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NURSING PAPERS
PERSPECTIVES EN NURSING

An Ethnoscientific Analysis of Comfort:
A Preliminary Investigation

The Prejudice of Language: Effects of Word Choice on Impressions Formed by Nurses

A Framework for Family Nursing

The Delphi Technique as a Method for Selecting Criteria to Evaluate Nursing Care

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EDITORIAL NOTE

It is our pleasure to welcome the new members of the Review Board and to thank the past members who gave so generously of their time and expertise to assist and, at times, work with authors in the development and revision of their papers. In selecting new members from the names submitted by the Deans and Directors, it is necessary to consider not only the curriculum vitae, but the type of expertise — research, clinical and functional, language, geographic area so that the Board will be as representative as possible on the important dimensions. We are grateful to those persons who were not selected for agreeing to submit their names and hope they will do so again another time.

NOTE DE LA RÉDACTION

Il nous fait grand plaisir de souhaiter la bienvenue aux nouveaux membres du Comité de lecture et de remercier les "anciens" membres qui ont si généreusement mis de leur temps et leur compétence au service des auteurs et, à l'occasion, travaillé avec eux à l'élaboration et la révision de leurs manuscrits. En choisissant les nouveaux membres, parmi les noms soumis par les doyennes et directrices, il importe de tenir compte non seulement du curriculum vitae, mais aussi des domaines de compétence — recherche clinique et fonctionnelle, et de s'assurer d'une représentation régionale et linguistique pour que le comité soit aussi représentatif que possible. Quant aux personnes qui n'ont pas été choisies, nous leur exprimons notre reconnaissance d'avoir bien voulu soumettre leur nom et espérons qu'elles poseront à nouveau leur candidature.

EDITORIAL

CARING: THE ESSENCE OF NURSING?*

Recently there has been considerable discussion and debate into the question: "What is nursing?" Several nurse leaders have generated theories into the nature of nursing, and some of these theories are now used as a framework for nursing curricula (Orem, 1971; Rogers, 1970; and Riehl & Roy, 1974). Limited testing of each of these theories has been conducted, and, as with many 'new' professions, these theories have competed with each other to establish a phase in nursing.

One of these theories, a holistic approach to patient assessment and care (Rogers, 1970), became a broad and pervasive philosophy, so that it is now shared with other health professions such as medicine. Perhaps holism is the correct approach to health care; but as it is shared it can no longer answer the question "What is nursing?"

Caring is the newest of the nursing theories. It is a paradigm shared by all nursing specialties as well as by administrators, teachers and nurse researchers both in hospitals and in the larger community. However, nurses have always maintained that providing nursing *care* to patients is the primary component of practice. What is new is that nurses are now attempting to understand the phenomena.

What is caring? What is nursing care? Leininger (1981) notes that caring as a construct has yet to be defined and operationalized. And such steps are essential precursors to the research phase.

The papers in this issue address caring issues from varying perspectives, using different methodologies. Two of the papers use linguistic analyses: The first by Morse is a preliminary attempt to define comfort using ethnoscience, and the second, by Lane and Rae, uses a questionnaire to ascertain the nurses assessment of the patient from written reports. In the third paper, Farrell and Scherer report on the development of indicators of standards of care using the Delphi technique, and in the last paper, Ericksen and Leonard describe the development of an assessment guide for the provision of care to families.

Research is needed — and urgently — to determine if indeed caring *is* the essence of nursing, and to elicit and describe caring behaviours

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* A number of subscribers have requested an issue on the "Essence of Nursing." The Editors hope that this editorial will challenge other readers to consider the topic and prepare papers for the Summer 1985 issue.

that are unique to nursing. It is hoped that these papers will stimulate further research in this area. Perhaps in a few years it will no longer be necessary to ask: What is nursing?

Janice M. Morse
University of Alberta Advisory
Committee for *Nursing Papers*

ÉDITORIAL

LES SOINS: L'ESSENCE DES SCIENCES INFIRMIÈRES?*

La question "Qu'est-ce que les sciences infirmières?" a récemment donné lieu à de nombreux et vastes débats. Plusieurs leaders du monde infirmier ont élaboré des théories sur la nature des sciences infirmières et quelques-unes de ces théories servent actuellement de cadre à des programmes d'études en sciences infirmières (Orem, 1971; Rogers, 1970; Riehl et Roy, 1974). Une vérification de chacune de ces théories démontre que, comme dans le cas de beaucoup de "nouvelles" professions, ces théories se font concurrence pour s'assurer d'une place dans l'évolution des sciences infirmières.

L'une de ces théories (holism), l'optique globale de l'évaluation du malade et des soins (Rogers, 1970), s'est transformée en principe largement répandu, de sorte qu'elle est maintenant partagée par d'autres professionnels de la santé, tels les médecins. La "vision globale" représente peut-être l'optique convenable en matière de soins infirmiers mais étant partagée, elle ne peut plus répondre à la question "Qu'est-ce que les sciences infirmières?"

La toute dernière théorie se rapportant aux sciences infirmières est celle des soins globaux (bien-être et traitement). Elle représente le modèle adopté dans toutes les spécialisations infirmières de même que par les administrateurs, les enseignants, et les chercheurs en sciences infirmières, tant dans les hôpitaux que dans les grands centres. Bien que le concept soit qualifié de "nouveau", les infirmiers et les

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* Plusieurs abonnés ont demandé que l'on publie un numéro consacré à "L'essence des sciences infirmières." La rédaction espère que le présent éditorial va susciter l'intérêt d'autres lecteurs sur ce sujet et les inciter à préparer des manuscrits pour le numéro de l'été 1985.

infirmières ont toujours soutenu que les soins dispensés aux malades, constituaient l'élément principal de l'exercice de la profession. Ce qui est nouveau c'est la tentative du personnel infirmier de comprendre le phénomène.

Que signifie soigner? Qu'est-ce que les soins infirmiers? Leininger (1981) affirme que le concept de "soins" reste à être défini et à être rendu opérationnel, et que ces étapes sont les préalables essentiels à la phase expérimentale.

Les articles contenus dans ce numéro traitent de "soins" selon des points de vue différents et en s'appuyant sur des méthodologies diverses. Deux d'entre eux emploient l'analyse linguistique. Le premier, rédigé par Morse, constitue une tentative préliminaire de définition du bien-être fondée sur l'ethnologie et le deuxième, de Lane et Rae, utilise un questionnaire pour établir l'évaluation des malades par les infirmiers d'après les rapports écrits. Dans le troisième article, Farrell et Scherer se penchent sur l'élaboration d'indicateurs de normes en matière de soins à l'aide de la technique Delphi; dans le dernier exposé, Ericksen et Leonard décrivent l'élaboration d'un guide d'évaluation concernant les soins dispensés aux familles.

Il importe de toute urgence de réaliser des recherches qui permettront de déterminer si les "soins" constituent réellement l'essence des sciences infirmières et d'établir une description des comportements particuliers à ce domaine. Il est à souhaiter que ces articles susciteront de plus amples recherches dans le domaine en question. Dans quelques années, il ne sera peut-être plus nécessaire de s'interroger sur ce que sont les sciences infirmières.

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AN ETHNOSCIENTIFIC ANALYSIS OF COMFORT: A PRELIMINARY INVESTIGATION

Janice M. Morse

Comfort is the most important nursing action in the provision of nursing care for the sick. Whereas *caring* provides motivation for the nurse to *nurse* and to provide maintenance, restorative, and preventative actions to promote health, *comforting* is the major instrument for care in the clinical setting.

In spite of extensive admonitions during most of the present century for nurses to "make their patients comfortable," research that has focused on comfort has used a limited approach. For example, it has examined separately physiological measures (such as exercise, massage or pharmacology) or technological measures (such as improved hospital milieux or gadgetry). Ironically, there is little known about the human act of comforting per se, or about the nurses' or patients' perception of comforting. The purpose of this paper is twofold. (1) The first task is to explore *comfort* as a construct, in an attempt to understand parameters and dimensions of this act, so that clarifying and defining comfort may stimulate further research in this area. The (2) second purpose is to demonstrate the use of a qualitative methodology, ethnoscience, for nursing research. Thus far few studies in nursing have used this technique (Bush, Ullom, & Osborne, 1975; Evaneshko & Bauwens, 1976). As many nursing problems lend themselves to the use of ethnoscience it is hoped that it will be used more widely in the future.

LITERATURE REVIEW

Comfort

Since the beginning of time comforting has been used by man to alleviate another's psychological or physiological distress. The act of comforting permits observation of the nature of relationships between men: love and loyalty, empathy and sympathy, and cooperation and caring. Although, over the centuries, comfort has been extolled by poets, painters and musicians, these basic emotive responses were ignored by the more objective and rational researchers until the 1950's.

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In spite of the fact that the traditional goal of nursing has always been to provide comfort, thereby relieving pain and distress, and restoring health, "comfort" has not been defined, and remains abstract.

Review of the literature shows that research on comfort as a construct has been virtually ignored, but that the two main components of comfort have been separately researched. These are *touch* (Burton & Heller, 1964; Dominian, 1971; Hollender, 1970; Krieger, 1975; Rubin, 1963; and Weiss, 1979) and *empathy* (Almeida & Chapman, 1972; Roe, 1977; and Todd & Shapira, 1974). This research reveals large variations in the use of touch or empathy to relieve distress; and the methods utilized depend on the interpersonal relationship, the sex and the culture of the dyad, and the need expressed by the distressed person.

Touch

Research examining the parameter of touch indicates that in many cultures tactile stimulation is greatest in infancy, and diminishes as the child develops (Leibman, 1970; Willis & Hoffman, 1975). There appears to be quantitative differences in touch according to sex, with females touching more frequently than males. For instance, in Jourard and Rubin's (1968) study, mothers touched their sons more than fathers did, and daughters touched their fathers more often than their sons did.

Within nursing, touch has been recognized as a basic human need (Burton & Heller, 1964; Dominian, 1971; Hollender, 1970). Yet, many care-givers report that they are uncomfortable touching patients. In an informal survey, Huss (1977) found that as many as 60 percent of her colleagues reported discomfort in touching, and some even expressed fear and anxiety. Burton and Heller (1964) note that it is unusual to find a psychiatrist who touches his patient during counselling, and psychiatrists are very often reluctant to examine the patient, even though they have the expertise to do so.

Barnett (1972) and McCorkle (1974) studied touch as it related to non-verbal communication in the area of patient care. McCorkle found that touch facilitated the establishment of a rapport with a seriously ill patient. Her measurement of the effectiveness of touch included four major categories of behavior (facial expressions; body movement; eye contact; and "general response of the patient"), and electrocardiograph changes on the patient's monitor. Krieger (1975) has extensively examined the effects of therapeutic touch, or the laying-on hands with the intent to heal, and found that this touch increased the hemoglobin levels in the experimental group.

Empathy

The second component of comfort, empathy, has been utilized and examined much more extensively in nursing. Two types of empathy are described by Almeida (1972): the articulate and the conscious, as between a nurse and a patient; and the inarticulate and partially conscious, as occurs between a mother and her small child. Most importantly, empathy is an acute awareness of the feelings and emotional needs of another, arising from the "critical element in social understanding and interpersonal transactions" (Roe, 1977, p.493).

Much cultural variation in the acceptance and utilization of empathy has been demonstrated (Borke, 1973; Roe, 1977; and Todd & Shapira, 1974). These differences are a result of the socialization processes and child rearing practices used in the culture (Roe, 1977). For example, differences between U.S. and British self-disclosure, anxiety and empathy were examined by Todd and Shapira (1974). They found that the Americans were more self-disclosing, empathetic, and favorable to psychotherapy than the British, who have been stereotyped as 'reserved'.

Implications for Nursing

The provision of comfort has been the role and responsibility of nursing since the earliest beginnings of the profession. Yet nursing has not, to the knowledge of the investigator, investigated the act of comforting. This research will enhance understanding of this action by providing emic description. With such definition of the construct, further research will be facilitated.

As previously described, there is ample evidence to support the notion that variation in comfort occurs according to sex, culture, and role of the informants, and the circumstances which initiate the need for comforting. However, this paper limits itself to the Anglo-American culture. The question this pilot study will answer is: What are the components and context of the act of comforting?

METHODOLOGY

Ethnoscience

Ethnoscience or "the new ethnography," is a method of "discerning how people construe their world experience from the way they talk about it" (Frake, 1962, p.74). It is a method of eliciting and analyzing information about a certain domain or topic, until the investigator can describe and comprehend the concept from the informant's perception of the domain. Ethnoscience provides an extremely reliable, valid, and valuable tool for obtaining knowledge from a cultural perspective (Spradley, 1979).

The ethnoscience method provides an emic analysis of culture. Cultural systems are determined by examining contrasts and phenomenological distinctions, or "things," that are "real, significant, meaningful, accurate, or in some other fashion regarded as appropriate by the actors themselves" (Harris, 1968, p.571). The main assumptions of the methodology are derived from linguistics, assuming formal patterns of behavior or "mechanical models," rather than probabilistic or statistical patterning (Pelto & Pelto, 1978, p.58). As the data are drawn directly from the informants, the method is most useful, and least biased, when little is known about a domain.

The utility and importance of the ethnoscience method to the nursing profession was first described by Leininger (1969). She noted that it was possible to close the "cultural discrepancies in health norms" by using ethnoscience to try to understand the patient's illness-experience, health problems and concept of health, so that realistic goals may be established in patient care. A complete discussion of the method of ethnoscience for nursing is presented by Evaneshko and Kay (1982).

Definition of Terms: For clarity, the following terms pertaining to the ethnoscientific method are defined as follows:

> Attributes: the contrasting values, or 'components' that differentiate between members of a constrast set (Frake, 1962, p.79).
>
> Componential Analysis: the formal semantic analysis of a set of terms which form a culturally relevant domain, proceeds by recognizing semantic distinctions (components) which apportion the terms of the set into contrasting subsets, so that every item is distinguished from every other item by at least one component (Burling, 1964, p.20).
>
> Contrast Sets: A series of terminologically contrasted segregates (Frake, 1962, p.79).
>
> Domain: The boundaries of a major category or classification system being analyzed (Sturtevant, 1972, p.136).
>
> Emic: Native categorization of behavior. The structural analysis of the purpose, meaning and attitude of the culture (Harris, 1968).
>
> Etic: Features that have been derived from the examination of one or more cultures (Sturtevant, 1972, pp.133-4).
>
> Lexeme: Labels, or 'local names', given to the categories, referring to a meaningful form whose significance cannot be inferred from anything else in the language (Leininger, 1969, p.5).

> Paradigm: A set of segregates which can be partitioned by features of meaning (i.e., a set, some members of which share features not shared by other segregates of the same set) (Sturtevant, 1972, p.140)
>
> Segregate: A terminologically distinguished array of objects, or category (Frake, 1962, p.76).
>
> Taxonomy: A series of complementary names that apply to the same object, or segregates in different contrast sets that may be included in the same category (Frake, 1962, p.79).

The ethnoscientific method evolves through approximately four stages: 1) the identification of the domain; 2) the identification of the segregates and subsets; 3) the analysis of attributes that distinguish segregates at particular levels of contrast (componential analysis); and 4) the formulation of a specific statement, a general statement, and an abstract statement for the generation of hypotheses, theories and etic analysis. Thus the researcher is able to discern the cognitive world of a cultural group, or the emic perspective, about a domain of knowledge.

Procedure

A small sample is commonly used in ethnoscience. Emphasis on depth of knowledge makes the data manageable. For this study a convenience sample of four informants was used. All four subjects were female, aged 23 to 29 years and Anglo-Americans. Two were married and full-time mothers; two were single and nurses.

Each informant was interviewed three times, and data were transcribed, sorted and analyzed between each session. During the first interview session, the domain was identified by asking the informant to describe and define comfort, and to state what it means personally. A tape recorder was used throughout the study and, in addition, all statements were listed on a large sheet of paper which was shared with the informant for clarification and verification. After determining the boundaries and many components of comfort, open-ended questions were used to elicit responses. Examples are as follows:

"Comfort is_____."
"You need comfort when_____."
"You give comfort when_____."
"Situations when you need comfort are_____."

Two techniques were utilized on the second interview: the sentence frame, and the card sort. The sentence frames provided further refinement of the data and were elicited using open-ended questions. For example:

"When you feel_____(feeling)_____you need_____(type of comfort)_____."

"When your_____(person)_____feels_____(feeling)_____I_____(type of comfort)_____."

Next, diadic and triadic card-sort techniques were used to identify contrast sets within each segregate. This was obtained by writing major attributes on cards and asking the informants to sort the cards into two and three piles respectively. The informants were then asked to give a name to each set.

During the last interview, the q-sort technique was used: all cards were presented to the informants to sort and to categorize. Again, each group of cards was then named by the informant according to a common characteristic.

RESULTS

The domain of comforting was shown to have two main segregates described by the informants as *touching* and *talking*. Later in the analysis a third minor segregate, *listening* evolved, which was used for "very stressed" persons. However, one informant was quick to clarify that "comfort was more than just listening — it was doing something: responding, sympathizing, getting a kleenex, making coffee or reaching out (physically)."

Four subsegregates, combinations of the two major segregates were then delineated (Table 1). *Touching* was further described as

Table 1

Major Components of Comfort

Domain	Segregates	Sub-segregates
Comfort	Touching	Touching/Hugging
		Touching/Little talking
	Talking	Talking/little touching
		Talking
	Listening	

"touching only," a non-verbal type of comforting, and "touching-with-little-talking." The "talk" with this latter type of comfort is used sparingly, and consists of consoling sounds, such as "Ah" with children, and "I know" with adults. The *talking* segregate was subdivided into "talking-touching," which is mostly dialogue with brief physical contact, and lastly, *"talking only,"* which is a relationship where touching is perceived to be unnecessary and/or inappropriate.

Table 2 displays the appropriate role-relations between actors for each type of comfort. Generally, touching or hugging may only be used where there is an intimate relationship between two persons. Essential to the relationship is a sense of trust between the two participants. At the other end of the continuum, talking-only was perceived to be appropriate for strangers, and inappropriate for those with whom one has established a relationship.

This pattern is not set, but may be adjusted under extremely stressful circumstances. For example, during a natural disaster it may be appropriate to comfort a stranger using touch, but more frequently in non-crisis situations, one may reduce, rather than increase the amount of touch used.

Table 2

Appropriate Role-relations for each Type of Comfort

Type of Comforting	Role
touching/hugging	husband
	own child
touching/little talk	child (not own)
talking/little touch	friend
talking	self
	stranger

The situation in which a certain type of comfort is offered is clearly prescribed, and this depends upon the perceived need of the person to be comforted (Table 3). Touching without using words or vocalizing is appropriate if the person in need of comfort feels alone or afraid. For nurses, the next category is the most significant: Touching-with-a-little-talking is needed for those who are ill, sick, in pain or in labor.

With children, this talking may be sympathetic vocalizing, or making soothing sounds.

Table 3

Type of Comfort Desired for Perceived Need

Domain	Comfort									
Segregate	touching				talking					
Sub-segregate	touching		touching/ little talking		talking/little touching		talking			Listening
subsets	Unloved	Afraid	pain, in labour	ill, sick	new situations (e.g. moving), insecure, afraid	sad, sorrow, depressed, loss (friendship or death), unloved	alone, lonely	bored, tired	rejected	discouraged, fail, lack confidence	frustrated, angry

With talking-and-a-little-touching, the touching diminishes and personal space between the dyad increases. The touching changes from the hug or the caress, to the brief hand on the shoulder, or the touch on the arm. This is appropriate in new situations, when the person feels ill or afraid, or when a person feels depressed, sad, alone, or unloved.

Talking-alone is used when the person feels lonely or bored, tired or rejected. Listening is needed when the person feels frustrated or angry, and needs to "vent-steam."

Comfort may be offered to a person whose need is perceived because of a life-situation, rather than being requested by the person in need. Examples of these situations are shown on Table 4.

The differences reported between comforting an adult and a child were on the dimensions of touch, talk, time, trust and place. The type of comfort needed by a child required more touching than an adult. Children need physical comforting by being held, caressed, patted and picked up. The comfort-talk does not have to be a rational argument,

Table 4

Situations Where Comfort is Administered to Others

Comfort														
TOUCHING					TALKING							LISTENING		
touching	touching/ little talking				talking/little touching			talking				listening		
to a son who has bumped his head	to a person in sorrow	to ill persons	to persons in pain	when a new baby comes (child)	to a person who asks	to a person who "has his face dragging on the ground"	to a quiet, subdued person	to a person who is alone, lonely	to a bored, tired person	to a person who lacks confidence	to a person who looks embarrassed, rejected	to a person who "talks in negative terms"	to a frustrated, angry person	

rather soothing sounds or the use of distraction is preferred. On the other hand, comfort for an adult was reported to be more verbal with less touching. Arguments must be rational, and, if the person was very stressed, nodding agreements and such statements as "That's right" and "I understand" are helpful. For the "time" dimension, comforting a child is a much shorter process than that for an adult, with the distress being quickly relieved. However, the children's needs were immediate and could not be delayed, or "put off." It was reported that comforting children was also an easier process, because they were more trusting than adults. Also one "must get inside the person's realm of privacy" and establish rapport before comfort can occur. Lastly, whereas the child may be comforted anywhere, the places where an adult may be comforted were limited to areas which had a sense of privacy.

Comfort may occur without the presence of a comforter. Self-comfort measures most frequently cited were: (1) praying; and (2) talking to oneself, saying, "It's o.k. to cry," "It will be all right tomorrow," or, "Why me, I don't deserve it," and "Those horrible people out there." Distraction self-comfort measures included: (1) not thinking of the problem, or putting it off; (2) keeping busy (cleaning the house); (3) going to bed early; and (4) giving oneself a treat (buying something or having a drink).

In response to the question "How do you know when you have been comforted?" the informants responded with such descriptors as "assured," "brave," "confident," "communicating and extraverted," "at ease," "in peace of mind," "in touch with self," and a "warm feeling of relief."

The next phase of the data analysis was to derive propositions or statements from the data. These are presented as follows:

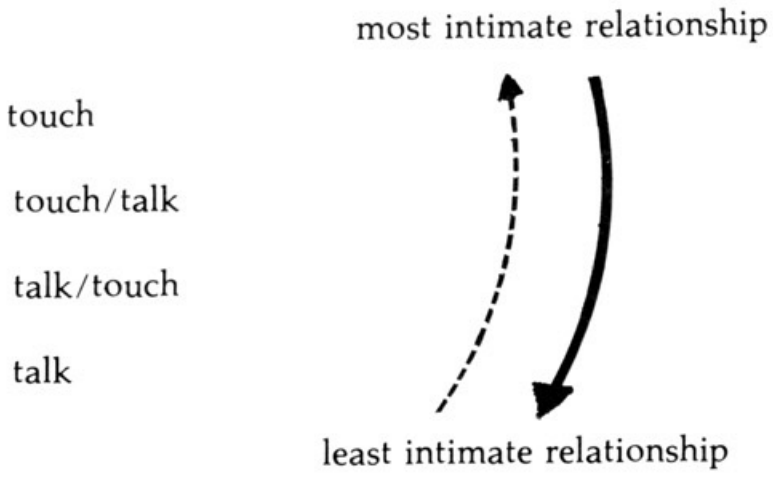
1. *Specific Statements:*
   a) Touching and hugging is the appropriate mode of comfort to use with the most intimate relationships, such as with one's husband or child.
   b) Touching, with a little talking, may be appropriately used to comfort a child that is not one's own.
   c) Talking, with a little touch is appropriately used when comforting a friend.
   d) Talking, without touching, is appropriate behavior when comforting a stranger.

2. *General Statements:*
   a) The two types of comfort, touching and talking and combinations thereof, are distinguishable under specific circumstances with specific people.
   b) The touching/talking ratio may be arranged in a hierarchy so that the amount of each variable utilized in the process differs according to the interpersonal relationship between those involved.
   c) The touch/talking components may be arranged in a hierarchy, so that the amount of each variable utilized in the process differs according to the needs of the preson being comforted. For example, touching and a small amount of talking is appropriate for physical problems such as pain and illness.

3. *Abstract Statements:*
   a) The less intimate the roles between the actors, the less appropriate is the use of touch.
   b) The greater the perception of the seriousness of the problem, the greater the amount of touch required and the less amount of talking required to provide comfort, regardless of the interpersonal relationships between the persons.
   c) Comfort measures vary according to situations, context and *meaning to each subject.*

DISCUSSION

From this study many suggestive ideas emerged. First, informants often stated that the type of comforting administered depended on the cause and severity of the problem, as well as to whom the comfort was to be administered. Further examination of the apparent "looseness" and flexibility of these categories, revealed the surprising consistency in which they were classsified. The following findings were revealed: One often utilizes comforting measures with less touch and more talking than has been specified; extenuating circumstances (such as a serious road accident) are required to appropriately increase the amount of touch used. Therefore, it is more acceptable, and easier, for one to move down the touch/talk hierarchy, than to move up. This may be illustrated as follows:



Second, the type of touching described by the informants was not the physiological, purposeful, "deep massage" touch that is often perceived to be administered by nurses. Instead touch resembled the type used in counseling — a touch of the hand, or shoulder, or a brief hug. Touch to relieve pain in a therapeutic manner (as massage) was

not described, and the touch component appeared to meet psychological rather than physiological needs.

There was surprising agreement between the nurses' and the non-nurses' perception of comfort suggesting cultural consistency with this behavior. The variable that differentiated the two groups was marital status. The relationship between husband and wife differed greatly from the relationship between the informant and the rest of the family, with other family members (sisters, brothers and children) being categorized less intimately and in the same class as "friends." One informant explained this apparent discrepancy as an attempt or need to "maintain face" and not sharing one's inner self with the family.

LIMITATIONS OF THE STUDY

The art of comforting is a learned response, culturally learned and transmitted largely through non-verbal mechanisms from earliest infancy. The study of comfort using ethnoscience was therefore a difficult and stressful task for the informants. Behavior that occurs unconsciously does not have a system of lexemes (or colloquial labels) to describe or analyze. It is recommended that this research be continued, incorporating other methods, such as participant observation and role play, to incorporate the non-verbal components.

The intimate nature of comfort, or the personal and private associations that the informants had with comforting, also added stress. All informants reported feeling moved during the interviews. One stated that it felt "as if you were going inside of my person — and that is much worse than invading my personal space — it is as though you are inside me."

In spite of the purported reliability and validity of emic analysis (Spradley, 1979) some authors question the etic analysis and formation of the abstract statements. The concerns are of reliability and external validity. Can the results be replicated using other informants and can the results be generalized? In grounded theory, the series of propositions or hypotheses that were derived from the data must be tested and confirmed. Only then may the theory building proceed. If these propositions are not supported, then the researcher must return to the original data to duplicate or extend this study so that new propositions may be derived and tested (see Glaser & Strauss, 1967). This inductive research method is an ongoing and evolving process, rather than a hit (and perhaps miss) operation. Thus, the sharing of preliminary results with the informant (and with others) for confirmation is an important part of this process.

As the responses from the four informants met with intra- as well as inter-subject agreement, the results are probably reliable and valid. However it is recommended that this study be replicated. As the two segregates of comfort, touch and talking, vary interculturally, it also recommended that the study be extended to investigate other cultural groups' perception of comfort. Further research to investigate the propositions presented is also recommended, so that we may have increased understanding about this essential part of nursing care.

CONCLUSION

This study was an attempt to define or to understand the act of comforting. For nursing, given that comfort is nursing's main instrument to assist the sick, research in the area is important.

Although ethnoscientific methods are used generally for the analysis of linguistic categories, the technique enabled the understanding of the cognitive domain of comforting. Two major segregates (*touching* and *talking*) and one minor segregate (*listening*) emerged. Furthermore, each of the four types of comforting in the subsegregates was categorized according to the appropriate context: the situation, the perceived need, and the role-relations between actors.

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RÉSUMÉ

Une analyse ethnoscientifique de la notion de confort: étude préliminaire

Malgré l'importance de la notion de confort dans le cadre des soins infirmiers administrés aux malades, la notion de confort en soi n'a pas, jusqu'ici, fait l'objet de recherche. L'auteur étudie les composantes et le contexte de l'acte de réconfort dans la culture anglo-américaine; à cette fin elle se sert d'une méthodologie ethnoscientifique. L'analyse révèle que l'acte de réconfort comporte deux principaux aspects distincts (le *toucher* et la *parole*) et un aspect mineur, l'*écoute*. On divise ensuite ces aspects en quatre sous-aspects selon des dimensions principales. Les composantes, les situations, et les rapports de rôle appropriés entre les acteurs, ainsi que le besoin perçu pour chaque type de réaction de réconfort, sont présentés. On n'a trouvé aucune différence entre la perception du confort chez les infirmiers et chez les non-infirmiers. Des suggestions d'études plus poussées sont proposées.

THE PREJUDICE OF LANGUAGE: EFFECTS OF WORD CHOICE ON IMPRESSIONS FORMED BY NURSES

Barbara J. Lane • Donna I. Rae

The language which nurses use to report to other nurses about their patients may have a significant impact on the impressions formed by the nurse and on the subsequent nurse/patient relationship. Not only intended but also unintended messages may be transmitted through the reporting nurse's choice of words and may create faulty prejudgements of the patient and impede the nursing process. For this reason, communication between nurses about patients is an important focus for nursing research.

An important part in socialization to any profession is the adoption of a common language. According to Yearwood-Grazette (1978) many professions devise exclusive languages, not understandable to those outside the group. Such technical language enables quick, concise communication. In nursing there are many examples of the type of code words to which Yearwood-Grazette refers. "Complain" may be used in patients' charts instead of more neutral words such as "states" or "reports." This may result in a negative bias toward the patients.

PURPOSE OF THE STUDY

The purpose of this study was to explore the impact of the word "complain" in communications on selected impressions formed by nurses and nursing students.

The denotative (dictionary) meaning of "complain" is "to express grief, pain or discontent; to make a formal accusation or charge" (Webster, 1971). The connotation accepted in the larger culture may be similar. However, one connotative meaning, specific to the medical and nursing worlds, takes from the definition above only the concept of expression, or reporting, and omits implications of dissatisfaction.

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IMPORTANCE OF STUDY

Prior to direct contact with a patient, three sources of information are available to the nurse: the chart, including the nursing notes; change of shift report; and informal information sharing among the staff. Because the nurse must assume care quickly and as assessment of a patient's frame of mind is an integral part of the nurse's effectiveness as a therapeutic helper, the influence of inappropriate descriptions of patients at this stage is critical in relation to her subsequent actions.

LITERATURE REVIEW

Communication has been described as ". . . the process by which we understand others and in turn endeavor to be understood by them. It is dynamic, constantly changing and shifting in response to the total situation" (Andersen, 1959).

In the area of professional communications, Cassell has been an important contributor. He differentiated between the denotative meanings of words which make basic communications possible and the connotations, or associations words evoke. "Beyond their frozen dictionary definitions," Cassell said, "words are extraordinarily versatile carriers of meanings. In any (verbal) communication . . . formal definitions serve as little more than a scaffold. The substance of the exchange depends on the immediate circumstances, the identity and intentions of the speaker and the perceptions and experience of the listener" (Cassell, 1980). Cassell stressed the importance of follow-up questions to clarify meanings and set the interaction on the right path. Such a safeguard is, unfortunately, seldom available in written communication.

Previous research also suggests that nurses may stereotype according to diagnosis. Larson (1977) found that patients with socially unacceptable diagnoses were characterized by nurses as less sincere, and less interested in learning than patients with more socially acceptable diagnoses.

No previous research on the unintentional introduction of bias toward a patient created by nurse-to-nurse communication was identified in the literature. Previous research has established, however, that nurses are influenced according to their interpretation of a patient's behavior, particularly as it relates to the reporting of pain. Rosenthal and her associates (1982) found that "good" patients are seen as those who are not labelled as unpleasant. Lorber's study revealed stereotyping of patients as "willful, problem" patients to the extent they were seen as emotional, complaining or uncooperative (1975, a). Even unintended suggestions that a patient is "complaining" may promote negative labelling.

METHOD

Subjects

The study had two phases, involving separate groups of subjects. The first group consisted of third year student nurses in the baccalaureate program of the College of Nursing at the University of Saskatchewan. The 66 students ranged in age from 20 to 43 and all were female. They provided a sample of convenience.

The second sample included 114 female registered nurses, employed in general duty nursing at the University Hospital. Their experience in nursing ranged from 4 months to 18 years, and their ages from 20 years to over 40. Their educational background, work experience and work setting varied.

Variables

The independent variables selected for study were the frequency of use of the word "complain" in nurses' progress notes. The dependent variables that were identified were health teaching by nurses; the nurses' perception of the psychological dimensions of patient pain; the amount of pain nurses anticipate patients will experience; the likelihood of the nurse wanting to get to know the patient personally; self selection of the patient by the nurse and the extent to which the nurse will conclude that other nurses will describe the patient as difficult or demanding.

Two extraneous variables were considered: order of presentation of case studies and patient characteristics. In the registered nurse group, type of educational preparation, work experience and area of employment were also considered.

Hypotheses

The patient characteristics included in the hypotheses were considered as dimensions of a general bias regarding the patient; for example, a "good" patient may be regarded by nurses as being cooperative and receptive to health teaching, as having less psychological component to pain, and so on.

The following hypotheses were tested:

I. To the extent patients' behavior is described as "complaining," those patients will be less often assessed to be accepting of health teaching that those whose behavior is described in more neutral terms.

II. To the extent patients' behavior is described as "complaining," those patients will be more often assessed to have a greater psychological component to their pain than those whose behavior is described in more neutral terms.

III. To the extent patients' behavior is described as "complaining," those patients will be assessed as experiencing less pain than those whose behavior is described in more neutral terms.

IV. To the extent patients' behavior is described as "complaining," those patients will be less often chosen as people the subjects would like to get to know personally than those whose behavior is described in more neutral terms.

V. To the extent patients' behavior is described as "complaining," those patients will be less often chosen as patients the subjects would like to be assigned to care for than those whose behavior is described in more neutral terms.

VI. To the extent patients' behavior is described as "complaining," those patients will be more often chosen as patients the subjects concluded other nurses would describe as difficult, demanding patients than those whose behavior is described in more neutral terms.

Research Instrument

The research instrument used to collect the data consisted of case studies, providing information on three fictitious female patients. The information included patient data, medical diagnosis, health history, and description of their present state. The patients were similar: all were in their early forties, lived in small towns distant from an urban centre, and were experiencing uneventful recovery following abdominal surgery. The diagnoses for the three patients were: severe biliary colic, subdiaphragmatic abscess, and perforated appendix. According to the notes, bowel sounds had returned for all three patients, they had begun to take oral fluids and were tolerating being out of bed for longer periods. All three were receiving intravenous therapy, intravenous antibiotics and Meperidine HCL (Demerol) 75mg q3-4h prn for pain.

For each of the three patients, three sets of nurses' progress notes were constructed, covering the period from immediately prior to surgery to the present. In the first set, in the six instances where the use of the term "complaining" or "c/o" was possible, "neutral" expressions were employed, such as "Patient states she has nausea" or "Patient reports severe right upper quadrant pain." In the second set of progress notes, in three of the instances where neutral terms had previously been used, "complaining of" or "c/o" was substituted for the more neutral phrases. In the third set of progress notes all six descriptions of discomfort used some form of the term "complain." Except for the six areas described, the three sets of notes were identical. Three sets of progress notes were written for each of the three patients.

Test Administration

Prior to the test administration, subjects were told the study had to do with impressions nurses form about patients. Each subject received a questionnaire (Appendix), the background notes on all three patients, and, for each patient, one form of the progress notes. The packages were so constructed that for one subject, Patient A would be presented as the one whose progress notes contained the high frequency of the use of the term "complain," while for another subject, Patient B might have the highest frequency of the use of the term "complain." In this way individual patient differences were minimized. Order of presentation of the patients was also varied, so one subject would be asked to read Patient A at first, the next Patient B, the next Patient C. This also meant that there was variation as to whether "medium" or "low" "complaining" frequencies were presented first. Analysis included testing for the effects of individual patient characteristics and order of presentation.

After reading the story the subjects completed a questionnaire which had been assessed for face validity and content validity by a panel of six practising registered nurses. Twelve senior nursing students were used to pretest the instrument and revisions were made. To reduce "test wisdom" among later subjects, participating nurses were asked not to talk over the research until the following day, by which time all of the testing had been completed. A check revealed two subjects who knew about the study and their questionnaires were discarded.

Reliability and Validity of the Tool

A major constraint of the project was the limited time of access to subjects: both the students and the registered nurses were released from their other activities for one session only, not to exceed 30 minutes. Consequently, length of the questionnaire was limited and the reliability checks of "split half" and "test-retest" were therefore precluded. A reliability measure was possible, however, in Cronbach's alpha, using the assumption that the items were indicative of one underlying dimension, such as a general bias concerning the patients. Cronbach's alpha produced a measure of internal consistency for each of the "low complaint," "medium complaint" and "high complaint" test situations. For both the nursing students and registered nurses, the value for the "low complaint" situation was low, being .26 and .09 respectively. On the other hand, for the "medium complaint" situation, the values were .61 and .73 respectively; and for the "high complaint" situation .58 and .63 respectively.

Findings

To analyze the influence of the term "complain," questionnaire responses were recoded according to whether the patient indicated by the subject represented the low, medium or high instance of the word "complain" in the nurses' notes, in that particular subject's package. To investigate the research hypotheses and examine for interaction between the different factors (complaining, order, patient characteristics), a series of two-way analysis of variance were used. After determining that the interaction was not significant, one-way effects were explored. Where a statistically significant relationship was demonstrated at a level of $p = .05$, the Scheffe comparison of means test was employed to determine the source of the significant difference.

Student Nurses

Table 1 shows the relationship between the use of complain, order of presentation of patients and description of patients to the six dependent variables. The variable of the use of "complain" in relation to descriptions of the patient in nurses' notes was shown to be related for all items except amount of pain.

Table 1

Level of Significance of F Between Complaining Term, Order of Presentation and Patient and Questionnaire Items, Student Sample

	Influence tested		
Questionnaire item	"Complain"	Order of presentation	Patient
Accepting of health teaching	.00*	.94	.00*
"Psychological" component of pain	.00*	.14	.37
Amount of pain	.91	.09	.03*
Choice to "get to know"	.00*	.34	.00*
Choice to be assigned to care for	.02*	.53	.00*
Likely to be assessed by others as being "difficult"	.00*	.68	.03*

* statistically significant at $p = .05$

Hypotheses I, II, IV, V, and VI were all supported. When patients' behavior was described as "complaining," students assessed them as less likely to be responsive to health teaching than those patients whose behavior was described in more neutral terms. A relationship was demonstrated between the frequency of use of the word "complain" in the progress notes and the assessment of a psychological component to the patient's pain. There was also a relationship demonstrated between the likelihood that students would select patients to care for, or choose to get to know, and the incidence of the use of the word "complaining" in the progress notes. Further exploration using the Scheffe test revealed that for each of the five hypotheses supported, the differences between the low complain and high complain patient situations were significant.

To the researchers the most interesting finding was that a positive relationship existed between the frequency of the use of "complaining" in the progress notes and the students' judgment that other nurses would assess the patient to be "difficult." The "high complaint" group, that is, those progress notes where six instances of the word "complaining" were introduced, accounted for the significance of the overall relationship when the Scheffe test was utilized to examine intergroup relationships.

Hypothesis III was rejected. The students were not influenced in their response when assessing the amount of pain experienced by the patient by the number of times the word "complaining" was used in the progress notes.

Registered Nurse Sample

The registered nurses in the sample showed a relatively high degree of "immunity" to culture-wide connotations of the use of the word "complaining." The findings for this group are presented in Table 2. Four of the six hypotheses were not supported.

Hypotheses II and VI were supported. The registered nurses did assess patients as having a higher psychological component to their pain when they were frequently described as complaining. They also saw these patients as more likely to be assessed as being "difficult" by their colleagues. One inference here is that this reflected the nurses' own feelings toward the patient.

The remaining hypotheses were not supported. The use of the word "complaining" did not influence the nurses' perceptions, choice of assignment or desire to get to know the patient better.

Table 2

Level of Statistical Significance Between Complaining Term, Order of Presentation, and Patient and Questionnaire Items, Registered Nurse Sample

	Influence tested		
Questionnaire item	"Complain"	Order of presentation	Patient
Probable accepting of health teaching	.29	.66	.00*
"Psychological" component to pain	.01*	.94	.22
Amount of pain	.12	.36	.00*
Choice to "get to know"	.44	.79	.00*
Choice to be assigned to care for	.72	.73	.00*
Likely to be assessed by others as being "difficult"	.04*	.11	.00*

*statistically significant at $p = .05$.

Order of Presentation

No significant difference was shown between the order of presentation of the patients and either the student nurses' or graduate nurses' responses.

Patient Characteristics

One patient situation, that of Mrs. Dickson, hospitalized with a subdiaphragmatic abcess, was assessed by both groups as being less accepting of health teaching, most often chosen as the one with the greatest "psychological" component to her pain, least often chosen as the person they would want to get to know, or want to be assigned to care for, and most often assessed as the patient likely to be judged by others to be a "difficult" patient. Neither students nor graduate nurses differentiated her from the others in relation to her actual pain.

DISCUSSION

In general, the results suggest student nurses may be substantially influenced by the nursing code term "complain," and whether or not others describe patients as "complaining" in the profession-specific context, students may interpret the remark with meaning from the larger culture. Graduate nurses showed a greater degree of immunity to the influence of the term. More research would need to be undertaken to determine the reason for this. However, it is interesting to note that, compared to the student sample, a relatively high item non-response was shown in the registered nurses' questionnaires, reaching 17% on one item. This could suggest an inability to discriminate between the patients according to the given criteria, which might also imply a greater immunity of the nurses to the "complain" phrase. During the test administration some subjects commented: "but I just can't choose between these patients" or "There isn't any basis for choice here."

Further research is also needed to determine the reason for the effect of the patient characteristics demonstrated in relation to the one case study.

CONCLUSION

In contrast to the student nurses, the registered nurses' responses (and non-responses) suggest that when coming into contact with "complaining" terms, they largely ignored culture-wide connotations of the expressions and interpreted non-judgment producing meanings. Even young and relatively inexperienced registered nurses showed a higher degree of immunity to the code phrase than did students. The protection was not complete, however, for the registered nurses. The use of "complain" did appear to promote an assessment of greater "psychological" component in the patient's pain, and a conclusion that other nurses would label that patient to be difficult and demanding.

A similarity between the groups was found regarding the relation between "complain" and assessment of the amount of pain being experienced by the patient. Neither the students nor the nurses seem to have been greatly influenced in their assessment of degree of pain by frequency of "complain" in the nurses' notes, although they were by patient characteristics.

Regarding patient characteristics generally, the results support previous work, indicating that, whether the practising care giver is a student or a registered nurse, stereotyping of patients may occur according to at least one characteristic of the patient background. For both students and registered nurses, on the other hand, patient

characteristics did not appear to bias the assessment of the "psychological" component to the patient's pain. Presumably individual characteristics and behaviors provide more important bases for such a conclusion than does diagnosis.

Limitations of the Study

The findings of the research must be interpreted with consideration of the low values of Cronbach's alpha found in the "low complaint" test situation. However, it may be that the low values only reflect that there was no element in that test situation to provide consistency. Further, the assumption was made that the questionnaire items reflected dimensions of a general underlying characteristic, a bias regarding the patient. To the extent the assumption is not warranted, the use of Cronbach's alpha as an indication of internal consistency is not justified.

A possible limitation for any research of this kind is that the conditions of the study were to an extent artificial and not clinical since real nurse/patient situations were not used.

Implications for Nursing Practice

For both practising student and graduate nurses, the message from the present research is clear: where code phrases are not specific to the sub-culture and may have different meanings in the non-nursing world, clarification of meanings is essential. In this particular case, neither students nor graduate nurses were completely free of bias toward patients where "complaining" was used in place of a neutral term.

The present research involved written communication. As to whether bias woud be found if spoken messages were used will have to await further research; however, reason would suggest code terms should be applied with caution in all references to patients.

The present study dealt with "first impressions" formed on the basis of patient characteristics or the language used by reporting nurses. The fact that such judgments may be altered on contact with the patient does not diminish the importance of minimizing those situations in which faulty pre-judgments arise. To the extent objective patient assessment is valued in the patient care setting, stereotyping should be avoided.

A vital related task for teachers is to impress on students the importance of clear, specific communication.

Implications for Further Research

The present study dealt with bias introduced through the reader's "unconscious" interpretation of the word "complain." In further research, an item such as the following might be included: "Do *you* think it makes a difference to your perception of the patient if the chart uses terms as 'complains' or 'c/o' as opposed to more neutral terms?" In this way, any relation between the bias shown in responses to the other items and expressed attitudes regarding use of the term could be explored.

Further research could pursue other concerns related to the project. Subsequent study on the effect of such terms as "complain" may be simplified through the use of more similar patient characteristics, such as omitting use of the patient's full name and town of origin and using the same diagnosis for all patients. Further research is needed to ascertain which of the characteristics in the patients' background data were responsible for the patient-related bias on nursing impressions found in the present study.

The patients "constructed" for the research were all females, to avoid bias related to gender. Further research might test for different expectations or interpretations regarding "complaining" behavior based on whether the patient is male or female.

Future studies may also fruitfully explore the student/registered nurse differences found in this study, specifically in relation to how "complain" affects their degree of attraction to the patient as patient or a person, and their assessment of the patient's probable acceptance of health teaching. Along the same line, examination of the relationships between pain assessment and the registered nurse's age and number of years since graduation may prove fruitful.

The present study demonstrated the use of one nursing code term and its effect on impressions nurses formed about patients. Further research is indicated to determine other phrases which may carry unintended meanings. Moreover, the role of oral communication and non-verbal language may be explored.

Examination of the extent to which a nurse's prejudging of patients has a negative effect on subsequent patient care is beyond the scope of this study. Further research is indicated to explore the relationship between the attitudes held by nurses and the quality of care.

Appendix: The Questionnaire

PLEASE ANSWER THE FOLLOWING QUESTIONS, COMPARING THE PATIENTS IN THE FOLLOWING AREAS.

How accepting would these patients be to health teaching compared to each other?

Most accepting _____ _____ _____ Least accepting

How much of a "psychological component" is there to each patient's pain, compared to each other?

Greatest psychological component to her experience of pain _____ _____ _____ Least psychological component to her experience of pain

Which of the patients is likely experiencing the *most* pain, compared to the others?

Most pain _____ _____ _____ Least pain

Which of the patients would you most like to get to know as a person, if possible?

Most like to get to know _____ _____ _____ Least like to get to know

Which of these patients would you rather be assigned to care for?

Most rather _____ _____ _____ Least rather

Which patient is likely to be prescribed by nurses as being a "difficult" or "demanding" patient?

Most "difficult" _____ _____ _____ Least "difficult"

The registered nurses were asked:

Do you practise nursing full time or part time? (State hours per week)

How long a shift do you work primarily?

What is your basic educational preparation for nursing practice?

How many years nursing experience have you had since graduation?

How old are you?

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RÉSUMÉ

Langage et préjugés: les effets du choix des termes sur les impressions que se font les infirmières

Le langage utilisé par les infirmières pour fournir à leurs collègues des renseignements au sujet des malades peut avoir un effet significatif sur les impressions créées sur l'auditeur ou le lecteur, ainsi que sur les rapports infirmier-malade qui suivront. La présente étude vise à examiner l'effet de l'expression "se plaindre" utilisée dans les rapports des infirmières. On a présenté à 66 candidates au baccalauréat et à 114 infirmières diplômées des renseignements écrits sur trois malades fictives, dont le diagnostic était semblable et les rapports identiques, sauf pour l'emploi de termes se rapportant à "se plaindre" dans les observations des infirmières au dossier de la malade. On a demandé aux sujets d'évaluer les malades, selon une échelle basée sur l'intensité probable de la douleur, l'importance de "l'élément psychologique" dans la douleur, et ainsi de suite. Les résultats ont démontré que les infirmières étudiantes manifestaient une plus grande sensibilité aux "plaintes" que les infirmières diplômées. Le diagnostic des malades a influencé les impressions des deux groupes. Les conséquences sur l'exercice des soins infirmiers et sur la recherche font l'objet de la discussion.

A FRAMEWORK FOR FAMILY NURSING

Janet Ericksen • Linda G. Leonard

A shortcoming of nursing has been its orientation toward individuals rather than social networks such as the family (Friedman, 1981; Logan, 1978; Schiarillo, 1980). It is generally accepted that health and illness behaviours are learned within the context of the family (Pratt, 1976), that the family unit is often affected when one or more of its members are experiencing a health problem (Logan, 1978), and that the effectiveness of health care can be improved by placing the emphasis on the unit rather than on just one individual (Hymovich & Barnard, 1979). However, the teaching and practice of nursing families has been made more difficult because of lack of frameworks providing direction for family nursing care.

Five years ago, faculty teaching a family course in the third year of the University of British Columbia School of Nursing recognized the need to help students more clearly conceptualize the structure, functioning and health-related needs of their clinically assigned well families. Existing frameworks and models of families were studied but the majority were better applied to families undergoing family therapy for various pathologies; other frameworks, though applicable to the study of the healthy family, were too limited in their scope of focus.

A search of the literature pertaining to groups other than the family uncovered Klein's (1968) framework for studying a community. He defines community as:

> patterned interactions within a domain of individuals seeking to achieve security and physical safety, derive support at times of stress and gain selfhood and significance throughout the life cycle. (p.11)

According to Klein, a community achieves these goals through the utilization of basic elements and processes such as structural characteristics and values; communication and decision-making; systemic linkage (linkage of one system to another and between the parts of the same system) and boundary maintenance (preservation and strengthening of the system itself). (pp.31-71)

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Klein's conceptualization of the community was consistent with what faculty believed and been teaching about families. In addition, it could be utilized when caring for both healthy families and families experiencing health problems. It would also permit the students to make a smooth transition from the model they were using in nursing individual clients (Campbell, Cruise, & Murakami, 1976). It was decided that the Klein framework would become the stepping off point for developing the family nursing framework.* Klein's definition of community became the definition of family because it permitted consideration of the major traditional and nontraditional forms of family, reflected the commonalities shared by families as well as the unique aspects found within each and recognized that families have goals or functions which change according to the maturational or unpredictable events in their lives.

Since its inception, the family framework has undergone a series of revisions; the authors have made further refinements and include these in the paper. The framework to be presented serves as a guide for working with and teaching about many different kinds of families and family situations. The authors will concentrate on providing an overview rather than attempting to be categorically comprehensive. Also, space does not allow a discussion of the variety of techniques used in assessing, planning, implementing and evaluating family nursing care while using this framework.

THE FAMILY FRAMEWORK COMPONENTS

The family as a system is seen in interaction with both the individual and the community systems in Figure 1. Although the main focus of this framework is on the family as a unit, the nurse may, at any given time, make an assessment of and intervene at the individual or community system level. The family, as depicted in Figure 1, has two major components: family processes and family functions. Family processes describe the patterns of interactions seen within the family; family functions represent those which the family is seeking to attain. Processes and functions are not discrete entities. As is consistent with systems theory, system components mutually interact with each other and the potential for overlap between the parts exists; data relating to any given function or process will ultimately affect other functions and processes.

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*The authors acknowledge the contributions of more than twenty third year faculty in creating and revising the framework.

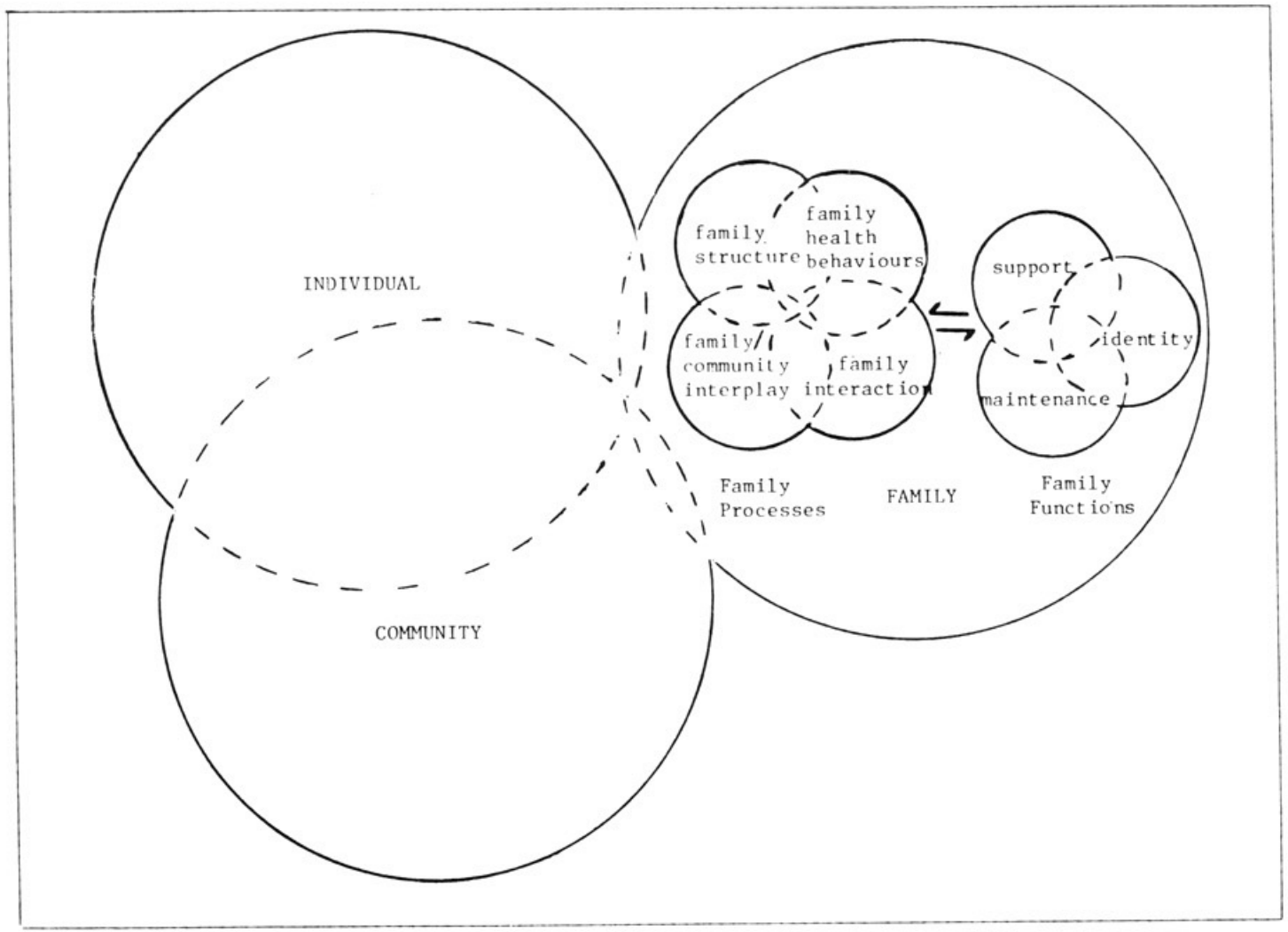

Figure 1. The family and its components. Shown in interaction with two other systems, the community and individual

Family Functions

Just as the individual seeks to achieve its goals, so does the family. Family goals have been termed family functions (Freeman & Heinrich, 1981; Epstein, Bishop, & Levin, 1978), family needs (Otto, 1973), and family tasks by various theorists (Duvall, 1978). Whatever their names, these goals encompass the same broad areas of family functioning throughout the life cycle: food, shelter, developmental nurturance; physical and emotional support; family self-worth and identity (Epstein et al., 1978; Friedman, 1981; Miller & Janosik, 1980). In this framework, goals are synonymous with family functions. The three functions are:

1. Maintenance function. The family is given the responsibility of providing for the physical and emotional safety as well as the security and nurturance of its members on a day to day basis and over time. Thus, the family seeks to provide such necessities as food, shelter, clothing, emotional and social nurturance and intellectual stimulation.
2. Support function. The family is also responsible for furnishing support during times of stress. It needs to respond to and/or plan for the pressures of everyday life, such as the sudden breakdown of the refrigerator, as well as family maturational and unpredictable events (eg. birth, death, loss of income).
3. Identity function. The family needs to establish for itself a sense of significance and selfhood — an identity and sense of social worth which is greater that what could be achieved by its individual members. This function is representative of the idea that a family has a distinctive collective view of itself which will be determined by views held within and outside of the unit. A particular family may see itself as part of a continuing heritage from past generations, a happy close-knit group and/or a unit effectively fulfilling its community responsibilities.

The family functions are regarded as nonhierarchical except as perceived by a particular family, i.e., a family may view one function as more important than the others. Also, a family may value one aspect of a function such as providing food and clothing more than other aspects, as for example, social or intellectual stimulation. What constitutes adequate achievement of a family function in a family's eyes will vary according to the family's values. Each family will have its own definition of satisfactory maintenance, support and identity. Individual family function definitions are an essential requisite of this framework and will be referred to in future sections of this paper.

Each of the functions can be met in a variety of ways both within the same family and among several families. For instance, the support function (support during times of family stress) could be met through an enduring belief that God will help the family weather all storms, effective problem-solving skills utilized by family members, ready access to a good listener outside the family and/or by asking for professional health assistance during a serious crisis period.

Family Processes

The various ways in which families operationalize their functions can be categorized; there are four categories which have been termed processes.

1. Family structure. This is defined as the relationship or organization of component parts of a family and includes, among others, members of the family, family subgroups, values and beliefs, roles and history together as a family. Each of the structural elements, as is the case with the elements of the other three family processes to be presented, will play a role in the achievement of one or more of the family functions. For example, a mother-daughter subgroup may surface when the family meals must be prepared (maintenance function), again during those times when the family has to decide how to cope with the abusive behavior of an inebriated husband-father (support function) and once again in the recognition that they are a family whose strengths rest in the female members (identity function).
2. Family interaction. This is the systematic and patterned exchange of verbal/nonverbal information of feelings. Included are the emotional climate, time spent together, communication, decision-making and problem solving patterns of the entire family and the family subgroups. Democratic decision-making may help one family decide how it is going to spend vacation time (maintenance function), comfortable and open discussions between husband and wife may help them plan for the financially troubled times which lie ahead (support function), and family get-togethers may reinforce the sense of family (identity function).
3. Family/Community interplay. This process represents the relationship between the family and the community. Elements of this process include the nature of neighbourhood and community involvements, use of services outside the family and environmental, community and neighbourhood factors which influence how a family behaves. A mother's part-time employment in the community may increase the amount of money available for family

necessities (maintenance function), attendance at a local parenting group may ease the pressures of childrearing (support function), and living in a crime-ridden neighbourhood may result in a collective feeling of vulnerability for the family (identity function).

4. Family health behaviours. These are the behaviours used by the family to maintain and promote its health, respond to daily stress and cope with maturational and unpredictable events. Health behaviours include the current health practices at the primary level (health promotion and prevention), secondary level (detection of health problems), and tertiary level (health practices for existing health problems); utilization of health services and support systems; health-related knowledge and skills. A family who gets adequate sleep may be better prepared to provide emotional security to its members (maintenance function); learning new ways to cope with a stressful family situation may help the members to support one another through the crisis (support function); and care of a dying family member in the home may give rise to family feelings of pride and dignity (identity function).

THE NURSE AND THE FAMILY

What follows is a description of how the family framework is used in conjunction with the nursing process. A summary of the key considerations in each phase of the process is contained in Figure 2. The ultimate goal in working with families is to assist them to achieve effective and desirable levels of functioning. Therefore, all steps of the nursing process are directed toward helping families attain this end.

Data are collected about 1) the four processes used by the family to meet the three functions, 2) the family's definition of the three functions, and 3) the family's satisfaction with how well it is functioning as a unit (Figure 2). A complete list of the data to be collected is contained in the Appendix. The guide, developed by the authors, was tested by their students and found to be helpful in providing concrete direction for data collection and in stimulating family self-exploration. Some situations, such as a family in the acute stages of a crisis, require assessment in a short space of time. In these circumstances, modifications in the type and amount of data to be collected can and must be made by the nurse.

In order to appreciate what underlies family behaviour and the family's degree of satisfaction, a careful assessment of the most pervasive family values is completed. Even though all families perform certain functions, they do so in accordance with their own values.

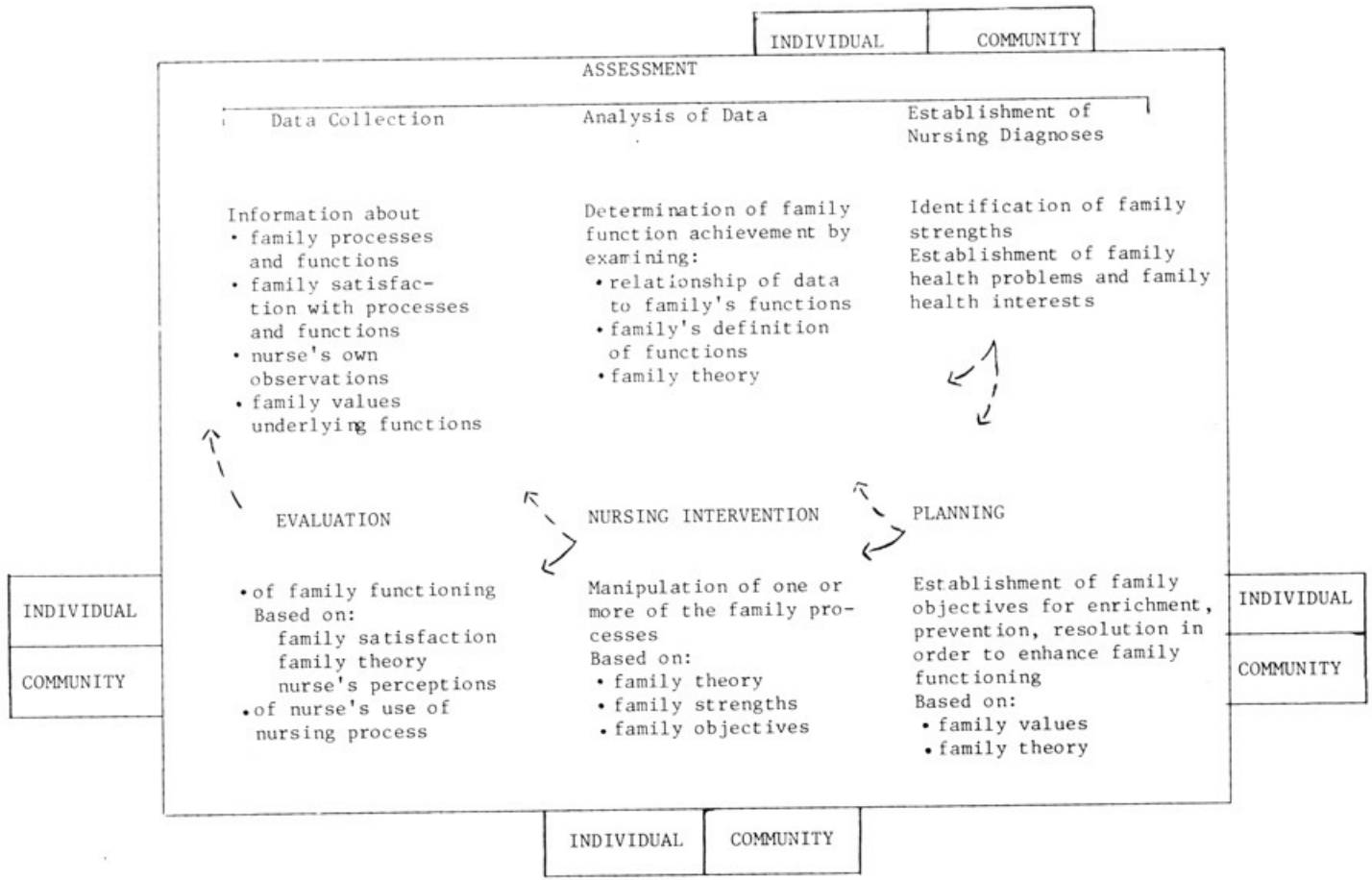

Figure 2. Use of the nursing process with the family framework. The points in the nursing process at which the nurse may direct attention to the Individual or Community System are also included.

These values influence how each family defines adequate functioning for itself. For example, a family may believe that one part of adequate maintenance is just enough money to feed, clothe and shelter its members while another sees that aspect of maintenance as enough money to eat out in expensive restaurants, dress in designer clothes and take yearly vacations to Europe. Values also influence how a family will perform the functions. One family may believe that it is important for all adolescent and adult members to contribute to the maintenance of the family, hence all members hold jobs and donate a portion of their salary to household costs. Another family may believe that it is important for the father to be the sole financial supporter; the money from any jobs held by other family members is, therefore, not used for family maintenance purposes.

The next step, analysis of data, involves the determination of how well a family is functioning. The collected data are examined by considerating 1) the family's definition of each of its functions, 2) how the data on the four processes relate to the functions, and 3) the significance of family data according to the literature on health and families. Stated another way, "Within the context of the four family processes, how does the family go about achieving its maintenance, support and identity functions?" "Does the family health literature support the way in which functions are achieved and the level of function achievement?" Literature utilized will include a wide variety of topic areas such as family maturational stages (Murray & Zentner, 1979; Hymovich & Barnard, 1979; Troll, Miller, & Atchley, 1979), family coping strategies (Friedman, 1981; Aguilera & Messick, 1979), health attitudes and practices (Miller & Janosik, 1980; Pratt, 1976), family communication patterns (Satir, 1967; Paolucci, Hall, & Axinn, 1977), and families at risk (Johnson, 1979; Schwartz & Schwartz, 1977).

At first glance, the analysis of data stage may appear ponderous as, conceivably, each piece of process data could be analyzed in relation to each of the functions. Practically, this is both impossible and unnecessary. Guidance as to what data should be focused upon is provided by considering the maturational and unpredictable family events and/or the health-related concerns deemed to have priority in the eyes of the family and the nurse.

After analyzing the data, the nurse, in conjunction with the family, makes diagnoses related to family function achievements. There are three broad categories of diagnoses that can be established: family strengths, family health problems, and family health interests. Family strengths come into play when family health problems require solutions or when families wish to pursue an interest related to family health. Family health problems consist of diagnoses related to lack of

or potential lack of family function achievements and family health interests are diagnoses related to areas of family functioning which are not problematic but instead are ones which families want to enhance in order to enrich their lives.

During the planning phase, objectives for enrichment of family functioning, prevention of diminished functioning and resolution of existing problems in functioning are established in accordance with the family's values. The interventions used to achieve family objectives involve manipulating one or more of the four family processes directing attention to pertinent elements of the family's structure; family interactions; interplay with the community; and/or the family's health behaviours. In addition to being built upon the objectives, interventions are based on the family's values, its strengths, and relevant family theories. The selection of objectives and interventions is a co-operative process involving the family and the nurse.

Evaluation of family functioning is an ongoing nursing task and may occur at any point when working with a family. It is based on the family's satisfaction with the status quo, the nurse's and the family's observations of what appears to be happening in the family unit, and the indicators of desirable and effective family functioning contained in the literature.

Also built into the evaluation portion of the nursing process is an assessment of how well the nurse is implementing the various phases of the process while working with a particular family. This gives the nurse the opportunity to review the appropriateness and effectiveness of his/her assessment, planning, intervention and evaluation skills.

It should be noted that the nurse may have occasion, while caring for the family, to direct attention to the individual family member system or the community system; this can occur during any phase of the nursing process, as is shown in Figure 2.

USE OF THE FAMILY NURSING FRAMEWORK AT UBC

The current family nursing course consists of 156 hours of family nursing content and clinical practice. Each student is responsible for using this framework while providing the nursing care to a minimum of two families who volunteer for the experience. The framework has also been utilized, though less extensively, by fourth year students while they work with families in a hospital setting or families in the community who have acute or long term health problems. In addition, components of the framwork have been incorporated into the clinical research projects of several faculty.

The preceding family nursing framework has served as a useful guide for working with and teaching about many different kinds of families and family situations. The knowledge, skills and perspective needed for nursing families differs from that required for nursing individuals. This framework allows the nurse to consider these differences.

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RÉSUMÉ

Programme de soins infirmiers en milieu familial

Pour répondre aux besoins d'orientation de l'enseignement et de l'exercice des soins infirmiers en milieu familial, les professeurs de l'École des sciences infirmières de l'Université de Colombie-Britannique ont mis au point une structure de programmes de soins infirmiers en milieu familial. Les fonctions communes à toutes les familles ont été déterminées: entretien de la famille, soutien familial et identité familiale. Les familles tentent d'exercer ces fonctions à partir de quatre catégories de processus: structure, interaction, rapports famille-collectivité, et attitudes face à la santé. La façon dont les infirmiers et les infirmières élaborent le programme familial dans les étapes et l'application de soins infirmiers fait l'objet de la discussion; un guide d'évaluation familiale qui s'est révélé un complément précieux dans l'enseignement et la pratique auprès des familles, est inclus.

Appendix: Family Assessment Guide

I. Data Collection

A. Family Functions

- family definition of and satisfaction with 3 functions.

B. Family Processes

1. Family Structure

- Household Members

Name	Birthdate/ place Age Sex	Occupation	Education (Grade in School if Child)	Ethnic Back- ground	Languages spoken	Religion Practiced
1.						
2.						
3.						

Relationship other than by birth/marriage eg. adoption, boarder, friend, etc.

Members Living Outside Household
Pets
Family Tree
- Drawing of Family Tree
- Family Member's Perception (collectively or individually) of who constitutes family

- Finances

- Subgroups
  - nature of and circumstances under which they form
  - family satisfaction with these groups

- Family Dwelling
  - number and size of rooms
  - purpose and use of rooms by family
  - furnishings
  - state of repair
  - nature of outside space eg. yard, garden
  - comfort and safety (See also Health Behaviours)
  - family satisfaction with home

- Family History
  - how family came together
  - length of time together as a family
  - significant events in past to present
  - coping strategies used to deal with significant events

- Values, beliefs, expectations, rules
  a) in this family)
  b) those of significance in families of origin) about:

education	health/illness
religion	occupation/work
marriage	money
parenting/childrearing	emotions
friendship	day to day living
mankind	families
sexuality	others significant for family

  - important values
  - conflicts over values, beliefs, etc.

- Roles

  positions occupied by each member
  competence of and satisfaction with performance
  acceptance of roles by family members
  flexibility in roles
  role conflicts
  current and past significant role models
  who "runs" the family?

- How does family describe themselves as a family regarding their structure e.g. large, flexible, complete, educated, multilingual, fragmented, etc.

- Significant values underlying this family process

- Nurse's observations

2. Family Interaction

- Activities and tasks
  - typical day or week for family

    - who participates in household tasks
    - times and activities when family is together
    - what happens when family member is missing for a period
    - who decides on family activities and tasks (See also Family Structure)

    - Communication (examine in relation to marital dyad; parent-child, child-child, family-extended family, family members-friend relationships; family group as a whole; other significant subgroups).

      - Content

        - communication patterns
          - topics of conversation allowed, disallowed
          - emotions openly displayed, covertly displayed
          - congruency of verbal and non-verbal messages
        - problem solving
          - what does family consider as major issues/problems in e.g. past year? those pending in near future?
          - degree of agreement amongst members that these are the issues

      - Process

        - communication patterns
          - who "talks" to whom, in what manner, about what and where?
          - ability of family members to listen and respond to messages
          - developmental appropriateness of messages
          - conducive or distracting environmental stimuli e.g. loud/soft music, TV
          - dysfunctional patterns e.g. scapegoating, triangling, physical and/or emotional abuse

        - problem solving (major problems and day to day issues)
          - how does family know there is an issue to be dealt with?
          - process used to deal with issues/problems
          - who is involved in solving problems/issues
          - satisfaction with process and solution
          - what happens when there is disagreement with process/solution?
          - does family follow through on decisions?

        - emotional climate
          - atmosphere transmitted by family e.g. comfort, tension, superficiality, depression, formality, suspiciousness, lightness, etc.
          - degree of mutual respect, support to one another, intimacy
          - degree of cohesiveness 29
          - Family Life Space Diagram

        - How does family describe themselves as a family regarding interaction e.g. close, self-sufficient, conflictual, open, honest, etc.

        - Significant values underlying this family process

        - Nurse's observations

3. Family/Community Interplay

Neighbourhood/Community
- length of time lived in community/neighbourhood
- knowledge of community
- family's perception of community
- family access to community e.g. car
- characteristics
  - physical e.g. topography, roads, open space, types and conditions of dwellings, properties, noise
  - population e.g. cultural-ethnic, maturational stages, density, transiency, crime level

- community services available	Who Uses and Frequency of Use
• food/restaurant • recreation /entertainment • educational/spiritual • shopping and general services (e.g. banks, mail) • child care • media (e.g. newspapers, T.V.) • transportation • community protection (e.g. police, pollution control, sanitation services) • other services (e.g. garbage disposal, post office) • health facilities/services (e.g. Meals on wheels)(See Family Health Behaviours)	

- Other support systems utilized, reasons for use, frequency of use (friends, extended family, neighbours)

- Family dwelling
  - indicators of psychological contact with community e.g. curtains open, view from major windows

- Family's participation in community life

- How does family describe themselves as a family regarding their interplay with the community e.g. actively involved, discriminated against, aware and interested, accepted part of community, reluctant/not reluctant to utilize community services, private, etc.

- Significant values underlying this family process

- Nurse's observations

4. Family Health Behaviours

Family Health History	Family Management, Satisfaction with Management	Health Resources Used and Satisfaction with Use
- health problems (diseases, illnesses, congenital, genetic, accidents) - other health related events (e.g. pregnancies, deaths) - in addition to above, other health concerns of past year (e.g. colds, fatigue)		

Family Health Practices	Family Members Responsible for	Knowledge and Skills Possessed by Family and Developmental Appropriateness of Health Teaching/ Interventions	Satisfaction with Practices	Health Services/ Support Systems Used Degree of Compliance/Involvement in Health Care
- Primary (health promotion and prevention) • nutrition • dental • smoking, alcohol, drug use • medications (prescribed and over-the counter) • hygiene • sleep, rest • stress management • recreation/leisure/ exercise • sanitation • emotional nurturance • safety within and outside home • sexuality/ reproduction (e.g. birth control, pregnancy) • immunization				

Family Health Practices	Family Members Responsible for	Knowledge and Skills Possessed by Family and Developmental Appropriateness of Health Teaching/ Interventions	Satisfaction with Practices	Health Services/ Support Systems Used Degree of Compliance/Involvement in Health Care
- Secondary (detection of health problems) • periodic examinations • developmental screening • self examination - Tertiary (health practices for existing health problems)				

- Effect of significant health related events, illnesses, practices, etc. on other processes
- How does family describe themselves as a family regarding health e.g. healthy, fit, always somebody sick, desperately trying to cope, etc.
- Significant values underlying this family process
- Nurse's observations

II. Analysis of Data

- role each process plays in achievement of maintenance, support, identity function

III. Nursing Diagnoses (family strengths, family health interests, family health problems)

THE DELPHI TECHNIQUE AS A METHOD FOR SELECTING CRITERIA TO EVALUATE NURSING CARE

Patricia Farrell • Kathleen Scherer

The identification of valid and reliable indicators of quality nursing care has been recognized as a priority for nursing research (Lindeman, 1975). In Canada, over the past decade, the response to this recognition has been the development of nursing standards (Manitoba Association of Registered Nurses, 1977; Chagnon, 1977; Alberta Association of Registered Nurses, 1981; College of Nurses of Ontario, 1976; Canadian Nurses Association, 1980).

As nurses operationalize the construct "quality nursing care," they are confronted with two tasks. The first task involves the description of the indicators of quality nursing care. The establishment of content validity of indicators has been lacking in the literature. Once the indicators have been described, the second task is their qualification. To date, most projects have focused on the first task. A common approach in these projects has been the selection of a small panel of clinical experts, which has been used to identify or to establish the face validity of the descriptors of quality care.

The project reported here was also concerned with the first task, that of describing indicators of quality nursing care. However, in selecting indicators and establishing their content validity, this project challenged the previous assumption that clinical experts could be viewed as representative of all practising nurses. Instead, the basic assumption was made that the opinions of all practising nurses were the most valid source of information about what constitutes quality nursing care. A second assumption was that these opinions varied widely and were dependent upon education, experience, and practice setting. In order to obtain a large sample of actively practising nurses and to minimize costs, a survey approach was used. The Delphi technique emerged from the review of survey methodologies as an approach that would elicit opinions and mold consensus.

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LITERATURE REVIEW

The Delphi Technique

This review primarily will focus on the use of the Delphi technique as a method for selecting criteria to evaluate patient care. The Delphi technique is used to structure the communication process and to allow individuals to deal with complex problems as a group. While the Delphi questionnaire format is similar to that of other survey formats, there are important distinctions. The distinguishing features of the Delphi technique include (a) a series of questionnaire administrations (rounds), (b) provision of feedback to each respondent following each round, consisting of the individual's response to each item and the group's mean or average response, and (c) an iteration process in which individuals are asked to reconsider their former opinions in light of the above feedback.

The Delphi technique may be particularly useful in a content area where there is divergence of opinion, and where empirical data are lacking. With this technique, all respondents are anonymous, a characteristic which is particularly helpful in avoiding the effect of influential leaders. The anonymity provided in the method guards against the influence of quantity or strength of personality (Linstone & Turoff, 1975).

While there are numerous modifications of the Delphi technique, three categories of its use are relevant to this review. Weaver (1972) distinguished between the exploratory Delphi, used to develop projections of future events, and the normative Delphi, used to facilitate goal-formation and thus shape the future. A third category may be called reactive, as panel members are asked to react to prepared information rather than generate ideas or items. Bramwell and Hykawy (1974) and Lemieux-Charles (1980) in nursing, and Bender, Strack, Ebright and Von Haunalter (1969) in medicine used an exploratory Delphi technique to identify expected changes in their professions, which could provide a baseline for measurement of real change. The normative Delphi was used by Lindeman (1975) to explore priorities in clinical nursing research, by Oberst (1978) to determine priorities for research in cancer nursing and by Ventura and Waligora-Serafin (1981) to identify priorities in mental health nursing.

Literature concerned with the use of the Delphi technique in the evaluation of patient care includes Milholland's survey of 14 general surgeons to estimate human surgical and mortality rates associated with liver trauma (Milholland, Wheeler, & Heieck, 1973). Osborne and Thompson (1975) administered a Delphi survey to a panel of 452 pediatric experts for their decision on criteria to evaluate ambulatory child health care. Holmes used a modified Delphi technique with seven medical faculty members to generate performance-based outcome criteria for evaluation of family-centered primary care (Holmes, Kane, Ford, & Fowler, 1978). Inui, Hill and Leiby (1979) used the method with nine physicians to develop setting-specific standards of care for diagnosis and prevention of tuberculosis. Romm and Hulka (1979) examined the effect of the Delphi iteration procedure in developing explicit criteria for ambulatory care assessment in a study involving thirty-one practising physicians who reacted to disease-specific criteria. Another study used a Delphi procedure with academic medical clinicians to develop criteria for ambulatory care (Hastings, Sonneborn, Lee, Vick, & Sasmor, 1980). More recently the Alberta Hospital Association has chosen the Delphi technique to develop outcome criteria for the evaluation of home care services (Shields, Note 1).

In all of the literature reviewed, content validity of the criteria sets was not reported. Measurement theory (Anastasi, 1968) has specified content validation procedures which include: (a) a review of the literature to identify the behaviour domain to be measured, (b) consultation with subject matter experts to identify the content sampling of the behaviour domain, and (c) use of resulting content sampling to serve as the test specifications.

From the literature review the practice of nursing was conceptualized as a universe with four behaviour domains: research, education, administration, and clinical nursing or direct nursing care. Direct nursing care was selected as the behaviour domain for the development of standards. Three frameworks which further defined the behavioural domain to be measured were also identified. The first framework, the nursing process, was generally accepted as nursing's application of the scientific method and was practised widely. The nursing process had also been used as a basis for the evaluation of nursing care (Hegyvary, 1979). Donabedian's (1966) health care evaluation model of structure, process and outcome was retained. Williamson's (1978) outcome model was adapted to the nursing process. Additionally, Bloch's (1977) definitions of criteria and standards were incorporated, as follows:

A criterion is the value-free name of a variable believed or known to be a relevant indicator of the quality of patient care.

A standard is the desired and achievable level of performance corresponding with a criterion against which actual performance is compared.

In this manner, the first requirement for the establishment of content validity was satisfied.

The second requirement for the establishment of content validity was the identification of the content sampling of the behaviour domain. The Manitoba Association of Registered Nurses Standards Committee, through a series of twelve drafts, described items which were indicators of the content sampling of the bahaviour domain (Scherer, Cameron, Farrell, Ramsay, & Vogt, 1982).

METHODOLOGY

This study was a collaborative project between the University of Manitoba School of Nursing and the Manitoba Association of Registered Nurses, conducted from October 1979 to May 1981.* The population of active practising nurses in Manitoba was sampled and supplemented with Canadian nurse educators and researchers and American nurse researchers. A Delphi questionnaire was designed and distributed. A follow-up of non-respondents was conducted. Results were analyzed and the quantitative and qualitative findings were used in the refinement of the second edition of the M.A.R.N. Standards of Nursing Care (1981).

Sampling Procedure

Four major strata were identified as representative of the nursing population: nurse administrators, nurse educators, nurse researchers, and nurses involved in direct nursing care. Operational definitions which would be compatible with existing data sources of provincial registered authorities were developed for each strata. Underrepresentation of Manitoba nurse educators and nurse researchers necessitated enlargement of the population to include Canadian nurse educators and researchers and American nurse researchers (Scherer, Cameron, Ramsay, Vogt, & Farrell, 1981). The population of 8980 nurses was enumerated. Proportional random sampling of this population resulted in 1411 nurses who were invited to participate in the Delphi survey. Of these, 662 indicated their agreement to participate by returning a sociodemographic profile.

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* Scherer, K. & Cameron, C. A project to measure the quality of nursing practice in the province of Manitoba was funded by a grant from the M.A.R.N. Research Fund.

Questionnaire Design

In designing the Delphi questionnaire, one of the content validation tasks was to ascertain not only that the standards were 'desirable' but also that they were 'necessary.' Two questions were developed and a five-point Likert response scale was used. This scaling technique was used in an attempt to minimize the influence of the midpoint (centering bias) and yet encourage diverse expression of opinions.

STANDARDS OF NURSING CARE

Instructions: Read the first item of the standards of nursing care. Then circle the answer (for each of the questions), which best represents your opinion about the item. Continue on with the second and each remaining item.

QUESTION 1

In general, across all types of nursing settings, this item must be present and/or put into practice in order for good nursing care to be provided. Do you strongly disagree, moderately disagree, neither agree nor disagree, moderately agree or strongly agree?

QUESTION 2A

This item may or may not apply in your setting(s) for various reasons. However, the present standards indicate that each item *should* apply. Do you strongly disagree, moderately disagree, neither agree nor disagree, moderately agree or strongly agree?

Figure 1. Likert Scale in Delphi Questionnaire.

The Likert categories were scaled from one to five: (1) strongly disagree, (2) moderately disagree, (3) neither agree nor disagree, (4) moderately agree, and (5) strongly agree. The five discrete categories resulted in interval level data. An a priori decision was made to accept items with a mean response score greater than 4. Items with a mean of 3 or less were rejected. Following qualitative appraisal, items in which the mean was between 3 and 4 were retained if the standard deviation was within $+1$.

Beside each question, space was provided for written comments. The questionnaire was pretested with 16 nurses, and was also translated into French. The questionnaire was mailed to each respondent with stamped, self-adressed, return envelopes. Follow-up cards were sent to non-respondents four weeks later.

Data Analysis

Four hundred and seventy-two nurses (71%) completed round one of the Delphi questionnaire. The grand mean response to question 1 was 4.59 and to question 2, 4.5, both indicating moderate agreement. Responses clustered about the mean within one standard deviation. Only two items were rejected based on their mean of less than 3. When frequency distribution of the responses within each strata was undertaken, it was found that 10-30% of the nurse educators either moderately disagreed or registered a neutral vote when compared to the grand mean. In order to determine whether this strata would alter their responses when provided with feedback on the entire group's response, a second round of the Delphi was administered to the 171 nurse educators.

A computer-generated round two of the Delphi survey consisted of the following feedback: (a) the group's mean response to each item and (b) that individual's previous response to each item. Researchers were asked to reconsider their responses in light of the group's response and to complete the questionnaire again. Follow-up cards were mailed to non-respondents. An 84% response rate (141 nurses) was obtained on round two of the Delphi. While the grand mean for questions 1 and 2 remained greater than 4 (moderately agree), the frequency distribution indicated that 10% moderately disagreed and 22% neither agreed nor disagreed. While 10% represented no change in strongly held opinions (the moderately disagree category), the neutral category was shifted upward (8%) between rounds one and two of the Delphi.

Quantitative responses to both rounds were content analyzed, summarized and forwarded to all respondents (Scherer, Cameron, & Farrell, 1981). All qualitative responses were considered in the process of content validation of the M.A.R.N. Standards of Nursing Care.

DISCUSSION

Two major limitations of this study concerned the English-to-French translation and the process for identification of the population. Although the questionnaire was professionally translated into French, comprehension difficulties were experienced by some French respondents, necessitating a re-translation and re-administration. Thus, questions about reliability of the French responses may be raised. A back-translation procedure and pre-testing should be used to minimize this effect in a bilingual country. The second limitation concerned identification of the population. Since no national data base exists, six months were required to access existing data sources for

population identification. Where these were deficient, new data sources were constructed. The fact that full-time nurse researcher positions are rare in Canada meant that nurse educator and nurse researcher positions were not mutually exclusive. This overlap in the operational definition variable, 'employed full-time', led to over-representation of nurse educators in the sample. This over-representation reflects actual practice and at this time is impossible to avoid.

In this study the second round of the Delphi resulted in no change in negative group opinion (moderately disagree). While this analysis did not examine individual changes, it could be said that opinions which were strongly held were not influenced by the Delphi iteration procedure. However, the process of individual and group feedback did effect some positive shift to the moderately agree in those who previously held neutral opinions.

In general, the basic assumption that nurses hold opinions about what constitutes quality nursing care was supported by this study. While previous research used exclusive panels of clinical experts, this project was designed to view all practising nurses as having expertise. This approach was also intended to prevent the imposition of standards developed by a non-representative group upon the general nursing population. While no significant variation was found among the four strata, membership acceptance and utilization are stronger when all members participate in standards development.

The second assumption of the project, that opinions about quality nursing care vary widely, is unresolved. The first round of the Delphi produced an overall consensus about the standards and the second round did not alter that consensus. While the results may seem to support Romm and Hulka's (1979) conclusion that a second mailing does not make an appreciable difference in the selection of measurement criteria, it is questionable whether a consensus would have been obtained if the first unrefined draft of the questionnaire had been administered.

In the examination of traditional response biases, the range of responses and resulting group means indicated that centering biases had been successfully reduced. Alternatively, the participants' expectancy that a consensus was the objective may have encouraged socially desirable or acquiescent responses. While no sociodemographic differences were found between respondents and drop-outs, analysis of non-respondents (those who refused to participate) was not possible. Non-respondents may be distinctly different in their social

acquiescence/deviance response set and this warrants further investigation. Also, reverse ordering of the Likert scale could have reduced this response set, and order effects require further study. A heuristic question may exist in considering whether the results from this project represent a socially desirable response set or nurses' beliefs that clients deserve quality nursing care as defined in the Standards. Whether the care which nurses deliver and patients receive approximates the Standards is the ultimate question.

The sample of experts used in this study represented the spectrum of nurses engaged in nursing. This not only added to the validity of the process but could serve as a motivating factor in terms of commitment to the Standards. The generic data base which resulted from this content validity study is now being used for instrument development to measure criteria and standards — the next step in quality assurance.

CONCLUSION

In the area of measurement of quality of care, the nursing profession has two options. One would be to wait until we have sufficient empirical evidence from which to evaluate nursing care; the other is to generate standards by using the judgment of experts in the field. Since little empirical evidence exists in the area of what constitutes quality nursing care, this project used the second option. In this study, experts in the field comprised representatives of the entire nursing population in Manitoba and a selected population in Canada and the United States. The Delphi technique in this validation study was valuable since it facilitated the examination, by a large group of nurses with varied education and experience, of what constitutes quality nursing care across a variety of settings.

Content validation of the criteria and standards through the use of the Delphi provided Manitoba nurses with a base from which to proceed to the next step in the evaluation of quality nursing care. This next step, or second task, is the quantification of the described indicators of the construct. To this end, instruments are now being developed* and their validity and reliability are being tested across a variety of settings.

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* Scherer, K., & Cameron, C. A project to measure the quality of nursing practice in the province of Manitoba is in progress and is funded by Health and Welfare Canada (NHRDP), Project No. 6607-1238-46.

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RÉSUMÉ

La technique Delphi comme méthode de sélection des critères d'évaluation des soins infirmiers

La technique Delphi est une méthode de rassemblement et de globalisation systématique de jugements raisonnés d'un groupe de spécialistes sur des questions et des problèmes particuliers. Son élaboration et son emploi dans les domaines commercial, éducatif, militaire et médical ont été bien documentés au cours des trois dernières décennies. La technique Delphi ne semble pas encore avoir été utilisée dans la sélection et la validation des critères d'évaluation des soins infirmiers. Le présent article décrit l'utilisation de la technique Delphi dans l'élaboration et la validation des normes génériques des soins infirmiers au Manitoba. L'opinion selon laquelle tous les infirmiers qui exercent leur profession sont des spécialistes constitue une façon originale d'appliquer la technique Delphi à ce projet. De plus, la stratification de ce groupe d'experts dans la réalisation de l'échantillonage a amélioré l'analyse Delphi. Enfin, la gradation des questions a réduit au minimum les erreurs systématiques communes aux enquêtes.

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