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PERSPECTIVES EN NURSING

NURSING EXPLORATIONS

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NURSING EXPLORATIONS: AN INTRODUCTION

JOAN M. GILCHRIST
Professor and Director
and
MOYRA ALLEN
Professor

The year 1980-81 marks the 60th anniversary and Jubilee Year of the School of Nursing, McGill University. This school has been blessed with the vision of a number of remarkable women beginning in 1920 with Flora Madeleine Shaw and Bertha Harmer, followed by Marion Lindeburgh, Mary Mathewson, Electa MacLennan in the 1940's, and by our predecessors in the 1950's and later, Rae Chittick and Elizabeth Logan.

Early programs focused on teaching, administration, and public health nursing as a specialty — a different type of nursing. Later programs developed a clinical orientation following the mode of the times, medical-surgical, maternal and child, psychiatric as well as public health nursing. More recently in the 1960's emphasis on the practice of nursing as a unity, despite age, diagnosis, state of health, and location of care or service, forced faculty to consider the critical elements which nursing encompasses across all situations and settings. If nursing is nursing wherever it goes on, what are its constants? Faculty identified many as old ideas in nursing, such as health, prevention and promotion, family and community, individuality, development, historical perspective, adaptation, readiness, nursing process, and so on. Aided by the rapidly increasing bodies of knowledge related to these and other relevant concepts, faculty have added to and modified the earlier ideas and integrated them within a framework to provide an overarching approach to the practice of nursing. At present faculty is implementing this approach in curriculum planning at all levels, exploring and elaborating the approach in various fields of nursing through faculty practice, and investigating and testing out bits of the approach in research and evaluation projects.

At this time faculty's approach to nursing takes into account four orientations to the client situations which confront nurses: a qualitative orientation to the *health* aspects, a context orientation to the *family*, a structural orientation to the *dynamics*, and a time orientation to the *future*. The knowledge from which these orientations derive constitutes a major part of the content of the nursing curricula at all levels. In addition to the content dimension suggested by the four orientations, faculty

employ a method of going about nursing which involves assessment, implementation and evaluation. In particular, faculty support an exploratory approach to data collection in assessment; goal oriented practice featuring collaborative relationships between client and nurse based on active participation, negotiation, and a balanced power distribution, and evaluation reflecting client responses in view of client goals. In summary, faculty's approach to nursing identifies the content with which nursing deals as subsumed under four orientations — health, family, dynamics, and future time, and the method nursing uses in actual practice as assessment, implementation, and evaluation.

The structural and management systems in the School to evolve, maintain and continue the development of these activities have been simple but effective.

Mechanisms were necessary in addition to the basic formal relationships to provide a context for our developing interests. The Research Unit in Nursing and Health Care, the Joint Appointments System with the School and the McGill Teaching Hospitals, and this journal *Nursing Papers* were all put in place to facilitate the work of individuals, curriculum and clinical interest groups, and those wishing consultation and collaboration in a specific area.

The flat organizational hierarchy in a milieu in which experimentation, colleagueship, and creativity were encouraged and obstacles to the development of the individual minimized has led to flexibility of thinking, breadth of interest, and autonomy of faculty. Staff workshops, group research projects, research/clinical presentations for the McGill-Teaching Hospital Community, and a faculty/student community health service in a rural setting have been important activities.

In particular, the Nursing Explorations Series of this the Jubilee year, focusing on assisting clients in learning to be healthy, families and health care, and an exploration and exposé of faculty and student activities in practice, education, and research were instructive and helpful. The two-day faculty workshop at the beautiful Gault Estate in St. Hilaire laid the groundwork for proposals for four pieces of research aimed at generating tools to measure quality of nursing care, health potential, quality of life of the cancer family, and the development of the concept of pain among children. It is our belief that these initiatives have been instrumental in forwarding the teaching, research, and practice goals of the School.

The content of this issue of *Nursing Papers* entitled *Nursing Explorations* serves to illuminate some of the faculty's work on the investigation and development of nursing here at McGill. The first three articles by Professors MacKenzie, Warner, and Gottlieb relate to the practice of nursing. Joining practice with education and research, Mrs. Mary Flower next

outlines the role of the health sciences librarian. The following three articles describe aspects of learning to nurse — the first two by Professors Mansi and Ross with an introduction by Professor Oseasohn refer to the generic baccalaureate program, and the last, by Professors Ezer and MacDonald and Researcher Attridge, to the non-nurse generic masters program. The last article by Professor Kravitz presents a design for evaluation of a nursing service designed to implement the School's approach to nursing.

The articles in this issue were written by members of the School of Nursing of McGill University to mark the School's 60th anniversary and Jubilee Year.

Les articles contenus dans ce numéro sont présentés par des professeurs de l'Université McGill à l'occasion du 60ième anniversaire et l'année jubilé de l'Ecole.

A LA DECOUVERTE DES SCIENCES INFIRMIERES UNE INTRODUCTION

JOAN M. GILCHRIST
Professeur et directrice
et
MOYRA ALLEN
Professeur

L'année 1980-1981 marque le soixantième anniversaire et le jubilé de l'Ecole des sciences infirmières de l'Université McGill. Historiquement, notre Ecole fut comblée grâce au sillage influent de plusieurs femmes remarquables dont à compter de 1920, Flora Madeleine Shaw et Bertha Harmer. Elles furent suivies dans les années quarante par Marion Lindeburgh, Mary Mathewson et Electa MacLennan; ensuite, Rae Chittick et Elisabeth Logan nous ont précédées depuis les années cinquante jusqu'à aujourd'hui.

Les premiers programmes furent centrés sur l'enseignement, l'administration et la santé publique; cette dernière étant considérée à l'époque comme un type différent de soins infirmiers. Par la suite, les programmes furent caractérisés par une orientation plus clinique — désignée suivant les tendances du temps: soit médico-chirurgicale, maternelle-infantile, psychiatrique tout en n'excluant pas les soins infirmiers en santé publique. Plus récemment, vers les années soixante, l'accent placé sur une pratique plus unifiée en soins infirmiers obligea les professeurs à étudier les éléments fondamentaux compris dans les sciences infirmières quels que soient les situations et les milieux. Si les soins infirmiers demeurent les soins infirmiers dans tout cadre d'exercice, quelles en sont donc les constantes?

Les professeurs identifièrent comme telles plusieurs notions traditionnelles dans les soins telles que: la santé, la prévention et la promotion, la famille et la collectivité, l'individualité, le développement, le point de vue historique, l'adaptation, l'état de préparation, la démarche nursing et ainsi de suite. Bénéficiant de connaissances en rapide évolution au sujet de ces notions ainsi que de d'autres concepts pertinents, les professeurs ont su modifier les premières idées, en ajouter d'autres puis les intégrer dans un cadre conceptuel formant ainsi la clef de voûte de leur pratique en sciences infirmières. A l'heure actuelle, les professeurs utilisent cette approche dans la planification des programmes d'étude à tous les niveaux; ils l'explorent et la développent dans les divers domaines des sciences infirmières grâce à la pratique; ils investiguent et valident des éléments de cette approche à l'aide de projets de recherche et d'évaluation.

Vis-à-vis les situations auxquelles les bénéficiaires ont à faire face, la façon dont les professeurs abordent aujourd'hui les sciences infirmières tient compte des quatre orientations suivantes: une orientation qualitative relative à la santé, une orientation contextuelle au sujet de la famille, une orientation structurelle vers la dynamique et une orientation temporelle vers l'avenir. Le savoir d'où proviennent ces orientations constitue une partie importante du contenu des programmes d'études à tous les niveaux. Outre la dimension du contenu suggérée par ces quatre orientations, le personnel enseignant utilise également une méthode d'approche en sciences infirmières; elle comprend l'appréciation, l'application et l'évaluation. Il s'agit notamment d'une modalité exploratoire de cueillette des données au moment de l'appréciation; ensuite, d'une pratique orientée vers l'atteinte d'un but caractérisée par des relations de collaboration entre le bénéficiaire et l'infirmière. Ces relations se fondent sur une participation active, une négociation ainsi que sur une répartition équilibrée des pouvoirs. Enfin, l'évaluation reflète les réponses du client en fonction de ses objectifs. En quelques mots, l'approche que les professeurs adoptent en sciences infirmières identifie le contenu sur lequel la discipline travaille et se situe dans les quatre orientations déjà énoncées, c'est-à-dire: santé, famille, dynamique et avenir; quant à la méthode utilisée dans la pratique, il s'agit d'un processus qui comporte l'appréciation, l'application et l'évaluation.

Afin de créer un contexte propice au développement de nos intérêts nouveaux, il a fallu mettre en place des mécanismes supplémentaires aux rapports formels déjà existants. L'Unité de recherches en sciences infirmières et en soins relatifs à la santé, le système d'affectation jumelé entre l'Ecole et les hôpitaux d'enseignement de McGill ainsi que la revue *Perspectives en Nursing* ont vu le jour pour faciliter l'oeuvre individuelle, celle des groupes responsables des programmes et des questions cliniques et enfin de ceux qui souhaitent des activités de consultation et de coopération dans un domaine particulier.

Une conception horizontale de l'organisation dans un milieu où l'on encourage l'expérimentation, la collégialité, la créativité et où les obstacles au développement de l'individu sont réduits au minimum conduit à un assouplissement de la pensée, à l'élargissement de l'éventail des intérêts ainsi qu'à l'autonomie du personnel enseignant. Au nombre des activités d'envergure, citont les ateliers des professeurs, les projets de recherche en groupe, les présentations de recherche et les présentations

cliniques à l'intention des hôpitaux d'enseignement de McGill ainsi qu'un service de santé communautaire impliquant des professeurs et des étudiants dans un milieu rural.

Durant cette année de jubilé, la série 'A la Découverte des Sciences Infirmières' est centrée sur l'aide aux bénéficiaires et à leur famille en vue de leur apprentissage en matière de santé. De plus, elle a permis une étude et un exposé des activités tant des professeurs que des étudiants dans la pratique, la formation et la recherche; l'ensemble de ces activités s'est avéré très éducatif et utile. L'atelier de deux jours ayant eu lieu récemment au magnifique domaine Gault du Mont Saint-Hilaire a permis de jeter les toutes premières bases de quatre projets de recherche qui en sont encore au stade embryonnaire. Ces projets visent à la création d'outils permettant de mesurer la qualité des soins infirmiers, le potentiel en matière de santé, la qualité de la vie des familles des cancéreux ainsi qu'à mieux comprendre le concept de douleur chez les enfants. Nous sommes convaincues que ces initiatives nous ont fait progresser vers l'atteinte des objectifs de l'Ecole relatifs à l'enseignement, la pratique et la recherche.

La teneur du présent numéro de *Perspectives en Nursing* intitulé 'A la Découverte des Sciences Infirmières' illustre les travaux du personnel enseignant relatifs à la recherche et au développement des sciences infirmières à McGill. Les trois premiers articles des professeurs MacKenzie, Warner et Gottlieb ont trait à la pratique en soins infirmiers. Ensuite, afin de rapprocher formation et recherche, Madame Flower esquisse une vision du rôle de bibliothécaire en sciences de la santé. Les trois articles suivants décrivent diverses facettes de l'apprentissage en sciences infirmières: les deux premiers écrits respectivement par les professeurs Mansi et Ross précédés d'une introduction du professeur Oseasohn se rapportent au baccalauréat générique (de base); le troisième article des professeurs Ezer et MacDonald ainsi que du chercheur Attridge a trait au programme de maîtrise générique à l'intention des candidats non infirmiers. Enfin, l'article du professeur Kravitz présente un modèle d'évaluation d'un service de soins infirmiers spécialement conçu pour la mise en application de l'approche propre à notre Ecole de sciences infirmières.

HEALTH AND NURSING: EVOLVING ONE CONCEPT BY INVOLVING THE OTHER

MARGUERITE WARNER
Assistant Professor

Five years ago I was one of the four nurses involved in a study of the development of health behaviour in children[1]. It was that project which first set me thinking about health. As we observed children in one situation and then another we could see them taking on various health ideas, attitudes and practices from a very young age. When we looked carefully at each child *across* situations we noticed another level of behaviour — a way of dealing with reprimands or difficult tasks, a way of deciding what to do or a way of getting along with other people. We wondered whether health behaviour was part of these general ways of behaving. Is health behaviour more than specific ideas, attitudes and practices?

As we went on to observe school-age children and adolescents these questions continued to intrigue us. Parents remarked on changes in the health practices of their older children. "He used to be so meticulous... in the bathroom all the time. Now we can't get him near water". They also talked about ways of behaving. "(Nine-year-old) Sandy is a born detective... has to figure things out for herself. But (five-year-old) Jamie! He actually *likes* rules... always making up a new one... drives us crazy sometimes. But he is more cooperative than Sandy." Although a child's specific ideas and practices changed from time to time, his way of behaving seemed to take shape and become quite consistent early in life. We questioned whether his general way of behaving was influencing the health ideas and practices which he accumulated or discarded along the way. These were fundamental questions about health and health behaviour which had not been identified and developed in the health literature.

At that time, the bulk of health research reflected a static concept of health on a continuum with illness, and defined health behaviour at the level of specific ideas and practices. However, the philosophical work of one author caught our attention. Bob Hoke (1968) proposed that "health is a behavioural and developmental process" involving multi-level responses to a total environment:

> Health is like other things than can be learned... not a static end-point but a way of pursuing one's goals... It is not something to have but a way to be. It is a procession, not a possession.

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1 'The development of health behaviour in children', an inter-university project across Canada, launched by F.M. Allen, Ph. D. Initial proposal supported by Health and Welfare Canada, Project No. 605-1237-44.

In other words, health is not a state or a quantity of some kind. Rather, it is a developmental process, the elements of which we were seeing in the behaviour which these children carried from one situation to the next. But Hoke discusses the health process solely as a phenomenon of the individual. Yet we had some remarkable evidence that the child's health behaviour was indeed a reflection of some larger group, in particular, his family. This could mean that the health process proposed by Hoke is, to a large extent, a social phenomenon, embedded in the process of associated living. As the pilot phase of this project came to a close, we had uncovered a rich store of insights and hypotheses concerning the concept of health, all generated by the original question — how do children learn health behaviour?

Within a few months, I began practising nursing at the Health Workshop, another project of the School of Nursing [2]. This project, still underway, is a community health service established to investigate and demonstrate the full function of nursing. It is based on a model of nursing which is uniquely aligned with health. Underlying the original proposal are two notions about health which give theorical guidance to our nursing practice. The first is well developed in an article by Ralph Audy (1971):

> Health is a continuing property, potentially measurable by the individual's ability to rally from insults, whether chemical, physical, infectious, psychological or social. Rallying is measured by completeness and speed. Any insults may have a "training function" and recovery will often be to a slightly higher level of health". The person or body learns something.

Important here is the idea that coping is an attribute of health, a type of health behaviour. In addition to adaptation in the physiological sense, the act of coping is a learning experience: one learns to be healthy. The second definition is from Bruhn and Cordova (1977):

> Wellness behavior is the development of an individual's ability to actively seek and change his life situation so that he can function at his perceived maximum capacity and satisfaction.

According to these authors, development is also an attribute of health. It is the harnessing of strengths and resources to the intentional work of achieving life goals. Being healthy is a way of developing; one may say,

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2 A prototype for community health nursing, 'The Workshop: A Health Resource' launched by F. Moyra Allen, Ph. D., and Marguerite Warner, supported by Health and Welfare Canada. Project No. 605-1300-42.

therefore, that it is learned. It seemed that Audy, and Bruhn and Cordova had each teased out an attribute of that way of "being and becoming" envisioned by Hoke. But how does one utilize ideas such as coping, development and learning in nursing practice? Jean Piaget (1973) states that "to understand is to invent, or reconstruct". And that is what had to be done — reconstruct through the practice of nursing these abstract notions about health.

Coping was chosen as the first point of enquiry because the literature provided some ideas of what to look for. Helen Perlman (1975), for example, summarizes our knowledge about coping this way:

> Coping is a person's effort to deal with some new, and often problematic, situation or encounter or to deal in some new way with an old problem. Its purpose is mastery or problem-solving at best; at the least, it serves to reduce tension and ameliorate the problem.

Coping then is a function of problem-solving. The act of coping, as an expression of health, could be differentiated into the various activities of problem-solving.

In practice, these ideas led to observing, eliciting and examining the ways in which people were dealing with the concerns which they brought to The Health Workshop. One young couple who was exasperated with their five-year old's behaviour, presented the problem this way. "Charlie will not do as he is told. He is noisy and rambunctious in the house — a bully with his little brother. He doesn't listen. That's the most irritating part. He *never* listens." How have they tried to deal with his behaviour? "We put him in his room and he tears everything apart. We've tried spanking him and we've tried reasoning with him." Was Charlie ever good? "Yes, he has his good days — fewer and farther between, but he is a very affectionate little boy who can be a lot of help sometimes too." Beyond this point, the parents were at loss to describe the circumstances of Charlie's good days and bad days, or the sequence of events leading up to Charlie's outbursts of "bad" behaviour. The mother complained of frequent headaches and of feeling nervous all the time. The father worried that he was learning to hate his son. They had no particular questions than, "How do we make him behave?" The problem-solving behaviour of this young couple was characterized by a random "jumping to solutions". There was minimal evidence of activities directed toward understanding Charlie's problematic behaviour. By combining the data combed from nursing practice with what is known about coping, it was possible to reframe this couple's concern in terms of problem-solving. They required assistance in gathering information about the circumstances of Charlie's behaviour and examining that information to gain a better understan-

ding of the situation. But the method of working with these aspects of coping was not yet clear.

Audy (1971) says that the act of coping is a learning experience, an opportunity to improve the quality of coping behaviour. This would suggest approaches to nursing practice which assist people to learn better (healthier) ways of coping. Since coping is essentially a problem-solving process, the nurse would attempt to create an environment and provide a structure in which people could interact with the situations they encounter in a problem-solving way. To go back to Charlie's family, the next logical step was to engage them in a learning situation wherein they could find and master new ways of coping with his behaviour. This meant involving them, first of all, in some excercises in observation and listening. As a group we viewed a short film depicting a typical day in the life of a pre-schooler. Throughout the showing we each jotted our observations, and then we compared notes. Charlie's parents were astonished at the amount of interpretation versus description they had given to the behaviours which they observed. To a lesser extent they noticed, by reading my notes, what they had *not* heard. We then went on to the business of gathering information at home. The couple decided to use a tape recorder because it was a familiar object in the home and an easier method than notetaking.

The above vignette helps to explain a further development in this exploration of the concept of health. As I worked with Charlie's family, I was attending to their coping (or was it their learning?) behaviours at the time of assessment and as they changed or did not change in response to nursing actions. Suddenly it occured to me that the problem (coping) and the method (learning) were one and the same. The act of coping is a learning act. And within a learning framework, nursing assists people to learn new ways of coping, thereby assisting them to become healthy. The real test of the significance of this concept of health and nursing comes in matching improvements in the quality of coping with pertinent indicators of better health status, e.g., better family functioning, reduction or disappearance of illness symptoms and ability to work or go to school.

Development, the other notion about health underlying our nursing practice, was less clear. Unlike coping which is problem-oriented, development is a goal-oriented process. Although we know a great deal about the problem-solving process, our knowledge about man's goal-achieving behaviour is minimal. This is due, in part, to the tendency to organize studies of development around biological maturation and chronological stages of the life cycle rather than the behavioural processes which energize and steer development. In his most recent work, Bronfenbrenner (1979) talks about "molar activities" as the principal and most immediate manifestations of development:

> A molar activity is an ongoing behaviour possessing a momentum of its own and perceived as having meaning or intent by the participants in the setting.

According to Bronfenbrenner (1979), molar activities are continuing processes with a momentum which is produced by the existence of intent. "The question of perceived aim is thus always relevant for defining a (developmental) activity" (Bronfenbrenner, 1979, p.45).

Once again I looked to nursing practice for opportunities to reconstruct and understand this developmental attribute of health. Working from the learning perspective, I gathered information about strengths and resources, purposes and aspirations when exploring problematic situations with clients. It is within this framework of thought that one is most likely to discover goal-oriented activities which, as Bronfenbrenner suggests, are not tied to the immediate situation but do come into play in the events of day-to-day living.

The developmental attribute of health appears to comprise at least three goal-achieving activities — calling forth potential, creating resources and taking aim. Calling forth potential includes noticing that potential and putting it to use. At The Health Workshop we have observed that some people, even while seeking assistance, act as though they will be able to deal with the problem. Voluntarily, or in response to questions about their strengths, they describe abilities and qualities which they perceive as positive. They demonstrate a sense of their own power (potential) as an agency residing within them. Others talk only of failure and inadequacies. I was working with two young men, each 20 years of age, at about the same period of time, when the contrast between the two revealed this activity of calling forth potential. They were both in university and had been at the top of their class until the past year. But now they were doing badly, questioning the value of "all work and little play" and dealing with pressures from the family to pursue a professional career. The one described himself as a procrastinator, as "all style and no substance". He was depressed and he found it difficult to think of his particular strong points. The other was dealing with a much stronger reaction from his family. Although he was discouraged and upset he had no doubts about his academic ability or his capacity to do something "worthwhile" in the future. He was able to incorporate this sense of his own potential into an assessment of the situation and later, into a decision to change his program of study.

Another developmental activity is that of creating resources. This refers to the ways in which people recognize, mobilize and regulate resources. Through nursing families dealing with similar if not identical events, it was possible to see some of the characteristics of this activity.

With the onset of a chronic illness in one of its members, one family could identify and begin to mobilize existing sources of emotional strength and practical assistance among neighbours, friends and community agencies. Another family struggled to maintain independence, bemoaned the lack of services and hesitated to "impose" on others. Some people search out reading materials and a variety of ideas and opinions; several others remain mystified and helpless. Rather than takig inventory of several available resources a family may latch on to one "referee" or authority who will take charge of the situation for them.

More recently, an elderly Irish lady taught us about the notion of regulating resources. Mrs. M. was referred to The Health Workshop by one of her neighbours. "Carrie has arthritis, a lot of stiffness in her knees, finding it difficult to get around. But she is also quite heavy — doctor told her to lose weight and I think she would like some help." When I met Mrs. M. she asked all the right questions about nutrition and dieting. She seemed to expect that I would set her up with a dietary regimen, information about nutrition, etc. Yet I wondered whether this type of assistance was really required. Mrs. M. understood the notion of a balanced diet and had adequate knowledge about the nutritious value and caloric content of many foods. Going along with her initial requests for information and advice, I also inquired about her own ideas and strategies. Gradually, she talked about the weight control methods which she had learned in seventy years of living. She enjoyed "weigh-ins" and periodic acknowledgement of her successes by another person. On one home visit, she pulled out a diet sheet which a friend had given to her. "I don't tell her I'm not following it — it's much too fancy. But she's a good friend and it's nice to know that she is interested. It's just a matter of potatoes and bread with me — I cut them out and off go the pounds — that's the way *I* do it". I was impressed by her remarkable ability to regulate, when necessary, the actual input of her friend and now, the services of a health resource. Mrs. M. wanted external reinforcement this time and she knew how to handle the information and advice which she had solicited as a "good" client but did not really need. This set me thinking about a young couple with a new baby who were having more trouble dealing with the "experts" among their well-intentioned friends and in-laws than with any other aspect of the new parent experience. How could they learn to regulate inputs while maintaining their network of resources?

Taking aim is a third developmental activity manifested by people who can set goals for the immediate situation and link a satisfactory solution with the general nature and direction of their development. When structuring a learning situation for a client I inquire about general goals early in the assessment phase. As we begin to consider strategy (specific goals and methods), I watch to see whether the client notices the link between

what we are doing and where we are going. Some people can see the aim in the action. Other people need help in learning how to identify and utilize their aims to decide on a course of action. One lady surprised me when she announced that since her last visit she had started the Scarsdale diet. I wondered how this linked with her presenting complaints of unrelenting tension and anxiety and episodes of physical weakness and fatigue at work. "Well, once I sorted out that goal of feeling better about myself and no longer being everybody's doormat, I went home and began to think about how to start. Most of it seems very complex but I do know that when I look good I feel happier, more confident. So I decided to start with these 10 lbs I've put on the past couple of years". At first glance, her decision to diet seemed aimless in terms of the larger problem, but not so. Once she got started, we then looked for possible links between how she was working on her physical appearance and how she might work on the "doormat" problem.

Attempting to see and work with the developmental attribute of health has been more difficult than the search for coping. Goal-achieving activities have not been investigated and documented as such, as have the activities of problem-solving. But by trying out Bruhn and Cordova's idea about health and Bronfenbrenner's concept of development, I am learning where to look and how to incorporate these ideas into practice. For it seems clear when one compares Mrs. M. with the couple with the new baby, as well as with the two young men dealing with a similar situation, that goal-oriented behaviour can be learned. People can learn to develop, just as they can learn to cope. Through discovering knowledge about the goal-achieving process, nursing could assist people to learn to monitor and manipulate their own progress toward higher levels of health.

It has been three years since I began investigating the concept of health underlying The Health Workshop project. The discoveries outlined here are products of a great deal of nursing practice and frequent exchange of ideas with my co-workers on the project and colleagues in the School of Nursing. Although there are still many questions to pursue, this unfolding concept of health can now act as a leading idea and be employed more purposely to produce questions and hypotheses with which to test the concept and, concurrently, the shape of nursing practice. I see health as a continuing process, comprising coping and development as its content and learning as the instrument of change in that process. Coping and development appear to be interrelated but the dynamics of that interrelationship is not yet known. How, for example, does a family maintain some equanimity and stability while it changes and grows with the developmental thrusts of its adolescent members? Theoretically, the continuing goal-achievement process connects with and threads through the coping process which emerges in response to one life event and then

another. Therefore, a family which can call forth its potential is likely to assume that it can cope with change and act accordingly. The type of assistance its members seek will be different from that of the family which has yet to discover the agency residing within it. This is but one hypothesis which awaits testing.

Finally, by evolving a concept of health through the practice of nursing, I am beginning to see a relationship between health and nursing which could be unique in the health care delivery system. The unifying theme of that relationship is yet to be articulated but therein lies a theory of nursing.

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RESUME

L'Evolution du concept santé par l'adjonction d'un concept novateur en sciences infirmières

Au cours d'une recherche consacrée au développement du comportement en matière de santé chez les enfants, le concept santé devint sujet d'étude. Ainsi, dans le contexte de la pratique infirmière à 'L'Atelier à Votre Santé', on choisit et l'on explore des définitions conceptuelles pour ensuite les reformuler à partir d'observations du comportement chez les bénéficiaires. La manière de faire face apparaît sous forme d'activités observables par lesquelles les familles s'efforcent de résoudre des situations problématiques. Le développement de ces habiletés se vérifie grâce à des actions faisant appel au potentiel et la création de ressources s'alliant à la poursuite d'un but. Les deux ensembles de comportements semblent avoir été appris; ils paraissent intimement liés et deviennent représentatifs de moyens d'être en bonne santé. En introduisant un concept novateur en sciences infirmières dans cette étude exploratoire, la modalité pratique des soins infirmiers se modifie en fonction de l'évolution du concept santé.

FAMILY HEALTH AS A PERSPECTIVE IN ASSISTING A FAMILY TO COPE WITH HOSPITALIZATION

FLORENCE MACKENZIE
Associate Professor, Coordinator of M. Sc. (Appl.) Program

In describing approaches to an expanded nursing role, a model of nursing is delineated which may be termed "situation-responsive" and complemental to the services of other health professionals. This model is in contrast to the more traditional "a priori" model of nursing where nursing services are seen as "replacement of" or "assistant to" other health professionals (Allen, 1977).

The dimensions of the model are as follows. As nurses work with families, emphasis is placed on the health aspect which is determined by how the family copes with the situation and how it is used in their development. The situation or problem is seen as an open system which alters over time. In assessing the situation the nurse draws information from family members and gathers related data from a variety of other resources. She identifies and employs the strengths in the situation as a groundwork for a plan of action. The implementation of the plan is geared to the best fit that can be achieved between the plan of action and the family situation. Finally the nurse notes the responses of the individual and family and tailors the plan for future action.

The theme of this paper is that this way of thinking about nursing may be used to guide the nurse wherever she is practising. The dimensions of this approach may be seen more clearly in primary-care settings where one nurses the family on a long-term basis. Nevertheless, the same dimensions are critical elements in any nurse-client involvement. Of paramount importance is the nurse's continuous assessment which capitalizes on the strengths of the family in building an ongoing plan of care.

The point at which one enters the family situation will influence the nurse's assessment. The data one gathers when the family is in a steady state will differ at least in part from that gathered when the family is dealing with a crisis. One such crisis might occur when a family member requires hospitalization. It follows then that a nurse who has nursed the family over time will be in an advantageous position to help the family cope with this event. She will have knowledge of the family strengths and ways of coping on an everyday basis as well as with other crises. On the other hand, it may be at this point where the nurse first meets the family and begins her assessment.

Needless to say, the number and complexity of problems leading to hospitalization are many and varied. To the family this happening may

signal the beginning of a life or the end of a life; it may be a single episode or one of many; it may provide respite or disquiet; it may lead to a gain or a loss; it may require a short-term or long-term stay; and it may be an event for which the family is well-prepared or ill-prepared.

Hospitalization as a stressful event for an individual has been well-documented in the literature. In *Stress in Hospital*, the author refers to much of the literature and research in this field (Wilson-Barnett, 1979). What is lacking, however, is knowledge on how the family deals with this event in a health promoting fashion.

The question arises, how does the nurse utilize a family health perpesctive when the family is faced with hospitalization of one of its members? When making an assessment the nurse searches for the strengths in the family. In her search she may pose such questions as — what does this event mean to this family? What roles are being played by the family members including the ill person? As a family, what arrangements are being made to manage this event? What information do they seek from the nurse when she makes herself available? What previous experience have they had with illness? with hospitalization? What did they learn from that experience? Drawing forth such information provides the groundwork which will enable the nurse to identify the family strengths on which to base a plan of action in assisting the family to cope with the event of hospitalization.

The following situations are included to illustrate how graduate students have used a family orientation as they worked with families who were faced with hospitalization of the mother in the family. In each situation the time frame differs but the focus on the health aspect remains the same.

> In the first situation, a graduate nurse student, S.P. was introduced through a social service agency to Ann Gold, a 65-year-old unmarried woman who lived with and cared for her semi-invalid 90-year-old mother. The initial assessment identified Ann's strengths through the excellent care she gave her mother despite the mother's inability to communicate. Ann's life revolved around the care of her mother. Another daughter visited but participated little in her mother's care. Throughout her life Ann's world had been dominated by her mother and sister. At the nurse's point of entry into the family, Ann spent most of her time with her mother except for quick trips to the grocery store. Ann's trust in S.P. grew as she participated in Mrs. Gold's care thereby allowing Ann to begin gradually to take longer periods to shop and to venture further from home.

S.P. continued to nurse this family over a three-year-period and was able to help Ann to find healthier ways of coping with everyday events. At the end of the first year, Ann had begun to develop a life for herself apart from the devoted care she gave her mother. With S.P.'s help, Ann's confidence in her decision-making ability increased. Taking a trip on the subway, buying clothes for herself, purchasing a television set were major accomplishments. She also began to think about a future without her mother and to entertain the possibility that her mother might require hospitalization. Over time the student focused on the health of the family and increeased her ability to find a plan of action best suited to them. When Ann's sister became ill with cancer and required hospitalization in the terminal stage, S.P. participated in her care and helped Ann to plan visits to see her sister. The student supported Ann's decision to employ a special nurse so that Ann could be assured her sister was receiving the care Ann felt was necessary. When her sister died Ann displayed her strength in making funeral arrangements. S.P. used this opportunity to maximize the experience as an illustration to Ann of how well she had managed.

Later in the year Mrs. Gold developed respiratory complications and was hospitalized first in an acute care setting and then in a nursing home. The major problem for Ann was to find a way to continue to care for her mother in the institution. S.P. reinforced the idea that this was Ann's right and together they planned how she might do this. The plan was that Ann would spend part of each day with her mother, attending to her needs as she had done at home. Although Mrs. Gold was oblivious to her surroundings and slept most of the time, S.P. recognized that the best way for Ann to cope with the hospitalization was to continue to manage her mother's daily care. S.P. coached Ann in dealing with the hospital system by helping her to negotiate her entry into the setting and to work within it. As Ann participated in her mother's care she interacted with other patients and families. Through the students' intervention Ann had her lunch each day in a restaurant run by volunteers and became interested in the role of volunteer. Knowing her mother was cared for in the hospital, Ann used her time when not with her mother to attend to some of her own needs such as shopping and visits to the dentist. When her mother passed away quietly, Ann expressed that she had done the best she could. Later, she became a volunteer in one of the social service agencies.

In this situation, because the nurse was involved with the Gold family over time, she and Ann were able to establish a plan of action suited to the family. Knowing the importance that Ann attributed to taking care of her mother, the nurse helped Ann to continue this life work while reinforcing her new strengths in developing an interest in other activities. Having learned from her successful coping with a variety of events including her sister's illness, hospitalization and death, Ann coped with her mother's hospitalization with a minimum of stress or one might say in a healthy fashion. She was then ready to face the loss of her mother and the changes in her everyday life.

> In the second situation, a graduate student became involved with the Main family when Mrs. Main, a widowed 60-year-old mother was in hospital in the terminal stages of cancer. As she cared for Mrs. Main, the nurse soon learned about this lady's strengths as they conversed about her life and the losses she was experiencing in leaving her family. In a short period of time, the nurse met all of the three children, their spouses and Mrs. Main's sisters. As a family they had a common goal to maximize the time they had left together, and the nurse's plan of care was made to fit that goal. The sister organized a 24-hour schedule with family members and friends sharing their time in sitting with Mrs. Main. The graduate student and nursing staff participated with the family as they cared for Mrs. Main. Individual family members were encouraged to express their loss in his or her own way and to relate to their mother (or sister) in the way best suited to the individual. Amongst the family's many strengths was their ability to use the nurse as a resource and to create a "home" environment within the institution.

This example illustrates how one family mobilized their many strengths in coping with and learning from the painful event of the hospitalization and death of a mother. The nurse moved along with the family members building on their strengths and helping them to achieve their goal.

In each of these situations the family was dealing with a common problem in today's society, that is, the family caring for an older parent and coping with the hospitalization of a family member. The examples were chosen because on face value there was much in common. However, tuning in to the family to identify and employ the strengths of the situation led to different plans of action so each family could achieve its particular goals.

One recognizes that hospitalization may disrupt family life to a greater or lesser extent than in these examples and that other plans of care would

be developed as strengths of each family are identified. Locating the strengths may require reframing situations so that the strong points come into focus and the nurse may work with, rather than against, the family strength. Two such situations were observed where the patient's plan to maintain her role as the household manager was viewed by the nurses as depleting the patient's energy reserve. When the situation was reframed so that the mother's activities were seen as a family strength, a plan of care evolved to work with the mother in maintaining her role and to rearrange hospital routines which allowed time for rest. In each situation family members were already supporting the mother's position and were willing participants in the plan of care.

When the same nurse works with the family over time, then hospitalization becomes one of many life events through which the family may learn and develop healthy ways of living. When the nurse's contact with the family is of a shorter duration the time frame may be different, yet the focus on the health of the family will provide one condition for the family to learn from the experience.

In a recent publication entitled *Nurses, Patients and Families*, the authors devoted a chapter to the families of patients, examining how "families come to pose problems for nursing staff " (Rosenthal, Marshall, Macpherson and French, 1980, p. 109). In the examples cited in this research, the focus on the family as a problem clouds the view of the family strengths, as the family and patient are seen as separate entities with the staff working between them rather than with the family as a unit. The authors acknowledge that the majority of families do not pose problems to the staff, with the inference being that these families fit into the hospital system. It is possible that by examining the situations where families did not pose a problem to the staff the researchers might have uncovered examples where nurses worked with the families to manage the stress of hospitalization.

As health professionals focus on coping as a concept, there is an accumulation of knowledge that signifies one direction for the development of nursing in the decade of 1980. In a new textbook Freidman (1981) draws attention to the family coping function because she feels "families have crucial coping patterns which need to be appreciated if we are to understand their impact on family life and assist families to stabilize and grow". In a comprehensive article Roskies and Lazarus (1980) trace the development of coping theory and then link this to the teaching of coping skills. These authors suggest directions of research which include the need for "a system of describing, measuring and evaluating coping" and "to know more about the development of coping strategies, especially how ineffective and effective patterns arise and are changed" (Roskies and Lazarus, p. 63). Educating nurses to identify family coping patterns

and to tailor their nursing accordingly could lessen the strain of hospitalization on families, patients and nurses. Describing, measuring and evaluating the process would lend credence to the nurse as a "shaper" of family health.

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RESUME

Une perspective en santé familiale: Un moyen d'aider la famille à faire face à l'hospitalisation d'un de ses membres

Le thème principal de cette présentation consiste en ce qu'une perspective de santé familiale est utile à l'infirmière quelque soit son milieu d'exercice professionnel. L'évaluation suivie à laquelle procède l'infirmière revêt une importance primordiale car elle permet de tirer parti des points forts de la famille dans l'établissement d'un plan de soins continu. Le moment où elle pénètre au sein d'une famille influe sur cette évaluation par l'infirmière compte tenu que les données qu'elle rassemble en situation dite normale diffèrent de celles qu'elle recueille en situation de crise; cette dernière peut précisément résulter de l'hospitalisation d'un membre de la famille. Lorsqu'une même infirmière s'occupe d'un groupe familial pendant un certain temps, l'hospitalisation d'un membre a de fortes chances d'aider cette famille non seulement à apprendre mais aussi à adopter un mode de vie sain. Lorsque les contacts de l'infirmière sont de courte durée, le cadre temporel risque de différer, cependant l'importance qu'elle accorde à la santé devient une condition d'apprentissage pour cette famille. Le fait de former les infirmières à reconnaître les modalités dont un groupe familial se tire d'affaire et à adapter les soins en conséquence peut amenuiser l'épreuve de l'hospitalisation pour les familles, les bénéficiaires et les infirmières. La description, la mesure et l'évaluation du processus de formation ajouteraient foi au rôle de l'infirmière comme 'façonneuse' de la santé familiale.

NURSING CLIENTS TOWARD HEALTH: AN ANALYSIS OF NURSING INTERVENTIONS

LAURIE GOTTLIEB
Assistant Professor

For the past several years, the School of Nursing at McGill University, has been involved in the development of a model for practice in which health promotion is one of its salient features. This model has been referred to as Situation-Responsive nursing (Allen, 1977). Several nursing demonstrations were established in the 1970's for the purpose of implementing the model of situation-responsive nursing and further describing its characteristics[1]. One such characteristic has been the identification of the types of interventions nurses use in working with clients on health-related situations[2]. This paper will briefly discuss the work that has been done on identifying those interventions associated with health-related issues.

The first headway made in the area of interventions was the development of a classification system of nursing strategies identified from nurses in three family practice settings. This system was developed as part of a larger project which evaluated this model of nursing in one demonstration setting and compared this model of nursing to the nursing taking place in two comparable settings (Allen, Smith and Gottlieb, 1980). Nineteen major types of interventions, along with their sub-types were identified and subsequently used to differentiate between interventions that were associated with health, as opposed to illness-related concerns. Further work on interventions was derived from analysis of data collected on the practices of nurses at the second demonstration known as The Workshop — A Health Resource[3]. The Workshop, as it became known, was an autonomus nursing service established in a middle-class suburb of Montreal. The reason for establishing this service outside the existing health care system was to give nurses an opportunity to more fully explore their role as facilitators and promotors of health (Allen & Warner, 1978).

Since the first eighteen months of this project were classified as a

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1 These innovative-type services to demonstrate a new approach to health care delivery were supported by the Research Directorate of Health and Welfare, Canada. Project Nos. 605-1234-46 and 605-1300-42.

2 Health-related situations refers to those situations of daily living and are found in the classification system of health-related situations developed by Gottlieb (Allen, Smith and Gottlieb, 1980).

3 Project 605-1300-42, Research Directorate Health and Welfare, Canada.

developing phase for establishing a prototype service in community nursing, an exploratory study was designed to identify key nursing approach variables that could be used in the subsequent evaluation phase[4]. This paper is based on an analysis of data collected on client-nurse interactions and interviews with nurses about their practice. In analysing these data, the constant comparative approach to qualitative analysis as described by Glaser and Strauss (1967) was employed. It was found that nurses varied in their approaches to practice in working with clients toward health (Gottlieb, 1979). One approach in particular embodied many of the characteristics of the model and is referred to as Style A.

Style A, nursing for health using a learning framework, was found to be contingent upon structuring goal-oriented learning experiences directed toward meeting the unique needs and problem-solving styles of the client[5]. The selection of interventions was directed toward changing or strengthening the client's way of dealing with health-related situations. Within this framework, the client and nurse became collaborators, the client taking an active role in his learning experience.

The approach to nursing was examined within each of the phases of the nursing process, that is, assessment, planning, implementation, and evaluation (Gottlieb, 1979). Within each of these phases, the content on which the nurse focused along with her framework and the strategies that she employed were identified. Although each phase of the nursing process was found to be overlapping, interactive, and contingent on the other, nonetheless, each stage had its own distinct properties. In Style A, the nurse focused on assessing the client's perception of his concern, finding out more about his level of motivation as well as his readiness to engage in 'health-work'. In planning care, the emphasis was on negotiating a plan of care tailored to the client's learning characteristics and situation as in the assessment phase. The implementation stage focused on the development, elaboration, and working out of health issues. The nursing strategies associated with this phase will now be described.

NURSING INTERVENTIONS USED IN THE IMPLEMENTATION PHASE

Figure 1 summarizes the interaction between the client's stage in the problem-solving process and the different strategies or roles the nurse used with each task. Each of these stages was worked on sequentially or independently, depending upon the assessment of the situation.

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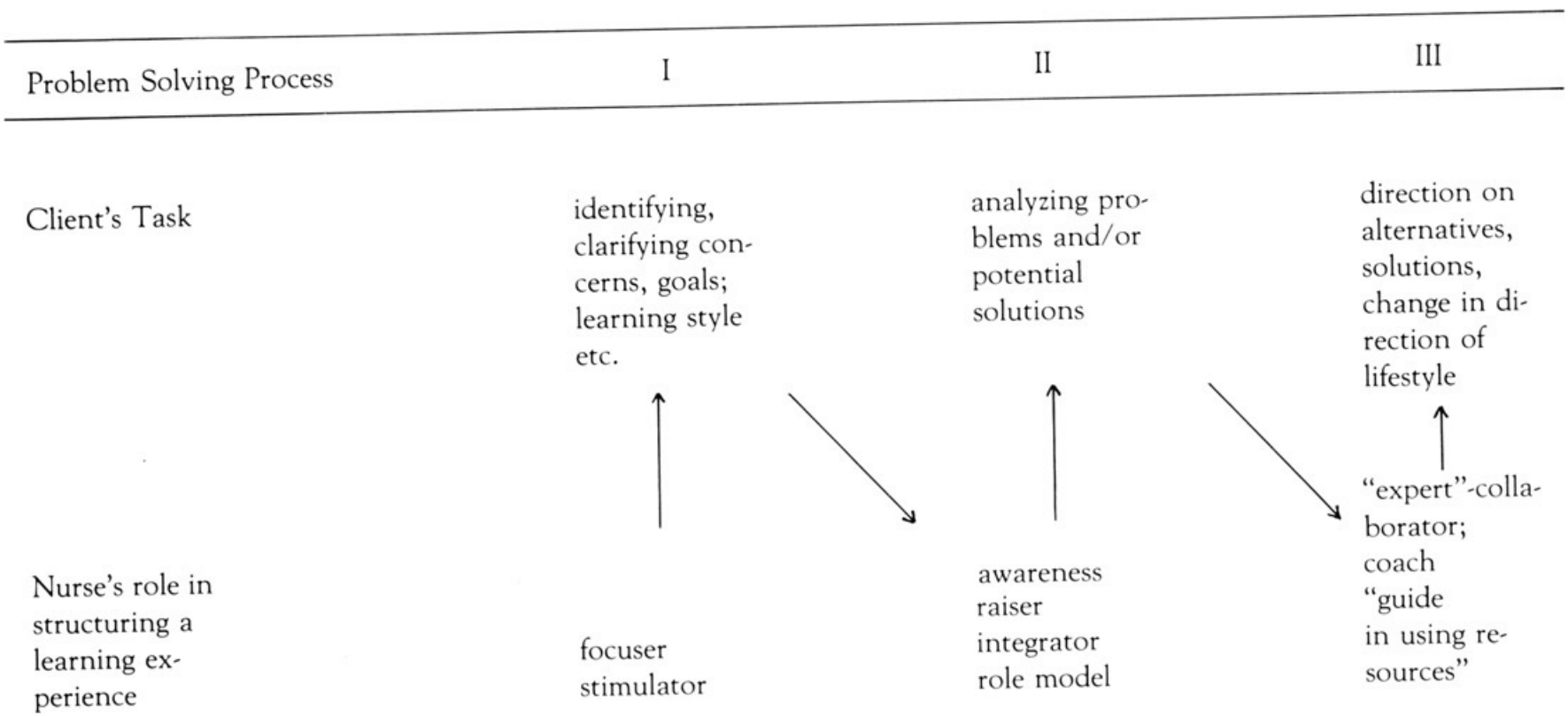
4 Dr. Charles Bourgeois was the project director of this phase of the research. Under his direction data were collected by Adele Carrier and Kent Farrell.

5 Client refers to the individual as well as to the family unit.

FIGURE I

Interaction between the client's stage of the problem-solving process and the role of the nurse



The first task of the client was that of identifying, clarifying and/or enlarging his perspective from which to view his concern. The nurse was found to play a variety of roles to accomplish this objective. One such role was that of *focuser*. In this role the nurse devised projects for the client that facilitated his approach to gathering information and/or which stimulated introspection. These projects were found to take a variety of forms such as structuring meaningful observational periods in which the client had the opportunity to observe his own or other family members' behaviors.
The following example illustrates this technique:

EXAMPLE: (mother having difficulty with her child's behavior)
Nurse: (I would like her) to do some homework to take some time to really observe her little boy and step out of the situation with him and observe his behavior, particularly around certain circumstances that irritate and frustrate her... to get her to actually observe what he does and the circumstances around his temper tantrums.

Another role that the nurse played was stimulator. By asking provocative questions that could not be immediatly answered or by giving material to reframe a situation, the nurse attempted to help the client to consider the situation in a new light. These two strategies were used to help the client discover aspects of the situation of which he had not been previously aware.

A second task in the client's process of problem-solving was learning how to analyze the situation. To foster analytical skills the nurse acted as *awareness raiser*, *integrator*, and *role model*. As an awareness raiser, the nurse attempted to bring that which had been learned from an intuitive level of functioning to a level wherein the client became conscious about what had taken place. Examples of strategies employed in this role were those of summarizing for the client what had taken place; pointing out indicators of progress towards achieving a goal, reviewing preceding events that appeared associated with the situation.

EXAMPLE: (The client discusses with the nurse the feeling of fatigue that she has associated with stressful situations).

Nurse: ...little discoveries you've mentioned (that the client has mentioned to cope with stress) like physical exercise, periodic relief from routine. Build those in, work those discoveries into your routine.

Analytical skills were also fostered when the nurse acted as a *role model*. In this role she demonstrated an approach to analysis. Her behavior

often served as a frame of reference for the client to later imitate. She was active in this role not only by demonstrating a method of analyzing a situation, but also by explaining what she had done, with the underlying rationale to her approach.

Nurse: Well, you've done your homework in the past week and so have I. I have summarized one problem or concern you have brought since October. In October you were talking about feelings of fatigue and feeling faint and the lack of serenity in your life. There is also a problem of management of time, in dealing with things that you have done. This is how you were explaining this. These were the problems you were experiencing and this is the explanation you were attaching to them...What you have done is jump from here to here (show the client her analysis of the situation and explain this analysis.) In October the focus of your tension was on finding time to rest. Over the winter your fatigue persisted and your feeling of being down and blue, but the explanation seems to have opened up. Anxiety makes you feel fatigue...These are the things you are experiencing as problems, fatigue, feeling of weakness. Lack of serenity and these were the possible reasons. First was the problem in managing time and over the winter you became concerned with your diet. It probably isn't your diet that is related to fatigue and physical weakness.

When the nurse worked with the client on finding a solution to his concerns, the emphasis continued to be on both the process of finding the solutiuon(s) as well as providing the needed knowledge and skills to enlarge the client's options (see phase III in Figure 2).

The process of decision-making required an active examination of possible solutions. The nurses' role was one of eliciting from the client the available alternatives open to him. Through discussion, questioning and mutual exploration, the client was assisted to consider and to weigh the feasibility of each option. The nurse participated in highlighting the factors that the client could consider in coming to his decision. This process is illustrated in the following nurse-client interaction:

Client: What do you think of my mother moving in with us? I know we'll eventually have to make our own decision. But do we have an option?

Nurse: I think space is the first factor you'd have to take into account. Is there enough room in which to live your own lives?

Client: We'd have to build an addition to our house.

Nurse: The second thing is that you'd have to canvas the opinions of everyone in the family, since it's a situation with which everyone has to cope...You'd also have to check to make sure there are no other facilities nearby that would better suit your purpose, a nursing home and the like...

Client: I realize it is not quite fair asking you that question!

Nurse: I am just trying to highlight some of the considerations that would go into my answer.

The second area in helping the client arrive at a solution was by expanding the client's repertoire of functioning. The nurse played an instrumental role in facilitating this kind of growth. As an 'expert' in health-related matters she possessed knowledge and skills from which the client could benefit. The manner in which information and suggestions were imparted was in keeping with the collaborative feature of this style of nursing. The client not only was encouraged to participate in sharing information but also was taught skills of acquiring needed information. Other skills that were developed within the client included those of assessment; technical skills related to the handling of equipment or the administration of treatment; the discovery and utilization of resources within himself, his family and his community.

The role of the nurse was not confined to the demonstration of these skills but she also helped the client employ these skills at the appropriate time. Successful incorporation and utilization of these skills, so that they became part of his pattern of behavior, were largely dependent on the nurses' method of demonstration and on the follow-up support that she provided. One such form of support was being available when the need to use the skill arose. By having watched the client practice the skill and having provided the needed reinforcement, meaningful learning experiences took place.

EXAMPLE: (The nurse discusses helping the family manage a child experiencing an asthmatic attack at home.)

And I got them to do things while I was doing things. I got them involved. And then gradually, I did a fair amount of coaching over the phone, so that after a while I wasn't going over as often... They would go and do something and report back to me that things were improving.

Another form of skill learning was helping the client learn how to use resources, be they people, community facilities and/or family members. Again the nurse and client had active roles to play. One such nursing role

was informing the client about available ressources while at the same time assisting the client to acquire skills for conducting further research into the resource and later, to initiate contact. Another purposeful nursing strategy was structuring experiential kinds of learning such as arranging for field visits to explore facilities or to learn about new approaches in dealing with a concern. Follow-up on these experiences took the form of reviewing with the client what had happened and/or assisting the client to apply what had been observed.

Further work on developing resourcefulness in the client was done by identifying with the client potential sources of support that had not as yet been considered. For example, interest shown by neighbours or family members was mobilized and these people were used in new and useful ways.

SUMMARY

The focus of the implementation phase was on structuring learning experiences to affect the client's approach to problem-solving. In developing and strengthening these abilities, knowledge and skills are acquired as part of this process. This approach to working with clients necessitates active involvement on the part of the nurse and the client: the client learned how to effectively deal with situations; and the nurse provided the conditions and the structure in which learning could best take place. The variety of roles that the nurse assumed was in response to his needs, based on an assessment of the client's learning style and his approach to problem solving. By focusing on the process of problem-solving rather than just on the content of the solution, the potential for changing the client's approach to dealing with a situation was felt to be enhanced. Thus, learning between situations could take place.

The strategies that have been described in this paper and the way they were used indicates how the nurse conceptualizes health. By using a learning framework, health takes on a dynamic quality. It is a concept acquired over time through active involvement in learning. The explication of a model can come about through several approaches, one being the study of nursing intervention. By examining the types of interventions, how they were selected, their aptness to the nursing process structure, the underlying framework guiding the nurse's choices of strategies, key elements of our model of nursing have begun to be fleshed out.

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RESUME

Guider le bénéficiaire vers la santé: Une analyse d'interventions en matière de pratique infirmière

Le but de l'article consiste à décrire les interventions propres à un style particulier de pratique infirmière faisant appel à un schème de référence sur l'apprentissage. Cette modalité de pratique des soins vise à travailler sur certains faits importants qui influencent l'état de santé. Ce type de soins infirmiers nommé Style A incarne bon nombre des caractéristiques d'un modèle de pratique infirmière en voie d'élaboration à l'Université McGill.

Le Style A dépend de la structuration d'expériences d'apprentissage ayant pour but de répondre aux besoins spécifiques du bénéficiaire ainsi que de tenir compte de ses façons personnelles de résoudre des problèmes. Pour atteindre ce but, l'autre décrit les divers rôles que joue l'infirmière durant la phase de mise en application du modèle de soins alors qu'elle structure des expériences d'apprentissage pertinentes.

THE ROLE OF A HEALTH SCIENCES LIBRARIAN IN NURSING EDUCATION IN CANADA

M.A. FLOWER
Nursing Librarian

In 1964 Dr. Vern M. Pings, who still continues to conduct well known in-depth studies of libraries in the health field, was requested to investigate the possibility of indexing the periodical literature in nursing. The result was one of the most valuable bibliographic tools we have: the *International Nursing Index*. In his report to the American Nurses Foundation Pings (1965) said that:

> This growing body of literature is only one indication of the fact that, during the past 60 years, the nursing profession has been working toward recognition as an academic discipline...although the profession can point to a body of literature identifiable as the scholarly record of nursing, scholarship is not confined to one specialization...the human knowledge with which today's nurse should be acquainted covers everything which may affect the health of any individual, community or nation. (p.116)

This statement still holds true today in Canada, where the nursing profession is working toward an expanding future, increasing control of its destiny, and an intensified understanding of its role in the delivery of health care. The trends, as Mussallem (1973) puts it, are toward broader and deeper clinical knowledge for the nurse in practice, with a return to patient-centered care and increased attention to social issues. With the support of research in the field, Mussallem hopes that the progression of nursing from its primarily private duty role in the 1930s through its primarily institutional role in the 1970s, both essentially illness-oriented, will now move out into the community where illness can be forestalled by appropriate health-oriented interventions.

To accomplish this future for Canadian nursing, in which the first priority will be not care of the ill but rather the whole situation of family and community health, the key is nursing education, according to Gilchrist (1980). What is required is a basic baccalaureate program which will produce students who can act autonomously; a master's program which socializes the student toward responsible leadership and furnishes

ticular building and entirely self-contained. Operationally, however, interlibrary borrowing is an automatic reaction to a request which cannot be fulfilled in-house. The exchange establishes a working relationship which, although it may be activated very seldom, nevertheless draws the library into a larger library community where it becomes part of the total information base. As budgets shrink and demands increase, formal links are established between libraries which are already working together. Union lists of holdings develop to speed cooperation, and a regional library service gradually becomes functional. In the end, a patron entering the nursing library in a university has access, not only to other libraries on the same campus, but to other libraries in different cities in the same field, and ultimately to any book in the world. Fortunately, not many nurses see any need to carry their search that far.

HOW A LIBRARY FUNCTIONS

The myth that a library is nothing more than a row of books is pernicious in a number of ways. It gives the library a somnolent quality which is at odds with the dynamism inherent in learning. It implies that anyone who wanders in and happens to find a book that seems to fit the topics knows how to use a library and gets all that is necessary out of it. Even with the serendipity factor on which all libraries depend, this is not so. You cannot manipulate the book stock unless you pay attention to the dynamics of information retrieval. You cannot break into the literature unless you understand its characteristics.

One of the chief elements of a library which is usually overlooked is the most active ingredient of all. Particularly in a health library, a librarian with a telephone in hand is the best retrieval mechanism yet devised. Familiar with the nursing book stock, familiar with the general content of other collections, familiar with search tools, current controversies and use trends, the librarian is at the centre of an information complex. In assisting those who are bewildered, or in a hurry, a good health librarian will always cater to specific differences in pace and approach. Each patron has an individual learning style and a charateristic point of view. The combination of the individual style of inquiry, the topic, and the purpose being pursued amounts to a unique situation which has been brought to the library for resolution (Dervin, 1977). The role of the librarian is to provide an access point and to contribute as much clarification and reinforcement to the situation as possible.

In today's fiscal climate an emphasis on searching tools, such as indexes, is important because in providing for the information needs of students and faculty a library which serves a nursing school can seldom provide all the primary material that is required. Indeed, if it were provided the users would not read it all (Stevenson, 1980). The library must therefore make use of printed secondary services in order to make the primary material that is to be used easier to locate. Librarians use these

basic tools for testing in real situations; and research training at the doctoral level. The goal is a science of nursing which will allow the profession to appraise systematically the inherent resources for improving the health status of individuals, families, and communities, and to mobilze and supplement these for health maintenance and restoration. To make this happen Gilchrist points to the development of three kinds of nurses: researchers, expert clinicians, and highly professional faculty.

What has this to do with libraries? All these different aspects of professionalism require the support of, and access to, what Pings (1965) calls "the scholarly record of nursing". This is the job of the library attached to the school of nursing at any university.

THE NATURE OF A LIBRARY

There are several ways a library in a university setting can be approached. A nursing collection as a study resource falls roughly into two concentric parts. There is a segment at the core that is usually very current and heavily used because it is directly relevant to the courses being taught at any given time. This segment tends to be on short-term circulation, and into it fall most of the requests from faculty for purchase. Selection is based on close cooperation between the library, the faculty and the students.

In time many of the items become outdated or superseded, and they move out into the larger pool of materials where are recorded the ideas of the discipline of nursing as they have developed historically and geographically. This total library content covers a wide range of nursing specialties, modern and historical practice concepts, and the scientific background for health care delivery in both illness and health. It overlaps social and behavioral science and education techniques. Its depth and scope are a measure both of the progress of nursing and of the astuteness of those who have been selecting the record.

A library collection is never just a docile batch of books, although there is a persistent myth abroad that books are all a library contains. In a good collection the juxtaposition of ideas can give off sparks at any time. When you read back to the beginnings of nursing, you find the same words we use today: *nursing procedure, research.* But those words now carry a load of meaning which had not been thought of then. You also find old ideas which have been discarded and laid aside in yellowing journals. Standing beside them on the shelves are new ideas packed with action. Sometimes, for a browser, the changing content of the words acts like a hidden fuse and an old idea lights up and adheres to a current one, giving a twist to the concept. Suddenly, a new research project is born.

Another characteristic of a library is the invisible community to which it belongs. Physically, a library may seem to be solidly placed in one par-

bibliographic tools themselves and often guide users through the process, on the assumption that an understanding of the way the library works will improve the possibilities of retrieval. From their contacts with both students and faculty they are aware that many simple shortcuts are outside the experience of both. Knowledge of these quirks would not only improve the quality of retrieval but would also shorten the time necessary to do a reasonably thorough job. The element of time is a major factor in many a poor search. Students never have enough of it. If, in addition, they come into the library unprepared with a systematic search technique, they can become frustrated very quickly. Should they compound the issue by avoiding all orientation sessions as a waste of time, the forseeable outcome is an eventual avoidance of the library as well. If this should be the result, their future careers could be severely hampered by their inability to assemble and assess information adequately.

LEARNING BIBLIOGRAPHIC SKILLS

In the course of the continuum of undergraduate and graduate learning each nurse must assimilate a great many specific skills. Most of them are applied to their procedure in direct dealing with a patient, but one is not. This one skill is undervalued and under-taught. It is the skill to manage the professional literature which is the background for nursing care. The nurse who can find answers in the record of nursing experience quickly and effectively will always have a clearer grasp of the possible solutions to problems encountered in working with people.

The best chance of acquiring this skill is at university, using the nursing library as the access point. The approach should not be haphazard. In the health field there is a certain uniformity. The literature is accessible through an extensive array of bibliographic tools which are produced under the auspices of the National Library of Medicine in Washington, D.C. They are all geared to a uniform thesaurus. With some guidance from the librarian, users can acquire a technique for approaching this literature by learning which questions to ask and which connections are likely to be productive (Langer, 1981). Furthermore, users can also learn to identify the type of inquiry which will be better pursued by way of a different bibliographic tool, such as *Psychological Abstracts* which has its own characteristic thesaurus.

When a librarian is consulted, therefore, there is no attempt to pinpoint arbitrarily which document should be used, although a key starting point may be suggested. What can be taught is a method of moving from such a document further into the literature. It is a method for tackling unfamiliar subjects which is most likely to yield results. In the course of the search the user may be led to other libraries and other bibliographic tools. The librarian posted at the nursing library is simply a facilitator, but the search skills learned by the library patron will be applicable, not

just at the moment in the current academic situation, but in any kind of health library which may be encountered throughout a long career. The bibliographic tools produced for the National Library of Medicine are now universally applicable in the health field, not just in North America but increasingly across the world.

As the literature expands, this bibliographic searching skill becomes so increasingly important that it should not be left to chance. It should be as compulsory as the clinical skills and not subject to the whim of the individual student to take or leave. The dimensions of its value are not self-evident before the fact, and beginning baccalaureate students, in particular, are notoriously unaware of the value it can have for them. At Duke University School of Nursing some experimenting has been done with a ten-week course designed to familiarize students with basic search skills and their usefulness in relation to the nursing profession. (Walser and Kruse, 1977). This may be too formal an approach, but development of a specific segment on bibliographic use, which could be inserted into one or more courses, should not be. Such cooperation between the librarian and the faculty of a school of nursing would be a genuinely progressive step toward the future research orientation of Canadian nursing. The Duke people claim that the benefits of their course accrue to "not only the student, but also the educator, the librarian, and ultimately, the medical community as well" (Walser and Kruse, 1977).

Academic librarians, as a group, are aware that many university people and many health professionals are relatively unsophisticated users of the library. They are already faced with too much information and they are not willing to expend too much energy seeking out more (Stevenson, 1980). Nor do professional people in the field find information gathering particularly rewarding. They usually need information quickly in order to make a decision, or write a report, or choose an experimental alternative (White, 1979). They want to find it simply, however, and with as little work on their part as possible. If it gets too difficult, they tend to resort to one of two working alternatives. Either they settle for the first thing that comes to hand or they simply ask a colleague. It is easy to minimize how faulty some of the information obtained in this way can be. Should efficient search skills become part of every graduate nurse's armoury, perhaps this particular phenomenon could be curtailed.

CONCLUSION

Extensive information covering all aspects of the field of nursing is available in the libraries which serve schools of nursing in Canadian universities. Not all of it is used efficiently, however, because the skills of the librarian are left out of account. If the nursing profession could accept the role of the librarian as a gatekeeper and guide through the literature,

the value of its bibliographic resources would be considerably enhanced. One area in which the librarian can make a direct contribution to nursing education is through training students in the use of bibliographic search skills with which to support their studies, their research and their practice.

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RESUME

Le rôle du bibliothécaire des sciences de la santé dans la formation en sciences infirmières au Canada

Une bibliothèque représente plus qu'une simple rangée de volumes et une collection d'ouvrages de sciences infirmières constitue un organisme doué d'une vie propre. Le bibliothécaire est le principe actif de cet organisme. Les usagers se servent d'une bibliothèque de différentes façons selon leur style d'apprentissage; cependant, l'adoption de procédés pour chercher en bibliothèque revêt de plus en plus d'importance à mesure que les infirmières canadiennes ont à faire face aux exigences de la recherche et à celles de l'élargissement de leur pratique. Si au cours de la formation académique, bibliothécaire et professeurs collaboraient en vue d'améliorer les habiletés d'investigation en bibliothèque, cela profiterait sans nul doute aux sciences infirmières au Canada.

INTRODUCTION TO BASIC CURRICULUM WORK

CECILE OSEASOHN
Associate Professor

The two following articles deal with the first and second year of our baccalaureate curriculum at McGill University. The students come to us after two years in CEGEP, having successfully completed the Health Science (academic) core for the Health Professions.

It is interesting that both articles deal with the notion of learning to nurse families. Our faculty is committed to this concept. But the tradition in nursing and the knowledge (biology and science) and the skills (comfort, safety, nutrition, etc.) that are basic to nursing do not easily or readily lead to the elaboration and specification of the knowledge, attitudes and skills needed to nurse families. Nursing and social science literature are just beginning to explore this area. We are struggling to identify strategies that will be effective in the Teaching/Learning process and that will entice the students to learn and to value working with families. At the same time we need to develop tools that can measure the outcomes of our interventions with families.

The curriculum committee of our baccalaureate program has met as a committee of the whole for the past three years and has reviewed and revised the curriculum. The new curriculum went into effect September 1981. We began by inviting members of faculty to present their views on the direction the curriculum should take. We listened and questioned each other, reviewed the literature, met in small groups and slowly evolved the direction to follow to implement the school's philosophy.

The first year was spent in studing the teaching-learning process and in determining the relative merit of the various methods for *monitoring student progress* in the program. Both papers refer to the use of such tools as clinical observation, paper and pencil tests and term papers.

Health and Family have emerged as major concepts of our curriculum and much of our time in the second and third year was devoted to operationalizing these concepts. The notion of health includes such ideas as 'health is a process of developing and living', 'health is potentially measurable by an ability to rally from insult', 'health behavior is learned', and 'the individual participates in the health of the family/group(s) to which he belongs'. The family is the social and economic unit of our society. It is the primary source for learning beliefs and values, roles and norms which influence health behaviors and practices.

These two articles demonstrate the result of faculty effort in the

development of the new curriculum. The articles by Mimi Mansi and Margaret Ross describe some of the learning experiences designed to assist students to learn to nurse families and the strategies used to monitor student progress. Learning experiences include an early exposure to families of various ages and ethnic backgrounds, families at varying developmental stages and in various situational crises. The emphasis is on ways to recognize and promote healthy behaviors including positive coping and problem-solving in individuals and in families. The unit of care is increasingly the family.

LEARNING TO NURSE FAMILIES: MONITORING CONTENT AND PROCESS

OMAIMA MANSI
Assistant Professor

The notion of valuing lies at the heart of the process of monitoring. Monitoring involves being deliberately engaged in a set of interrelated actions and processes, the intention of which is twofold. Given that the curriculum provides the conditions sufficient to promote learning to nurse families, the first is to observe the extent to which the essential components of learning to nurse families is actually being learned. The second is to provide feedback for adjusting curriculum structure and process so that learning of the valued components can be promoted. In other words, monitoring learning can be viewed as a process of formative evaluation culminating in summative evaluation at specific points in the program (Bloom et al, 1977; Tyler, ed., 1974), whereby both student progress in learning to nurse families and the conditions deemed necessary for that kind of learning are monitored.

Being an integrated curriculum, McGill's B.Sc.(N) program is characterized by some overlap in traditional content areas. In addition to that, concepts of family and health run as threads throughout the three-year program. With such a curriculum design, it is difficult to monitor learning without establishing mechanisms to increase the probability that (a) unnecessary repetitions as well as omissions in content are avoided, (b) learning conditions are set and sustained so that the above concepts continue to be developed as the student moves through the program, (c) expectations in terms of scope and depth in student's attitudes, knowledge and skills continue to expand towards achieving critical goals of the program and that (d) there are some means of eliciting, identifying and promoting students' behaviours which indicate progress in learning to nurse families. Two kinds of monitoring provide us with the above mechanisms. Since the curriculum can be perceived as the structural apparatus and the medium through which learning to nurse families is provided, the first kind of monitoring has to occur at the curriculum level. Therefore, monitoring curriculum content and processes becomes a necessary activity. The second essential activity is monitoring the day-to-day operationalization of the curriculum at the courses level. This is the level where it is critical to (a) specify those behaviours which best reflect students' progress in *learning* to nurse families, and (b) identifying strategies which are best suited for eliciting and evaluating those behaviours which reflect students' progress in *nursing* families.

MONITORING OVERALL CURRICULUM CONTENT AND PROCESS

Efforts here are directed primarily towards increasing the probability that concept development related to learning to nurse families will be established and promoted throughout the curriculum. These strategies have been instrumental in shaping our B.Sc.(N) curriculum over the last three years. The first strategy is that faculty members regularly share their understanding and basic premises related to

a) the main attributes of the concepts "nursing of family" and "family health" which are to be taught throughout the curriculum;
b) specific attributes which are emphasized in various parts of the program;
c) specific learning conditions including supportive knowledge and selected clinical experiences with families which are established and sustained in various parts of the program;
d) specific learning outcomes faculty expect to achieve and methods of evaluating them; and
e) actual outcomes which are achieved.

A second strategy involves use of a feedback loop whereby faculty members feed the knowledge and observation gained from implementing each course back into the structure and operation of the curriculum so that

a) deficits are remedied;
b) teaching-learning in each segment is modified and improved on the basis of new data;
c) each subsequent segement in the program builds on outcomes actually achieved in the previous segment.

A third strategy focuses on faculty members collectively examining and establishing consensus on the global knowledge and skills about family nursing which are critical for baccalaureate graduates to possess at the end of the program. This particular strategy allows for sound decision-making relative to the sequence of learning situations and the selection of areas of emphasis in various parts of the program.

A fourth strategy evolves around faculty's participation in monitoring overall curriculum content and operation as well as the particular course each teaches. Curriculum discussion takes place as part of the ongoing process of curriculum development so that all faculty members participate and understand how pieces fit together into the whole. In our experience, this organizational structure is proving to be most profitable.

Implicit in the above is the idea that it is essential for monitoring to become an ongoing integrated process of curriculum work. Once there is a consensus on the content and method of each course, there are periods when monitoring is more critical in achieving its purposes in relation to

the overall curriculum. Critical periods are best delineated to parallel the organizational structure of the curriculum. Here, the beginning and termination of specific nursing courses provide for natural points of interpretation, reflection and examination of all content, process and outcomes.

MONITORING OF LEARNING TO NURSE FAMILIES AT THE COURSES LEVEL

At this level, it seems most useful to explore what is going on fairly early in the course, soon after the students become involved in what faculty considers to be critical learning experiences in the particular course and again towards the end of the course. I tend to think that regardless of where the course is situated in the curriculum, its length and its subgoals, the times identified above remain critical.

The first dimension on which this kind of monitoring occurs is relative to sampling of behavioural indicators (Hooton, 1979) which reflect students' progress in learning to nurse families. All behaviours are not equally important in judging progress. The question then is what to monitor. Critical behaviours listed below are expected to be increasingly observed as students expand their ability to nurse families*. More or less of this pattern of behaviours will be seen depending on where the course is situated in the curriculum.

The *first* group of behaviours centers around learning to collect data relevant to nursing a family. As students progress one should see the following pattern of behaviours.

a) The students' bank of data includes more and more information on the particular family as a functioning unit as opposed to its individual members. Students become increasingly interested and able to collect data about the family structure, dynamics, patterns of communicating with one another, patterns of decision-making and problem-solving relative to health issues, life style, common interests and resources that the family uses as a unit, attitudes and beliefs about health and illness, and norms of health practices.
b) Students become increasingly sensitive to shifts of the family's focus on issues, for example, being able to detect a shift of the family's attention from enjoying good nutrition given limited financial resources, to a concern with how a specific member is coping with an acute crisis.
c) An increase in the students' ability to discriminate between what is the family norm and what is strictly an individual member's norm in relation to: health attitudes and values, utilization of health resources, commitment to the other members' health and well being. For example, students are able to identify that although the norm in one family is that the family is responsible for teaching health practices to its

* The framework used for nursing the family is that which is reflected in the paper of M. Allen and M. Warner, 'The Workshop — A Health Resource: A Prototype for Community Health Practice' (1978).

members, one of its members may hold that the physician's responsibility is to look after the health of the family, should a problem arise.

The *second* group of behaviours centers around learning to assess and plan in relation to the family as the unit of concern. The following behaviours should be increasingly observed:

a) Students' nursing assessments become geared to the identification of that which the particular family as a unit, its strengths and resources, what it considers to be the main health issue and the goals to be achieved, risk factors and problems, how the family as a unit deals with the common concern rather than focusing on one member's concern and one member's way of handling the concern. For example, a student is able to identify that, for a family, understanding and incorporating into their lifestyle those behavioural and functional changes associated with aging of a member can be the major health issue, despite the presence of a retarded 31-year-old son and another member with a recent diagnosis of cardiac disease. Another example is a student being able to identify that the family's strength may be reflected in the collective motivation of its members and the ability to participate and plan together with the school a means of influencing destructive health practices of one adolescent member in that family.

b) The students' approach to planning is increasingly characterized by (i) working in collaboration with family members to identify priorities and goals, to develop a plan of action and monitor its success, (ii) an appreciation of family and environmental conditions, (iii) a consideration that the family is composed of more than one member although the intervention may clearly relate to one person, (iv) increased acceptance and ability to provide guidance and support for the family as opposed to being the doer. For example, in dealing with nutritional practices of an old family, students take into consideration availability of grocery stores and what they sell. They consider the nature of the demands placed upon the health of the more mobile member in assisting a less mobile one. They are able to accept the role of supporting a younger capable member of a family to help the grandmother with daily hygiene rather than taking over and doing the task themselves.

c) Students' interventions reflect a perspective that nursing care is geared to how this family unit is now or how it will cope with eventual, similar health-related issues. It is a perspective which views health as evolving, and which does not negate the influence of each family member but goes above and beyond the notion of the individual. For example, students become increasingly able to set the stage for the family members to examine how they have been dealing with an aging member, to understand the aging process, and to anticipate further

changes and explore how they may prepare for them and manage them given the skills acquired thus far.

The *third* group of behaviours centers around students learning to evaluate nursing care in relation to the families with whom they are involved. The following behaviour is critical to monitor:
Students' evaluation of the outcomes of nursing care is increasingly made on the basis of how the particular family as a unit has moved along in dealing with their particular events and in achieving the goals which members have set for themselves rather than noting an individual member's responses. Meanwhile, they feed outcomes to the family so that they continue to learn how to cope healthfully with their life situations, problems and illnesses, to develop their potential and to use their resources. For example, students are able to evaluate with the family if strategies the latter used to reduce stress of a crisis-stricken member have thus far not achieved the goals desired. Further, this family member's anxiety is increasing beyond his ability to cope with daily activities and decision-making. From there, students discussed the family's proposed strategy to ask a physician to assess the need for the temporary use of tranquilizer . The focus of the next step would be to assist the family to learn from this experience, to be able to help its members through stress.

The *fourth* group of behaviours centers around the students' acquisition of critical kinds of knowledge and attitudes necessary for nursing families: One should see a gradual increase in the students' knowledge of nursing assessment and nursing measures to promote family health. This knowledge should be increasingly utilized, valued and tested out by students. One should see a gradual shift in students' attitudes towards considering family health as evolving and the family as providing the medium for influencing health status and practices of individual members. For example, students are able to provide and discuss information about availability of services and of over-the-counter drugs with the view that the family can be helped to learn how to manage long-term illness, birth control, deal with drug abuse, etc.

In summary, the student increasingly approaches the nursing situation in ways which indicate (a) that nursing is geared towards the family as a unit which is composed of more than the sum of its individual members, (b) that health promotion is seen as a family affair as much as it is an individual's affair while appreciating that pain and illness are individually experienced, and (c) that working to collaborate with family members towards learning to live healthfully is evolving as part of the student's nursing practice.

The process of monitoring learning at the course level takes place on a *second dimension*, that is, how to monitor the behaviours described above. There are selected strategies which are best suited for monitoring the students' progress with respect to the number and frequency of occurence of the above-mentioned behavioural indicators. These strategies are also selected to best suit the philosophy of teaching-learning upon which the curriculum is predicated. At the baccalaureate level the student learns how to nurse. Therefore, experiencial learning and direct involvement in clinical practice are highly valued and constitute a major portion of teacher and student time. Thus, much of the progress in learniing how to nurse the family occurs and is readily seen in the student developing an approach to clinical decision-making, implementation and evaluation of nursing care.

a) The following group of strategies seems to be most helpful in monitoring behaviours which reflect progress in clinical decision-making:
   (i) On the basis of intensive study of methods of evaluation used in the B.Sc.(N) program and an analysis of available literature, it is evident that participant observation, one-to-one and small group discussion, and analysis of student reports of clinical work constitute the most suitable strategies for monitoring behavioural indicators of progress in clinical decision-making (M. Hooton, 1979; C. Oseasohn, 1980).
   (ii) Another useful strategy in monitoring progress in clinical decision-making is related to setting the conditions necessary for eliciting and fostering those significant behaviours. Monitoring progress in clinical decision-making is most fruitfully done within the context of the students' actual clinical learning experience and should take place over time. Feedback can be made directly to students with the expectation that it will be used.

b) Some of the suitable strategies for monitoring increase in breadth and specificity of student knowledge of family nursing are: paper and pencil, objective and short free response items which may or may not be structured around videotaped or simulated situations, and semi-structured interviews.

Therefore, an overall monitoring of the scope and speed of the student's progress in learning to nurse the family is achieved through a combination of (a) and (b). The above methods assume that in monitoring the student's expanding ability to nurse family, one focuses on those behaviours which indicate progress in the process of *learning* to study and nurse families as opposed to a focus on monitoring the quality of the student's nursing practice. This perspective is predicated on the belief that at the baccalaureate level education, the student is studying the

science of nursing towards learning how to practice the profession as opposed to developing her nursing practice or studying the practice of nursing. Therefore, what is monitored is the students' progress in learning how to nurse families. Included in this is learning how to evaluate outcomes of their nursing care which is a crucial dimension of learning to nurse*.

SUMMARY

It is probably obvious by now that monitoring is viewed as an ongoing, overall process of formative evaluation culminating in a summative evaluation **. The latter takes place at the end of the program and at the points of interruption which are provided by the organizational structure of the curriculum, e.g., the end of each course. Inherent in this is the notion of a functioning feedback which allows for facilitation of concept development relative to nursing the family towards health promotion.

Monitoring of learning involves not only progress in student learning at the course level, but also of operation of the apparatus through which learning is provided. From the students' perspective, monitoring of learning to nurse the family starts at day one of entry to the program and terminates at the end of the final year. From a curriculum development perspective, it is an ongoing process. The process of monitoring students' progress in learning is not sufficently productive without monitoring curriculum content and process.

* Research relative to socialization of medical students indicates that they are coached on how to assess situations when things do not turn out well. However, as they go through the socialization program they focus increasingly on the process of doing the work and decreasingly on the final outcome (Butcher & Stelling, 1973), a tendency we prefer to avoid in nursing education.

** Summative evaluation of student performance is designed primarily to identify the students' learning achievement at the end of each course for purposes of promotion. Summative evaluation is not designed to assist the students in improving their performance in the course for which this kind of evaluation is made; however, summative evaluation is used to orient faculty to the level at which students will start the following course. Results of summative evaluation of student performance is also used to direct faculty to examine the effectiveness of methods they utilized in achieving the desired learning outcome. Modification of teaching-learning methods can only be made the next time the course is offered. On the other hand, formative evaluation is designed to explore student learning achievement at various points during the course with the intention of feeding the results back to the student to further her learning. The result of formative evaluation is used immediately not only to direct faculty to examine effectiveness of methods and processes utilized in achieving the desired learning outcomes, but also to direct faculty to modify their teaching-learning methods in order to achieve learning outcomes which approximate the desired ones more closely.

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RESUME

L'apprentissage des sciences et soins infirmiers en milieu familial: Approches favorables à cet apprentissage

Le but de l'article consiste à examiner le mode de supervision de l'apprentissage en tant que démarche d'évaluation formative à des stades précis du programme pour parvenir à l'évaluation sommative. Cette supervision porte aussi bien sur les progrès des étudiants quant à leur ap-

prentissage des sciences et soins infirmiers en milieu familial que sur les conditions favorables à cet apprentissage. En premier lieu, la nature de la supervision est élaborée à la lumière de ce qui précède. Ensuite, on précise les aspects à surveiller. Enfin, compte tenu de ces aspects, l'auteur identifie et examine brièvement les méthodes de supervision de l'apprentissage.

LEARNING TO NURSE FAMILIES

MARGARET M. ROSS
Assistant Professor

Maternal and Child Health appears in our B.Sc.(N) program as an eight-credit course placed at the end of the second year of learning to nurse.The concepts of health, family and development which permeate the entire curriculum continue to be developed during this segment of student learning. The course focuses on several events of family life, one of which is the birth of a child and the incorporation of a new family member.

The student brings to the course a sound basis in the biological and social sciences and the beginnings of critical thinking. During their two previous years, they have engaged in clinical experiences which fostered the building of a body of knowledge and acquiring a repertoire of skills to serve as a basis for nursing families. The following situations describe the characteristics of families in the order they are presented to the students from their year of entry to the program:

1) families with elderly parents and/or grandparents who are living in a home for the aged;
2) families with an adult member who requires surgical intervention for a short-term health problem;
3) families with an adult member who is experiencing a health problem of a chronic nature;
4) families who are rearing young children.

At this point in the curriculum, the students have nursed a minimum of seven families. These experiences have afforded them the opportunity to compare and contrast family structure and function with a particular reference to health as well as styles of working with families in a health promoting way.

To discover how families incorporate a new infant, students nurse a family in hospital during labor, delivery and the early post-partum period. As well, they choose a family to follow after discharge from hospital and to nurse on a long-term basis.

Criteria for selection of families for the students include:

a) *Family Structure.* Students nurse a nuclear single or dual career family. They also become involved with a family with an extended network or a single parent family;
b) *Culture.* With a variety of cultures to select from, students work with at least one family from a culture other than their own;
c) *Number of Children.* Students nurse a family having its first child as well as one with one or more children at home;

d) *Method of Delivery.* The majority of students nurse a family in which the method of the mother's delivery is vaginal and one in which a Ceasarian Section is indicated;
e) *Method of Infant Feeding.* Students nurse a family in which the mother is breast-feeding as well as one in which she is bottle-feeding the newborn.

During the month of study, students nurse a minimum of two and a maximum of four families. They learn to identify changes in behaviour which relate to the establishment and maintenance of the family unit. They also engage in an examination of attitudes, feelings and values which confront them as they nurse these families.

Critical behaviours which summarize their method of nursing are:
1) Assessment focuses on the family as a unit rather than on individual members of the family;
2) Planning of care involves identifying goals and priorities in collaboration with the family;
3) Care is delivered in a manner which assists the family to learn to cope with issues affecting its health;
4) Evaluation of care incorporates the famiily and is based on the family's response to the plan which is used as feedback for further assessment and planning.

Three aspects of student behaviour are monitored to assess progress in learning to nurse families. Their clinical work demonstrates in practice the development and use of knowledge about nursing families. Clinical conferences provide information about attitudes and values which are challenged by the nature of the experience and which influence their way of nursing. Clinical assignments reveal the fund of knowledge and conceptual ability of the learner. A compilation and analysis of data from these three sources are used to determine progress in learning to nurse.

This paper describes the learning outcomes of a major aspect of Maternal and Child Health, which is learning to nurse families who are in the process of incorporing a new member. The data were gathered during the months of May and June 1980 as two groups of students engaged in learning experiences which were developed to foster this end. The learning outcomes are categorized according to the method used to monitor the students' learning.

CLINICAL PRACTICE

Data gathered by ongoing day-to-day observation of students' interaction and nursing of families revealed three indicators of learning related to the development and use of knowledge in practice.

There were three changes of an interpersonal nature evident in the students' behaviour.

Becoming comfortable with babies. The majority of students had no prior experience with infants. Their level of comfort with infants was evident from the initiative taken and the manner used to handle, cuddle, talk to and generally interact with them. Two statements made by students reflect their increase in comfort with babies. "I can now bathe, diaper and bundle a newborn without having the temperature drop", and "I've learned to soothe crying newborns by bundling and cuddling them tightly. Initially, I was afraid to hurt them".

Interacting with a dyad and/or triad. Since mother and/or parents and baby were together during most of the students' clinical experience, they needed to interact with the family as a unit. Over time, as they got to know each member of the family, students acquired the sensitivity and skills necessary to attend and respond to more than one interactional stimulus. Most students concurred with the observation of one of their peers: "My impression of the family changed after I had spoken with Mr. B. and had seen him with his wife and baby. A family is more than the sum of its parts. I think that to really nurse a family, one needs to interact with all of its members".

Helping families learn. Students identified a major focus of nursing centers on assisting parents to develop parenting skills. Assessing the level of knowledge and skill of parents, selecting strategies which foster learning, and evaluating the outcomes of these strategies formed an important part of their experience. One student described the mother's anxiety and awkwardness with the baby: "Mrs. M. held Shelley with caution and handled her gingerly. Both she and her husband asked many questions and gave the impression of feeling insecure with the baby. All their questions plus my own experience with learning about newborns have really proved to me that parenting is a learned behaviour".

ASSESSMENT AND TECHNICAL SKILLS

Students added to their repertoire of skills those needed to assess the health and development of the enlarging family.

Physical assessment of the mother and baby. Students learned how to auscultate fetal heart rates, palpate uterine height and consistency and use the Apgar Score, growth charts and the Denver Development Screening Test in their assessment of the development and health of mother and baby.

Assessment of learning and health needs. As their experience progressed, the students' data base revealed more and more information about the family's patterns of interaction, problem solving and decision making. As well, their data included resources available to and used by the family.

Students identified strengths and weakenesses within the family and used all of these data to help the family identify and cope with their learning and health needs. One student expressed, "Although most families appear to be concerned about the development and health of their babies, there are many individual differences within each family's situation that influence their needs and ways of meeting their needs". Another student described the situation: "We spent an hour talking about ways of resolving the grandparents' traditional view of infant feeding which evolved from an old Chinese custom with the parents' commitment to breastfeeding".

CLINICAL DECISION MAKING

Learning indicators related to clinical decision-making included evidence that the students were incorporating the family in identifying goals and priorities. Their nursing interventions gradually became more responsive and accountable to the changing situation with the family's response being used for further assessment and planning. In this way, students' clinical decision-making became an ongoing and dynamic process.

Examples of these observations include the student who explained the decision to bathe the baby at noon, "Mr. and Mrs. S. share their family responsibilities and intend to continue doing so with the care of Jeanie. Since Mr. S. will be in at noon to visit and it is important for him to become involved with Jeanie's care from the start, we decided to wait until he arrives to bathe the baby". Another student stated, "My work with the family changes each day as the mother becomes more rested and is able to assume more responsibility for the care of the baby".

CLINICAL CONFERENCES

Data generated from post-clinical conferences revealed many attitudes, feelings, and values with which the students were attempting to deal. Through acknowledgement and exploration of these attitudes, feelings, and values, students examined their influence on nursing.

Many students were unprepared for the intensity of labor and the resultant fatigue experienced by mothers. Statements such as, "There must be an easier way" and "It's too bad that fathers cannot take turns having babies", revealed their feelings about what they had observed. Others felt somewhat overwhelmed by the experience of observing a birth. "It's such an emotional experience" and "I felt as if I had worked as hard as the parents when the baby arrived", were typical of comments made by students.

They demonstrated a need to confront their feelings about privacy and sexuality as a result of nursing these famiilies. One student remarked,

"Having a baby is such an invasion of privacy". Some students stated that they identified with the mother during labor and delivery, and commented on the intimate nature of the nursing activities involved. Generally students viewed parenting as a serious undertaking. One student stated, "The idea that having a child is the most natural thing in the world may be true, but I'm not sure. The changing ways of living and the existence of many alternate lifestyles make having a baby now a more difficult decision than ever". Another student concurred, "Parenting is a risky process because it involves a deep commitment to the unknown. The outcomes of human relationships cannot be predicted".

There were several ways in which these feelings, attitudes and values influenced their nursing. They were in part responsible for some of the difficulties students encountered when doing physical assessments of the mothers, assisting with breastfeeding, discussing birth control, as well as other nursing activities. Their identification with the mothers' experience interfered with an objective analysis of the medical management of pain during labor and delivery. Many students found it difficult to accept some mothers' egocentricity during the early post-partum period and tended to be somewhat critical of it.

During post-clinical conferences students attempted to come to terms with these attitudes and feelings which were interfering with their learning and their nursing.

CLINICAL ASSIGNMENTS

Data from the students' clinical papers revealed knowledge about family development and nursing a family, and is categorized under the following headings.

The Developing Relationship Between Parents and Their Newborn. There were four indicators of this developing relationship in the data.

The methods used by parents to gather information about their infant. Students identified sight, hearing, and touch as the senses most frequently used by parents to get to know their child.

One student wrote, "Mrs. V. positioned the baby facing her while still on the delivery table. She smiled broadly for several minutes after which she handed the baby to her husband. He gingerly took the infant and held her in his arms as both he and the baby stared at each other".

Another student stated, "Together the parents touched the baby gently. The mother kissed him on the forehead and on both cheeks and the parents eyes were glued to the baby in wonderment".

A third student wrote, "Initially, Mrs. B. heard every breath that the baby took and every movement that he made. When a period of time went by that he did not stir, she would get up to make sure that he was still breathing".

The tendency for parents to wish to be in close proximity to their infant. Statements such as, "Mrs. D. wanted to have her daughter in her room as much as possible. She was watchful and wanted to do as much as possible for Karina", revealed this characteristic of new parents. Students interpreted these kinds of behaviours as evidence of the commitment of time and energy needed to establish and maintain a relationship.

An increase in sensitivity to the behaviour and needs of the infant. One student wrote, "The parents are becoming more in tune with the baby's needs. For example, they explained to me that Michael has a certain cry that means, 'I'm wet', and another that means, 'I'm hungry' ". Another student wrote, "Mr. D. stated that he now knows how to hold the baby so that she will stop crying". These types of observations were made during the home visit and were related to the fact that time is an important element in the establishment of a relationship.

Identification and claiming of the infant by the parents. Students viewed "looking for family ressemblances" and "settling on a name" as part of the process of establishing a relationship with their infant. Two quotations from the data exemplifying this are:

"At the delivery I observed one of the father's first comments to his wife was 'he's got your eyes and your nose'. Another mother claimed that her baby looked very much like the baby's brother," and "I saw that Mrs. V. regarded her baby as different from the other babies in the nursery when she said, 'I think that Stephen is cuter than all the other babies in the nursery.' "

THE IMPACT OF THE BIRTH OF A CHILD ON THE LIFESTYLE OF A FAMILY

The data described five changes which impact on the lifestyle of a family as a result of the increase in size.

An increase in feelings of responsibility experienced by parents. Examples from the data reflecting this phenomenon include statements such as, "When Mrs. M. was burping her baby she observed out loud 'how vulnerable and totally dependent babies are on their parent' ". "Mr. B. described his participation in the birth of his daughter as a humbling experience". One student wrote, "The parents have changed from individuals responsible to, and for, each other to a collective responsible for the growth, development, and health of another human being".

Changes in activities of daily living. Students described many changes relating to the use of money, time, and space as well as revisions of personal habits such as sleeping, bathing, and eating as impacting on the lifestyle of the family. They also reported that the relationships between parents as well as with families and friends were also undergoing changes as a result of the new arrival.

Alterations in decision-making patterns. All students commented on the addition of another significant variable in the process of making family deci-

sions. One student wrote, "The baby's schedule must always be considered when making even the smallest decision. The pattern seems to be that parental activities must be scheduled around the baby's needs".

Change in status. Students remarked that the arrival of a child moves the parents along in the generational scheme of life. "In one aspect, the childhood of the parents comes to a screeching halt as the baby's needs take precedence. Parents lose their status as the young generation".

An increase in stress. One student recalled that in the Social Readjustment Scale of Holmes and Rahe, life changes experienced by the family correlated with illness susceptibility. According to these authors, when enough changes occur within a year and add up to more than 300 points, a greater incidence of ailments can occur. This student identified that the addition of a new family member adds up to 397 points.

HEALTH ISSUES WHICH PARENTS ARE LEARNING TO WORK THROUGH

There were six categories of health issues that families, who are incorporating a new child, are working through as revealed in the students' data.

Acquiring a sufficient amount of rest and sleep. The problem of fatigue in parents repeated itself over and over again in the students' data. It appeared to be more of a problem for the women; however, men were not totally exempt. One student wrote, Mrs. D. told me that she often gets insomnia waiting for her daughter to wake up at night and feed. Mr. D. also wakes up and keeps them company as he can't sleep while his wife is awake. He stated that although he thinks that his wife is more tired than he, he also feels tired a lot of the time".

Learning to provide for the growth, development, and health of the child. Parents had many questions about the development and care of their infants. "Is the baby getting enough to eat with just breast milk? When can I take her outside? Do you think that he sleeps too much? Should I bathe the baby every day?" These represent a sampling of questions that parents asked students.

Students also described other ways parents meet their learning needs. Talking situations over with friends and relatives, reading contemporary literature, and phoning their pediatrician and/or his nurse were some of the learning methods revealed in the data. Parents also expressed separation anxiety as a result of losing contact with the hospital, an important source of information for them. One student wrote, "Mrs. F. stated that in the hospital she had received a great deal of attention, teaching and supervision but now that she and her husband were in charge, they felt unprepared and anxious".

Maintaining optimal nutritional status. Issues relating to nutrition that were evident in the data are:

a) *Weight reduction.* Most women were anxious to return to their pre-pregnant weight and were attempting to do so.
b) *Provision for breast feeding.* Some women were concerned about maintaining their supply of milk while cutting down on their food intake. One student wrote, "Both Mr. and Mrs. M. expressed concern about the adequacy of her diet as a lactating mother. Wanting to regain her figure, Mrs. M. appeared reluctant to eat the recommended dietary quantities for breast feeding".
Fostering the adjustment of siblings to the new baby. The students described sibling behaviour which reflected their attempts to adjust to the increase in the size of the family. Ways parents assist their older children to deal with this issue were also evident in the data. An example from one student's paper describes how, "Three-year-old Elena has become quite demanding of her parents, especially of her mother. Although well able to feed herself, she now sometimes insists on being fed. At other times, she lies down and wants to be completely covered with a blanket just like the baby. Both parents are attempting to spend time with Elena doing special things with her, so that she knows she is loved and is as special as the baby".
Deciding on a suitable method of contraception. The data revealed that parents were in the process of exploring methods of contraception in an attempt to select the one most suitable to their needs. Many women had used oral contraceptives prior to this pregnancy and intended to return to their use. However, many couples were in the process of selecting another method of contraception while the mother was breast-feeding.
Dealing with unfinished business. A few students nursed families who, a short time before, had experienced a pregnancy that had resulted in an unfavorable outcome. These students wrote about the impact of this experience on the parents' responses to the arrival of a healthy baby. "Mr. and Mrs. D. had a special need to discuss their newborn who a year ago had died one hour after birth. This is important as they adapt to their new baby girl with fear hovering over them in view of the tragic outcome. Both parents admit that they are scared that they will also lose Karina. I noticed that Mrs. D. frequently uses phrases such as, 'I promise nothing will happen to this one!".

HOW THEY NURSED THE FAMILY

The following words were used repeatedly to describe how the students nursed their families.
Being available. Students discussed the importance of being available as part of the nursing role. One student remarked, "I offered to make myself available by telephone and to maintain contact with the family by home visiting during the next year".

Listening. This appeared to be an activity that was valued in itself as a way of nursing. One student wrote, "Listening to Mrs. D. review her delivery seemed helpful". Another stated, "It seemed important for me to listen sympathetically to a description of their first baby and his death to allow parents to express and work out their feelings".

Supporting. Other words were used to describe this activity and included validating, reassuring and encouraging. Descriptions of this activity from the data include, "One of my nursing interventions was to reassure the family that their son was developing normally", "I validated the parents' impressions that the baby had grown considerably" and "I encouraged the family to use the Laleche League for support from other families with breastfeeding".

Exploring. There were many examples of exploring behaviour in the data. A particularly descriptive one is, "Helping them examine where their energy expenditure should be directed seemed helpful. We wrote down everything that had to be done during the day and then numbered them in order of importance. Some things were then knocked off the list".

Teaching. This activity was also described as instructing, explaining, clarifying, demonstrating and providing information. One student wrote, "A very essential nursing intervention was providing information and anticipatory guidance so as to prepare the parents for future decisions. I instructed them about growth spurts that occur at two and six weeks as well as at three months". Another student stated, "I described the differences between loose stools and diarrhea to one parent who asked the question".

SUMMARY

This paper has attempted to demonstrate the learning outcomes in relation to the concept of learning to nurse families, which are generated from a short-term experience sequenced at the end of the students' second year of learning to nurse. A critical factor which is taken into account when planning the curriculum is the knowledge and skill level of students. This experience is developed in a way which allows students to build upon and expand concepts and ideas of nursing which have been learned throughout two previous years of study and which will continue to be developed during their last year of study. These concepts and ideas are also readily revealed in the clinical situation. The total program focuses on allowing students to actively engage in the process of acquiring knowledge about families and nursing families, so that as they progress in learning, their way of nursing becomes accountable to the health of the family as a unit.

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RESUME

Apprentissage des soins infirmiers en milieu familial

Comment peut-on former des infirmières et des infirmiers en vue d'une pratique axée sur la santé de la famille? Le présent article décrit les résultats relatifs à l'apprentissage des soins à l'occasion d'un court stage dans le cadre d'un programme d'études dont la principale ligne de force est représentée par les soins infirmiers à prodiguer aux familles afin de favoriser la santé.

Des expériences éducatives furent choisies auprès de familles qui vivaient des événements importants, par exemple, l'arrivée d'un nourrisson. L'exploration et l'analyse de ces expériences ont montré aux étudiants les éléments qui entrent en jeu dans les soins infirmiers auprès de familles qui font face à de tels événements. Ces éléments de contenu se sont greffés à l'apprentissage de compétences en matière de relations inter-personnelles, de techniques, d'évaluation et de décisions d'ordre clinique; il en est allé de même des changements d'attitudes et de valeurs ainsi que des aspects du savoir en sciences infirmières qui constitue l'axe de la pratique professionnelle en milieu familial.

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ANNOUNCEMENT

The National Association of Nurses in Israel, the Israel Medical Association, and the Society for Medicine and Law in Israel will sponsor the First International Congress on Nursing Law and Ethics to take place in Jerusalem, Israel during the week of June 13-18, 1982.

IMPLEMENTING PROGRAM PHILOSOPHY THROUGH CURRICULAR DECISIONS

CAROL ATTRIDGE *
Associate Professor, University of Victoria
School of Nursing

HELENE EZER
Assistant Professor

and

JUDITH PINKHAM MACDONALD
Assistant Professor, McGill University
School of Nursing

INTRODUCTION

This article represents curriculum development in progress. It describes for the reader the rationale, implementation and outcomes of the first clinical nursing experience for a different type of student in a different nursing program.

The program in question is an innovative program in graduate nursing education (M.Sc.(A).) initiated at McGill University School of Nursing in September, 1976. The program has certain unique features in that it draws baccalaureate graduates of Arts and Science who have no preparation in Nursing. An emergent curriculum style closely adapted to the needs and characteristics of this new type of student would prepare the person according to a strongly valued model of nursing which itself has certain unique properties and emphases. The following is a description of the first clinical experience these students undertake upon entry into the program, the rationale behind it, some observations of its effect, and the implications these observations have for future curriculum development.

CURRICULAR RATIONALE

In making decisions about this first critical learning experience, three sets of factors were considered: the characteristics of the students, the

* At the time the article was written (1980), Carol Attridge was Researcher-Evaluator for this programme at McGill University School of Nursing; Assistant Professors Ezer and Pinkham MacDonald continue to teach in the programme.

beliefs about teaching and learning held by faculty, and the approach to nursing valued by the school.

Student Characteristics: While not much was known about baccalaureate, non-nurse graduates as recruits for Masters programs in Nursing, these students were expected to be mature, highly-motivated individuals, with a sound, academic background who could bring fresh perspectives to nursing. They were also thought to possess a high degree of self-direction in their approach to learning and to be able to tolerate a certain amount of ambiguity and insecurity. With appropriate learning experiences, they could be helped to develop their nursing in potentially different and creative ways given the different basis from which they would begin.

Beliefs about Teaching and Learning: The faculty members in the program held strong beliefs about the most appropriate ways of helping graduate students learn about nursing. For students these included discovering meaningful/relevant knowledge for themselves, learning to manage/direct their own learning and nursing, deriving knowledge and skill in nursing through the description and analysis of their own nursing and its effects, and using rational and defensible means to accomplish the above. For faculty, certain approaches were also strongly valued. These included structuring the broad parameters of experiences which fostered the approach to nursing valued by the school, and working with students' educational needs and interests as they arose within the curricular situations in which students were placed.

*Beliefs About Nursing**: As it is not appropriate here to document fully the approach to nursing valued and fostered by the school, a description of its more important features follows.

A primary focus of nursing must be on *health*. Health is seen as not merely an absence of illness, nor as simply a capacity to cope with problems as they arise. Rather it is viewed as an active process where one learns from all life events and uses this knowledge to function in more thoughtful, autonomous, and productive ways. Illness and other crises, as part of life events, are only one aspect of nursing's concern. This view of health and nursing is broad and suggests few limits to the type of problems which legitimately fall within the nurse's purview.

The primary unit of concern for the nurse is seen to be the *family* unit. The nurse therefore defines health/illness situations in terms of the family rather than the individual. For example, she is concerned with the development of children in healthful ways, with the adaptation families make in coping with illness and other life events. Issues of this kind tend

* Documentation of some of the rationale for this approach to Nursing by F.M. Allen. See References.

to be broad, complex and changing, influencing and influenced by other family/life events. They are viewed, understood and often best worked with *over time*. In helping families/individuals to deal with and learn from these events, the nurse must meld her professional knowledge and expertise with the understanding she has gained of the family with whom she works. This results in a broad range of possible approaches to the practice of nursing in a single situation.

Given these beliefs, the data collection and assessment phases of the nursing process are seen as open, exploratory and ongoing. The nursing plan, with its focus towards health, makes use of the strengths, resources and other positive forces in the family rather than weakenesses, lacks and limitations which may exist. The *collaboration* of nurse and client is seen as important at every phase of the nursing process. This results in a unique nursing plan where the nurse's response is tailored to each situation she encounters.

CURRICULAR DESIGN

What first experience would best fit these learner characteristics and these strongly valued beliefs about nursing, teaching and learning? First, the philosophical emphasis on health and family suggested a community and family experience away from the individual and illness-orientation of the usual hospital institution. It also suggested a selection of families who were not experiencing illnesses of a severe nature. Second, the perspectives about the complex nature of nursing problems, about the importance of exploratory, ongoing assessments and situationally-tailored plans suggested a longitudinal experience with families where students might become familiar with particular family health concerns, and begin to work with these in some deliberative and relevant fashion. Third, the view of the perspective learner as intelligent and mature, capable of considerable self-direction suggested an experience where the student could work independently with families without à priori instruction or modelling of "the way it's supposed to be." For these reasons, in their first clinical experience, students were assigned two healthy families in the community, with whom they would work closely for at least their first academic year. The bulk of the work would take place in their clients' homes, for the most part independent of faculty or other direct supervision. For the initial four months of their program these families would comprise the only clinical contact with patients the student would have. The direction and supervision of this experience was to be done through fieldnotes, tutorials, seminars and assignments of various kinds.

Selection of Families: The selection of families for this experience was given careful consideration. Faculty wanted students to focus on health and healthy living. Therefore families with members with severe, acute or major debilitating chronic illnesses were to be avoided. Such families could

be healthy but beginning students, operating with a lay perspective of what nurses do, might become preoccupied with the more obvious disease process and difficulties it caused. Severe and obvious illness can create "noise" in the healthy family system and disguise from the student the normal patterns of family living. Moreover, at this early stage, the students were not prepared to deal with the very specific nursing needs such families might present.

Other factors were considered. Faculty wanted families who would represent different stages of both family and individual growth and development, who were typical of major utilizers of health care services, and who would provide opportunities for students to contact other agents and agencies of the health system. Such a scheme would enable students to see the array of resources available and to develop some idea of nursing's place among them.

Two types of contrasting families were chosen: the first, an elderly family; the second, a young and developing family expecting a baby in the near future. The former would provide the student with opportunities to gain first-hand experience with the problems and solutions of growing older in today's society. The latter would enable the student to learn about and participate in a common experience of family life — the birth and incorporation into the family unit of a new infant. Hereby, the students would nurse the expectant mother in the prenatal, perinatal and postnatal periods in hospital and at home.

To secure elderly families, voluntary agencies providing services for the elderly were approached and permission to enter their clients' homes was obtained both from agency and client. Entrance was typically via some kind of 'Friendly Visitor' program which provided social and other (shopping, transportation) services for these families. While this provided easy access to a bank of elderly clients, entry via a 'Friendly Visitor' role sometimes led to client expectations of the student which were not intended by the program and which could be difficult for the student to alter. Faculty also learned, after the first year's experiences, that some clients so gained were not families in any sense of the word but were widows or widowers, lonely, without social networks of any kind, making it more difficult for a student to develop a concept of "family".

Expectant families were chosen whose date of delivery was in late January. This gave students the opportunity to begin to know and work with the families prenatally, as well as to complete a clinical experience in an obstetrical unit. These experiences would help to prepare the student to nurse the family throughout the period of labor and delivery and thereafter.

NATURE OF SUPERVISION

Students began home visits to clients within three weeks of their entry into the program. In seminar during the preceding period, students had an opportunity to read and discuss some of the concepts central to the program (nursing, health, family, etc.) Despite their seemingly sophisticated background, most students had traditional ideas about nursing in this early period. Though they had access to information available about their prospective clients, students were not given specific guidelines for how to handle a home visit, nor were they accompanied by a faculty member. Students reacted to the absence of such guidelines in different ways. Some decided to use their first visit to gather information, to "get to know" the family, and did not think they could prepare themselves in advance. Others felt the need for more structure and went to elaborate lengths to find books or articles that outlined "all the things you need to know" to enter a client's home and begin to "nurse". An example of such an attitude is the following:

> First when I went in, I read about the elderly and goals and home assessment and stuff and I went (with) a head full of ideas (and)... objectives. Looking for skid mats, looking for hand rails... sweet smells, fresh paint, kitchen ustensils. I guess I spent a couple of months fishing around really trying to meet ideals, you know, wanting her to move into the most modern (apartment), getting her a roommate. All these ideas, I had for the ultimate in what I thought elderly people should be living like[2].

The belief that these students should be allowed to discover and develop their nursing identities while capitalizing on their unorthodox backgrounds precluded the use of "modelling" in this first experience. It was the faculty's view that the student would become aware of her own strengths and limitations, as she experienced successes and difficulties, as she established rapport, learned communication skills and planned care in collaboration with her clients. It was only after the student became more confident in her own skills that she could be expected to examine the work of others. For this reason it was generally a few months into the experience before the teacher might choose to "model" a particular approach in an effort to assist the students to solve problems they were encountering.

The curricular events to guide the independent experience consisted of weekly individual tutorial sessions where there was examination of fieldnotes of family visits, as well as seminar discussions of important concepts and clinical experiences, and term papers which forced students to look back and review these longitudinal experiences that they might see more clearly, both their own and their clients' change and development.

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[2] C. Attridge cited all students' remarks from her (unpublished) research data, 1976-80.

Fieldnotes and Tutorials: For each family visit, students submitted detailed fieldnotes describing events to their faculty advisor. These were intended to be a complete description of the physical and social environment, the verbal and non-verbal communication and the student's interpretation of these. As such, they formed the basis for the advisor's work, with the student providing information about the student's perspective and analysis of the situation at this early point in the program. Since these notes provided the primary source of data about the students' work with clients it was crucial that they quickly learn (through coaching, questionning, challenging) to provide as complete a picture as possible. It was in these intensive sessions that faculty provided the support and guidance which pushed students to follow their own leads, to direct their own learning, and to begin to develop their own nursing. Students were encouraged to observe and assess, to plan and act, to evaluate and revise. The faculty directed students to an orientation which fit the philosophy of the program through the questions they asked and the alternatives they raised.

For example, in the following interaction the student illustrates how her advisor took her report of a prescriptive first client visit, and with simple questionning pointed her toward the concepts of responsiveness and collaboration, so important in the School's philosophy of nursing.

Student: When I went into this situation (pregnant family) the very first time I had very definite ideas about what I was going into this for... (I was to be) a sort of resource, an information resource for her, and it would be an opportunity for me to see what pregnancy was all about, and to see a labour and delivery. So when I went in there I must say I had not psyched out the situation (laughing). I just sort of walked right in and said, "That's what I'm here for."

Interviewer: Where did you get that idea from?

Student: In my head... nobody said anything (about what I should do), so... that's what I came up with. So I went in the first day and told her (client) we are going to talk about these things and those things and if you have any questions you can ask about these things and if I don't know the answers, I can look them up for you. Which in retrospect is amusing 'cause she didn't want any information at all hardly. And I had no sense — I mean, I was *completely* insensitive to what *she* wanted!

Interviewer: Mmmmm

Student: So, after I handed in fieldnotes, Marie (the advisor) said in the fieldnotes, "Did you asked what she wants?" (laughs), which I thought was a very wise question. It really got me thinking. That was the first inkling I had, and it didn't come from me, it came from Marie, that there are other approaches to take and that the purpose of my being there was broader than just to give her information on health, breast-feeding and things like that. That sort of made me back up, loosen up, and let her (the client) take the controls a bit over what was going on.

When students focused on the problems, weaknesses, lacks and limitations of their clients, as they invariably did, advisors countered by guiding the students to see and use the strengths, the potentials and resources their families possessed. Communication skills, relationship establishment and termination, nursing process, social networks, family roles and the like were themes arising from clinical work that were discussed in both tutorial sessions and seminar. Advisors had to operate from a broad, generalized knowledge base, to resist the temptation to nurse clients through the student, to tread the fine line between too much and too little direction and support, and to be prepared to risk student error in judgment or intervention. Every attempt was made to direct students to needed resources and information without usurping their roles as primary workers in their client situations. As many avenues as possible were opened but it was the student who had to develop and use them.

The tutorial format, one-to-one, had distinct advantages. First, the beginning characteristics and subsequent learning of each student could be individually assessed and teaching strategies carefully tailored and paced to her educational needs. For example, students who entered the program with well-developed interpersonal skills could move quickly into other areas of learning. Second, the format also drew into sharp focus individual obstacles to learning, such as rigidly held values, inadequate knowledge, poor judgment and the like. There were some disadvantages. The approach demanded considerable time and energy from advisors who were dealing with students on an individual basis. Since the student group was small in number the task was easier.

Term Papers and Seminars: Through written assignments, students were forced to summarize and examine their long-term family experiences as a related sequence of activities. For many students, this served to 'crystallize' their progress. It helped them to look at development in

themselves and in their clients over time, phenomena which are less clear to students when immersed in their day-to-day work with clients. Assignments later in the year asked students to generalize from their particular family circumstances, to select and discuss concepts which were applicable to a wider variety of families.

The seminar experience created opportunities for students to learn vicariously from each other's experiences and to examine concepts which seemed common to many or all students. Parts of these three-hour sessions were carefully structured to introduce content which could be used for concept-building. At other times, the discussions arose from the descriptions of their own nursing that students brought to the group. Seminars worked more or less well in this early stage, dependent as they were on the nature of the group dynamics involved, the ability of students to risk in public, the degree to which they were able to assume responsibility for seminar direction. At times seminars were successful; at others they seemed slow-paced and less productive.

EFFECTS: PROCESS AND OUTCOMES

While, with most students, the experience planted the seeds of important features of the program's approach to nursing and learning, it also produced some unanticipated effects.

The Nature of Nursing: Client, Focus and Process: First, for most students, the experience set firmly in place a perspective which sees the client — individual or family — as part of a much larger life-space. He has a history and a future; he is a part of a complex milieu and his milieu is a part of him. The students saw, experienced and learned to value this definition of client. They carried it to other settings where they nursed and they experienced frustration when there was only limited access to clients' broad circumstances.

Second, the experience began to widen students' perception of the situations with which nurses worked. Most students entered the program with an image of nursing that was predominantly illness-oriented, physical/technical care-centered and hospital-based *. The community experiences began to broaden these parameters to include a variety of concerns other than illness, many of which might be seen to fall within the realm of health and healthful living.

Student: (describing some of the things she was doing with her pregnant client)
I mean she was going through a lot of transitions in a foreign culture with a new husband whom

* Documented by Professor C. Attridge. See References.

> she had never met before she married (him)... she needed somebody to be there to support her through those transitions...

The occasional student resisted altogether the push of the faculty away from a strictly illness orientation, and eventually left the program.

Third, students began to realize that almost everything they did in their client situations was legitimized by faculty as part of nursing as long as it met certain criteria. It must be rational: that is, it must be based in some kind of reasonable evidence. It must fit: that is, it should suit the particular circumstances within which the student was working. It must be constructive: that is, directed toward some positive benefits for the clients involved. Students assumed a variety of roles and functions. They acted as facilitators, problem-solvers, advocates, information researchers, negotiators, coordinators, companions, care-givers, emotional supporters. There were some restrictions here which students soon learned. The companion, 'friendly-visitor' role was not approved by faculty if this role did not soon develop beyond the level of friendship. Students themselves were uncomfortable with the limitations of this role and strove to go beyond it to incorporate 'professionally' defensible activities although they learned to accept and value friendship as an important part of relationships with their clients.

Certainly, almost all students widened their views of their clients, increasing considerably the amount, kind and quality of the data they obtained, and the number of interpretations they could draw. Some, however, were consistently hesitant in taking action, continuing to collect information, and demonstrating a lack of certainty about when data were sufficient to warrant intervention. Some, in their efforts to be "collaborative" and "responsive" tended to assume a more passive than active role in their work with clients.

These were observations about some students which became clearer later in the program. How much of this hesitancy can be attributed to the nature of the early experiences is uncertain, but it is likely that the tendency to vacillate is not corrected by a program which explores the variety of approaches in nursing practice and which often deals with non-crisis events that do not call for immediate or predetermined interventions. Students who had this difficulty needed far more specific suggestions and follow-up of their nursing than did others within the program.

The Pacing of Work: Students learned to conduct their nursing according to the pace of family life and the demands of the situation. The passage of time in families and in the community proceeded much more slowly than in, for example, the more fast-moving institutional setting. Students learned they had time to collect data about clients, look up information,

discuss with advisors, move back to their clients, and to repeat this process with generally no urgency to meet particular time pressures that were often inherent in acute-care nursing in institutional settings. Learning and nursing proceeded at the student's and the client's pace. Though this "slower" pace was suited to the independent learning that was demanded of the students, it caused, for many, the need to readjust suddenly and considerably when they entered more quickly-paced nursing settings.

Familiarity with the Health Care System: As intended, most students came in contact with a variety of representatives and agencies of the health care system through their clients. It was not unusual, for example, that an elderly client became ill, was admitted to hospital or nursing home or even died; that an expectant mother attended prenatal classes or clinics; that a young child had minor surgery in hospital; that a widowed spouse entered an elderly residential home. Students encountered physicians, nurses, social workers and acted as mediators between client and health care agents, informing, explaining, and facilitating interaction between them.

Student: ... At that particular time, she (the client) was viewed as a lady with low intelligence and someone that doesn't cooperate very well. This was the general attitude of staff. Since I was accessible and I knew her (to be different), I decided to change their image. I went on a quiet day... and had a chance to talk with a particular nurse who was very familiar with (her client). (Student goes on to describe how staff nurse agreed and decided the client just needed a little more time and understanding.)

An interesting and rather provocative observation was that students viewed these extensions of the formal health care system from within the clients' perspective and, in several instances, assumed a client advocate role:

Student: The social workers got her a ticket to (go home to) Froshiber Bay the next day... and she just wasn't ready to go. She thought maybe things would change (for the better) now with the baby here and everything. I could very well understand her side, I mean "He's the father of my child and don't want to leave right now" and... I conveyed this message.. (but) they said no, she either goes tomorrow or she doesn't go at all.

Interviewer: They were deciding what was best for her?

Student: Yeah!, and she realized this too — she said, "How can they?" and I said, "I agree with you".

Students learned to value strongly the opportunity to be independent, responsible, and self-directed, values which are quite congruent with the program philosophy. However, their acceptance of these values resulted in considerable frustration when they encountered the more tightly-controlled and much more constrained environment of the hospital centre. Some students had difficulty making an adjustement to that environment and voiced frequent and strong criticism of it.

SUMMARY

This description of a small slice of a new three-year graduate program is intended to illustrate how faculty made curricular decisions which they hoped would reflect and implement strongly valued beliefs about nursing, teaching and graduate education. It also highlights the fact that each decision results in a variety of effects — some anticipated and desired, some unintended and less productive. The fact that curricular planning may have a variety of outcomes is accepted (at least in theory) by those who make these decisions. However, the expectations in terms of outcomes tend toward an often unrealistic ideal. A careful consideration of the variety of outcomes, and the willingness to make judgments about the relative value versus the drawbacks of curricular decisions becomes a critical element of whatever plans are made.

In this case the results of the curricular experience described here have, for the most part, been perceived as gratifying, and faculty are satisfied with the extent to which it has achieved the goals to which they aspired. It remains for faculty to examine and deal with some of the side effects of this experience, for example, its impact on student adjustment to the acute-care setting, and by so doing, develop further its potential to achieve program goals.

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RESUME

Mise en oeuvre d'une approche en sciences infirmières au sein d'un programme d'études novateur

L'article décrit la logique interne, la réalisation et les résultats de l'expérience clinique dans un programme novateur en sciences infirmières. Les étudiants, détenteurs d'un baccalauréat es arts ou es sciences abordent directement les sciences infirmières dans le cadre d'une maîtrise. Ce programme original a été conçu pour former des infirmiers capables d'assumer des fonctions de responsabilité dans le système canadien de prestations de soins en matière de santé, tout en tenant compte de la constante évolution du système.

Le programme d'études constitue une tentative ayant pour but le développement de valeurs profondément enracinées au sujet de la santé, de la famille et de la discipline. Enfin, les auteurs présentent les résultats des décisions relatives au programme d'études durant le premier semestre en vue d'une mise en application de la philosophie sous-jacente.

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THE HEALTH WORKSHOP: DESIGN TO EVALUATE A PROTOTYPE IN PRIMARY NURSING CARE *

MONA KRAVITZ †
Research Associate

RATIONALE FOR DEMONSTRATION AND EVALUATION

The health status of Canadians remains relatively stable, in spite of massive illness detection and treatment measures and aggressive campaigns to provide "prudent" information about how people ought to live their lives. According to Health and Welfare Canada (1974) we have made marginal gains in the last two decades in altering the rates of dying, and sickness and disability. Health promotion is low in the scheme of things and, when considered, is fractionated as the preventive component of medical regimens: exercise is prescribed as part of the treatment plan to recover from heart attack, weight reduction is advised to ward off hypertension. Popular opinion conveys the idea that the attributes of healthy living are well known, that the line to health is simple and direct. Well-being can be achieved through compliance with the latest medical suggestion and adherence to an aesthetic style of life. If we eliminate cigarettes, reduce alcohol and calories, do moderate exercise, see the doctor regularly and drive with care, good health will follow.

The Workshop ethos takes issue with this undue emphasis on correcting deficits in people's behaviour [1]. Workshop nursing seeks, instead, to recognize and built potential. Health is seen as a variable in its own right, quite distinct from that of illness and worthy of the largest part of attention in clinical and research endeavors. Health situations may entail or-

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* The Workshop service was funded for two years in a middle income suburban community as a Special Health Care Program (Research Programs Directorate, Health and Welfare, Canada No. 605-1300-12). This sector was selected because it was representative of people who consume large portions of expensive medical services for lifestyle-related difficulties; families with young children predominate to form a study group with considerable potential for change; existing models for improving health care are based largely on information from the medically indigent of disadvantaged populations. The Workshop closed in August, 1979 owing to a lack of funding.

† Mona Kravitz is a research associate on leave from the faculty of the McGill University School of Nursing to complete a Ph.D. in epidemiology and health.

[1] The program is conceived as a learning centre. Clients do not need a specific problem or crisis to become a member. Staff include nurses with preparation at the Master's level, practitioners prepared through a generic baccalaureate program, a health librarian, a community development worker, administrative and support personnel. Physicians and other professionals (e.g., social workers, nutritionists, educational psychologists, media persons) are not formally located in the Workshop but practise *in situ* in a specialized resource capacity.

dinary events of daily life or crisis situations including management of illness or disability (Gottlieb, 1981) [2]. The Workshop program is a nursing response to society's need for services which augment health in addition to those aimed at preventing and curing disease. The program is framed as a community-based learning resource where families and nurses actively pursue agenda of health work: exploring questions germane to well-being, making sense of available health information, searching for and testing health practices, noticing and mobilizing unexploited opportunity and potential. The goal is for members to augment their skill in managing the spectrum of situations affecting everyday family and community life (e.g., becoming a parent, moving to a new community, integrating illness, growing old, finding one's way through the health system.) The nurse works with Workshop members in discovering productive approaches to health and illness contingencies. The task for evaluation was to explore the work of generalizing this innovation — to provide evidence to support or to negate its value.

Can a nursing service directed toward long-term family health strengthen the health care system, and at what cost?

OVERVIEW OF THE RESEARCH PLAN

Questions central to evaluation are as follows:

1. Given potential for change, do families utilizing the Workshop service achieve a higher level of competence in health behaviour than non-utilizer families?
2. Do families who utilize the Workshop service maintain or achieve satisfactory levels of health function?
3. Is the Workshop a viable type of service in particular sorts of communities?

Major variables identified in these questions are described and analysed along the following dimensions:

1. Competence in Health Behaviour as assessed through a repertoire of responses in situations affecting health —
   (a) problem-solving style
   (b) utilization of resources
   (c) perceived skill in health care decisions
2. Health Status — A composite of ordinary impairments (patterned after a modified version of Grogono's Index for measuring Health Status).

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2 Laurie Gottlieb's taxonomy for the content of health work is available in Allen, M., Frasure-Smith, N., & Gottlieb, L. 'Models of nursing for a changing health care system: A comparative study in three ambulatory care settings — Part II: Appendix.' Montreal, McGill University School of Nursing, 1981.

3. Viability of Service —
   (a) community awareness of health opportunities,
   (b) participation in shaping the Workshop concept,
   (c) cost of a unit of service per unit of health outcomes.

A quasi-experimental design was planned to test the hypotheses implied in questions (1) and (2). Individual studies (Community Awareness Telephone Survey, Utilization Study, Cost/Benefit Comparisons, Corroborative Evidence Projects) yield data to establish an overall point of view on the question of viability. Prognostic stratification of clients (Potential for Change)** and of nurses (Approach to Nursing)*** permit a more detailed analysis of family data. Client outcomes are examined in relation to degree of susceptibility of the Workshop member to the nursing manoeuvre. The study of nursing approach helps us appraise outcomes in relation to degree of implementation of the practice model in demonstration.

CRITERIA FOR EVALUATION: WORKING HYPOTHESES

1. COMPETENCE IN HEALTH BEHAVIOUR
   a. *Problem-solving style*

Clients who have used the Workshop service are more likely to learn to manage health situations than Non-Utilizers of The Workshop service.

Clients who have used The Workshop service will learn to solve health problems more effectively than Non-Utilizers of The Workshop service.

Dimensions on which the client's problem-solving approach is evaluated are as follows:

1. Type of Situation — Focus of client in the situation;
2. Context of Situation — Client perception of the unit within which the situation exists;
3. Perspective — Client perception of the extent and complexity of the situation;
4. Assessment — Sources of information and knowledge client draws on to identify the situation;
5. Plan — Attributes within individual/family upon which client bases his action responses;
6. Time Frame — Scheduling of health work for individual/family;
7. Evaluation — Client's method of identifying outcomes of health work.

** Potential for Change involves: interest in learning about health and in changing health behaviour; history of success/failure in school, work, social and family life; and concentration of illness/disability.

*** Another self-administrated questionnaire was created and pre-tested to aid in locating type and level of nursing style as defined by the Model in demonstration.

The chart which follows depicts "valued" attributes of the Problem-solving style expected in Workshop Users as well as "less valued" attributes of the Problem-solving style expected in Non-Utilizers. Each pair is followed by two examples: one valued behavior (+) and one less valued behavior (−).

b. *Utilization of resources*

Clients who have used The Workshop service will perceive a larger number of sources of assistance in health matters than Non-Utilizers of The Workshop service.

Clients who have used The Workshop service will make "better" use of health care resources than Non-Utilizers of The Workshop service: less reliance on physicians for non-medical situations, more reliance on self, family, neighbours, community supports, with periodic assistance from the nurse.

c. *Perceived skill in health-care decisions*

Clients who have used The Workshop service will assess their ability to solve health problems as higher than Non-Utilizers of The Workshop service.

2. *Health Status*

Clients who have benefited from The Workshop service (who have learned to notice and mobilize health care resources in an effective manner) will maintain or achieve satisfactory levels of health function.

Here we have a fruitful basic research question. Can Competence in Health Behaviour stand on its own as an indicator or predictor of health, or is its usefulness dependent on its association with "illness" status (health defined as the absence of impairement)? What does it mean when Competence and Health Status fail to coincide? How do we interpret the situation where family and nurse define the individual as healthy, the individual judges himself to be healthy, and the doctors consider the individual to be unhealthy (assuming that family, individual and nurse use the criterion, the ability to cope with health and illness contingencies)?

3. *Viability of Service*

a. *Community awareness of health opportunities*

X percent of citizens (families, individuals) residing in the catchment are knowledgeable of The Workshop's essential goals, activities and policies.

b. *Participation in shaping The Workshop concept*

X percent of citizens residing in the catchment area use The Workshop as a *health* resource. Service statistics monitor the nature and extent of lay and professional involvement with the service.

c. *Cost of a unit of service per unit of health outcome*

The cost of a unit of service is calculated and appraised in relation to

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers
Type of Situation	
Health Situation The client focusses on *health* aspects of the situation, that is, on the individual/family's *accommodation* to events of daily living with customary, unusual, and crisis situations including illness and hospitalization. Examples: + Health is a state of wellness which continually develops. We learn how to be healthy through trying to manage everyday stresses over time. Every time we experience a health problem, we learn something to help us cope better with other problems in the future.	Illness Situation The client focusses on the *illness* aspects of the situation, that is, medical conditions and disease including diagnosed psychiatric illness referring to etiology, pathology, symptomatology, diagnosis, treatment, etc. – Health is a state of wellness where disease and other unusual events are absent. We can achieve health by preventing illness and by following good health habits. We need to come into a health service for regular check-ups, take required vaccinations and follow orders when we are ill.
Context of Situation	
Family The client perceives the situation within the context of the *family* and as a phenomenon of the family (or group). Examples: + I try to get other family members involved in health problems: It is better to work on problems together.	Individual The situation is viewed as belonging to the *individual*; it may affect the family and vice versa. – I try to cope with health problems alone: I do not like to burden other family members.
Perspective	
Longterm The client views the situation as an *open* system; the situation develops, changes, influences and is influenced by other life events.	Episodic The client views the situation as a *closed* system with beginning and end, and isolated from other happenings.

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers
Perspective (Cont'd.)	
Examples: + Health problems are tied up with how I run my life: Becoming healthy is a life-long process.	– People run into health problems from time to time: When this happens, I work hard to correct the situation.
Assessment	
Exploratory	A Priori
The client employs an *exploratory* method: observes and gathers information and evidence from the individual/family, and makes use of other sources of information and knowledge — library, neighbours, professionnals — seeking the most reasonable explanation of the situation.	The client employs an *a priori* method; the client makes use of existing knowledge and experience to define the situation.
Examples: + When faced with a health problem, I do a lot of detective work before I decide what the problem is. I discuss issues with other people, do some reading on the subject and think about similar experiences from the past.	– When faced with a health problem, I seek the best advice I can get from health professionals. I rely heavily on expert opinion to clarify the situation for me.
Plan	
Potential	Deficiency
The client recognizes and utilizes the *strengths* and *positive* forces in the individual/family upon which to build and develop the plan of action.	The client concentrates on the *deficiencies*, lacks and failures in the individual/family upon which to establish the plan of action.

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers

Plan (Cont'd.)

Examples:

+ We try to use the strong points we have in coming up with a health plan.

– We try to overcome the weak points we have in coming up with a health plan.

Time Frame

Wait

The client times health work based on a continuing assessment of the individual/family's *readiness.*

Examples:

+ Often what to do is clear but the timing of the plan is wrong. We hold the plan until it seems ready for us.

Zoom

The client adopts the *professional's time schedule* for implementing the plan.

– Once the plan is clear, it is important to follow it as quickly as possible. The longer the delay, the harder it is to get along.

Evaluation

Individual/Family Outcomes

The client notes the *individual/family's responses* and *outcomes* to the plan and fashions further health work on these developments.

Examples:

+ The health professional and the family agree on specific goals. My family tries to achieve these goals. If the plan does not work, we try to figure out why so that we can build a better plan.

Professional Objectives

The client notes discrepancies between the individual/family's *outcomes* and the *expected outcomes* of the *professionals*; further planning is based on strengthening the original plan and reinforcing its method.

– The health professional sets specific goals which I agree with. My family tries to achieve these goals. If the plan does not work, we look at where we slipped up and try again. You cannot expect to succeed on the first try.

outcomes produced (quantity by type), then the range of choices among service options for specific health situations is costed. What is the purchasing power, for example, of a visit to The Workshop as compared with a visit to the hospital emergency department for help in managing a family member with chronic illness? What are the "choices foregone" in each set of utilization decisions? (Respondents are asked to indicate their first and second choice for assistance with an array of coping events. They may select friends, neighbours and other types of lay assistance, specify from a variety of health or other types of professionals, or choose no help at all. Once we are clear on the "value" of specific responses we can calculate, in dollar terms, the consequences of utilization decisions.)

Plan For Data Collection and Analysis

The field situation precludes a classical experiment with random assignment to contrasting treatment groups. Instead, a Quasi-Experimental design is established to approximate control as much as possible. The use of Solomon Blocks as outlined by Campbell and Stanley (1963) helps with major threats to validity, especially the effect of testing.

*QUASI-EXPERIMENT**

Outcomes: Competence in Health Behaviour, Health Status

Group	Pre-test	Post-test (6 months)?
1. Workshop Users N = ?	+	Competence Hi Health Status Hi
2. Community Non-Users N = "	+	Competence Lo
3. Workshop Users N = ?	–	Competence Hi Health Status Hi
4. Community Non-Users N = "	–	Competence Lo

Sample size depends on (among other factors, e.g., funds, manpower, number of variables in final measures) the size of the difference in outcomes desired. How much of a difference between comparison groups is clinically important?

In assessing the results, clients will be stratified according to their 'potential for change'. In measuring the variable, interest and involvement in learning about health, changing health behaviour and working

* All groups are measured for Potential for Change and Competence in Health Behaviour. Only Workshop Users are tested for health status. Groups (1) and (2) receive pre- and post-tests. Groups (3) and (4) are not pre-tested. All groups are followed forward in time.

with ideas are investigated. Items such as the following may be included:

— How interested are you, is your family as a whole, in learning to be healthy? (ordinal response options to two separate questions)

— Thinking about how you and your family deal with health matters, would you like to:
  ( ) Continue In The Same Way
  ( ) Change Health Practices Somewhat
  ( ) Make Major Changes In Health Practices

— Are you an "Ideas Person"? (By this I mean a person who likes to think and talk about the things that influence health?) (ordinal response options)

— How successful have you been in the following areas? School, Work, Social Life, Family Life (ordinal response options)

— Have you and/or your family experienced much illness or disability? If yes, please describe the situation(s) and indicate whether a hospital stay was necessary.

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* Complete Bibliography available from the School of Nursing, McGill.

RESUME

'L'Atelier A Votre Santé': Evaluation d'un prototype de soins infirmiers primaires

Cet article présente un modèle d'évaluation d'un service de soins infirmiers communautaires-type: 'L'Atelier à Votre Santé'. Le Projet de recherche vise à déterminer la pertinence, l'utilité et la rentabilité d'un tel service au sein de la collectivité qu'il dessert ainsi que la mesure dans laquelle les familles ayant recours à ce service sont en meilleure santé que les

autres. On évalue le comportement des familles en matière de santé en examinant leur façon de résoudre des problèmes, leur utilisation des ressources et la perception de leur capacité à prendre des décisions relatives à la santé. Quant à la rentabilité du service, elle est évaluée selon la connaissance qu'en ont les membres de la collectivité, la participation des citoyens au façonnement du concept de 'L'Atelier' et les coûts d'une unité de mesure de service par unité de mesure de résultats relatifs à la santé.

L'auteur, Mona Kravitz, est chargée de recherche à l'Ecole de sciences infirmières de l'Université McGill, en congé d'études pour l'achèvement de son doctorat en épidémiologie et santé.

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