite instamment à nous soumettre des articles qui traitent de la clinique, qui décrivent sous un angle nouveau les réactions des personnes et de leur familles ou qui proposent de nouvelles approches en matière de soins infirmiers. Partager avec nous les résultats de vos études pilotes et de vos recherches. C'est la seule façon que nous ayons de mieux en mieux comprendre nos bénéficiaires ou nos clients et d'élaborer des pratiques cliniques réalistes.

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[1] Larson, Jenneice B. and Stinson, Shirley M. Analyse intérimaire des données: Quelques statistiques de Main-d'oeuvre. Dans *Ph.D. (Nursing)*, Glennis Zelm, Odile Larose, Shirley Stinson (eds.). Ottawa: L'Association des infirmières et infirmiers du Canada, 1979, p. 71.

# TAILORING NURSING EDUCATION PROGRAMS TO MEET THE NATURE OF COMMUNITY NEEDS*

by
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The invitation to be your theme speaker is an honour and a responsibility which I accepted willingly but with many misgivings. The theme as stated incorporates a philosophy that is basic to planning any educational program which prepares candidates for entrance to professional practice, since professions accept an obligation to be of service to society. Yet within the theme lies a broad range of questions pertinent to our concerns as members of the nursing profession and members of the academic community. Selection from that range proved even more difficult than I had anticipated. There are also connotations to the term "tailoring" which have troubled my thoughts. This word usually refers to a process which involves consultation with the purchaser, selection by him of a design and fabric suited to his wishes, measurement and meticulous attention to construct with exact fit. If the tailoring is successful the result is a garment that is functional and appropriate to the needs of the purchaser. Are the nursing education programs which we tailor proving to be functional and appropriate in meeting the needs of our purchasers — ultimately the community — and can we hope to achieve an exact fit?

I propose to develop a focus within the theme by reviewing briefly the nature of community needs which our programs are attempting to meet and the areas of unmet need which we could or should meet. Against this background I intend to examine the degree of freedom we have and the types of constraints placed on us in tailoring our programs, and then to identify what seem to be crucial issues to be faced.

The education programs which are CAUSN'S primary concern are, by definition, programs of nursing education within a university system. A majority of these are programs at the baccalaureate level which prepare candidates for entry into practice as registered nurses. Each university school was established in response to environmental

* Paper presented to the Canadian Association of University Schools of Nursing, Spring Conference and Council Meeting, May 1979.

conditions unique to its location at the time but with shared values about the aims of university education for nursing. Although the pace and form of development has varied among schools, all in recent years have been active in curriculum evaluation and revision reflecting recognition of the rapid changes taking place in Canada's health care system and the increasing demands being placed on nursing. Whatever the approach used, the process of curriculum revision has included the assessment of changing community health needs, the acceptance of an obligation for nursing to contribute to meeting those needs, and a redefinition of the specific role of the nurse who is prepared in a university program.

It should be noted that the nursing profession supports both a diploma and a degree route for entry into practice as a registered nurse. Faculty responsible for diploma programs would also carry out an assessment of community nursing needs and make decisions as to the range and level of needs the diploma program should prepare its graduates to meet. Because of the lack of differentiation of legal status at the point of entry to practice, it is not too surprising for an assumption to be made by the community in general that there is little difference between the beginning practitioner who has a degree and one who has a diploma. When both are employed on the staff of a hospital the expectation is that either can cope with a broad range of nursing needs and decisions as assigned by the employing agency.

Because of the method of university financing and the provincial responsibility for education there is some expectation that the community of immediate concern to university nursing programs will be the region or province in which the university is situated, with specific attention to the health needs of various population groups within that community. Yet there is also a valid point of view which argues that universities are, at the least, a national resource rather than a regional or provincial resource. The mobility of Canadians within Canada and in travel to other parts of the world, the reception of immigrants to this country and the mobility of health professionals as they pursue career opportunities are all influences toward using a broad definition of community. So a decision has to be made about the extent of community we intend to serve, the sources of data we will use to identify the nature of present health needs and the trends to be anticipated for the future. For an audience such as this, it is hardly necessary to mention the many sources of data about the needs for health care both in terms of demands for and utilization of services and in the statistical evidence of unmet needs. Much of these data, for example morbidity and mortality rates, have substantiated

the need for curative services during illness but provide only indications of need for care to promote health maintenance and health-enhancing behaviour. Documents such as Lalonde's *A New Perspective on the Health of Canadians* (1974) have encouraged health professionals and the general public to accept a more comprehensive definition of the nature of health needs and this has been reflected in the design of nursing education programs by university faculty.

I have suggested that a realistic assessment of community health needs can be made with existing data. The clarification of nursing needs within the complex of total health needs is more difficult, possibly because the definition of nursing is diffuse, expands and contracts in relation to the presence or absence of other health professionals and varies with the education and career aspirations of its practitioners.

For many years, and more forcefully within the past decade, attention has been given to re-defining the role of nursing and clarifying the contribution that nurses can make to health care as independent professionals in a collaborative rather than a dependent role. Frequently innovative nurse researchers and writers have formulated proposals for improvements in health care based on a more independent role for the nurse which incorporates caring and decision-making functions which many nurses recognize as already within their competence. One such proposal "An Open Health Care System Model" by Madeleine Leininger (1973) provides for attention to the social, cultural and environmental aspects of the client community and emphasizes health promotion, health maintenance and health restoration. It is interesting to compare this with the model proposed in *The Community Health Centre in Canada* (1974) in which there is more constraint placed on the role of the nurse. Another example of creative redefinition of the nurse's role is being carried out in the demonstration of "The Workshop" under the direction of Dr. Moyra Allen at McGill. These models, among others, have highlighted methods of practice and a level of competence which many nurses believe are appropriate for nursing and would be effective ways of meeting needs for health care, some of which are now neglected. Yet others, along with physicians and administrators, view these models as too independent of medical authority to be safe or organizationally acceptable.

Many examples could be cited of expansion and contraction of the nurse's role in relation to the supply and availability of other health workers, especially physicians. The degree of responsibility for diagnosis and treatment expected of nurses posted in northern areas

is well-known and such nurses suffer a special form of culture shock when they return to large hospitals in southern Canada and find their role sharply constricted. In this province when the Nurse Practitioner Pilot Project was under way there was a definite change in acceptance of this role by physicians as the likelihood of an increasing supply of physicians in rural communities developed.

There is considerable evidence that a broader perception of nursing responsibility and of capacity for a more independent role is held by nurses prepared in a baccalaureate program and is demonstrated early in their practice. This is partially a result of the scope and length of their educational experience and may also reflect a different approach to career selection than is held by those who choose a shorter program of preparation. Evidence is accumulating that the changing health care system could use a larger proportion of nurses with preparation at the baccalaureate level and will require sharper delineation at entry to practice between the roles and responsibilities of baccalaureate nurses and those with shorter preparation. There have been many attempts to grapple with the implications of the quality of our present system of education for meeting emerging needs for nursing. The Report of the Alberta Task Force on Nursing Education (1975) presents an analysis of community needs for nursing on which are based recommendations for changes in education. This report is of interest not only because of the expansion of university nursing education which it proposes but also because it is a report of the Department of Advanced Education and Manpower.

In general, university nursing programs at the baccalaureate level have accepted a generic model as functional and have designed programs to enable the graduate to enter nursing practice in a variety of settings, to use a self-directing, problem-solving approach and to be accountable for her continued learning and competence in practice. Response to changing community needs has been shown by recent curriculum changes such as increased emphasis on concepts of health promotion and health maintenance, on mastery of more comprehensive skills of health assessment and greater attention to health needs and health care of the aging client.

Specialization in a clinical area of practice or in functional areas of teaching and administration is not now regarded as appropriate in the undergraduate program, although the student may have various options during the baccalaureate program that will allow some introduction to these areas. Specialization with mastery of a selected area of practice is included in programs of graduate study.

From evidence collected in surveys of graduates we — as university teachers — believe we have programs that supply our communities with practitioners who are prepared to deal with major health needs and to demonstrate competence in a broad spectrum of nursing activities. If this is so, can we be satisfied to have areas where these nurses are needed but not employed? A major area of unmet need for effective health care is among native groups both in rural areas and as migrants into cities. Although needs for illness care persist and graduates have preparation to care for patients with acute illness, are we making adequate provision to deal more effectively with the need to help clients change behaviour and lifestyles likely to be injurious to health? Some writers have suggested that universities have not served society well as innovators and promoters of needed change in the health care system. Dr. Marguerite Schaefer, in an article in *Health Care Issues* (Fall 1974), deals with this role of the university as a "fighter for change" and contrasts it with the ideal of the university as the preserver of knowledge which works "to promote *gradual* social program". This criticism of universities as somewhat inflexible and slow in responding to a need for change is specifically directed at nursing programs in universities by Jeanne Marie Hurd (1979). She is not only critical of curricula but also of the educational methods and their effects on students.

Other questions that could be raised by each of us about the "fit" of nursing education program to the needs of the community might include:

What community need is our program *primarily* designed to meet?

Are we measuring the output of the program in ways that are reliable and have validity for the public that provides the resources for our use?

To whom and how do we communicate information about the aims and accomplishments of our program?

To what extent have we accepted the judgment of consumers about nursing needs in identifying and selecting those that our program should aim to meet?

Can the program focus on the needs of the outside community and simultaneously meet the academic standards of the university community?

What of the needs of the student community that gains entrance to our program, personal needs for development through education and vocational need for a credential

that is portable in the wider community where they seek employment?

What consideration do we give to the needs expressed by our professional community, our colleagues in associations and in service agencies?

Are we prepared to state priorities among community needs that our program could meet and, in a time of restricted funding for university education, select those that we will meet?

My hypothesis is that although we have been conscientious and persistent in our attempts to tailor university nursing education programs to meet community needs for nursing, our perception of the nature of those needs is congruent only in part with the perception of other members of the community. Our perception differs from that of many consumers of health care, from members of other health professions, from funding agencies and from many colleagues in other fields of nursing. A recent example of this gap in perception occurred during a conversation I had at the Convocation Tea. I was speaking to a friend of one of the graduates of the post R.N. program. After a complimentary remark about the graduate's achievement her friend said, "What does she plan to do? Now that she has her degree she won't go back to nursing." Let me hasten to add that I do not imply that our perceptions are in error, but until we find ways to close that gap, we will lack credibility and support. Perhaps we should state that our programs are designed to meet only certain selected needs within the range of the community's total nursing needs. If this be so then, as members of a profession that supports both a diploma route and a degree route to registration for nursing practice, we must work with colleagues in nursing to clarify public understanding of the dual system.

What evidence do I have to support this hypothesis? One consistent indicator is that employment practices and personnel policies in a substantial number of health care institutions give only token emphasis to the desirability of a baccalaureate degree in nursing as a qualification for nursing practice. Advertisements for positions as head nurse, supervisor or director convey a clear message when they state, following a requirement about experience, "baccalaureate degree desirable" with some adding "but not required". These same institutions do not appear to believe there is any relationship between initial recruitment of B.S.N. graduates and their later availability within the agency for promotion. On the other hand these employers may have found that new graduates from university programs do not

practice in a way that meets the nursing needs of patients in their care. The difficulties new graduates face in coping with "reality shock" have been described vividly by Marlene Kramer (1974). Others have referred to different kinds of difficulty and suggested that these result from inadequacies in the educational program. This is the point of view of Jeanne Marie Hurd to whom reference was made earlier.

Another kind of evidence is supplied by requests from employers who identify a need for post-diploma courses of specialization. The Canadian Nurses Association in 1973 issued a position statement on Specialization in Nursing based on work done by Hall, Baumgart and Stinson which recommended such courses. The response to requests for short courses of specialization has been uneven at best. If we perceive these needs but believe that such educational programs cannot be appropriately provided by the university, do we take action to encourage development elsewhere? We may deplore the "quick-fix" approach of a multitude of short courses, particularly if there is an expectation that these will add up to meet requirements for a degree. But in terms of the urgency of the need, and the time and freedom of nurses to enrol in more comprehensive educational programs, short courses may be a realistic answer.

Another type of gap in perception sometimes exists in regard to the educational opportunities needed for registered nurses to achieve the B.S.N. On one hand it is difficult to accurately assess the demand for such opportunities and the motivation for continuing in an academic program. On the other hand it is difficult, particularly for women who have family responsibilities, to perceive the objectives of a university program as tailored to meet their needs. Add to this a certain difficulty in achieving flexibility within a university system, compounded by the need of the system to deploy resources in the most economical way possible, and the perception of unmet need in the professional community may be reinforced.

Many of you could bring forth evidence to disprove my hypothesis and argue convincingly that differences in perception of need would not be a problem if we could produce a critical mass of nurses with university education. Better prepared nurses would demonstrate that nursing and health care needs could be effectively met. It seems logical then to advocate the baccalaureate degree as the basic preparation for entry into the practice of professional nursing. Other personnel prepared in different programs identified as non-professional patient-care assistants would function in association with and under the direction of the nurse. This is the proposal outlined in the

American Nurses Association Position Paper (1965) and is the basis of the Resolution on Entry into Professional Practice approved by the New York State Nurses Association (1974) for implementation by 1985. A similar proposal was presented by the Alberta Task Force (1975) with a specific timetable for achievement through a combination of university based baccalaureate programs and articulated baccalaureate programs.

A recommendation regarding the baccalaureate degree as mandatory for entry into practice has been discussed by CAUSN on more than one occasion with reactions ranging from enthusiastic acceptance to extreme caution. Three intermediate points on that scale could be classified as reluctant approval in principle, delay until further evidence is presented, and a clear willingness only to back into the future.

Although a mandatory degree program seems inevitable to many, it is still primarily at the stage of examination and review among those involved in university nursing programs and some groups within nursing associations. There is a paucity of evidence that the wider community — the consumers of nursing care and the government departments responsible for funding nursing service — share these perceptions of the nature of the needs for nursing that *should* be met and that *could* be met most effectively by nurses prepared for practice in a university program of nursing education. We may believe that their view of need for nursing is simplistic and tied to a model which perceives nursing as needed most to assist with cure of illness of an acute and/or life-threatening nature. Recognition is given to the need for sufficient quantity of nurses, where and when the need is apparent, but the prevailing view of the wider community is that the cost of the nursing component within health care should be restrained, and that the additional time and cost of university preparation should be required for only a small proportion of the work force. It is now 15 years since the Hall Commission (1964) included a recommendation that 25% of the supply of registered nurses should be prepared at the baccalaureate level. Progress toward that goal has been slow.

Some administrators of nursing service have contributed to and supported a perception of the nature of community nursing needs similar to the above and as a consequence have required that staff have university preparation for practice. This is the situation in many public health nursing agencies where vigorous recruitment has secured a high proportion of staff with a baccalaureate degree.

Dr. Margaret McClure of New York spoke to the WRCAUSN meeting in Winnipeg in February 1979 and emphasized the requirement for improved education of nurses as the basis for competence. She made particular reference to the perception of this need by Nursing Service Administrators in New York and their conviction that baccalaureate education was a prerequisite for the assurance of quality nursing service in hospitals. The seqüel to their conviction was their action in bringing to the New York State Nurses Association the resolution to which I referred earlier. Their personnel policies in hiring staff nurses reflect this conviction.

But I reiterate — there is a gap between our perception of the nature of nursing needs and the perception of the community which we aim to serve. I suggest that gap will exist until we find ways of demonstrating conclusively that there are serious unmet needs which could be ameliorated by nursing practitioners prepared in education programs which we tailor to meet those needs. The community — and governments which set policy and determine the allocation of funds for the range of health services — will then have a more comprehensive understanding of the cost-benefit ratio of university nursing education programs and will make informed judgments whether or not to supply the resources we believe are necessary.

I have attempted to show that as nurse educators we are concerned that the educational programs we design should competently prepare practitioners of nursing to meet the present and future needs of the community, or communities, we serve. I have suggested that we are aware of changed needs and increasing demands placed on nurses and that we acknowledge the fact that, although in Canada access to health care is regarded as a right, there are significant areas of unmet need here in this country. Against this background let us consider what freedom we have and what constraints are placed on us in tailoring university programs in nursing education.

We have one important freedom that we have perhaps failed to recognize as a freedom. I refer to the dual system of educational preparation for nurse registration/licensure. This permits us freedom from the direct pressures of responsibility for a quantitative supply of nurses in response to the fluctuating market. There are adequate numbers of diploma programs and since the larger proportion of the nurse manpower reaches the market from those programs, we are free to consider emerging needs and to select our areas for concentration.

Another freedom that we have is the availability to us of the resources of the university. This provides support in curriculum

implementation because there are general basic classes shared with students in different colleges. The university setting also allows faculty to evaluate their endeavours in teaching, research and scholarly and professional work. Associated with this is the concept of academic freedom to pursue excellence in a climate of responsibility and mutual respect.

As you will see, these examples of freedom also carry with them concomitant restraints. The dual system of preparation for entry into the practice of nursing contributes to widespread misunderstanding of the role and responsibility of nursing. And, in the agencies where services are provided to meet the nursing needs of clients and the community, there are not only registered nurses with two levels of preparation. There is, in addition, a large group of other persons with varying kinds of preparation classified as nursing personnel. Confusion about who is a professional nurse, what responsibilities she can handle, and in what educational setting she should be prepared presents a major constraint for future planning.

In the present context of university budget restrictions, it is hardly necessary to comment that the access to university resources does not imply unlimited freedom. Nonetheless, I do not believe that there is evidence that the financial resources that flow through other channels to support nursing education programs are much more liberal.

A serious constraint in terms of resources is the relatively small supply of well-qualified candidates for faculty positions and the limited opportunities for graduate study in nursing available in Canada for members of the nursing profession who wish to embark on an academic career. This constraint has been highlighted by the Conference on Doctoral Education in Nursing held in November 1978. The magnitude of the need for well prepared teachers in nursing is greater when we include in the estimate the numbers of qualified teachers required by the diploma programs.

One aspect of this constraint is that of the balance desirable between expertise as a clinical practitioner of nursing and expertise in other areas such as teaching, curriculum, nursing administration, research. As a practice profession we must address ourselves to the problems of practice including the need to ensure that nurses maintain and improve competence as nursing practitioners and that this element, to me the core of the profession, is retained under the control of nursing. As we observe the influences on the practice of nursing and situations in which non-nurses are acquiring greater control over the administration of patient care including nursing care, we can forecast further shifts in decision-making authority away

from nurses so that others will decide the parameters of nursing practice and the priorities to be set. It is crucial that students in their educational program be taught by nurses whose commitment to and accountability for clinical practice is unequivocal whatever their major area of teaching or their specialization as practitioners.

Reference has been made to the lack of understanding by the public of the present responsibilities of nurses and their potential for changed contributions to health care. Everyone knows what a nurse is, or at least they are familiar with such symbols as the cap, and they have an ideal of a person who gives compassionate care during illness with a continuing devotion to duty. I would suggest that this traditional image of the nurse and the consequent favorable impression the public retains was the result of much contact, planned and unplanned, between nurses and the community they served which was reflected in a perception of nursing that is part of folklore. This limited outdated image must be replaced. This can only be achieved if we give more attention to co-operative work with consumers in assessing the health care needs of their community. We must encourage them to explore with us the ways in which the potential of nurses for improved services is now untapped or restricted, and how this potential can be released.

One other constraint that I wish to mention before leaving this topic is the constraint imposed by our difficulties as members of a profession in which the majority are women. Strong social values about the role of women influence the priorities that women may give to the needs and requirements of their career and to their professional affiliations. One area in which ambivalence affects our functioning may be seen in variations in quality and persistence of nurses' involvement in broad issues of importance to the progress and power of the nursing profession. There is evidence that nurses, as a group, do not show consistent support for their association and to their colleagues in nursing. Disagreement is healthy and essential for productive change but we must find ways of eliminating divisiveness once the issues have been discussed and a decision reached. It is a serious constraint when nurses as a group do not support the endeavours of their colleagues and instead allow themselves to be aligned with the aims of other professions and/or authorities who in their own interests — not the interests of improvement of health care — do not wish nursing to become independent, competitive, and powerful. This question, which was categorized as an issue of unity among nurses, was presented in an interesting and convincing fashion as an article in American Journal of Nursing (1975) recording a discussion among a group of well-known American nurses.

In conclusion then, what are the issues to be faced if university nursing education program are to achieve a more exact "fit" to the nature of community needs for nursing? First there is an issue of credibility in our definition of the *nature* of community needs which our graduates are prepared to meet. This occurs among a large number of the average nurse members of the profession; it occurs among other health care workers; and it occurs among the members of the community who are consumers of health care.

There is also an issue of our credibility with non-nurse members of the university community. How are we like other nursing education programs and how different? In what ways are we similar to other faculties and how dissimilar? Can we achieve greater clarity about what our mission and place should be vis-a-vis other university programs?

Second, there is the issue of achieving acceptance of the baccalaureate degree as the requirement for entry to the practice of nursing or supporting a clear division of the role and functions for each of two levels of registered nurses. Resolution of this issue will involve consultation with the registration bodies, determination of financing and other resources, achievement of support from professional associations, unions, employers, other health care workers and of the general public, our community.

Third, if decisions are taken that the baccalaureate degree will be required as the entry to practice, subsequent issues will have to be resolved. Would there be adequate numbers of candidates to meet the needs, and would they accept this obligation of greater preparation time. Would there be sufficient nurses remaining in practice over time to justify the social cost of the longer program with the concomitant need for greater educational costs for preparation of faculty, and for administrators and specialists in service agencies.

*REFERENCES*


Alberta. Department of Advanced Education and Manpower. *Report of the Alberta Task Force on Nursing Education.* Edmonton: Department of Advanced Education and Manpower, September 1975.

American Nurses Association. *Educational Preparation for Nurse Practitioners and Assistants to Nurses.* A position paper. Kansas City, Missouri: American Nurses Association, 1975.

Canada. Royal Commision on Health Services. *Report* (Vol. 1). Ottawa: Queens Printer, 1964.

Canadian Nurses Association. *Ph.D. (Nursing).* Proceedings of the Kellogg National Seminar on Doctoral Preparation for Canadian Nurses, Ottawa, September 1978. Ottawa: Canadian Nurses Association, 1979.

Hall, O., Baumgart, A., and Stinson, S. Specialization in nursing — Where? When? How? *The Canadian Nurse,* May 1972, 40-42.

Hasting, J.E.F. *The Community Health Centre in Canada* (Vol. 1). Report of the Community Health Centre Project to the conference of Health Ministers. Ottawa: Information Canada, 1972.

Hurd, Jeanne Marie L. Nursing and the degree mystic. *The Canadian Nurse, April* 1979, 37-39 and May 1979, 36-38.
Kramer, Marlene. *Reality Shock*. St. Louis: C. V. Mosby Co., 1974.
Lalonde, Marc, *A new perspective on the health of Canadians: A working document*. Ottawa: Department of National Health and Welfare, 1974.
Leininger, Madeleine M. An open health care system model. *Nursing Outlook*, 1973, *21* (3), 171-5.
McClure, Margaret L. *Quality assurance and the professional process: Baccalaureate degree for entry into practice*. Paper presented at the annual meeting, Western Region, Canadian Association of University Schools of Nursing, Winnipeg, February 1979.
Nurses and nursing issues. Roundtable discussion. *American Journal of Nursing, 75* (10), 1849-59.
Schaefer, Marguerite J. Universities and future health care. *Health Care Issues* (Madeleine M. Leininger and Gary Buck, Eds.). Philadelphia: F. A. Davis, 1974, 117-24, (Health Care Dimensions series).

# RESUME

**Comment élaborer les programmes de sciences infirmières pour qu'ils répondent à la nature des besoins de la collectivité.***

La conception d'un programme qui permet aux infirmières de répondre aux besoins de la collectivité oblige les professeurs d'université à résoudre une foule de questions difficiles sur la composition de telle ou telle collectivité, la nature de ses besoins en matière de santé et sur le rôle que devront être capables d'assumer les futures infirmières.

Les responsables de ces programmes se heurtent à beaucoup d'obstacles: Les restrictions budgétaires qui affectent aujourd'hui les universités, le nombre relativement restreint de candidates qualifiées pour les postes d'enseignement, les possibilités limitées en matière d'études supérieures en sciences infirmières au Canada et la confusion qui règne quant aux responsabilités que les infirmières professionnelles sont à même d'assumer et le cadre dans lequel elles doivent recevoir leur formation.

Le problème crucial est de savoir si le grade de bachelier constituera le point d'entrée pour exercer la profession d'infirmière dans l'avenir. Par conséquent, il faut établir une distinction nette entre le rôle et les fonctions d'une infirmière bachelière et ceux d'une infirmière dont la formation a duré moins longtemps. Pour résoudre ce problème, il faudra consulter les autorités qui émettent le permis d'exercice, déterminer les ressources financières et autres et obtenir l'appui des associations professionnelles, des syndicats, des employeurs, d'autres travailleurs de la santé et de la population en général.

*L'exposé original a été présenté à la conférence de printemps de l'Association canadienne des écoles universitaires de nursing à Saskatoon, le 29 mai 1979.

# ORIENTATIONS DU PROGRAMME DE BACCALAUREAT

par THERESE FORTIER*

*INTRODUCTION*

Après douze ans d'existence, l'Ecole des Sciences infirmières de l'Université Laval entreprend la révision de son programme de baccalauréat. Notre Ecole, comme celles des autres universités du Québec, est actuellement soumise à des interrogations pressantes sur la nature de la formation donnée. Ces interrogations proviennent tantôt des organismes subventionnaires, tantôt de l'Ordre professionnel, tantôt des planificateurs des services de santé. Les premiers s'interrogent sur la nécessité de deux niveaux de formation, l'un collégial et l'autre universitaire; le deuxième conçoit le baccalauréat comme étant une spécialisation après les études collégiales; les troisièmes s'inquiètent du manque de préparation des infirmiers pour oeuvrer en santé communautaire. Notre principale motivation pour entreprendre ce lourd processus de révision fut néanmoins le Conseil de l'Université Laval qui, par résolutions spéciales, demandait dans un premier temps, de réviser nos orientations et, dans un deuxième temps, de réviser en profondeur le programme.

Dans la suite de cet exposé, nous décrirons brièvement les étapes de la démarche poursuivie. On y cherchera en vain une référence explicite à un ou des cadres conceptuels connus en soins infirmiers, que ce soit au niveau des orientations de l'Ecole ou au niveau du programme. Le refus d'un cadre conceptuel pré-déterminé s'intègre dans une remise en question globale d'une démarche à partir de schèmes traditionnels, car ceux-ci nous ont semblé piégés dans une recherche d'identité professionnelle. Notre école a plutôt choisi de définir d'abord les besoins communautaires auxquels elle tentera de répondre. En conséquence, la première étape en fut une d'analyse des besoins de santé de la population et de la réponse du système face à ces besoins. La deuxième a consisté à faire un retour critique face à la formation universitaire. Dans la troisième, nous avons posé les bases des orientations de l'Ecole et plus particulièrement celles du programme de baccalauréat. La quatrième est actuellement en cours et c'est l'élaboration du programme comme tel.

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* Communication à l'Association Canadienne des Ecoles Universitaires de Nursing lors du Congrès des Sociétés Savantes à Saskatoon, mai 1979.

# 1. LE SYSTEME DE SANTE FACE AUX BESOINS ACTUELS

## 1.1 Les problèmes de santé prévalents

Les problèmes de santé des Québécois ne sont guère différents de ceux de l'ensemble des Canadiens mais le Québec se situe néanmoins au dernier rang parmi les provinces canadiennes en ce qui concerne l'espérance de vie. Le taux de mortalité périnatale s'est amélioré au cours des dernières années mais, dans les régions de l'est du Québec, il demeure toujours supérieur aux autres provinces. La baisse de la natalité s'accompagne d'un vieillissement progressif de la population avec son cortège de maladies chroniques, d'handicapés et de problèmes socio-économiques. Des densités de population extrêmement variables font ressortir concurremment les problèmes liés à l'urbanisation et ceux qu'entraîne la dispersion des populations sur d'immenses territoires. Certains groupes ethniques comme les indiens et les esquimaux sont perturbés dans leur mode de vie par l'exploitation des richesses naturelles du milieu. L'analyse des habitudes de vie a démontré que les Québécois, comme bien d'autres, prennent des risques qui entraînent une augmentation des accidents, des maladies cardio-vasculaires, des cancers, des maladies hypertensives, de l'obésité.

## 1.2 Réponse du système à ces problèmes

La dimension sociale de la plupart de ces problèmes appelle des interventions qui dépassent les limites du système de santé. A l'intérieur même du système, les interventions curatives sont de peu d'efficacité sur l'évolution de l'histoire naturelle des principales maladies. Cette constatation, maintes fois répétée, n'a pourtant pas eu d'effets sensibles sur les attitudes des professionnels et, en conséquence, sur les attitudes de la population. Les services curatifs sont hypertrophiés et leur structure hiérarchique n'offre qu'une seule porte d'entrée qui est celle du médecin. L'usager s'y adapte en formulant sa demande en terme de maladie, les autres ressources ne lui étant accessibles que sur prescription. Le vieillard, le malade chronique ou l'handicapé sont généralement mal reçus dans ce système où les services sont organisés en fonction d'une techonologie de pointe. Nous avons de surcroît si bien réussi à faire croire à la toute puissance de ce système que la population démissionne devant la prise en charge de sa propre santé.

La dernière décennie fut marquée au Québec par une volonté politique de planifier les services de santé en fonction des besoins prioritaires. Les structures se sont modifiées afin de permettre une

meilleure intégration des soins préventifs et curatifs. Des départements de santé communautaire ont été créés afin de rendre certains centres hospitaliers responsables de la planification et de la coordination des services sur leur territoire. Les centres locaux de services communautaires sont appelés à compléter ce tableau organisationnel afin de rendre les soins plus accessibles et continus. Les leaders de ces changements ont ainsi voulu répondre plus adéquatement aux besoins de la population. Il est à propos de se demander si la formation universitaire des infirmiers a aussi été marquée par une volonté d'adaptation aux besoins nouveaux.

## 2. RETOUR CRITIQUE SUR LA FORMATION UNIVERSITAIRE

Il n'est pas dans notre propos de nier les efforts de changement qui ont été effectués à l'intérieur des programmes. Néanmoins, nous nous sommes donné à l'Université Laval un cadre de formation qui manque de spécificité. Après une formation de base presque essentiellement en sciences biologiques, les stages s'effectuent en spécialités cliniques: pédiatrie, chirurgie, médecine et autres. L'importance des connaissances nous différencie certes des programmes collégiaux mais le processus de formation nous paraît encore trop calqué sur le modèle médical.

Les connaissances préalables sur lesquelles repose notre enseignement des soins infirmiers comportent elles aussi des ambiguïtés. Nous nous limiterons à donner deux exemples de cet avancé en choisissant le concept d'intégrité bio-psycho-sociale de l'être humain et le concept d'autonomie.

L'être humain acquiert une constitution physique, un mode de penser et des habitudes de vie dans un environnement physique et social particulier. Il est exposé à des risques reliés à des facteurs de personne, de temps et de lieu. L'hérédité même se traduit par une capacité d'utiliser son environnement d'une façon particulière. Les comportements qui en résultent sont si particuliers à un milieu donné que les coutumes appropriées ici peuvent être désastreuses ailleurs. Que l'on songe aux conséquences de l'allaitement au biberon dans certaines régions du monde, de la transplantation de nos horaires de travail chez les esquimaux et autres exemples du genre. Or, comment espérer que l'étudiant puisse situer l'homme en développement dans son habitat physique et social sans la connaissance de l'organisation sociale et de ses valeurs dominantes, des facteurs d'influence d'ordre socio-culturel et écologique sur la santé, des risques inhérents aux différents âges, de l'histoire naturelle des problèmes de santé? A

quelques exceptions près, le champ actuel des connaissances de l'étudiant infirmier est réduit aux aspects biologiques de la santé et de la maladie. Son champ d'observation est également réduit en majeure partie à l'être humain en situation de maladie et isolé en milieu hospitalier.

L'autonomie de l'usager est un autre concept qui émerge mais sans préoccupation suffisante pour les fonctions qui pourraient être bien mieux assumées par la personne elle-même, les parents, les enseignants, ou les groupements populaires et bénévoles. Malgré la quasi impuissance de l'appareil thérapeutique face aux principaux problèmes actuels de santé, on continue à entretenir les gens dans l'illusion de notre efficacité. Comment toutefois aider la personne ou le groupe à se reprendre en charge et à participer à la décision sans une connaissance des représentations culturelles de la santé et de la maladie, des facteurs de dépendance liés à l'organisation du système de santé, des pratiques de santé culturellement acceptables, des moyens efficaces de diffusion de l'information, des développements récents en prévention? Lorsque les connaissances de base sont insuffisantes, les processus mentaux acquis par la seule application répétée et systématique d'un plan de soin ne sauraient être garants de soins de qualité.

## 3. ORIENTATIONS DE L'ECOLE ET DU PROGRAMME

Les orientations préconisées originent essentiellement des principaux besoins décélés dans la population et des nouvelles fonctions assignées au Système de santé au Québec.

### 3.1 Orientation de l'Ecole

Dans notre démarche il a d'abord fallu déterminer, parmi tous les besoins, quelles étaient nos préoccupations majeures comme école universitaire en sciences infirmières. C'est ainsi que nous avons opté en priorité pour une réponse aux besoins suivants:

- — Promotion de la santé.
- — Prévention axée vers les problèmes de santé prévalents.
- — Attentes réalistes de l'usager envers le système de soins.
- — Utilisation par l'usager de son potentiel individuel, familial et communautaire.
- — Participation de l'usager à la décision de l'équipe de soins.
- — Planification adaptée aux réalités épidémiologiques, sociales et culturelles d'une communauté.
- — Intégration des dimensions familiales et communautaires dans l'approche individuelle.
- — Coordination et continuité dans les interventions.

Les programmes d'enseignement ou de recherche auront donc comme axes principaux de développement: la prévention et la promotion

de la santé, l'autonomie optimale de la population et les dimensions communautaires du soin.

Dans cette perspective, nous avons défini le champ d'études en sciences infirmières comme conduisant à :

— l'identification des manifestations de la santé et de la maladie chez un individu ou une population ;

— l'identification des facteurs de risque qui sont une menace à la santé ;

— l'interprétation de ces manifestations et de ces facteurs de risque en fonction des réalités biologiques, psycho-émotives, économiques, socio-culturelles et écologiques du milieu dans lequel vivent l'individu ou les collectivités ;

— l'utilisation de modes d'interventions qui permettront aux individus d'assimiler, d'intégrer à leur vécu quotidien le diagnostic et le traitement qu'ils doivent subir s'ils sont malades, d'utiliser leurs propres ressources pour lutter contre la maladie et sauvegarder leur santé et qui permettront aux collectivités d'améliorer, de protéger leur santé et de prévenir la maladie en recourant rationnellement au système de soins ;

— la coordination du soin et des mesures préventives ;

— l'éducation de la population en matière de santé.

Présentement l'Ecole offre deux programmes de formation : un programme de baccalauréat où sont admis les détenteurs d'un diplôme d'études collégiales ayant suivi le profil sciences de la santé et un programme de certificat en santé communautaire pour les infirmiers diplômés. Le plan de développement prévoit dès 1979-1980 un démarrage de la recherche afin que nous puissions amorces des études de 2ème cycle aussitôt que possible.

3.2 Orientations du programme de baccalauréat.

La tendance fondamentale du programme prend sa source dans une conception de l'homme vu comme un être intégré dans une communauté, qu'il soit hospitalisé ou non. Jusqu'à maintenant l'intention exprimée de considérer l'usager comme une unité physique, psychologique et sociale ne s'est guère concrétisée dans une démarche congruente. Les plans de soins visant l'entourage du malade et l'utilisation des ressources communautaires sont souvent restés lettre morte afin de ne pas perturber les horaires de travail ou la structure hiérarchique de prise de décision. Plus fondamentalement, il s'agit pour certains professionnels d'une fausse perception de l'autonomie, en ce sens que l'usager devrait selon eux se libérer des influences de son environnement pour réussir sa réadaptation ou se maintenir en santé.

C'est là nier que l'homme est à la fois partie et produit de son environnement.

Le programme doit donc ouvrir son modèle de soin aux dimensions communautaires, que ce soit en approche individuelle ou en approche collective. Le soin à un individu hospitalisé, en service externe ou à domicile, relève d'une gestion qui fait intervenir les ressources de l'usager et de son entourage, les ressources de la communauté et les ressources institutionnelles dans la solution des problèmes et la prévention.

Les soins de santé d'une collectivité relèvent d'un processus de planification qui, depuis l'avènement de la réforme du système de santé au Québec, a modifié considérablement notre approche des populations. A partir des hautes instances gouvernementales jusqu'aux unités de services les plus près de la population, ce concept est appliqué dans une perspective tantôt stratégique, tantôt tactique, tantôt opérationnelle. Ce sont les processus liés à ce dernier type de planification que nos étudiants devront apprendre. On ne peut d'ailleurs prétendre prendre le virage vers la santé sans intégrer dans notre programme les savoirs utiles à l'identification des problèmes de santé dans une collectivité, à la recherche des facteurs de risque, à la compréhension de leur histoire naturelle et des points d'intervention possibles, à l'établissement de priorités d'intervention et à l'évaluation de ces interventions.

Il nous semble toutefois difficile de viser à une égale compétence du diplômé dans les deux champs d'action soit: (1) les soins individuels dans les centres hospitaliers ou les services de première ligne, (2) soit l'approche collective auprès d'une communauté. Un large tronc commun permettra à l'étudiant d'acquérir les capacités intellectuelles nécessaires aux deux domaines, mais il aura à choisir vers la fin de ses études entre l'un ou l'autre afin d'y acquérir les habiletés spécifiques.

Il ne s'agit donc plus plus, au niveau universitaire, de restreindre la formation à l'exécution de procédures de soins, dans un modèle préconçu et universel. Il n'y a pas de recettes toutes faites pour freiner l'utilisation abusive des soins, pour modifier les comportements de santé, pour développer le potentiel d'autonomie des usagers, pour adapter les interventions à la culture et à l'environnement des personnes et des groupes, pour favoriser la participation aux décisions ou pour changer les perceptions des professionnels envers le fonctionnement d'équipe. Il est possible par ailleurs d'agencer les connaissances de telle sorte que l'étudiant puisse graduellement élargir son champ de vision sur les problèmes de santé et en arriver à

percevoir les interventions relevant de sa compétence ou de celle des autres professionnels. Le travail en équipe avec d'autres disciplines va de pair avec cette démarche. C'est pourquoi la formation pratique devra se faire dans un contexte pluridisciplinaire, en vue d'élaborer des plans d'action conjoints.

Le rôle prépondérant des habiletés techniques dans le traitement cède le pas à la capacité de saisir les multiples dimensions d'un problème de santé, de situer l'apport des usagers, des professionnels et des établissements dans la prévention ou la solution des problèmes, d'opérer la gestion d'un programme de soin individuel et d'un programme collectif de santé. Nous ne pouvons en outre parler d'adaptation aux besoins sans préparer nos diplômés à améliorer les services par une participation active aux études menées dans leur milieu de travail, par une mise à jour de leurs connaissances et de celles de leurs collègues infirmiers.

Nous trouvons dans la définition de l'exercice professionnel la confirmation que nos diplômés pourront légalement s'acquitter des fonctions auxquelles les a préparés notre programme. Voici le texte du projet de loi 273, article 36:

> "Constitue l'exercice de la profession d'infirmière ou d'infirmier tout acte qui a pour objet d'identifier les besoins de santé des personnes, de contribuer aux méthodes de diagnostic, de prodiguer et contrôler les soins infirmiers que requièrent la promotion de la santé, la prévention de la maladie, le traitement et la réadaptation, ainsi que le fait de prodiguer des soins selon une ordonnance médicales."

## 4. CONCLUSION

Nous ne pouvons décrire à ce moment-ci les objectifs du programme ni sa structure parce que l'élaboration n'est pas terminée. Vous pressentez sûrement les défis à relever dans l'élaboration des objectifs, dans la sélection des sciences de base et dans le choix des apprentissages. Il ne manquera pas de critiques externes pour suivre l'évolution du programme et pour juger de la qualité de nos diplômées. La capacité d'auto-critique et d'innovation du corps professoral est quand même garante d'un effort intensif pour éviter de retomber dans les pièges dénoncés.

Une question vient tout naturellement à l'esprit: "Qui admettrons-nous dans le programme?" Pour autant que les mêmes objectifs universitaires terminaux puissent être atteints par l'ensemble de la clientèle étudiante, il nous sera possible d'accueillir des infirmiers diplômés, tout en accueillant les finissants du programme général des

collèges. Il faudra pour ce faire prévoir des mécanismes d'évaluation des candidats, des mécanismes d'admission et des cheminements pouvant tirer le profit maximum des acquisitions antérieures de ceux qui auraient déjà à l'entrée une formation d'infirmier. Cette formule nous semble compatible avec un seul programme de baccalauréat pourvu que sa souplesse soit pensée à la phase d'élaboration. Notre position est justifiée par la nature même du programme que seule une université peut assumer et qui prépare à des fonctions pour lesquelles il y a carence dans le monde du travail.

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# RESUME

**Université Laval: Orientations of the baccalaureate program.**

In response to urgent questions addressed to Quebec universities regarding nursing education, l'Université Laval is in the process of revising its baccalaureate program. This revision is based on an analysis of the health needs of the population and the way the health care system responds to them. This analysis calls for a careful examination of University preparations in order to rethink or reconsider the present biological and hospital emphasis as opposed to a community oriented approach.

Without a predetermined conceptual model, the revision of the program rests upon a vision of man, hospitalized or not, as an autonomous being integrated in a community. Man is at the same time part and product of his environment. Based on this model, the main aspects of the revision involve a turn towards health through illness prevention and promotion of health through coordination and continuity of care in a community and sociocultural perspective. Consequently, technical skill gives way to the multidimensional aspects of nursing care, especially the bio-psychosocial ones.

Even though the objectives and the structure of the revised program are still at the developmental stage, the new program will include a broad common core allowing the student to acquire the intellectual capacities necessary for: 1) individual care in hospitals or primary care 2) a collective approach towards the community. Near the end of his studies the student will select one area of concentration in order to acquire some specific abilities.

With the same terminal objectives for both groups (and some appropriate mechanisms), the program will be open to both graduates of colleges (DEC general) and graduate nurses.

In the near future l'Université Laval will offer a Master's program.

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# PATIENT/PROFESSIONAL INTERACTION AND ITS RELATIONSHIP TO PATIENTS' PSYCHOLOGICAL DISTRESS AND FREQUENT USE OF HEALTH SERVICES

By GINA BROWNE, Ph.D., Reg.N.*

*Statement of the Problem*

A number of factors affect a person's visit to any health professional or service. At one extreme, use of health services is determined by illness but as Zola (1966) pointed out, there is a "vast bulk of illness as such, defined subjectively and clinically, which is not brought to the attention of the health professional by patients." Antonovsky (1962) argued that the "vast bulk of what is brought to physicians by patients and thus, their use of health services is concerned with quite minor physical disorders."

A large proportion of sociological research on health service utilization has dealt with the organization of health professions (Anderson, 1973; Friedson, 1970) and with access to and distribution of medical care (Mechanic, 1975). Another great mass of utilization studies has dealt with individual client perceptions, psychological traits, satisfactions, stress and health (Eichhorn, 1972; DeMiguel, 1974).

Few studies have examined both what happens to a person and how he behaves with certains utilization patterns once he has sought help. Mechanic (1975) suggested that: "Illness is not only an event that happens to people but an important explanation that can be used to sustain one's social identity and social functioning." Since verbal behaviour is one important expression of identity, this study examined the differences in the patient's verbal presentation of the illness and the professional's verbal response. The study described the interaction process between professionals and patients at the time help was sought or once utilization had occurred.

## *REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK*

Since an illness can be used to sustain one's social identity and social functioning, it can be conceptualized as an interactive role. In this sense, an interactive role is defined as a bridge between intrapsychic and social life. The interactive role both expresses and seeks to

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* Paper presented to CAUSN, Learned Societies, held at the University of Western Ontario, June 1978, and to the National Conference on Nursing Research, Winnipeg, December 1978.

confirm one's view of self. A disordered view of self is enacted and confirmed through a deviant interactive role. The converse of this deviant role is the co-operative interactive role.

The most sustained definition of illness as a deviant role derives from Parsons' (1952) conceptualizations of the functions of the sick role. Parson' "sick role" refers to activity of those who consider themselves ill, undertaken for the purpose of getting well, which leads to exemption from usual responsibilities. The activities or expectations of an occupant of this role are (1) the sick person is exempt from social responsibility and this exemption requires legitimation; (2) the sick person cannot be expected to take care of himself by an act of decision or will and thus, must be helped; (3) the sick person must want to get well whereby the state of being sick is undersirable and the legitimation of his illness is conditional and relative to his getting rid of the illness as soon as possible; and (4) the sick person should both seek help and co-operate with medical advice (Parsons, 1952).

In contrast to Parsons' (1958) view of illness as deviance, this study was developed from the premise that adherence to the Parsonian expectations of the sick role is a type of conformity. A divergence from one or more of the expectations of the sick role (rule breaking) was considered an element of the "real" deviant.

Becker's (1975) work has emphasized the social definition of deviance and has expanded it to include not only the quality of rule breaking that lies in behaviour itself, but also the product of a process which involves the responses of others to the behaviour. That is, deviant acts must be implicitly or explicitly labelled by the audience.

In particular, this study investigated sick persons' verbal deviation from their obligation to co-operate or work on getting well (the task) and health professionals' implicit verbal sanction of that deviant process by co-operating in the "avoidance" process. "Avoidance of the task" was defined as the act of verbally departing, withdrawing, leaving, keeping away from or approaching the issue at hand such as "feelings," "symptoms," etcetera.

This lack of co-operation in getting well has performed some of the following functions: a means of relief from social tensions (Sigerist, 1960), a way of achieving particularistic goals (Field, 1957), a means of catharsis, legitimation of failure and resolution of conflict (Shuval, 1970, 1973), and a form of liberation from the burdens of everyday life (Herzlich, 1973).

These psychosocial studies have addressed the situational and trait factors leading to a person seeking help, but have failed to look at the

interaction during the help seeking process which may maintain the frequency of the pattern. These studies have focused on more easily measured characteristics of the patient which are "neither predictive, alterable" (Becker, 1975), nor consistent with theoretical notions of co-operation and deviance which underlie compliant or non-compliant behaviour.

Co-operation and deviance by definition (Webster, 1971) and as theoretical constructs (Becker, 1968)* suggested a study of the interaction (communication) versus individual traits of patients and health professionals. The issues investigated were: (1) was the avoidant, or co-operative, interaction of patients and professionals related and (2) was the avoidant, or co-operative, interaction of patients and professionals related to the frequency of patients' use of health services or their health status? An interactionist view of help seeking and help giving focusing on deviating from or avoiding the task was an alternative to the trait or situational view (Bowers, 1973).

This plan was in keeping with Becker and Maiman's recent systematic reviews of over two hundred studies (1952-1975) on sociobehavioral determinants of compliance. These studies recommended the investigation and actual recording of the health professional-patient interaction as a most productive dimension for future exploration (Becker and Maiman, 1975; Watzkin and Stoeckle. 1972). It was this issue of interactional correlates of symtoms distress and utilization patterns that was investigated in the present study.

To test this argument of interactional correlates of patients' symptom distress and utilization patterns a conjecture was advanced. Briefly, it stated that there was a relationship between health professional and patient verbal behaviour. The deviant behaviour of patients would relate to their high distress and utilization patterns.

From this conjecture, three hypotheses were deduced.

*Hypotheses*

1. There is a significant relationship ($p.< .05$) between the proportion and type of health professional and patient verbal behaviour. The avoidant verbal behaviour (deviance) and approach verbal behaviour of the health professionals and the patients are related.

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* "Co-operation" refers to the act of working with another or others to a common end characterized by mutual benefit. In P.B. Gove (e.d.), *Webster's Third New International Dictionary*, p. 501. "Deviance" refers to the state of diverging from an accepted, normal or expected conduct (rule breaking) and the implicit or explicit label of that departure by the deviants' audience. In H. S. Becker, "On Labelling Outsiders," *Deviance: The Interactionist Perspective*, pp. 13-17.

II. There is no significant difference ($p > .05$) in the verbal behaviour of general practitioner and nurse practitioner types of professionals.

III. There is a significant relationship ($p < .05$) between patient verbal behaviour patterns and their psychological distress and utilization of services. Patients' avoidant verbal patterns (deviance) relate to their high psychological distress and use of services; health professional and patient approach-approach verbal behaviour relate to patients' low psychological distress and use of services.

*Definition of Terms:*

1. Avoidant verbal behaviour consists of utterances which can be described as intellectualizations, defensive jokes, long narratives or story telling, blaming or hostile attacks.
2. Reciprocal speech refers to a short (3 second) length of time that a participant in communication "keeps the floor." Extended speech, in contrast, refers to either participant talking for longer than 3 seconds.
3. Approach verbal behaviour consists of utterances which can be described as clarifying, reflective, building, an addition to the topic at hand.
4. Psychological distress consists of anxiety, depressive, obsessional or interpersonal types of distress or symptoms.

## *DESIGN OF THE STUDY*

### *Description of the Population Sampled*

During two weeks in April, a random schedule was devised for audiotaping the eight professionals (nurse practitioners and family physicians) in general practices, each in conversation with eight patients. Each morning prior to office hours, eight patients who had made appointments for the day with that professional scheduled to be taped were selected on the basis of their frequency (above and below 5 visits/year) of use of services during the previous year (April, 1975 to April, 1976). The four most frequent and least frequent users for the day were selected for each of eight professionals during a two week data gathering period.

## *INSTRUMENTATION*

The following sources of data were gathered on each patient:

a. Audiotape recordings were made of the 64 professional-patient interviews. Typescripts of three randomly sampled minutes, one from the beginning, middle, and end of each interview were prepared. Three-second utterances or a change in the type of utterances were marked on the typescript. The utterances were coded

on to the typescript as they were simultaneously heard on the audiotape. The codes used were those developed by Agazarian and Simon (1967) in their Sequential Analysis of Verbal Behaviour (SAVI System).

This system categorizes 28 types of verbal behaviour into approach, contingent, and avoidance categories of behaviour. The three-minute fashion sample from each audiotape was based on (1) the 3 minute precedent in the psychotherapy research literature and (2) a preliminary validity study conducted to determine the representativeness (adequacy) of various sample sizes from the 64 audiotapes (Browne, 1977).

b. Patients were asked to fill out:

i) the 58-item self-report Hopkins Symptom Checklist - HSCL (Derogatis, 1974),* on a four-point scale of distress from (1) "no-distress" to (4) "extreme distress," in areas of somatic obsessive, interpersonal, depressed, or anxiety types of distress.

ii) a one-question function level index on a five-point scale from (1) "no dysfunction" to (5) "extreme dysfunction."

iii) an eight-item "days of sickness" and "frequency of use of services inventory."

The frequency of the patient's use of services during the preceding year, number of consultations with specialists, and length of the patient's relationship with the practice was noted from the patient's record.

This information was gathered prior to the patient's interview with the professional during the usual 5-7 minute "waiting period."

*RESULTS*

Over the sum of the 64 three-minute random samples of conversation a total of 5,745 codes units of verbal behaviour were derived. Professionals had 2,993 coded units and patients had 2,752 coded units of verbal behaviour.

These instances of patient and professional verbal behaviour were paired sequentially and summed into a SAVI Matrix as in Table 1.

The four quadrant SAVI Matrix in Table 1 distinguishes between who is responding to whom in either reciprocal (short) or extended speech. Since the verbal behavior is paired, it is possible to determine the probability of the patients' or the professionals' avoidant or

* The Hopkins Symptom Checklist (1974) has been assessed for its factorial invariance across professional assessments versus patient assessments and also within patients across social class (Derogatis, 1971, 1972). Results, in general, indicated a high level of invariance for HSCL dimensions, both between doctors' reports and patients classified as depressed, neurotic and normal and among patients of various social classes (Derogatis, 1974).

TABLE I

TOTAL INSTANCES OF UTTERANCE PAIRS IN 64 PROFESSIONAL/PATIENT INTERVIEWS DISPLAYED BY SAVI AREAS AND QUADRANTS

| | EXTENDED PROFESSIONAL RESPONSE TO THE PATIENT - (QUADRANT I) | | | RECIPROCAL PATIENT RESPONSE TO THE PROFESSIONAL - (QUADRANT II) | | |
|---|---|---|---|---|---|---|
| | AVOIDANCE | CONTINGENT | APPROACH | AVOIDANCE | CONTINGENT | APPROACH |
| AVOID | A 34 1.2% | B 19 0.6% | C 8 0.3% | A 14 0.5% | B 18 0.6% | C 7 0.2% |
| CONTING. | D 17 0.6% | E 692 23% | F 243 8% | D 119 4% | E 270 10% | F 318 12% |
| APPROACH | G 8 0.3% | H 114 4% | J 117 9% | G 91 3% | H 154 6% | J 598 22% |
| AVOID | A 14 0.5% | B 120 4% | C 90 3% | A 290 11% | B 33 1% | C 7 0.2% |
| CONTING. | D 16 0.5% | E 296 10% | F 174 6% | D 44 2% | E 228 8% | F 99 4% |
| APPROACH | G 15 0.5% | H 368 12% | J 488 16% | G 23 1% | H 94 3% | J 345 13% |
| TOTALS | 104 3.6% | 1609 53.6% | 1280 42.3% | 581 21% | 797 28.6% | 1374 50% |
| | (QUADRANT IV) RECIPROCAL PROFESSIONAL RESPONSE TO THE PATIENT | | | (QUADRANT II) EXTENDED PATIENT RESPONSE TO THE PROFESSIONAL | | |
| | TOTAL PROFESSIONAL PAIRED INSTANCES = 2993 | | | TOTAL PATIENT PAIRED INSTANCES = 2752 | | |

approach response given the similar nature of the antecedent verbal stimulus. In this way the "relational" hppothesis I can be tested with the reciprocal speech quadrants II and IV.

Table 2 tests the significance of the difference in the proportion (Ferguson, 1971) of patient avoidant responses under the two different professional antecedent verbal stimuli.

Table 2 illustrates that the proportion of patients' avoidance was greater following professional avoidance than following professional approach verbal stimuli. Similarly, the proportion of patients' approach verbal behaviour was greater following professional approach antecedent conditions than professional avoidant antecedent conditions.

Inspection of Table 2 shows that the proportion of the nature of the patient response and the immediate professional stimulus are related.

While the raw data in Table 1 illustrated that professionals approached most of the time regardless of the patients' antecedent stimulus, Table 3 offers a test on that data and can be interpreted to mean that professional avoidant verbal behaviour was significantly greater under patient avoidant antecedent conditions than under patient approach antecedent conditions.

TABLE 2

THE SIGNIFICANCE OF THE DIFFERENCE IN THE PROPORTION OF PATIENTS' AVOIDANT AND APPROACH RESPONSE UNDER TWO DIFFERENT PROFESSIONAL ANTECEDENT CONDITIONS:

A TEST OF INDEPENDENT PROPORTIONS

| | PROFESSIONAL AVOIDANT STIMULI $P_1$ | PROFESSIONAL APPROACH STIMULI $P_2$ | DIFFERENCE IN PROPORTION $P_1 - P_2$ | ERROR $S_{P_1-P_2}$ | Z SCORE |
|---|---|---|---|---|---|
| PROPORTION OF PATIENT AVOIDANCE RESPONSE | 14/39(.36) | 91/843(.11) | .25 | .0530424 | 4.71** |
| PROPORTION OF PATIENT APPROACH RESPONSE | 7/39(.18) | 598/843(.71) | -.53 | .0737265 | -7.18** |

** = THE PROBABILITY OF Z VALUES OF 2.58 OR MORE IS $<$.01

TABLE 3

THE SIGNIFICANCE OF THE DIFFERENCE IN THE PROPORTION OF PROFESSIONALS' AVOIDANT OR APPROACH RESPONSE UNDER TWO DIFFERENT PATIENT ANTECEDENT CONDITIONS:

A TEST OF INDEPENDENT PROPORTIONS

| PROFESSIONAL RESPONSES | GIVEN PATIENTS' AVOIDANT STIMULI $P_1$ | GIVEN PATIENTS' APPROACH STIMULI $P_2$ | DIFFERENCE IN PROPORTIONS $P_1 - P_2$ | ST'D ERROR $S_{P_1-P_2}$ | Z SCORE |
|---|---|---|---|---|---|
| PROPORTION OF PROFESSIONALS AVOIDANT RESPONSE | 14/224 (0.6) | 15/871 (.02) | .04 | .0120249 | 3.33** |
| PROPORTION OF PROFESSIONALS APPROACH RESPONSE | 90/224 (.40) | 488/871 (.56) | -.16 | .0373991 | -4.28** |

WHERE $S_{P_1-P_2} = \sqrt{PQ\left(\frac{1}{N_1} + \frac{1}{N_2}\right)}$

$$Z = \frac{P_1 - P_2}{S_{P_1 - P_2}}$$

$$P = \frac{F}{N_1} + \frac{F}{N_2}$$

$$Q = 1 - P$$

** = PROBABILITY OF Z $<$.01

TABLE 4

THE SIGNIFICANCE OF THE DIFFERENCE IN THE VERBAL BEHAVIOUR OF 3 SENIOR FAMILY PHYSICIANS & 3 NURSE PRACTITIONERS

1. RAW SCORES

| | NURSES 1 | 2 | 3 | DOCTOR 1 | 2 | 3 |
|---|---|---|---|---|---|---|
| AVOID | 14 | 10 | 18 | 10 | 7 | 28 |
| CONTINGENT | 212 | 210 | 202 | 184 | 226 | 119 |
| APPROACH | 166 | 220 | 162 | 165 | 143 | 134 |

2. TOTAL SCORES

| | AVOID E | CONTINGENT | APPROACH | TOTAL |
|---|---|---|---|---|
| DOCTOR | 45 (39.64) | 529 (525.31) | 442 (451.05) | 1016 |
| NURSE | 42 (47.36) | 624 (627.69) | 548 (538.95) | 1214 |
| TOTAL | 87 | 1153 | 990 | 2230 |

$X^2_2 = 1.7126$ NOT SIGNIFICANT

Similarly, professional approach verbal behaviour was significantly greater under patient approach antecedent conditions. The proportions in Table 3 show that the nature of the patients' verbal stimulus affects the nature of the professionals' response. Thus, professional behaviour was related to patient behaviour. It could be said that, unwittingly, patients taught professionals how to behave.

Table 4 presents the number of paired instances of avoid, contingent and approach behaviour for each nurse and senior physician.

The chi square on the total nurse and physician scores is 1.7126 which at two degrees of freedom is not significant.

Thus, it can be further said that there is no difference in the pattern found for nurse and doctor groups.

Each SAVI area was tested in a search for the type of behaviour which was related to patients' distress and use of services. This lengthy analysis is reported elsewhere (Browne, 1977).

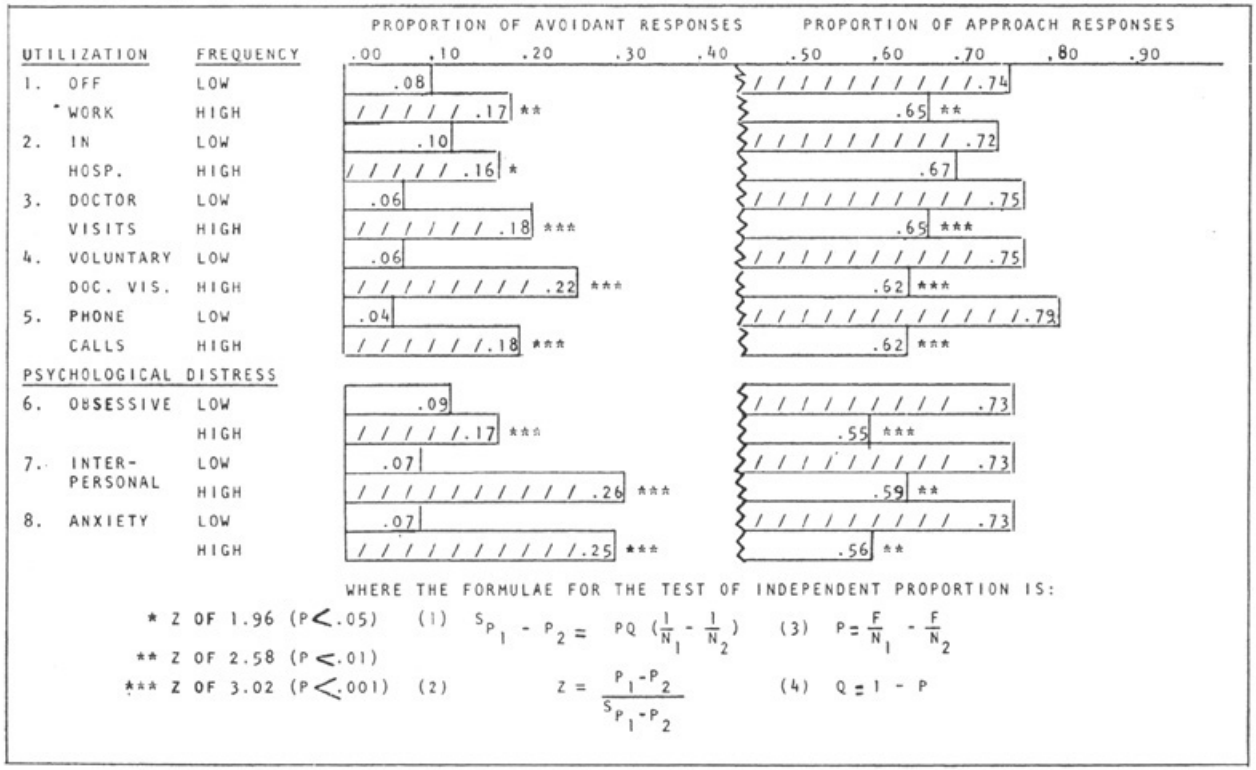
Table 5 illustrates that:

1. The proportion of patients' avoidant response to the professionals' approach was significantly greater for patients who were (a) frequently off work; (b) frequently in hospital; (c) frequently

TABLE 5

THE RELATIONSHIP BETWEEN PATIENTS' AVOIDANT OR APPROACH RESPONSE TO PROFESSIONAL APPROACH AND THEIR HIGH PSYCHOLOGICAL DISTRESS AND USE OF HEALTH SERVICES:

A TEST OF INDEPENDENT PROPORTIONS




WHERE THE FORMULAE FOR THE TEST OF INDEPENDENT PROPORTION IS:

* Z OF 1.96 ($P < .05$)

** Z OF 2.58 ($P < .01$)

*** Z OF 3.02 ($P < .001$)

(1) $S_{P_1 - P_2} = PQ\left(\frac{1}{N_1} - \frac{1}{N_2}\right)$

(2) $Z = \frac{P_1 - P_2}{S_{P_1 - P_2}}$

(3) $P = \frac{F}{N_1} - \frac{F}{N_2}$

(4) $Q = 1 - P$

attending the family practice; (d) frequently initiating the contact in those visits versus responding to the follow up requests of professionals; (e) frequently phoning the practice and who (f) reported high degrees of (i) obsessional, (ii) interpersonal, and (iii) anxiety distress.

It seems the patients' avoidant response to professional approach is the "rule in use" which is broken by the frequent attenders. The avoidance is in the service of the enacted goal — not to get well. Thus illness continues while, on the surface, patients appear to be trying to get well.

Table 5 also also illustrates that, conversely, patients who infrequently come to or phone the family practice or hospital are approaching their behaviour and report low levels of psychological distress.

In summary, this study found

a) a relationship between professional and patient verbal avoidance and approach behaviours during the task of symptom exploration,
b) no difference between nurses and doctors in their pattern of approach or avoidance conversation, and
c) strong relationships between patients' avoidance of professional approaching behaviour and their psychological distress and overuse of all health services.

## *DISCUSSION AND IMPLICATIONS*

### *Implications for Interaction Theory, Sick Theory and Practice*

The relationship found between similar approach-approach and avoid-avoid behaviours of professionals and patients (reported elsewhere, Browne, 1977) is consistent with Spiegel who, among others, states that a "mutually regulative process is ongoing whenever two people relate" (Bloom, 1965, quoting Speigel). It is also consistent with Goffman's (1967) proposition that "interaction is a circular and simultaneous co-occurence of persons fitting their acts into the ongoing acts of another."

The avoidant behaviour findings of patients reported here is important to focus on as this is a crucial theoretical obligation of those who are sick as Parsons has outlined (1951). These findings of avoidance behaviour on the part of patients who produced nine times more avoidance than did professionals when engaged in extended speech support the proposition of Michael Balint (1968) who suggests that the "real reason people seek help is difficult to express and thus, their presentation of symptoms is often laden with avoidant manoeuvres."

Since the proportion of professional avoidance verbal behaviour was greater and related to patient avoidant antecedent stimuli,

Rubington and Weinberg's (1968) "Interactionist View of Deviance" is also supported. Here, the rule-in-use (co-operation) was broken by the patients' avoidance and was implicity sanctioned by the reaction of the audience, the professionals' avoidance.

However, the relationship found between professional approach and patient avoidance verbal behaviour indicates that a good deal of "therapeutic work" was occurring. Here, professionals met Halpern's (1965) "crucial tactic of therapy by not becoming ensnarled in the patient's disturbance perpetuating manoeuvres" (avoidance). This relationship showed that the proportion of professional approach behaviour was significantly greater than the proportion of their avoidance behaviour under patient avoidant antecedent conditions.

The significantly greater proportion of professional and patient avoidant responses occurring among dyads with patients highly dysfunctional, overusing services, and psychologically distressed, offers a different perspective in which one might interpret the additional meanings of (1) Korsch's (1968) finding that 68% of patients' main expectations were not verbalized, (2) Francis' (1969) finding that friendliness and warmth on the part of professionals did not in itself increase compliance, and (3) Davis' (1968) finding that verbal compliance is inversely related to patients' malintegrative behaviour. The proportion of professional and patient avoidance behaviour being significantly greater, in this investigation, among patients who frequently used health services and reported high levels of dysfunction and distress, explains some of the dynamics that may have been operant in Vuori's (1972) finding that in ambulatory care — "patients' willingness to return to the same doctor was primarily determined by instrumental (sick role confirming) versus expressive factors on the part of the professional." In other words, it seems from this investigation that health service utilization is as Vuori suggests: patients come back when they get what they want from professionals. The findings of this investigation suggest that part of what frequent users of primary care services get from professionals is a confirmation of a behaviour that enables them to stay sick.

The rise in the interest of consumer satisfaction is typified in such statements as that of Korsch (1972) who stated "26 percent of mothers of children in a pediatric outpatient clinic did not verbalize their greatest concern nor were encouraged to do so." While this fact is well taken, it is nevertheless an oversimplification and fails to acknowledge the patients' contribution in defocusing from the issue.

Empirical investigations similar to the present study with which one could relate the findings of this study wer not found. It seems

this study makes a special contribution in describing one way in which the verbal behaviour of professionals and patients is reciprocally influenced. Professionals and patients avoided significantly more following the other participant's avoidant behaviour than when following an approach behaviour. Conversely, professionals and patients approached significantly more following the other participant's approach than when following an avoidant behaviour.

Further, on each health status and health service utilization variable, patients' avoidance of professionals' approach was judged to be significantly greater among patients who were dysfunctional, psychologically distressed, and high users of health services. Conversely, patients' approach following professional approach was judged to be significantly greater among patients who were functionally healthy, non-psychologically distressed, and infrequent attenders of family practice services. These finding contribute a description of the difference in the "social treatment" simultaneously elicited and received by psychologically distressed and frequent attenders of family practice services as they compared with non-distressed patients who infrequently attended the practice.

This description of the "social treatment" elicited and received by this "costly" group of patients contributes a little more understanding of one area where health professionals' care of this group of patients may be ineffective. Whether or not this pattern of care can be reversed or eliminated without untoward effects to patients and to other areas of service in the health system is a question for further research.

*Implications for Educational Theory and Practice*

Perhaps the strongest implication for education in the findings of this study has to do with the subtle, yet mutual, influence process inherent in interpersonal relationships.

In this study it is not exactly clear who teaches whom to avoid the task but in that (1) professionals predominantly approached the task regardless of the patient's antecedent stimulus but (2) were influenced to avoid more under avoidant antecedent stimuli from patients than under approach stimuli, it seems possible to suggest that, at times, the patient is teaching the professional how to behave.

Since a major part of a health professional's initial and continuing education takes place in interaction with patients, it is clear that more attention than is usual in professional schools must be paid to the patients' influence on professionals to act in a certain way. This force of socialization of professionals is rarely mentioned because professionals' control of patients is usually assumed.

> In spite of the societally defined
> power advantage given to practitioners,
> patients do often attempt to exert some
> measure of control. . . (in the relationship).
> (Bayes-Bautista, 1976)

Second, more interaction research could accompany evaluation of observable student and professional competence. The education in a good many professional schools has remained preoccupied with content to the exclusion of the interpersonal influence process in groups or dyads. These interaction results clearly indicate that the emphasis in professional education between content and process should be shared.

Finally, the results of this study illustrate how patients may keep themselves ill by avoiding getting well and how professionals collude in that process. There is a great need for professionals to become more active in teaching patients how they keep themselves sick and more active in eliciting from patients a decision to stay well. The need for them to be astutely aware of their interaction process with patients as a correlate of patient outcomes deserves mention.

*Implications for Health Care, Research, and Practice*

Beginning to place emphasis on interaction studies as an adjunct to "quality of health care" studies is an additional implication of this study.

Presently, a good deal of the "process of giving quality care" studies in the health sector have emphasized the adequacy with which a disease is treated by a methodology which retrospectively analyses patients' records. This study certainly indicates the importance of the "interaction process" by which the symptoms are presented and treatment is offered. The results here clearly indicate that "material" is avoided by both participants which relates with measures of patient outcome. There seems to be a difference in the problem listed on the chart and the problem avoided in the interview particularly with the charts of patients who use services frequently.

Not only the quality of the process of giving care but also the effectiveness of its delivery to frequent users of primary care services is in serious question. The implications for future research elaborates some approaches for dealing with these concerns as well as the limitations of this study.

*Future Research*

Several lines of enquiry are suggested by the present study. One, a simultaneous study of the process and content of interviews would

suggest the common issues that are avoided by professionals and patients, as well as the interactional approaches that are most successful in uncovering that material, depending on the avoidant strategy used.

Since this study is an ex post facto design based on a purposeful sample, a larger random sample of patients in more than one group practice would help estimate the prevalence of this avoidance of getting well and thus, the degree of effectiveness and quality of giving care which is in question.

Since the analysis of hypothesis I results showed a relationship between avoiders and frequent users, it would be fruitful to see if an educational programme for these same health professionals would be productive in reducing the avoidance, increasing the wellness, and thus reducing the frequency of this population's use of services. This latter type of study would have an experimental design where conclusions about what is causing what could be appropriately made.

This latter type of research could be done in a community of family practitioners with an agreement to investigate the circumstances of a "new patient's" last point of contact with the health system. This agreement would be essential because frequent users of services can go elsewhere when their tactics to influence the professional fail. This selection process on the part of patients serves to set up the same deviant process elsewhere and the circular spiraling overuse and distress can continue.

*Methodological Issues in Interaction*

*I. Methodological Contributions:*

A. *Design:*

1. The development of typescripts in this study controlled and made uniform the rater's perception of what occurred; this tactic amplified the reality to be rated and thereby increased the percent agreement achieved between raters.

   *Sampling:*

2. The high correlations among 1½ minute, 3 minute, 6 minute samples of interaction in the substudy of the thesis (Browne, 1977) was evidence (a) to substantiate the sample precedent in psychological research of three minutes (b) to warrant further investigations of the minute opening of conversations or interviews found to be of such predictive clinical value among clinicians.

B. *Statistical:*

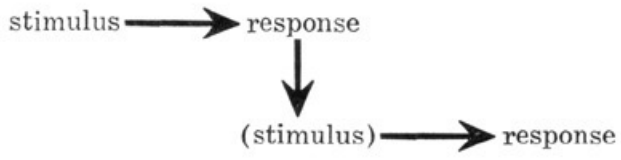
   The pairing of utterances and separating out of extended talk within the (1967) SAVI Matrix in this study was a design

method of testing the hypotheses about antecedent stimuli and response. This was a mechanical way to plot out the interactional correlate of high vs low users as the statistical method of "pattern analysis" is difficult to understand statistically and remains an under-developed art.

*II. Methodological Limitations or Issues:*

A. *Design:*

1. This study of verbal interaction in the role analysis tradition scores the effect of what was said. The ethnomethodological ("grammatical syntax") analysis of the *meaning,* or *intent* of the message, therefore was not analyzed. It was however argued, as in psychoanalytic terms, that the verbal behaviour was an act. . . "as if" . . . the intent were, in this case, to approach or avoid.
2. This study was one of "interaction" where the stimulus and response of both participants as actor and respondent was analyzed. The limits of the state of the art of pattern analysis made it difficult to develop the investigation into a study of the transactional pattern of




where one could have seen the professionals' response to the patients' avoidant response of his/her original approach. If this were possible it would have been possible to test theoretical notions about interactive deviance where the professional implicitly labels and confirms the views of the patient by his, her own avoidance.

B. *Statistical:*

3. Some statisticians argue that more sophisticated analysis in the parametric family of statistics could be done with these frequency counts of verbal behaviour. Others argue that the data are strictly nominal and were amenable to only non-parametric analysis. Subsequently only non-parametric proportional analyses are reported. I performed other multiple regression analyses to find the same behaviour ("patient avoidance of professional approach") to be predictive of the frequent attender and psychologically distressed person.
4. A stronger test of agreement than "percent agreement" is a test known as Cohen's Kappa (1960) which substracts chance

agreement from percent agreement among judges in each discrete category (in this case 28 SAVI categories).

> Kappa has been generalized in a number of directions. When the relative seriousness of the different kinds of disagreements can be specified, the statistic "weighed Kappa is appropriate" (Spitzer, Cohen, Fleiss and Endicott, 1967; Cohen, 1968)... Kappa has also been generalized to the case where more than two raters rate each subject (Fleiss, 1971).
>
> (Fleiss, 1973, pp. 146-147)

*REFERENCES*


Agazarian, Y. A theory of verbal behaviour and information transfer (Ed.D. Dissertation, Temple University, 1968). University Microfilms, 22-25.

Agazarian, Y. and Simon, A. *Sequential analysis of verbal interaction (SAVI).* Philadelphia, Penn: Research for Better Schools, Inc., 1967.

Anderson, R. Societal and individual determinants of medical care utilization in the U.S. *Milbank Memorial Fund Quarterly,* 1973, *51,* 95-124.

Antonovsky, A. A model to explain visits to the doctor: With specific reference of the case of Israel. *Journal of Health and Social Behaviour,* 1962, *13,* 446-54.

Bayes-Bautista, D. E. and Balint, M. *The doctor, his patient and the illness.* London: Pitman Medical Publishing Company, 1968.

Bayes-Bautista, D. E. Modifying the treatment: Patient compliance, patient control and medical care. *Social Science and Medicine,* 1976, *10,* 233-238.

Becker, H. S. On labelling outsiders. In E. Rubinton and M. D. Weinberg (Eds.), *Deviance: The Interactionist Perspective.* New York: McMillan, 1968.

Becker, M. H., Drachman, R. H., and Kirscht, J. P. A new approach to explaning sick role behaviour in low income populations. *American Journal of Public Health,* 1974, *64,* (3), 205-216.

Becker, M. H. and Maiman, L. A. Sociobehavioural determinants of compliance with health and medical care recommendations. *Medical Care,* January 1975, *13* (1), 10.

Bloom, S. M. *The doctor and his patient: A sociological interpretation.* New York: The Free Press, 1965.

Bowers, K. S. Situationism in psychology: An analysis and critique. *Psychological Review,* September 1973, *80* (5), 307-336.

Browne, R. B. *Patient and professional interaction and its relationship to patients' health status and frequency of use of health services.* Ph.D. Thesis, University of Toronto, 1977.

Cohen, J. A co-efficient of agreement for nominal scales. *Educational Psychological Measurement,* 1960, *20,* 37-46.

————. Weighted kappa: Nominal scale agreement with provision for scaled disagreement or partial credit. *Psychological Bulletin,* 1968, *70,* 210-220.

Cole, S. and Lejeune, R. Illness and the legitimation of failure. *American Sociological Review,* 1972, *37,* 337-356.

Davis, M. Variations in patients' compliance with doctor's advice: An empirical analysis of patterns of communication. *American Journal of Public Health,* 1968, *58,* 274-288.

De Miguel, J. M. A framework for the study of national health systems. Unpublished paper submitted to the VIIIth World Congress of Sociology, Toronto, August 1974.

Derogatis, L. R., Klerman, G. L. and Lipman, R. S. Anxiety states and depressive neuroses: Issues in nonsological discrimination. *Journal of Nervous and Mental Disease,* 1972, *155* (6), 392-403.

Derogatis, L. R. R., Lipman, R. S., Rickels, K. Uhlenhuth, E. H., and Covi, L. The Hopkins Symptoms Checklist: A self-report symptom inventory. *Behavioural Sciences,* 1974, *19,* 1-15.

Derogatis, L. R., Lyman, R. S., Covi, L. and Rickels, K. Neurotic symptom dimensions. *Archives of General Psychiatry,* May 1971, *24,* 454-464.

Eichhorn, R. L. and Aday, L. A. *The utilization of health services: Indices and correlates.* A Research Bibliography. Lafayette, Indiana: Purdue University, Dept. of Sociology, 1972.

Ferguson, G. E. Tests of the significance of the difference in proportions. In *Statistical analyses in psychology and education* (3rd Ed.) Toronto: McGraw-Hill, 1971.

Field, M. *Doctor and patient in Soviet Russia.* Cambridge, Mass.: Harvard University, 1957.

Fleiss, J. L. Measuring nominal scale agreement among many raters. *Psychological Bulletin,* 1971, *76,* 378-82.

————.*Statistical methods for rates and proportions.* Toronto: John Wiley and Sons, 1973.

Francis, V., Korsch, B. M., and Morris, M. J. Gaps in doctor-patient communication. *New England Journal of Medicine,* 1969, *280* (10), 535-540.

Friedson, E. *Professional dominance.* New York: Atherton Press, Inc., 1970.

Goffman, E. *Interaction ritual: Essays on face-to-face behaviour.* Garden City, New York: Anchor Books, 1967.

Gove, P. B. (Ed.). *Webster's third new international dictionary.* Springfield, Mass.: G. and C. Merriam Co., 1971.

Halpern, H. M. An essential ingredient of successful psychotherapy. *Psychotherapy,* 1965, *2,* 177-180.

Hershey, J. C., Luft, H. S., and Gianaris, J. M. Making sense out of utilization data. *Medical Care,* 1975, *13* (10), 838-854.

Herzlich, C. *Health and illness: A social psychological analysis.* European Monographs in Social Psychology, No. 5, Douglas Graham (trans.). London: Academic Press, 1973.

Kasl, S. V. and Cobb, S. Health behaviour, illness behaviour and the sick role. *Archives of Environmental Health, 12* (2), 246-266.

Korsch, B. M., Gozzi, E. K., and Francis, V. Gaps in doctor-patient communication. *Pediatrics,* 1968, *42* (5), 855-871.

Korsch, B. M. and Negrete, V. F. Doctor-patient communication. *Scientific American,* 1972, *227,* 66-74.

Mechanic, D. The comparative study of health care delivery systems. In A. Inkeles, J. Coleman, and N. Smelser (Eds.), *Annual Review of Sociology, Vol. 1.* Palo Alto, California: Annual Review, Inc., 1975.

Parsons T. Definitions of health and illness in light of American values and social structure. In E. G. Jaco, *Patients, physicians and illness.* New York: The Free Press, 1958.

————. *The Social System.* Glencoe: The Free Press, 1952.

Shuval, J. *Social functions of medical practice.* San Francisco: Jossey-Bass, 1970.

Shuval, J. and Antonovsky, A. Illness: A mechanism for coping with failure. In *Social Sciences and Medicine, vol. 7.* Great Britain: Pergamon Press, 1973.

Sigerist, H. E. The special position of the sick. In *Henry E. Sigerist on The Sociology of Medicine,* M. I. Roemer, (ed.). New York: M. D. Publications, 1960.

Spitzer, R. L., Cohen, J., Fleiss, J., and Endicott, J. Quantification of agreement in psychiatric diagnoses. *Archives of General Psychiatry,* 1967, *17,* 83-87.

Twaddle, A. C. The concepts of health status. *Social Science and Medicine,* 1974, *8,* 29-38.

Vuori, H. Aaky, T., Aine, E., Erkko, R., and Johansson, R. Doctor-patient relationships in eight of patients' experiences. *Social Science and Medicine,* 1972, *6,* 723-730.

Waitzkin, H. and Stoeckle, J. D. The communication of information about illness. *Advances in Psychosomatic Medicine,* 1972, *8,* 206.

Wolfe, S. and Badgeley, R. F. *The family doctor.* Toronto: MacMillan of Canada, 1973.

Zola, I. K. Culture and symptoms: An analysis of patients presenting complaints. *American Sociological Review,* October 1966, *31,* 615-630.

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# RESUME

**Interaction bénéficiaire-professionnel relativement à la détresse psychologique et à la fréquence d'utilisation des services de santé.**

Au cours des dix dernières années, des centaines d'articles ont traité des bénéficiaires recourant de plus en plus aux services de santé. On a tenté d'expliquer cet usage à partir des traits individuels de personnalité, de l'organisation du système de distribution de soins et de système social. Peu d'études ont investigué le processus d'interaction entre les clients et les professionnels. Parmi ces études, aucune ne tire parti des analyses d'interactions verbales entre les professionnels et les clients en rapport avec l'usage que ces derniers font des services et avec leur état de santé. La présente étude montre la relation qui existe entre les bénéficiaires évitant les interactions verbales et leur fréquence d'utilisation des services de santé de même que leur mauvais état de santé.

# LEARNING TO OBSERVE

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"Nursing is a process that is theoretically grounded in practice. That is, nursing knowledge is generated from experience with patients" (Hooton, 1975). Given this philosophy of nursing, the learning of nursing must have as its focus the student and her experiences with patients. An exploration and analysis of these experiences will reveal the content of nursing for the learner. Although the type of experience provided is important, it is particularly crucial for the teacher to attend to how the student learns. "Knowledge is a process, not a product" (Bruner, 1960). "The emphasis is on the way the student learns rather than on the nursing skills she acquires" (Riley, 1972). The patient is the prime source of data for this approach to nursing and for the learning of nursing. The plan of care evolves from the data gathered in the patient situation and the effectiveness of this plan is measured in terms of the patient's response.

Observation is a primary skill in nursing and is an important and valuable method of study. The learner builds up a comprehensive health assessment after reconstruction of the patient and his/her situation based upon many sorts of observations and sometimes from a compilation of many small cues. With skill and purposeful effort applied to this process of observation, the student can learn to identify nursing outcomes that are more consistently valid and meaningful. Observation, always a part of the nursing process, needs to come under more conscious control of the learner. In order to learn to use the patient as a prime source of data, the student must develop her observational skills.

This paper describes a program in learning observational skills. It was experienced by students during their first six weeks of study towards a baccalaureate degree in nursing. Concurrently, as observers, they were experiencing their first contacts with patients in the medical clinics of our teaching hospitals. The overall intent of the program was to introduce the students to the approach to learning just described. Learning experiences were planned in a sequence which would allow the students to move from the known to the unknown and from the simple to the complex. The focus was on the process of learning as opposed to the content or outcomes of learning.

Specific goals of the program were identified. In a successful program for learning observational skills, each student would:

1. participate actively in the process of learning.
2. be emotionally as well as intellectually involved in the learning experience.
3. add to her repertoire of skills, ones which would allow her to be a more astute observer.
4. gather more data of higher quality from an experience through observation.
5. give others more precise descriptions of what she had observed.
6. elicit from the data gathered, knowledge pertaining to the content of nursing.

The teaching methodology flowed from the overall intent and purpose of the program. It was based on the students' ability to attend to data. In light of this, it seemed important to control the variables to which the students were to attend. Six discrete experiences were selected to meet the goals of the program. The teacher took care in introducing these experiences to avoid providing preconceived solutions. Rather, she asked questions which sought further descriptions and clarification of data presented. She provoked the students to examine the process of their learning. In this way, the teacher attempted to assist the students to enlarge upon their observational skills and to use the data collected in the development of nursing knowledge.

*THE PROGRAM:*

The program consisted of the following series of classes:

1. Pre-test — Observation and Description of Video Tape Recording
2. Observation of Inanimate objects
3. Park Observation
4. Description of Observations
5. Film "The Eye of the Beholder"
6. Post-Test — Observation and Description of Video Tape Recording

*Pre and Post-Test:*

The intent of this exercise was to provide all the students with the same stimulus in order to obtain a baseline from which to assess change in their observations. The students were given an opportunity to observe a video tape recording and then to describe their observations in writing. The same tape was shown again at the end of the term. In making unstructured observations, the students had maximum freedom to record what they observed since the instrument used to collect the data was a blank piece of paper. These descriptions were then assessed for change.

It was important that the stimulus for the pre and post-test be the

same in order to meet the objectives of the exercise, that is, to look for change in the students' descriptions of what they had observed. In order for the students to deal with the task as efficiently as possible, the tape which was chosen as a stimulus needed to be simple and noncontroversial in nature, contain few variables to which to attend, be short in length so that fatigue was not a problem to the students, and contain no auditory or visual interferences so that it would be easy to look at and listen to. With these considerations in mind, a black and white video tape was selected; it was approximately ten minutes long and presented a young woman feeding an eighteen month old child. This stimulus met these criteria: it was simple in nature, contained few variables, and had a high probability of content familiarity to the students.

The students were given the following instructions. "Observe the videotape recording and following your observation record the data you have gathered from the tape in writing. You may have all the time you need to do so." A record of the time taken to complete the assignment was made: the time was noted when the students began to write and again when each student submitted her paper.

*Class No. I: Observation of Inanimate Objects:*

The focus of this class was to highlight the use of the five senses as observational tools for the process of gathering information or data. Specific objectives for the students included:

1) To discover the senses most predominantly and most infrequently used as data collectors.
2) To examine the type of data gathered by each of the senses.
3) To consider the relationship between the quantity and quality of data gathered and the completeness of the knowledge acquired about a situation experienced.

The stimulus for this experience demanded the use of the five senses for observation. Three inanimate objects were used: a colourful Russian doll, a rubber squiggly toy, and a danish pastry wrapped in saran wrap. These objects revealed data which pertained to color, size, shape, sound, taste, odor, temperature, and texture. The students were asked to observe the objects and describe to each other their observations without labelling the objects. This exercise lent itself to small groups (approximately 6-10 students) with the teacher eliciting descriptions of the objects from the students and recording them on the blackboard. Once the students had exhausted their repertoire of descriptions, the teacher then engaged the group in an analysis of the recorded descriptions.

In order to facilitate this analysis, the following questions were used as guides to discussion:

1) How did you observe?
2) What senses were used to observe?
   most frequently?
   least frequently?
   rarely or never?
3) What type of data was gathered by each of the senses?
4) How did your feelings about the objects influence your observation?
5) How did your response to the objects influence your observations?
6) How do the descriptions relate to the objects?

The descriptions elicited from the students revealed data which pertained to color, size, shape, sound, odor, temperature and texture. During the discussion, the students discovered that the senses of sight and touch were most frequently used to gather the data. One student stated that while she heard the crinkling sound of the saran wrap, she did not consider shaking the doll or rubber toy as she knew that she would hear nothing. In point of fact, the Russian doll was wooden and contained other dolls which she would have heard had she shaken them. Another student stated that she had considered unwrapping the pastry and tasting it however had not done so. Several students giggled and quickly passed the rubber toy on to a classmate indicating that the experience of handling the toy was unpleasant. One student stated that because she did not like the feel of the toy, she did not attend to it as deliberatively as she did to the other objects. A few students described various functions that the objects might serve and a few judgmental statements such as "it is pretty", "it feels terrible", and "it smells good" were made. The students pointed out that descriptors such as terrible, good, ugly, etc. were not useful as they were non-specific, too general and open to a variety of interpretations.

*Class No. II: Park Observation:*

The intent of this exercise was to provide the students with an observational experience which increased the number of variables that the students needed to attend to while observing. Specific objectives for the students included:

1) To identify the variables which influence one's ability to observe.
2) To examine how each of these variables influence how and what one observes.
3) To examine how decisions about what one will focus on are made in a multi-variable situation.

The students were given the opportunity to spend one half hour observing in a public park of their own choosing. Following this

experience, they were asked to record their observations in writing and bring their description to class. The role of the teacher was to assist the students to analyse both the process of data gathering during the experience as well as the outcomes of the process, that is, the data gathered. The following questions were used to foster this analysis:

1) How did this experience differ from the in-class observational exercise?
2) What were the variables that contributed to this difference?
3) What feelings were conjured up while observing in the park?
4) How did these feelings influence your observing?
5) What type of observations were made during this experience?
6) How do the observations relate to the reality of the park?

The park observation proved to be a very different experience from the in-class exercise. Students recognized a tremendous increase in the number of variables that needed attention while observing in the park. Some chose to focus their observing on one part or aspect of the park. More attempted to provide a more general picture of the entire park. The students found they were observing people who were in turn observing them. A decision about whether or not to take notes needed to be made. Some felt that notetaking would interfere with the observation process yet were concerned about their ability to recall data. Others who took notes felt conspicuous doing so and suspected that one could miss data while recording.

Most of the students felt that their description did not do justice to the park. One stated that the park was more than the sum of the parts she had described. Another stated that although the ability to describe the physical layout and composition of the park was important, other elements such as the history of the park and demographic data about the users of the park would add to the comprehensiveness of their knowledge of the park.

*Class No. III: Descriptions of Observations:*

The focus of this class was to examine the use of language to describe and communicate observations to others. Specific objectives for the students included:

1) To examine the words and expressions used for specificity, objectivity and descriptiveness.
2) To discover the variety of meanings placed on the same word or expression by different persons.
3) To explore ways in which situations may be represented or misrepresented by the use of language.

This exercise also lent itself to the use of small groups (approximately 4-6 students). Group I described to group II a picture taken from a photograph album. Group II then attempted to picture in their minds the photograph just described to them after which they had an opportunity to actually inspect the photograph. Group II then compared the reality of the picture with their perceptions of the photograph which were based on the descriptions of group I. This exercise was repeated several times using different pictures. The students were asked to "observe the picture and describe your observations to your classmates." The role of the teacher was to assist the students to examine the outcomes of their use of language in the sharing of their observations with their classmates. The following questions were used to provoke discussion:

1) Based on this experience, how effective were you in representing the picture to your classmates?
2) What sorts of problems resulted from your descriptions?
3) What sorts of variables influence the use of and meaning attached to words and phrases?
4) How can one determine that the meaning intended by the use of a word or phrase is the meaning received?

The describing students found it difficult to find words or phrases which would allow the blind group to mentally visualize the picture as they themselves were seeing it. Language presented a few obstacles. The English students did not understand some of the French descriptors and the French students missed out on some of the English descriptors. It was felt that shades of meaning which might be important were lost in the translation. The describers usually started out with fairly general descriptions such as "it is a winter scene" or "it is a picture of a baby." They then attempted to fill in the details.

The blind group was allowed to ask questions of the describers. After seeing the picture, they learned that the answers to the very concrete and specific questions had provided the most useful data. The blind students stated that they immediately formed an impression of the picture with the first descriptions given. They felt that this first impression related to something they had seen or experienced. Each subsequent piece of data added to and altered that impression.

When the describers had exhausted their ability to describe, the blind students had to form a mental image of the picture before being allowed to see it. Some students revealed that they were left with several mental images and found it difficult to choose one.

*Class No. IV: Film, "The Eye of the Beholder":*

The focus of this class was to explore the variables which influence

how one interprets one's observations or perceives a situation. Specific objectives for the students included:

1) To discover the variety of interpretations that may be placed on a single stimulus situation.
2) To examine the variables which influence how one observes.
3) To explore ways of monitoring the influencing factors relating to one's perceptions.

The film demonstrates how perception of the same event varies from person to person depending on his feelings and on what the person is prepared for or wishes to see. It also demonstrates how a person often simplifies things not understood so that he may leave out important facts or substitute others even if distortion results. The film depicts a day in the life of a man by the name of Michael as observed and interpreted by several people. His mother considers him a dreamer, a taxi driver calls him a professor, his landlord refers to him as a lunatic, a waiter sees him as a lady's man, and his cleaning lady thinks he is a murderer. Following these interpretations, there is a short break in the film. At this point the students were asked for their impressions of Michael's experience. The film ended with Michael's interpretations of the events of the day.

In order to facilitate discussion, the following questions were explored:

1) What were some influencing factors that caused each person to misinterpret Michael's experience?
2) How did Michael's behavior contribute to their misinterpretation?
3) How may one promote the accurate interpretation of an event or an experience?

At the break in the film, the students were at a loss as to how to interpret Michael's behavior. They felt that each of the interpretations presented was plausible but that it was highly unlikely that they were all accurate. A few new interpretations were thrown forward as being equally plausible.

Students suggested that the mother saw what she wanted to see and that the taxi driver had selected a portion of what he had observed and based his interpretation on that. They thought that the waiter and the cleaning lady might have based their interpretations on their past experience with other men who reminded them of Michael. The students assessed Michael's behaviour as somewhat extreme in nature and attributed the wide variety of interpretations to this.

*COMPARISON OF PRE AND POST-TEST:*

An analysis of the pre and post-test revealed that a few students had more data of a descriptive nature on the pre-test than on the

post-test. Some students' responses to the pre and post-test were essentially the same, however, for most students, change from the pre and post-test was readily identifiable.

*Timing:*

The students took more time to complete the descriptions of their observations on the post-test. They took an average of one half hour to complete the pre-test and forty minutes to complete the post-test.

The written descriptions in the post-test became more specific and detailed. Statements such as "the baby is happy" or "she is a good mother" decreased in number; rather, the smile on the baby's face and the behavior of the woman were described. Responses to the post-test included fewer generalizations and assumptions without substantiating data, and few value judgments about the interactions between the woman and the child. In general, the observations more clearly revealed the content of the video tape recording.

*Organization of the Data:*

There was a change in the order of the data presented. More emphasis appeared to be placed on observing and describing the appearance and behavior of the woman and the child. Descriptions of the setting, although more clearly described, played a less significant role. Descriptions were presented in a more organized and grouped fashion with less jumping from one focus of observation to another.

*Use of Data:*

Students attempted to place meaning on their observations in both the pre and post-test. In the pre-test there were more statements such as "the mother is reinforcing the child's behavior." In the post-test the descriptions would read, "by saying good boy, the woman is reinforcing the child's attempt to feed himself." There was greater use of substantiating data to support the interpretations of their observations.

*CONCLUSION:*

The observational process in nursing extends beyond observing and recording based on perceptual skills and knowledge. Also needed are the cognitive skills to assess the state of the patient and plan patient care; for these skills, theoretical knowledge as well as empirical knowledge is necessary. The students were concurrently engaged in acquiring the related and relevant theoretical scientific knowledge that is needed in order for an efficient and effective plan of care to evolve.

Each phase of the program described pertained to a portion of the process of gathering empirical knowledge. The pre-test revealed where the students were in terms of their observational skills prior to

implementation of the program. In addition to providing a means for assessing change in observational ability, this information is necessary to develop a teaching process responsive to student needs.

Throughout the program the variables that the students were asked to attend to increased in number and the analysis carried out became more complex and comprehensive. Initially the students were skeptical about the relationship of these classes to the learning and practice of nursing. Gradually, through their clinical experience, the relevance and significance of learning to gather data systematically became more evident to them. The post-test revealed change in the data gathered by a majority of the students. The total program focused on allowing the students to engage actively in the process of acquiring empirical knowledge with the intention that, as the students progressed in learning to nurse, the data base from which they derived their plan of care would become more comprehensive, relevant, valid and reliable.

*REFERENCES:*

Bruner, Jerome. *The process of education.* Cambridge: Harvard University Press, 1960.

Hooton, Margaret. The B.Sc. (N.) Program at McGill. *Nursing Papers,* 1976, *7* (4), 14-19.

Peplau, Hildegard. What is experiential teaching? *American Journal of Nursing,* 1957, *57,* (7), 884-86.

Riley, Irma. The B.Sc. (N.) Graduate as a nurse practitioner. *Nursing Papers,* 6 (2), 19-20.

# RESUME

## L'apprentissage de l'observation

Ce compte rendu décrit un programme d'apprentissage visant à développer l'habileté d'observation; il fut administré à des étudiants du baccalauréat en sciences infirmières durant les six premières semaines d'études. Le but général était de présenter aux étudiants une façon d'apprendre qui met l'accent sur l'observation en tant qu'habileté primordiale de l'infirmière et que méthode d'étude importante.

Le programme consiste en une série de six cours et inclut une épreuve avant et après son administration. Ces cours ont porté principalement sur le processus d'apprentissage plutôt que sur la matière ou sur les résultats de cet apprentissage. Chaque phase du programme se rapportait à une partie du processus par lequel l'étudiant acquiert un savoir empirique. Le contrôle précédant la mise en oeuvre du programme a montré le niveau de compétence des étudiants en matière d'observation. Au fur et à mesure que le programme s'est déroulé, on a augmenté le nombre et la complexité des variables que devaient observer les étudiants. L'épreuve en fin de cours dénote un changement dans les données recueillies par la majorité des étudiants; ces renseignements ont été évalués au point de vue du moment des observations, de leur qualité, de leur organisation et de leur utilisation.

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