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Analysis of Nurses' Verbal Communication with Patients

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EDITORIAL

The late arrival of qualitative research in nursing is an interesting phenomenon in that the core of any profession lies in its practice. To understand practice one must understand the context in which care is given. Many of the early quantitative studies were focused on questions which could best be answered through a qualitative approach. Yet it was not until the mid 1970's that a number of carefully designed descriptive studies appeared that focused on nursing in the contextual setting. It was the beginning of the eighties before phenomenology made its appearance as a method in nursing research, and then in somewhat tentative form.

Early research by nurses was limited by the methodology rather than selecting a method appropriate to the questions posed. In many cases this led to research projects conducted on the basis of "recipes" rather than attempts to develop creative research designs.

Because we have not conducted careful observational studies, many of the questionnaires which have been developed and used are based on inadequately developed constructs. As a profession we have often used experimental design, not because it suited the nature of the problem at hand, but in a misguided effort to establish our "scientific" credibility. This has led to a reverse approach to research where we have tested constructs which have not been grounded in practice.

Recently more nurse researchers have moved toward qualitative approaches to the study of nursing practice. The initial leadership in Canada came from nurse-researchers at McGill University with considerable development subsequently taking place at the University of Manitoba, the University of Alberta and the University of British Columbia.

Nursing must examine priorities and select research methods based on the questions that need to be answered. Qualitative research demands careful observation and description. Such studies can lead to the knowledge base for nursing, including the development of diagnostic theory, which in turn can be used as one basis for improving patient care.

Peggy-Anne Field, R.N., Ph.D.
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ÉDITORIAL

L'apparition tardive de la recherche qualitative en sciences infirmières constitue un phénomène intéressant puisque l'essentiel de toute profession réside dans son exercice. Si l'on veut saisir l'exercice de cette profession, il faut comprendre le contexte dans lequel les soins sont administrés. Bon nombre des premières études quantitatives avaient mis l'accent sur des questions auxquelles il convenait vraiment de répondre par une démarche qualitative. Et pourtant ce ne fut pas avant le milieu des années 70 qu'un certain nombre d'études descriptives soigneusement conçues firent surface, études qui insistaient sur l'observation des sciences infirmières dans leur propre contexte. Ce n'est qu'au début des années 80 que la phénoménologie apparut comme démarche de recherche en sciences infirmières; même alors, ses débuts furent plutôt hésitants.

Les premières recherches effectuées par des infirmières étaient limitées par les méthodes plutôt que par le choix d'une méthode appropriée aux questions posées. Par conséquent, on vit de nombreux projets de recherche menés comme autant de "recettes" plutôt que comme des tentatives de mise au point de concepts de recherche créateurs.

Etant donné que nous n'avons pas effectué d'études d'observation soignées, bon nombre des questionnaires qui ont été mis au point et utilisés sont fondés sur des concepts inadéquats. En tant que groupe professionnel, nous avons souvent eu recours aux concepts expérimentaux non parce qu'ils convenaient à la nature du problème étudié, mais plutôt parce que nous cherchions, malencontreusement, à établir notre crédibilité "scientifique." Cette situation a abouti à une démarche qui allait à l'encontre de la recherche, par laquelle nous avons été amenés à vérifier des concepts de recherche qui n'ont pas été fondés dans la pratique.

Récemment, un plus grand nombre de chercheurs en sciences infirmières ont opté pour des approches qualitatives de l'étude de la pratique des soins infirmiers. Au Canada, l'élan initial a été donné par des infirmières-chercheurs à l'université McGill; par la suite l'Université du Manitoba, l'Université d'Alberta et l'Université de la Colombie-Britannique ont emboîté le pas et réalisé des progrès considérables dans ce domaine.

La profession infirmière doit examiner les priorités et choisir les méthodes de recherche fondées sur les questions auxquelles il faut répondre. La recherche qualitative exige une observation et une description soignées. Des études dans ce domaine peuvent mener aux connaissances de base des sciences infirmières et notamment au développement de la théorie diagnostique qui, à son tour, servira de base à l'amélioration des soins des malades.

Peggy-Anne Field, R.N., Ph.D.
Co-rédactrice en chef
Perspectives en nursing

STUDENTS' PERCEPTIONS OF CLINICAL TEACHING

Judith Mogan • Janet Knox

Evaluation of faculty, especially by students, has become an important issue given the emphasis today on student consumer rights and tight university budgets.

As Thomas Brothen (1979) pointed out at a recent conference on Improving University Teaching, "Educational institutions must attract and hold students and be prepared to demonstrate they are serving students' needs" (p. 408). Because educators want to know that they are meeting students' needs, numerous standardized rating forms that allow students to evaluate their instructors have been developed. These are widely used to document teaching effectiveness for academic advancement, administrative decisions, and self-improvement (Aleamoni, 1973; Irby & Rakestraw, 1981; Seldin, 1980). These classroom rating scales are generally considered valid and reliable indicators of teaching effectiveness (Thorne, 1980).

Evaluation of the nursing teacher is especially complicated. Classroom rating scales are not sufficient because of the additional component of clinical instruction. As Jacobsen (1966) points out, "In the clinical situation the relationship of student to teacher is a significant one. The learning situation is often one that cannot be repeated, and the clinical learning milieu is not usually controlled specifically for the teaching of the nursing student only" (p. 218).

In marked contrast to extensive research on classroom rating scales, few investigators have developed clinical evaluation tools (Brown & Hayes, 1979). Valid and reliable student rating forms are unavailable. Furthermore, descriptions of effective and ineffective clinical teaching behaviours in all health professions are scarce (Brown & Hayes, 1979; Irby & Rakestraw, 1981; Stafford & Graves, 1978), although they are needed to help faculty to improve their teaching (Abrami, Leventhal, & Perry, 1979).

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This project was partially supported by a University of British Columbia Humanities and Social Sciences Research Grant #25-9625.

The focus of this paper is on a study that identified effective and ineffective aspects of clinical teaching as perceived by students. As well, changes in students' perceptions of what constitutes these aspects at different levels in professional nursing education were examined.

The identification of students' perceptions is an important facet in the development of a more effective teacher evaluation tool. Since the information was derived from comments of a large group of university students (N=435), one can assume that they represent a reasonable indication of students' impressions of what helps or hinders their learning. As well, the study reveals five main categories of clinical teaching behaviours (see Figure 2) and thus can assist clinical teachers to increase their own teaching effectiveness. Areas deemed important by teachers but neglected by students, serve to point out weakenesses in the students' ability to evaluate and thus point out areas to be emphasized in the teaching of evaluation. However, the study will also be of interest to nursing educators because it shows that students have difficulty in the evaluation process. Students, over the four years of baccalaureate program in nursing, did not show a marked difference in identifying areas of effective and ineffective teacher behaviours. Although nursing education emphasizes the need for nurses to be able to evaluate peers effectively, even in senior years these students did not show an increased ability to do so more specifically.

METHOD

Setting

The study was conducted at the University of British Columbia School of Nursing. The School offers a four-year baccalaureate nursing program and allows Registered Nurse students to join generic students at the third year level. During the time of the study Registered Nurse students and generic students followed the same curriculum. No distinction was made between the two groups. Students in all four years took general education and nursing theory courses and gained practical experience in a wide variety of clinical settings including in-patient agencies, community health centres, schools, clinics, and homes. Each clinical rotation lasted approximately six to eight weeks and students were asked to evaluate their teachers after each clinical rotation.

The evaluation form was introduced four years ago after several evaluation tools had been tried and rejected. The present form, which is also used by other health sciences faculties at our University, is brief (see Figure 1). The first item asks the student to rate the teacher's per-

formance as "excellent," "above average," "average," or "unacceptable." Next, two open-ended questions ask students: "What are the most effective aspects of this individual's instruction?" and "How could this instructor's effectiveness be improved in this course?"

1. How do you rate the effectiveness of this instructor in this course?

   ________excellent ________above average ________average

   ________below average________unacceptable

2. What are the most effective aspects of this individual's instruction?

   ____

   ____

   ____

3. How can this instructor's effectiveness be improved in this course?

   ____

   ____

   ____

Figure 1. Student ratings of teacher effectiveness

The evaluation procedure involves student collection of the evaluation forms and collation of the comments by a central office outside the School of Nursing. A typed summary sheet of all comments is returned to the instructor and a copy is kept at the central office for one year. This process ensures anonymity of students since the instructor does not see the student's name or handwriting.

This evaluation process offered the investigators an ideal opportunity to collect data on effective and ineffective clinical teaching behaviours in a manner similar to that described by O'Shea and Parsons (1979) but without the necessity to request students to respond to a research questionnaire. We used the summary sheets for the academic year 1980/81 from 58 consenting faculty members (92% of all eligible faculty members) as our data base. The data consisted of the responses from 99 first year students, 71 second year students, 91 third year students, and 74 fourth year students.

Design and Procedures

The study was qualitative in design. It used pre-collected data of students' evaluations of clinical teaching. The responses to the two open-ended questions on the evaluation form were the primary focus of analysis. Ratings were reviewed as well. A research assistant deleted all identifying information (name, clinical agency, and personal pronouns) from the forms and sorted them into years.

The data were analyzed using the method of constant, comparative analysis (Glaser & Strauss, 1967) to generate categories. These categories were refined to provide a description of students' perceptions of clinical teaching over the four years of a baccalaureate program in nursing.

In conducting the analysis, the first step was for both researchers to read all the summary sheets and identify broad categories of effective and ineffective teaching behaviours. Once tentative categories were identified, the summary sheets were read as year groupings and the categories redefined. The researchers spent time discussing the categories and noting exceptions or differences. The data were then re-examined and recategorized until agreement between the two researchers was reached. Agreement was determined by individual examination and categorization of the data followed by comparison with the other researcher. Data were then normalized to the total number in each year and each category and expressed as percentages. Finally the responses made by the students in the four years were compared.

Limitations of the Study

1. Data were pre-collected; areas desirable for research but not included in the original data could not be supplemented.

2. The population consisted of generic students and Registered Nurse students.

Responses from these potentially different groups could not be distinguished.

FINDINGS AND DISCUSSION

Students in all four years rated the majority of their teachers as excellent or above average. Indeed, there seemed to be a reluctance to identify a teacher as below average and only one fourth year student identified a teacher as unacceptable (see Table 1). These findings are consistent with research data from general education (O'Hanlon, & Mortensen, 1980), which show that most teachers are rated above the midpoint on student rating scales (on our scale "average" is the midpoint), and that most students are generous in their evaluation of faculty (Hoyt, 1973).

Table 1

Distribution of Students' Ratings of their Clinical Instructors

	Excellent		Above Average		Average		Below Average		Unacceptable		No Comment	
	%	N	%	N	%	N	%	N	%	N	%	N
First year	45.5	45	32	32	16.5	16	3	3	0	0	3	3
Second year	32	23	55	39	10	7	1.4	1	0	0	1.4	1
Third year	39	35	46	42	10	9	4	4	0	0	1	1
Fourth year	35	59	45	76	14	29	3.5	6	.6	1	1.8	3
Mean (x)	37.9	162	44.5	189	12.6	61	3	14	.6	1	1.8	8

The analysis of student comments reflected the findings described by O'Shea and Parsons (1979); all students found it easier to list effective rather than ineffective teaching behaviours. However, negative comments increased as students progressed through the four years of the program.

Effective and ineffective behaviours portrayed the same qualities, the former stated in positive, the latter in negative form. For instance, an organized teacher was described as effective, a disorganized one as ineffective. It was thus possible to group both positive and negative comments into one category.

All student responses could be fitted into five categories identified by content analysis (see Figure 2). They are:

1. Teaching ability — defined as the process of transmission of knowledge, skills and attitudes, and the creation of an atmosphere in which this is done.

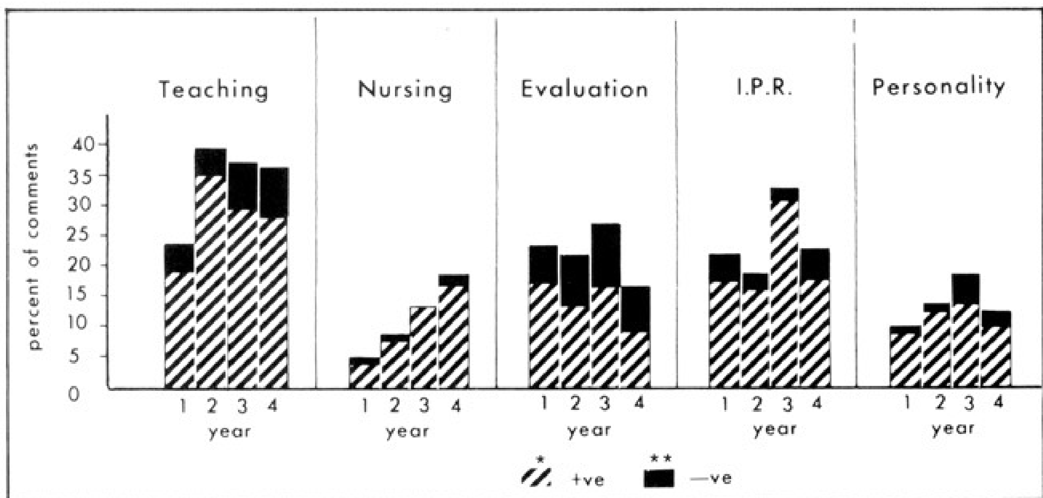
2. Nursing competence — defined as theoretical and clinical nursing knowledge and attitude toward the nursing profession.

3. Ability to evaluate — defined as the type and amount of feedback the student receives from the teacher regarding clinical performance and written clinical assignments.

4. Interpersonal relationship — defined as a state of reciprocal interest or communication between two or more people excluding specific therapeutic communications between nurse and patient.

5. Personality — defined as the totality of the individual's attitudes, emotional tendencies, and character traits which are not specifically related to teaching, nursing, or interpersonal relationships but may affect all three.

The most frequent student comments referred to the instructor's ability to teach. This area was also significant in showing an increase in ability to appraise teaching effectiveness as students progressed from first to fourth year. The most critical difference was in increasing awareness of not only the teacher's behaviour (or process of teaching) but also the outcome of teaching (or what the student had learned). First year students did not comment at all on teaching outcome. Second year students commented occasionally on what they had learned. By third and fourth year, these comments had increased in number and refinement.



* +ve: Students' comments describing effective aspects of the teacher's instruction.

** −ve: Students' comments describing ineffective aspects of the teacher's instruction.

Figure 2. Distribution of comments in each of the five categories of teaching behaviours

Another difference, noted over the years, was in the area of independence. Beginning students valued an instructor who allowed independence at the level of capability. By fourth year, students valued a teacher who fostered independent thinking.

Despite these differences, the majority of comments, in essence, remained the same. All students wanted the instructor to be available, to be organized, to give clear instructions and explanations and to give guidance and/or supervision as necessary.

Judging from the number of comments, students attributed little importance to the instructor's knowledge in nursing, although there was a slight increase of observations from students in the first year compared to those in the last year of the program. This finding, which is contrary to those described in the literature (Eble, 1970; Irby & Rakestraw, 1981; Kiker, 1973; Seldin, 1980), is difficult to explain. Possibly students were reluctant to comment in an area where the instructor's expertise is taken for granted. It is also conceivable that many students saw the nursing staff rather than the clinical instructor as their role model and thus did not evaluate the teacher's nursing competence.

From the few comments made, it appears students valued an instructor who was an expert clinician and a good role model. They also appreciated the instructor's theoretical knowledge and therapeutic communication skills with patients. Negative comments

were minimal and related primarily to the instructor's lack of practical skills and/or familiarity with the clinical area.

The teacher's ability to evaluate the students appeared important to all of them and thus was an area regarded rather critically, especially by fourth year students. Students unanimously agreed that instructors who set high but clear standards were more helpful than teachers whose demands were inconsistent or unreasonable. Frequent, if not constant, feedback was especially appreciated by students in the first and second year. The most vehement criticism was directed against the teacher who gave negative feedback in front of others and against those whose evaluation was considered unfair.

A supportive, helpful instructor who is approachable and non-threatening was seen as effective by students in all four years. Conversely, intimidating and nonsupportive behaviour was criticized most often. First year students would have liked a more supportive teacher, while fourth year students requested more respect.

The instructor's personality also seemed to help or hinder students' learning. Comments in this area were similar throughout the four years. Students valued an enthusiastic teacher who was well organized but at the same time flexible. A few comments regarding the instructor's sense of humour and cheerfulness were also made.

IMPLICATIONS AND CONCLUSIONS

The main purpose of our study was to assist our faculty to improve their clinical teaching by examining students' perceptions of effective and ineffective teaching behaviours.

Our findings indicate that students in our School were able to describe behaviour that helped or hindered their learning. However, they rarely addressed the issue of learning. Thus we do not really know what students learn from their clinical teacher, nor do we have any indication whether students learn more from a teacher they rate high. Furthermore, we do not know whether teacher behaviours, perceived by students as helpful, do indeed contribute to their learning. A more detailed evaluation tool may have also provided more specific evaluations. These and similar questions, although outside of our present study, certainly need to be answered before one can make more definitive statements about teacher effectiveness.

Another area requiring closer scrutiny is our observation that students' evaluation skills did not markedly improve over the four years of our program. This was even more surprising, given the addition of Registered Nurse students in the last two years of our program, a group who had considerably more experience in evaluation and who

were expected to be more adept at critical appraisal. Although these data might be specific to our School, they certainly point out the importance of including the teaching of evaluation in a university nursing curriculum for both generic and Registered Nurse students, since as professional nurses they will be involved in performance evaluation of self, peers, and subordinates.

The data also suggest that an open-ended evaluation form does not provide the student with enough direction for evaluation of clinical teaching. With such a form the students are left to develop their own criteria for effective teacher behaviours. A lack of these criteria may have resulted in vague comments that provide little direction to the teacher for improvement.

Since the main purpose of student evaluation of teachers is to provide the data to assist teachers to improve their teaching (Centra, 1977; O'Hanlon & Mortensen, 1980), it is suggested that a more structured form be designed using teacher, student and practising graduate input. Such a form would not only provide data for teacher improvement but could also contribute to the scarce descriptions of effective and ineffective teacher behaviours.

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RÉSUMÉ

Perception de l'enseignement clinique chez les étudiants

La littérature sur l'efficacité des enseignants dans le domaine clinique est rare et il n'existe que peu de documentation sur les perceptions qu'ont les étudiants de l'efficacité des professeurs cliniques. Le présent projet a été conçu afin de recueillir des données sur de telles perceptions et de comparer la façon dont les étudiants, au cours de chacune des quatre années d'un programme, perçoivent leurs enseignants cliniques. L'étude a été menée dans une école universitaire de sciences infirmières où les étudiants participent activement à l'évaluation du corps enseignant. Les données ont été recueillies pendant l'année 1980-81 à l'aide d'un formulaire standardisé d'évaluation de l'enseignant, préparé par le corps professoral. L'analyse des données a révélé que les étudiants répartissaient les caractéristiques des enseignants en cinq domaines principaux: personnalité, compétences pédagogiques, compétences infirmières, capacité d'évaluer, et rapports personnels. Dans chacune des catégories, les étudiants ont signalé chez l'enseignant des comportements efficaces et des comportements inefficaces. Au cours des quatre années, les étudiants se sont exprimés sur les mêmes types de comportements et de caractéristiques. On a trouvé que les évaluations des étudiants selon l'échelle d'évaluation ne cadraient pas toujours avec les commentaires écrits. Ces observations devraient, d'une part, fournir des données qui permettront l'élaboration d'un outil plus efficace d'évaluation, outil capable d'aider les enseignants à devenir plus efficaces, et d'autre part, proposer des domaines où les étudiants peuvent avoir besoin d'aide au cours du processus d'évaluation.

RESPONSES

Carolyn Attridge

It is my pleasure to respond to the Mogan and Knox article on "Students' Perceptions of Clinical Teaching." I commend them for their study of an area (student evaluation of clinical teaching) which has been the subject of much talk in nursing education but of very little research as their literature review clearly indicates. I found the article interesting and stimulating, and some of the questions and ideas it led me to consider I will discuss briefly here.

Methods

First, some questions about methodology. What were the procedures used for administration of the forms to the students in the sample? The authors, using a retrospective approach, had no research control over administration variables. I am aware through my own and others' experience with teacher evaluation that forms are often administered hurriedly, with short time periods allotted for responding, at the end of some other educational activity considered by the teacher as more important. Yet time allotted must surely affect the specificity of students' comments secured, a variable which apparently was of interest to the authors.

A second question here has to do with repetitive use of the form. The article states the number of students involved but does not make clear how many forms per student were obtained. Forms were apparently administered after every six to eight weeks' clinical rotation. For any student did this occur once, twice, several times a year? Repetitive exposure to one instrument can have an off-putting impact on respondents and may reduce the accuracy and detail of their responses. This factor may help to explain the lack of increasing specificity of students' comments over time, specificity which the authors apparently were hoping to see.

A third question is concerned with the mix of post-basic and generic students in the study especially in the third and fourth program years. Though the nature of the study did not permit student evaluations to be categorized as to type of student, it would be informative to the reader to know at least the proportion of data derived from each group.

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Finally, in reviewing Figure 2, in order to interpret the percentages, it would be helpful to know the total number of comments categorized and how widespread any category was among the student sample. For example, apparently only 5% to between 15% - 20% of comments over the four years were concerned with the nursing competence of teachers. Can the reader assume that 5% to 15% - 20% of *students* were concerned with this area of teacher performance?

Findings

Now, some comments about findings. First, the five categories of response which emerged are interesting. Most, in my view, comprise teacher behaviours which strongly affect what I call student *quality of life* in a program. Teachers' personality characteristics, their interpersonal relationships, the environments they set for learning, their approaches to feedback to students, etc. all affect the way that students *experience* a program, any program, and it is not surprising to me that these concerns supersede in students' minds such variables as the amount of learning obtained. Moreover these are the variables students can best pronounce upon; no one else in a program can experience such behaviours through students' eyes. And we, as teachers, can strongly benefit from such data. I am therefore somewhat perplexed by the authors' statement that:

> Areas deemed important by teachers but neglected by students, serve to point out weaknesses in the students' ability to evaluate and thus point out areas to be emphasized in the teaching of evaluation. (p. 5)

Students evaluate differently than teachers and these differences result from their perspectives of the learning situation. But do such differences constitute "weaknesses"? I am unclear here about which areas "deemed important to teachers" students should be taught to better evaluate.

A second and related comment has to do with the authors' concern that students' evaluation skills did not markedly improve over the years (p. 11). I am unclear what criteria to assess improvement' the authors were using. Were students expected to widen their perspectives to include different categories of concern, for example, perceived teacher impact on student learning, as they moved through the program? The consistency of student responses over the years seems to attest to the importance that the five categories of behaviour found in the study held for them. The authors are right to suggest that if comments on other behaviours, perhaps viewed as less important to students than teachers, are desired by teachers they must provide more direction to students in their evaluation forms. Were students

expected to become more specific in their comments as they became more senior? Here factors such as time allowed, boredom with the instrument (discussed above), relationship with the teacher, etc. may have been operating.

Third, the most interesting finding for me was the low incidence of comments on teachers' performance as nurses. For me, this adds credibility to other findings that the *nursing* abilities of teachers are not highly visible to students; usually because students do not *see* their teachers nursing patients in the clinical field. This apparent lack of *visibly* competent potential nurse role models among those members of the students' role-sets who are closest to them over time and in physical proximity, that is their teachers, is unfortunately one of the more serious deficiencies in the educational process that nurse educators must address. The Mogan and Knox data are supportive of this inference and studies of this variable alone are important to pursue.

I thank *Nursing Papers* and Mogan and Knox for the opportunity to share some of my thoughts about this paper and look forward to more studies and more dialogue about this topic so relevant to nursing education.

Darle Forrest

Nursing students, as consumers of education, are clearly indicating they want a voice in determining the effectiveness of teaching. Nursing teachers concerned with the implementation of a sound educational program recognize the value of seeking student perspective of the educational process. The study by Mogan and Knox provides further confirmation for the importance of the above points in relation to clinical teaching.

The primary question that arises about the study has to do with the validity of the evaluation form used to collect data from students. The specific question is whether the evaluation tool assesses what it was intended to measure, namely student perceptions of clinical teaching. As

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the authors indicate, the evaluation form (which is brief, open-ended, and general in nature) is used by other faculties on campus, yet they point out that "classroom rating scales are not sufficient" for measuring the specifics of clinical teaching.

A second problem of the study has to do with the methodology for the classification of students' responses. For example, how would the following imaginary response by a student, on number 2 of the evaluation form, be categorized: 'this clinical teacher is a warm person who cared about me and what I learned'. It seems such a statement overflows into categories 1, 4, and 5, and one is left with no clear understanding as to how such a response would be categorized or what the consistency of such categorization would be.

The comments by the authors that students attributed little importance to the teachers' nursing knowledge needs further examination. It is not conceivable that students interpreted questions 2 and 3 of the evaluation form as relating to teaching and instructional strategies rather than the teachers' nursing knowledge? Hence the result that teachers' knowledge in nursing was not commented upon may derive from the inadequacy of the rating form to elicit such a response.

A similar criticism applies to the statement by the authors that students rarely addressed the issue of learning. Again, this does not seem surprising since the two questions on the evaluation form are focused on aspects of the teacher's instruction and not on the *product* of that instruction. Student perceptions can relate to instructional outcomes and/or teacher behaviours. The first area taps student perception of learning and the second area taps student assessment of the conditions the teacher provides for learning and includes teacher traits and teacher use of self.

Concluding that "students' evaluation skills did not markedly improve over the four years" is questionable when one recognizes the inadequacy of the evaluation form to provide information on that question. As well, Registered Nurse students who entered the program at the third year level were not distinguished from the four-year generic students.

Indication that a teacher's ability to evaluate the students appeared important to "all" students would suggest that all respondents commented in regard to this category. Since this is unlikely, perhaps the authors were referring instead to the particular students whose comments could be classified in category 3.

I would concur with Mogan and Knox that a more structured evaluation tool (and I would add, a more comprehensive instrument) is required for the purpose of student evaluation of clinical teaching.

Such an instrument would survey the important teacher behaviours involved in clinical teaching from the perspective of both students and teachers, and incorporate both content and process dimensions. Such an evaluation form could comprise statements or questions which reflect the important aspects alluded to above. A Likert scale could be incorporated for the rating of each statement, which would present fairly explicit data in regard to student perception of the teacher behaviour described in each statement. Space for student comment in regard to each statement would provide descriptive data. A "picture" of student perceptions is readily presented in the data. Teacher strengths and weakenesses, as perceived by students, are readily spotted. If an evaluation tool is developed locally, then psychometric data should be collected about its validity and reliability. One needs to know that the outcomes measured are the ones intended to be measured and, as well, that the tool measures with consistency.

In a review of evaluation on teaching by Cohen, Trent, and Rose (in the Second Handbook of Research on Teaching) the following major factors emerged consistently from student ratings of teacher effectiveness. Teachers were seen as effective if there were present: 1) clarity of organization, interpretation and explanation, 2) encouragement of discussion and presentation of diverse points of view, 3) stimulation of students' interests, motivation and thinking, 4) manifestation of attentiveness to and interest in students, 5) manifestation of enthusiasm.

As pointed out by Mogan and Knox, the major purpose for student evaluation of teaching is to provide feedback to the teachers so they can maximize their effectiveness with students. The literature suggests student evaluation of teacher effectiveness, if conducted systematically, provides useful and reliable information about:

1) a teacher's skill in terms of personal effectiveness
2) the rapport a teacher has with students, and
3) the way a course or class is organized and managed.

The clinical setting is unique in providing the opportunity for one to one or small group teaching. In addition, Schweer and Gebbie state in their book, *Creative Teaching in Clinical Nursing* (3rd ed.), that the effectiveness of clinical teaching is directly proportional to the kind of relationships the teacher establishes with students. It would seem, then, that the students' perceptions of their relationships with the clinical instructor is of critical importance in the evaluation of clinical teaching.

Florence MacKenzie

Evaluation of courses by students is a common practice in many universities. In this study the authors have been realistic in capturing the data already available on the current course evaluation forms used in their university and then to examine this data in light of the question concerning the students' perception of clinical teaching. Since the same form was used by students in each year of the four year program this allowed for comparison of the students' responses across the four years. The authors wisely acknowledged the limitations of this means of collecting data since they were restricted to the information available on the form.

As in other studies which asked students to rate their teachers, the students in this program rated teachers as excellent or above average. This result brings in to question the purpose of such a rating scale. What is the students' interpretation of average? How does such a rating influence teacher effectiveness?

In the content analysis of the students' responses to the open-ended questions which asked about the effectiveness of the instruction, the researchers identified five categories (teaching ability, nursing competence, ability to evaluate, interpersonal relationship, personality). The most frequent comments referred to teaching ability. This is not surprising in that the question asked what are the most effective aspects of the individual's instruction. Little difference was noted in the responses from one year to another. In sum, students viewed the effective instructor as being available, organized, issuing clear instructions, and giving guidance as necessary. No teacher would argue with such comments. One other category identified by the researchers was knowledge of nursing. The authors interpreted that because few students' responses referred to the instructor's nursing knowledge then it would follow that they attributed little importance to the teacher's ability. It is difficult to agree with this interpretation as it is likely that the problem lies in the design of the form which asks for evaluation of the instruction and not the content of the course. This points to the difficulty in using a common form to evaluate all courses.

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In examining the distribution of comments in each of the five categories of teaching behaviours (Figure 2) several observations are in order. The number of comments is not recorded in the figure nor is the number mentioned in the body of the paper. It would be interesting to know how many comments were made in each year for each category, in addition to the percentage which does appear in the figure. It is also noted that compared to the other years, year 3 has a greater percentage of comments in the categories, evaluation, interpersonal relations and personality. In addition, no ineffective comments are recorded in the nursing category. One might query what is different about the instruction in year 3.

The researchers identified the inadequacies of the evaluation form in that it did not bring forth the students' perceptions of what they learn from the teacher nor did it provide the students with enough direction for evaluation of clinical teaching. The researchers expressed concern that the students' evaluation skills did not show marked improvement over the four years. In exploring this further one might question if the students receive any feedback about their evaluation. In other words, what do the students learn about evaluation through completing these forms? Do they know whether or not their evaluation contributes to teacher effectiveness? Is there a relationship between the students' perceptions of the effective teacher (ability to evaluate category) who is supportive, helpful, approachable, non-threatening and the tendency of the students to identify effective rather than ineffective teaching behaviours.

This study has shed light on the use of course evaluation by students in one university school of nursing and has raised several useful questions for future research.

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ORIENTATION TO ACADEMIA: THE SOCIALIZATION OF NEW FACULTY

Winnifred C. Mills

Canadian schools have enjoyed an association with universities since the early 1920's (Street, 1973, p. 126). In the university system generally, appointments are offered to individuals prepared at doctoral level. Such persons tend to be familiar with the university milieu and the general expectations of academia. Because of the shortage of doctorally prepared nurses in Canada, the greater number of faculty appointments are of individuals prepared at the master's level. Each year substantial numbers of baccalaureate graduates are appointed on a sessional or short term basis (CAUSN, 1980, p. 3).

Once an appointment is accepted, it is to the advantage of the employer to facilitate effective functioning of the appointee as speedily as possible. Depending on the nature of the appointment, effective functioning may include not only teaching responsibilities but also the mind set necessary to step forward on the long road toward tenure.

A planned orientation program has become an expectation of nurses moving into new jobs in practice settings. Orientation is equally important for the newcomer to the faculty ranks in academia.

ORIENTATION AS ONE ASPECT OF SOCIALIZATION

In this study questions were asked to determine whether an orientation program could be expected to contribute toward the appointees' socialization to academia:

1. What orientation do individuals believe they need when they assume a university faculty position?

2. What orientation does the administration (dean or director in a college, school or faculty) believe individuals need when they move into their role as new faculty members?

RESPONSIBILITIES OF THE FACULTY ROLE

Faculty appointments in nursing may be of a short-term sessional or part-time nature, may be a continuing tenure-track appointment, or may be an appointment dual in nature, where the incumbent shares time and expertise and carries responsibilities in an agency or institution

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associated with but apart from the university. Short-term appointments may be narrow in scope, may require the incumbent to supervise groups of students (often beginners) in laboratory/clinical settings, and may include participation in some classroom teaching and committee work. The responsibilities can be similar to those accepted by teaching assistants in other faculties.

Tenure-track appointments carry the expectation that the individual will begin at once to recognize and respond to the threefold responsibility of academia: teaching, research and service (Holliman, 1977). Nursing faculty groups often define their primary responsibility as teaching (perhaps because it is the role in which they feel most comfortable) and include in that role the requirement for active involvement in a clinical practice setting (Williamson, 1976, pp. 80-85). The additional aspects of the faculty role, namely research and service, may be neglected by the new appointee in pursuing what is seen as most important (i.e., teaching). Fort short-term appointees, teaching may indeed be the major function in their faculty role.

THE PROBLEMS OF SOCIALIZATION TO ACADEMIA

Styles (1980) identifies three dichotomies with which a new faculty member must deal. The first is the traditional-contemporary dichotomy which contrasts our early conditioning as females (and possibly also as nurses) for conformity, dependency, modesty and non-assertiveness with current expectations that the modern professional career woman must be independent, assertive, ambitious and career-conscious. The second dichotomy describes differences between the values of the academic and the professional. The academic values research, inquiring into abstract problems with scholastic detachment, whereas the action oriented professional provides a service and sees the need to address concrete societal problems. Styles notes that in some universities questions are still being raised about the appropriateness of professional schools on the academic campus. The third dichotomy occurs within the bureaucracy of the health delivery settings where we nurse and teach. Armed with professional standards and educational goals, we are tossed by the storms within institutional hierarchies, by government fiscal manoeuvres and by political machinations in the health care system.

Because of the complexity of the role faculty members are expected to assume, the entire first year of employment is likely to be one of initiation for the newcomer. Conway and Glass (1978) suggest delaying aspects of faculty socialization (information about tenure requirements, organizational structure and expectations about research) for as long as six months in order to decrease the information

overload. In their view, planned socialization addresses three issues: the need for information (some immediately related to the teaching assignment, student needs and clinical setting), the political naïveté of the neophytes, and the assignment or selection of mentors.

If little effort is expended in guiding the newcomer through the period of orientation, the individual is likely to fall back on previous role models and experiences as a guide to current expectations (Given, 1975). Earlier associations may not have fostered behaviour appropriate to the more complex university setting and failure to adapt fully to the faculty role can result. This maladaptation has been defined by Barley and Redman (1979) as "the inability to achieve balanced productivity in more than one of the university's defined missions of teaching, research and service" (p. 43). Faculty role development is a process of maturation in academia, occurring over time, with growth proceeding through stages of academic sophistication where the individual moves from a rather narrow view of self and the teaching-learning process to a much broader philosophy of education and teacher/student relationships (Ralph, 1973, pp. 61-68). If little individual development has occurred among faculty members, the group may be operating at lower levels of the suggested academic continuum. In such an environment, it is difficult for aspirants to scholarly levels of faculty functioning (e.g., research based practice) to succeed in their efforts, because of pressures and demands occasioned by the majority reference group who recognize as their primary concern their day to day teaching tasks and student needs. A planned orientation program should identify for the neophyte in academia the broad perspective of the university's expectations with regard to "balanced productivity" in the realms of teaching, research and service.

Given (1975) describes the problem of role definition for nurse educators and the lack of viable reference groups in the educational setting. Because the teacher often works with a group of students in relative isolation from colleagues, there may be no adequate comparison through which to assess the adequacy and efficacity of the teaching process. Beginning teachers may rely on recall of their own experience as students to guide their teaching behaviour and may lack sufficient formal preparation in the strategies of teaching, in either the classroom or clinical setting. If an individual's role perception is limited to functioning as teacher, then productivity in areas of research or service will be reduced or non-existent.

Motivation results from factors both intrinsic and extrinsic to the individual. The scholarly activities involved in research and publication provide both intrinsic and extrinsic motivation. Because the doctorally prepared individual has enjoyed increased exposure to such stimulation, motivation is stronger, resulting in greater productivity at this level (Blackburn, 1974, pp. 75-99). Blau (1973) has noted that in a climate where colleagues engage in active research the scholarly activity of the peer group is enhanced.

A form of collective maladaptation is described by Barley and Redman (1974) in universities where institutional attitudes mitigate against recognition of nursing among the prestigious professions. While opportunities exist for discrimination in and against nursing (an undeveloped discipline, peopled mainly by women), greater problems may result from "benign neglect" where a passive attitude toward the needs of the nursing department results in lack of support, interest or opportunity for faculty to be recognized, to develop, or to participate in the wider university mission.

> Nursing faculty members still tend to be isolated from the mainstream of the university life, tend not to be involved in the informal techniques of maneuvring for power, and generally move more slowly through the rank and tenure process than do members of other disciplines. (Welch, 1980, p. 725).

Andreoli (1979) sees the commonly accepted functions of the university, teaching, research and service, as interdependent, stating "faculty members who say they are giving all their time to teaching do not turn out to be better teachers" (p. 48).

In a model developed by Andreoli (1979), faculty productivity is the output of a faculty workload system which involves input from both the human and organizational subsystems. These components of this model indicate aspects of orientation which should assist new faculty members in the pursuit of their three-dimensional academic role.

ORIENTATION IN CANADIAN SCHOOLS OF NURSING

Design

The study was designed as a descriptive survey. Questionnaires with matching content were used to elicit information from dean/directors and new faculty members. Statements based on review of the literature on socialization described seven categories of content for an orientation program (Andreoli, 1979; Barley & Redman, 1979; Conway & Glass, 1978; Given, 1975; Holliman, 1977; Welch, 1980; Williamson, 1976). The categories included orientation to the educational environment of the nursing program, to the academic environ-

ment, to the social environment, to the political environment, to the geography and physical support system, to the local professional nursing milieu and to the community with its resources. (See Appendix for questionnaires)

Respondents were asked whether an orientation program was offered in 1980-81, whether the content described was part of their orientation program, and to rank-order the importance of the content.

The dean's/director's questionnaire asked for school statistics: number of full-time faculty (tenured, tenure-track, other); new appointments for 1980-81 by range (1-3, 4-6, 7-9, and 10 or more) and new tenure-track appointments by range. Other questions related to the planning and implementation of an orientation program.

The faculty-member's questionnaire asked whether the respondent had held a previous university appointment and their highest level of academic preparation.

Open-ended questions allowed comments throughout both dean/director and faculty questionnaires.

Analysis of the Data

Descriptive statistics were to be calculated, as appropriate, for the two questionnaires. The Mann-Whitney U-Test and the t-test were to be used as a basis for interpretation of differences between dean/director and faculty responses on questions relating to the content of orientation programs and the priorities ranked by individuals in each group. The chi-square and the Mann-Whitney U-Test would also be used to determine whether a difference existed in the ranking of priorities by those faculty members who had received an orientation and those who had not, and between those faculty members who had held a previous university appointment and those who had not. Comments made in response to questions 11 and 12 on the dean's/director's questionnaire, and questions 7 and 8 on the faculty questionnaire were to be listed and a content analysis done.

Population and Data Collection

The groups invited to participate formed a non-random purposive sample (Treece & Treece, 1977, p. 104). The 22 schools listed as members of the Canadian Association of University Schools of Nursing (CAUSN, 1980) were polled, with one dean/director questionnaire and an estimated number of faculty questionnaires being sent to each school listed. No identification of respondents was requested. Questionnaires were mailed, with a covering letter accompanying each, in January, 1981. The deans/directors were asked to

distribute the faculty questionnaires to the appointees new to their institution in the 1980-81 academic year. A reminder was sent to deans/directors in March, 1981 and the final responses were received in April, 1981.

A total of 145 faculty questionnaires were circulated. This number represented an estimated total of new faculty possibly appointed in the 1980-81 academic year. Ten of these were returned by one dean/director where no new appointments had been made and 80 new faculty members completed and returned questionnaires. Twenty-two deans/directors responded, 19 providing information about orientation programs in their schools. Two schools indicated that no orientation program was given and one school made no new appointments.

Limitations

1. The questionnaire was presented only in an English version which may have limited responses from Francophone colleagues.

2. The questionnaire was reviewed by colleagues for face-validity prior to its use but was not previously tested in a pilot study.

Findings

Data from Deans'/Directors' Questionnaires

The number of full-time faculty positions reported by 21 deans/directors is shown in Table 1.

Table 1

Number of Full-time Faculty Positions in 1980-81
Reported by Twenty-one Deans/Directors

Status	Number of positions	Percent of positions
Tenured	198	39.2
Tenure-Track	194	38.4
Other	113	22.4
Total	505	100.0

New tenure-track appointments in 1980-81 were reported in ranges by 21 deans/directors as shown in Table 2.

Table 2

New Tenure-track Appointments in 1980-81
Reported by Twenty-one Deans/Directors

Range of appointments	Deans reporting	Percent of deans
No tenure-track appointments	2	9.5
1-3 appointments	13	62.0
4-6 appointments	6	28.5
7-10 appointments	—	—
More than 10 appointments	—	—
Total	21	100.0

Total new appointments in 1980-81 reported in ranges by 21 deans/directors is shown in Table 3.

Table 3

Total New Appointments in 1980-81
Reported by Twenty-one Deans/Directors

Range of appointments	Number of deans/ directors reporting	Percent of deans
No new appointments	1	5.0
1-3 new appointments	5	24.0
4-6 new appointments	11	52.0
7-10 new appointments	2	9.5
More than 10 new appointments	2	9.5
Total	21	100.0

These figures show that 16 schools (76%) of those Canadian university schools responding appointed small numbers (up to six) new faculty in the 1980-81 year. Only four schools (19%) reported appointing more than seven new faculty members. (Table 3)

Nineteen deans/directors reported that a planned orientation had been offered to new faculty in their schools in 1980-81. Two schools reported no orientation given. The duration of the orientation was reported as one to three days by six respondents (28.5%), one week by seven respondents (33%) and more than one week by six respondents (28.5%).

Deans/directors were asked to check which of seven categories of content were included in their orientation program and the results are shown in Figure 1.

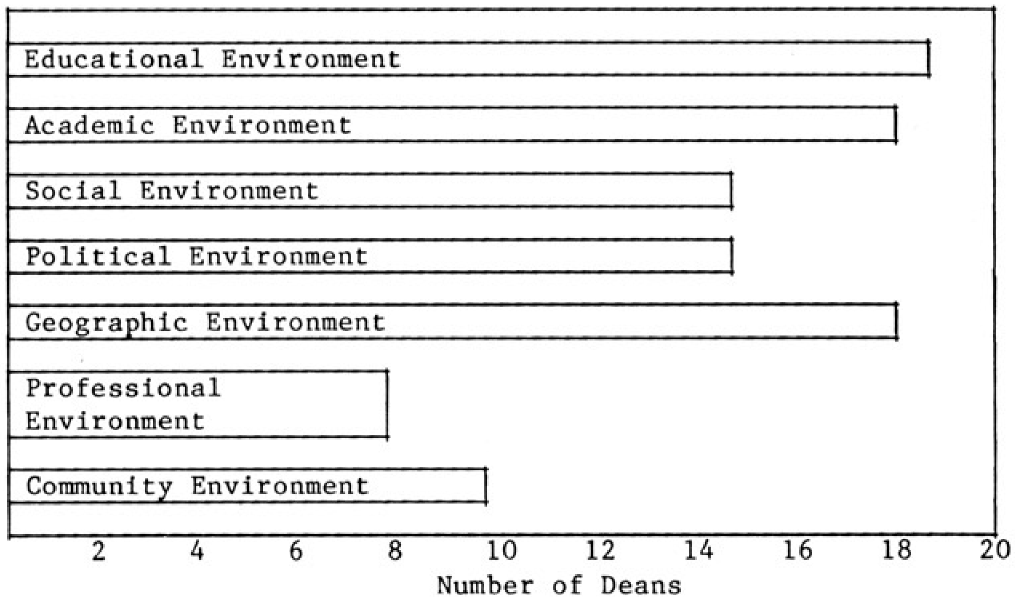

Figure 1. Content of orientation programs reported by deans (N=19).

Using the same descriptive categories that indicated content of the orientation program, the deans/directors were asked to rank order the categories, from one to seven, according to priorities for their setting. The results are shown in Table 4.

Discussion of Dean/Director Data

The responses from 21 deans/directors indicate that the number of faculty members struggling up the tenure track is nearly equal to the total number now tenured in the reporting schools. No dean/director reported more than six tenure-track appointments in 1980-81 and two schools reported no new tenure-track appointments in that period. Despite this fact, a quarter of the reporting schools (24%) appointed one to three new faculty members and 52% of the schools reported four to six new appointees each. Two schools (9.5%) reported seven to ten new appointments and another two schools reported more than ten new appointments. Either the number of tenure-track opportunities is limited in the reporting schools, or available applicants for faculty positions lack the academic preparation necessary to allow tenure-track appointment. Since only four schools reported appointments of more than seven new faculty members, an orientation program would be a small group activity in the majority of schools.

A planned orientation program had been given in 19 of the responding schools and the programs varied in length with the majority being

Table 4

Priorities in Content of Orientation Program
Ranked by Twenty-one Deans/Directors in 1980-81

Priorities in content		Ranking of priorities								
		1	2	3	4	5	6	7	Missing	Total
Educational	frequency	11	7						3	21
Environment	%	52.5	33.5						14	100
Academic	frequency	8	6	2	1				4	21
Environment	%	38	29	9	5				19	100
Social	frequency		1	2	3	4	5	2	4	21
Environment	%		5	9.5	14	19	24	9.5	19	100
Political	frequency		1	4	6	1	2	3	4	21
Environment	%		5	19	28.5	5	9.5	14	19	100
Geographic	frequency		3	4	2	4	1	2	5	21
Environment	%		14	19	9.5	19	5	9.5	24	100
Professional	frequency		1	4	2	2	3	4	5	21
Environment	%		5	19	9.5	9.5	14	19	24	100
Community	frequency		1	2	2	4	4	3	5	21
	%		5	9.5	9.5	19	19	14	24	100

one week or longer. Several respondents indicated that the orientation extended over a long period of time, even through the first year, and was planned to meet individual needs. The program was planned and implemented in 14 schools by a combination of faculty members and administrative personnel. No funds were budgeted by any school for the orientation program as a special item, and only one school reported that a formal written evaluation of the program had been done.

While all seven content areas outlined for orientation were included by some schools, responses indicated gaps in some programs. Orientation to the social milieu of the university was reported by 15 out of 19 respondents and orientation to the political milieu by 15 respondents. Comments indicated that three categories (geography of campus and physical support system, local professional milieu, and community and its resources) were not regarded as important unless the individual appointee requested information or was from a distance. This attitude could result in new faculty experiencing some difficulties if they are hesitant about asking questions in a new and often confusing setting and perhaps missing an excellent opportunity to emphasize the desirability of close liaison and cooperative effort between university faculty and leaders in the professional associations.

In rank ordering their priorities among these same categories 11 deans/directors (52.5%) emphasized orientation to the educational environment as primary importance and eight (38%) emphasized orientation to the academic environment. The other categories of content were ranked lower or omitted (see Table 4).

Data From New Faculty Members' Questionnaires

Highest level of academic preparation reported by respondents is shown in Table 5.

Table 5

Highest Level of Academic Preparation Reported by New Faculty Members 1980-81 (n=80)

Level of preparation	Frequency	Percent of respondents
Doctorate	5	6.25
Master's Degree	45	56.25
Baccalaureate Degree	30	37.5
Total	80	100.0

In this group of respondents 28 (35%) had held a previous university appointment while 52 (65%) had not held a previous university appointment. An orientation program had been offered to 59 (74%) of the group while 21 (25%) reported no orientation had been given them (see Table 6).

Table 6

New Faculty Members Reporting Received an Orientation Program and Previous University Appointment

		Received an orientation program		
		Yes	No	Row Total
Has held previous university appointment	frequency	21	7	28
	total %	26.3	8.7	35
Has not held previous university appointment	frequency	38	14	52
	total %	47.5	17.5	65
	column total	59	21	80
	total %	73.8	26.2	100

For those receiving orientation, 36 (45%) reported a program of one to three days, 7 (9%) reported a program of one week and 13 (16%) reported a program of more than a week. Categories of content that faculty respondents indicated were included in their program are shown in Figure 2.

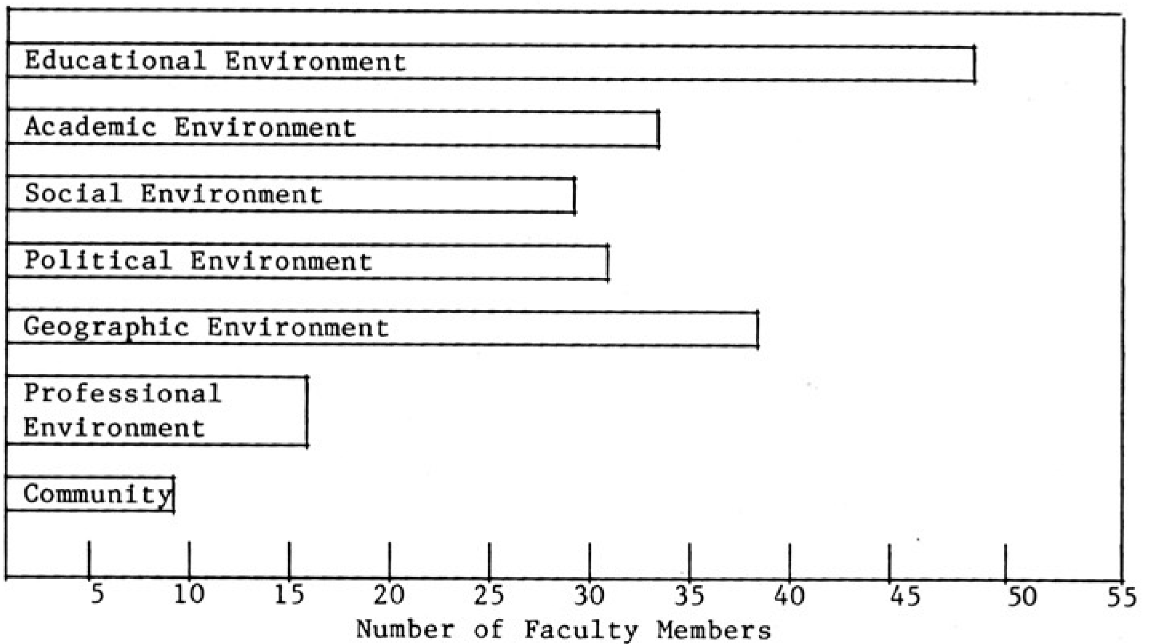

Figure 2. Content of orientation program reported by faculty (n=59).

Orientation to the educational milieu was reported by 50 appointees (85%) and orientation to the academic environment was reported by 37 appointees (63%). Thirty-two appointees (54%) reported orientation to the social environment, 33 (56%) reported orientation to the political environment and 40 (68%) reported orientation to the geography of the campus and the physical support system. Only 16 appointees (27%) reported orientation to the local professional environment and only 8 (13.5%) reported orientation to the community and its resources.

Priorities in content desired in an orientation by faculty are shown in Table 7.

Application of the chi-square to the data was planned to determine whether a difference existed in the ranking of priorities identified as desired in an orientation program by individuals with doctoral, master's or baccalaureate preparation. The chi-square could not be used because the small number of doctorally prepared individuals made cell frequencies inadequate. The Mann-Whitney U-Test was used to determine whether a difference existed in the ranking of priorities by those faculty members who had received an orientation program and those who had not. There was no significant difference between the two groups in this study. The same test was used to determine whether there was a difference in the ranking of priorities by those faculty members who had held a previous university appointment and those who had not. There was no significant difference between the two groups in this study.

Respondents were grouped by level of preparation and comments on open-ended questions were content analyzed using, as a framework, the seven categories included in the questionnaire. These comments are too detailed for this report but are available in the study (Mills, 1982, pp. 38-40) and are discussed below.

Discussion of Data From New Faculty Members

Eighty faculty members completed and returned questionnaires. Nearly two-thirds (65%) of the new faculty members responding had not held a previous university appointment. More than one-third (37.5%) of the respondents are prepared only at the baccalaureate level. Of the remaining two-thirds, 56.25% were prepared at the master's level and 6.25% had doctoral preparation.

Comments made about the content of the orientation program suggest that many new faculty members feel the need for help with the teaching/learning process. Several indicated a need for more orientation to the clinical areas and "to the health care system in a new pro-

Table 7

Ranking of Priorities in Content of Orientation Program
Reported by New Faculty Members in 1980-81 (n=80)

Priorities in content		Ranking of priorities								
		1	2	3	4	5	6	7	Missing	Total
Educational Environment	frequency	62	10	4					3	80
	%	77.2	12.7	5.1					3.8	100
Academic Environment	frequency	10	42	15	6	1	1	1	4	80
	%	12.7	51.9	19	7.6	1.3	1.3	1.3	5.1	100
Social Environment	frequency	2	5	9	17	17	15	11	4	80
	%	2.5	6.3	10.1	21.5	21.5	19	13.9	5.1	100
Political Environment	frequency	2	6	16	22	10	13	7	4	80
	%	2.5	7.6	20.3	27.8	11.4	16.5	8.9	5.1	100
Geographic Environment	frequency	4	6	19	8	10	19	8	6	80
	%	5.1	7.6	24.1	10.1	12.7	24.1	10.1	7.6	100
Professional Environment	frequency	1	5	8	16	24	16	5	5	80
	%	1.3	6.3	10.1	20.3	30.4	19	6.3	6.3	100
Community	frequency	2	1	4	7	13	8	40	5	80
	%	2.5	1.3	5.1	8.9	16.5	10.1	49.4	6.3	100

vince." These comments, together with the majority choice of "educational environment" as the highest priority category in orientation, would suggest that this group of appointees feel considerable insecurity about their teaching role and see teaching as their major responsibility. For short-term appointees this is likely to be an accurate perception of their role. For tenure-track appointees a wider vision of the academic role is necessary to their success and productivity and would have to be fostered through an ongoing system of socialization.

All the new faculty respondents believed that an orientation program is necessary and all made a comment about 'why'. The majority of the comments reflected a need for personal support, for example, to decrease stress, anxiety and uncertainty in a new environment. Although the degree of personal stress being experienced by new faculty was not addressed in this study, comments indicate that the respondents did find their initial experience stressful. Perhaps more effort needs to be directed toward 'caring' for new faculty members early in their appointment. The suggestion by several respondents that a buddy system for new appointees be used might help to meet this need.

Other comments about orientation related to its usefulness to increase efficiency and effectiveness in the teaching role. Given that 65% of the respondents had not held a previous university appointment and that 37.5% were baccalaureate prepared the responses are not surprising.

CONCLUSIONS

The responses from deans/directors indicated that the numbers of tenured and tenure-track faculty are almost equal in the reporting schools and a substantial number of "other" full-time faculty hold short-term appointments. Part-time appointments were not included in this study. These responses indicated that the tenured faculty have, in addition to their threefold academic role, a very heavy responsibility. They often carry out some administrative chores. They act as mentors and consultants to their tenure-track colleagues (almost equal in numbers to themselves) and as resource persons and guides to the large number of short-term and part-time appointees. In the majority of schools, an orientation program would be a small group activity serving the needs of up to ten new faculty members.

A planned orientation program had been given in 1981 in 19 of the responding schools and the programs varied in length with the majority being reported by deans/directors as one week or longer. Several deans/directors indicated that the orientation extended over a long period of time, even through the first year and was planned to meet individual needs. Interestingly, the majority of new faculty members (64%) reported a program of one to three days with the remainder

reporting one week or longer. It is possible that deans/directors and new appointees have differing perceptions of the nature and scope of the orientation.

Results suggest that deans/directors are more aware of the need for orientation to the academic milieu than are faculty members — not a surprising finding in view of the academic naïveté of the new faculty group. Since the majority of our university nursing program faculty are still less than doctorally prepared and include many individuals who themselves graduated only recently from master's programs, it is necessary that the organizational subsystem, described by Andreoli (1979) operate effectively to counter weaknesses inherent in the human subsystem.

Some aspects of the orientation are related to achieving immediate function in the university system. These include orientation to the geography of the campus and the physical support system. Orientation to the community is necessary for the welfare of the individual. Orientation to the educational milieu has some general implications for all appointees (e.g., grading systems, student records and other school policies) while details of course and clinical setting should be designed to meet individual needs. For the appointees prepared at baccalaureate level, the orientation program should focus on the educational milieu and their teaching role since this is likely to be their major responsibility. Orientations to the academic and political milieu are of particular importance to tenure-track and may be managed over an extended time period to acquaint them with the requirements of their academic role over and above the teaching function. Orientation to the social milieu should be made available to all appointees to help them integrate easily into the life of the school and the wider community. Orientation to the local professional milieu also seems to be neglected although it offers an excellent opportunity to establish, via the professional associations, a liaison between education and service so necessary to the achievement of our goals in nursing.

An orientation program must be seen as more than a mechanism to ensure the immediate teaching effectiveness of a new faculty member. It is a logical first step in the ongoing process of socialization to academia.

In this study both dean/director and faculty responses supported the need for orientation in the categories included in this study and described in the questionnaire. In addition, new faculty members indicated a need for personal support to relieve stress experienced in starting their new position. All deans/directors and faculty agreed that a program of orientation would assist new members to assume their role in academia.

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RÉSUMÉ

Vocation universitaire: l'initiation des nouveaux professeurs

Le présent article fait état des résultats d'une étude faite en 1981 auprès des doyennes/directrices et des nouveaux professeurs de 22 écoles universitaires de sciences infirmières. Elle a été conçue afin d'examiner l'utilisation qui est actuellement faite des programmes d'orientation destinés à intégrer les nouveaux professeurs au sein du corps enseignant. Les responsabilités des professeurs sont vues par rapport à la nature des fonctions de ces derniers. Les concepts fondamentaux de l'orientation sont tirés de la littérature sur l'initiation des professeurs. L'auteur examine les moyens d'aider le nouveau venu à répondre à ses besoins immédiats; il se penche aussi sur son orientation par rapport au milieu pédagogique, universitaire, politique et social dans lequel s'intègre le programme de sciences infirmières. L'orientation au sein du milieu professionnel local est un domaine souvent négligé, qui offre cependant d'excellentes occasions d'établir les rapports étroits souhaités entre l'enseignement et la profession. Les réponses données par 80 professeurs à des questions non dirigées ont révélé que tous les répondants éprouvaient la nécessité d'un programme d'orientation. Deux autres domaines sur lesquels le questionnaire ne portait pas directement, reflètent 1) la nécessité pour les professeurs de trouver un appui personnel leur permettant de réduire leur stress, 2) leur conviction que l'orientation est susceptible d'accroître leur efficacité pédagogique. Les doyennes/directrices tout autant que les professeurs ont constaté la nécessité d'offrir un programme d'orientation qui servirait de première étape dans la socialisation en milieu universitaire.

APPENDIX: THE QUESTIONNAIRES

ORIENTATION OF NEW FACULTY IN UNIVERSITY NURSING PROGRAMS

Faculty Member's Questionnaire

This study of orientation needs forms part of a greater area for consideration, i.e., socialization and development of faculty in the academic milieu. You can help by completing this questionnaire.

Please indicate your response by placing and X or appropriate answer in the space beside each statement.

Do not write in this space.

1. I have held a university appointment in nursing prior to my present position.

   Yes ☐

   No ☐

2. My highest level of academic preparation is

   doctorate ☐

   master's degree ☐

   baccalaureate degree ☐

   other (please specify) ☐ ____________________

   ____

3. An orientation program was offered to me at this university at the time I began my appointment.

   Yes ☐

   No ☐

   If the answer to No. 3 is YES, please complete the questionnaire. If the answer to No. 3 is NO, please go to question 6.

4. The duration of the orientation program was

   1 - 3 days ☐

   one week ☐

   more than one week ☐

5. The orientation program included (please check all statements which apply):

   orientation to the educational environment of the nursing programs, e.g., conceptual framework, curriculum, course content, clinical placements, student evaluation and records, etc. ☐

orientation to the academic environment, e.g., expectations re: research, publication, service, teaching, library resources, colleague networks, peer review and evaluation, promotion, etc. ☐

orientation to the social milieu of the university and the nursing program - organizational structure, history, traditions, student organizations, faculty club, etc. ☐

orientation to the political milieu of the university - governance and decision-making structure throughout the university; faculty association activity, concerns related to economic welfare of faculty members, etc. ☐

orientation to the geography of the campus and the physical support system - secretarial staff, mail and dispatch, AV department and equipment, library services, supplies, etc. ☐

orientation to the local nursing professional milieu, including introduction to provincial association staff, executive or committee members, CAUSN representatives, etc. ☐

orientation to the community and its resources, e.g., housing information, city maps, bank and shopping information, points of interest, etc. ☐

6. Please number these aspects of an orientation program (described in Question 5) according to priorities for you as a new faculty member.

orientation to the educational environment of the nursing programs. ☐

orientation to the academic environment. ☐

orientation to the social milieu of the university and the nursing program. ☐

orientation to the political milieu of the university. ☐

orientation to the geography of the campus and the physical support system. ☐

orientation to the local nursing professional milieu. ☐

orientation to the community and its resources. ☐

7. Other aspects of orientation for new faculty members in nursing which should be considered include:

____

____

8. I believe an orientation program for new nursing faculty member is necessary ☐

not necessary ☐

because ______________________________________

____

ORIENTATION OF NEW FACULTY IN UNIVERSITY NURSING PROGRAMS

Dean's/Director's Questionnaire

This study of orientation needs forms part of a greater area for consideration, i.e., socialization and development of faculty in the academic milieu. You can help by completing this questionnaire.

Please indicate your response by placing an X or appropriate answer in the space beside each statement.

Do not write in this space.

1. Full-time faculty teaching in this University in nursing programs in 1980-81 number as follows: (please write numbers)

   tenured _____

   tenure track _____

   Other _____

2. New appointments in 1980-81 numbered

   1 - 3 ☐

   4 - 6 ☐

   7 - 10 ☐

   over 10 ☐

3. New tenure-track appointments in 1980-81 numbered

   1 - 3 ☐

   4 - 6 ☐

   7 - 10 ☐

   over 10 ☐

4. An orientation program was planned for new faculty members appointed for 1980-81

   Yes ☐

   No ☐

If the answer to question 4 above was 'yes,' please complete the remaining questions.

5. The duration of the orientation program in 1980-81 was

   1 - 3 days ☐

   one week ☐

   more than one week ☐

6. The orientation program for new faculty was organized by

- the dean/director ☐
- associate dean/director ☐
- non-nursing administrative officer ☐
- faculty members ☐
- combination of the above ☐
- other (please specify) ☐ ____________________

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7. The orientation program for new faculty was implemented by

- the dean/director ☐
- associate dean/director ☐
- non-nursing administrative officer ☐
- faculty members ☐
- combination of the above ☐
- other (please specify) ☐ ____________________

---

8. Funds were allocated towards the orientation program in 1980-81 as a separate budget item.

- Yes ☐
- No ☐

If yes, please specify the nature of the disbursements

---

9. A formal (written) evaluation of the orientation program was done by participants in 1980-81.

- Yes ☐
- No ☐

10. The orientation program included (please check all statements which apply):

- orientation to the educational environment of the nursing programs, e.g., conceptual framework, curriculum, course content, clinical placements, student evaluation and records, etc. ☐
- orientation to the academic environment, e.g., expectations re: research, publication, service, teaching, library resources, colleague networks, peer review and evaluation, promotion, etc. ☐
- orientation to the social milieu of the university and the nursing program - organizational structure, history, traditions, student organizations, faculty club, etc. ☐

orientation to the political milieu of the university - governance and decision-making structure throughout the university; faculty association activity, concerns related to economic welfare of faculty members, etc. ☐

orientation to the geography of the campus and the physical support system - secretarial staff, mail and dispatch, AV department and equipment, library services, supplies, etc. ☐

orientation to the local nursing professional milieu, including introduction to provincial association staff, executive or committee members, CAUSN representatives, etc. ☐

orientation to the community and its resources, e.g., housing information, city maps, bank and shopping information, points of interest, etc. ☐

11. Please number these aspects of an orientation program (described in Question 10) according to your priorities for your setting.

orientation to the educational environment of the nursing programs. ☐

orientation to the academic environment. ☐

orientation to the social milieu of the university and the nursing program. ☐

orientation to the political milieu of the university. ☐

orientation to the geography of the campus and the physical support system. ☐

orientation to the local nursing professional milieu. ☐

orientation to the community and its resources. ☐

Comments: ____

____

____

12. Other aspects of orientation for new faculty members in nursing which should be considered include:

____

____

____

____

____

Thank you for helping with this project.

RESPONSES

Janetta MacPhail

In her article on "Orientation to Academia: The Socialization of New Faculty," Professor Mills addresses a very important topic. In recent years a great deal of emphasis has been placed on orientation of new staff in health care agencies, which has certainly become an expectation of the majority of new graduates from nursing programs. Many articles have been published in nursing journals and books have been published on the topic of staff development, of which orientation is one component. The importance of orientation for new staff is reflected in the fact that it is bargained for in collective agreements, which suggests that administrators in health care agencies may not place as much importance on orientation as do staff nurses. A good deal has been written and stated by nursing service administrators and hospital administrators about the cost of orientation that is being assumed by health care agencies.

While most deans/directors of basic nursing programs and most faculty undoubtedly expect that their new graduates will receive a proper orientation to the health care agencies in which they choose to practise, similar emphasis has not been placed on orientation of new faculty in university nursing programs. At least this is not reflected in the literature or in programs presented at educational conferences Nonetheless, it is possible that nursing facilities have placed more importance on orientation of new faculty because of their service orientation than have faculties in other disciplines within the university.

Professor Mills's study was designed to determine whether an orientation program could be expected to contribute to socialization into academia. More specifically, she endeavoured to determine the relative importance attached to various aspects of orientation, as perceived by deans/directors of university nursing programs in comparison to the perceptions of new faculty appointees. Her further question was whether an orientation program can contribute to socialization of new faculty.

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Professor Mills states that her study was a "descriptive survey". A questionnaire was designed based on statements derived from literature on socialization. The respondents were asked if the content in relation to each of the seven categories was part of their orientation and to rank order the importance of the categories in relation to an orientation program. The investigator acknowledges two limitations of the questionnaire; namely, (1) that it was presented only in English and yet French speaking faculty were included in the sample; and (2) that the questionnaire was "reviewed by colleagues for face-validity prior to its use" but was not previously tested in a pilot study.

These limitations place definite limits on the findings of the investigation. If a questionnaire is not tested for validity and reliability, there is no way of knowing the degree to which the questions measure what they intended to measure. If a questionnaire is not determined to be reliable it cannot possibly be valid (Polit & Hungler, p. 434). The investigator notes that presenting the questionnaire in English only may have "limited responses from Francophone colleagues." In addition to limiting responses, it is possible that the questions elicited incorrect responses if the questions were not understood or were misinterpreted.

The investigator states that "a non-random purposive sample" was used. Purposive sampling is not a highly recommended approach as it "provides no external, objective method for assessing the typicalness of the selected subjects" (Polit & Hungler, p. 457). If a purposive sample is used, the data must be treated with extreme circumpspection.

The investigator states that "descriptive statistics were to be calculated, as appropriate, for the new questionnaires." She then proceeds to delineate inferential statistics that were selected for analysis of the data, namely, the t-test, the Mann-Whitney U-test, and chi-square. "Inferential statistics are based on the assumption of random sampling from populations" (Polit & Hungler, p. 538). It is difficult to determine if the investigator had planned to use the inferential statistics as stated and then changed the plan, because the statistical analysis used is indeed descriptive statistics, using number and percentages for the most part. The chi-square statistic was attempted but found not to be appropriate and the Mann-Whitney U-test was used. Since an inferential statistic was used inappropriately, one cannot place confidence in these findings.

In addition to data collected by the questions in the questionnaires, the investigator collected data from open-ended questions or comments that were added by the respondents. She stated that the comments made by faculty members recognize the need for help with the

teaching/learning process. In addition, she stated that many indicated a need for more orientation to the clinical areas and to the health care system in a new province. It is encouraging that the faculty themselves recognize the need for orientation to clinical areas, to the community, and the system. It is distressing to note the low ranking assigned to orientation to the community by the deans/directors. Do not faculty need this kind of orientation if they are expected to provide meaningful supervision of students in practice, to practise themselves, and to be involved professionally in the community in which they choose to work? It is also dismaying to note that two schools provide no orientation for new faculty. It is difficult to imagine how a dean/director would expect new faculty to assume the faculty role in a responsible manner if no orientation is provided to role expectations and the academic environment.

The investigator states that comments about orientation were related to its usefulness to increase efficiency and effectiveness in the teaching role. It would seem logical that a well-planned orientation would be perceived by faculty in academia as increasing efficiency and effectiveness in all aspects of the academic role. An orientation to research and other scholarly activities and the service responsibility are as important as orientation to the teaching role, which unfortunately has been the only role perceived important by many nursing faculty.

Some of the conclusions stated by the investigator do not seem to derive directly from the data collected. For example, she concludes that "based on the number of tenure-track appointments the tenured faculty have, in addition to their threefold academic role, a very heavy responsibility. They often carry out some administrative chores, they act as mentors and consultants to their tenure-track colleagues (almost equal in number to themselves) and as resource persons and guides to the large number of short-term and part-time appointees." It is difficult to understand how this conclusion can be drawn from the numbers of tenure-track appointees in contrast to the numbers in non-tenurable positions, which is implied in the conclusions.

Another conclusion that is difficult to understand is that the investigator concludes that the deans are more aware of the need for orientation to the academic environment than are new faculty. Yet, the data indicate that 76% of the deans rate the importance of orientation to the academic environment as a first, second, or third ranking, whereas 83.6% of the faculty rate it within these first three categories.

Despite the inadequacies in study design and interpretation of the findings, this study brings to attention the importance of a planned orientation program in academia. It would be interesting to conduct a comparative study of different approaches used in orienting new faculty to ascertain those which are most effective and efficient in socializing both neophytes and experienced faculty into an academic environment that requires research and scholarly endeavours and involvement in practice, in addition to the usual emphasis placed on the teaching role in nursing faculties.

Polit, D., & Hungler, B. *Nursing research: principles and methods.* Toronto: J. B. Lippincott Co., 1978.

Margaret F. Munro

I found it of considerable interest to read and respond to Mills's paper since I was quite probably one of the "new" faculty appointees who where surveyed in 1981. The topic of faculty socialization is one of concern for me as an academic administrator with responsibility for orienting new members to a nursing faculty. Her results and the discussion of them were informative and succinct.

I would like to respond to the research design, the analysis of the data and the implications for those of us in academia. Although some readers may be concerned about the validity and reliability of findings in a study using non random purposive sampling I would suggest two reasons for reducing those concerns. First, Mills is not conducting experimental research but rather an exploratory survey of the current Canadian scene. The total population of Canadian university schools is so small but diversified that a pilot study is not really necessary to test out a survey instrument and a representative sample would be difficult to define. This brings me to my second point, she is able to quote her results from deans of all Canadian university schools who had new faculty appointed, thus basing her report on population parameters rather than sample data for that segment of the study.

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In relation to the data from new appointees, the ratio of 80 respondees to the basic sampling frame of all new appointees is unknown. From the data on the range of new appointees per school this sampling frame could range from 84 to approximately 120. The addition of one factor, the actual total number of new appointees in all schools combined would provide the reader with the ratio of respondees without jeopardizing the anonymity to any school.

The questionnaire instrument seems to have been designed to reflect the seven major categories of orientation identified in the current relevant literature. Mills cites face validation of her instrument by colleagues. One question I have in this area of the study is that of operational definitions of the categories for response. If such definitions were provided and validated by these colleagues, the reader can gain a greater sense of the validity and reliability of responses obtained from other colleagues, the deans and faculty members who were study subjects.

My reading of Mills's report suggested one additional measure of relationship which was projected but not reported, the use of a Mann-Whitney U-Test to determine the difference in ranking of priorities by deans and by newly oriented faculty members. A rough estimation from the text and the data in Tables 4 and 7 suggests that the difference would not be significant. Differences in perceived focus of content, depicted in Figures 1 and 2 are particularly interesting in the areas of academic, professional and community environments. Her results seem to suggest that the respondents were not receiving as much content in these areas as the deans perceived being provided. One wonders if this results from the information overload and self-concept problems discussed by Conway and Glass (1978).

I would raise only two additional questions in relation to the results and their implications. One question is that of wondering how the distribution of new faculty, the distribution of respondees and the perceptions of orientation might relate. Is there a richer orientation provided for one or two new faculty members or does a larger group serve as a stronger stimulus for planned orientation? Secondly, is there a need to address the proposal of staged orientation discussed by Conway and Glass (1978)? As one who had a careful, thorough and individualized orientation to a new position, I find myself still needing answers to questions which affect my role in a university school — perhaps I always will.

Conway, M. E., & Glass, L. G. Socialization for survival in the academic world. *Nursing Outlook*, 1978, *26*, 424-429.

ANALYSIS OF NURSES' VERBAL COMMUNICATION WITH PATIENTS

Darle Forrest

Nursing educators and practitioners recognize the importance of a nurse's ability to communicate effectively with patients (La Monica, 1979; Travelbee, 1971). The question is, do nurses employ the kinds of communicative behaviours believed by a number of researchers (Brammer, 1979; Carkhuff, 1969; Carkhuff & Berenson, 1977; Egan, 1975) to be therapeutic for patients?

Some kind of communication, verbal and/or nonverbal, occurs during every encounter a nurse has with a patient. "No matter how one may try, one cannot not communicate. Activity or inactivity, words or silence all have message value" (Watzlawick, Beavin, & Jackson, 1967, pp. 48-49). Maslow (1965) has pointed out that "every person is a psychotherapeutic influence or a psychopathogenic on everybody he has contact with . . ." (p. 77). Carkhuff and Berenson (1977) charge that the interactions between helpers and helpees have a "for better or for worse" effect upon the helpee (p. 5; p. 228). Accordingly, the communication of a nurse forms a vital component of patient care — for good or for ill. In defining therapeutic communication Rossiter (1975) suggests communication can be therapeutic for a patient in two ways: by eliciting "accurate" information which in turn affects patient care, and secondly, in and of itself, communication has health promoting effects.

While all aspects of nurse-patient communication are important, the present study is focused on an analysis of nurses' verbal behaviour with patients, particularly the verbal communication techniques that foster patient self-exploration. According to Egan (1975), patient self-exploration is the goal of the first stage of helping.

A literature search was conducted with the intent of locating nursing studies in which a verbal communication analysis system was developed and used to examine nurse-patient verbal communication. The search, covering the past six years, revealed four such studies. A review of these studies, in regard to both the system developed and the results of its use, is presented.

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Clark (1981) analyzed verbal behaviour of nurses in one-to-one nurse-patient interactions by coding (a) any instance of a direct question or indirect or implied question or cue from a patient and (b) any verbal behaviour which could be identified from a list developed by the author. The list of verbal behaviours consisted of those behaviours known to encourage or reinforce communication and those behaviours which might discourage or block the development of communication. The system was not an exhaustive one in that only those verbalizations were coded that were judged to fit the criteria. Clark reported few examples of nurses asking open questions or of active encouragement or reinforcement, very little evidence of the technique of reflection, and few examples of positive response to cues. There were "many instances of nurses asking closed and leading questions and also of missing or avoiding indirect questions or cues" (Clark, 1981, p. 15). The statistics on which these findings were based were unreported by Clark.

In a study to determine the verbal information patients receive from nursing students, Faulkner (1979) coded each piece of communication, defined as uninterrupted speech from one individual, of both nurse and patient according to categories relating to type of question, response to question, information offered, and so on. As interpreted by the author, the data indicated nursing students do not give information to patients and patients' questions are often ignored.

Beanlands and MacKay (1981) attempted to analyze affective verbal communication between nurse and patient by coding nurse responses into two broad components: those responses which indicated acceptance and those responses conveying a lack of acceptance or blocking communication. The classification system was comprised of eight defined categories. Communication behaviours listed as accepting accounted for 54 percent of the interactions while 46 percent of the interactions nurses conveyed to patients messages of nonacceptance.

A content analysis system whereby specific verbal communicative behaviours of nurses were measured was developed by Stetler (1977). Three broad categories consisting of positive, neutral, and negative verbal behaviours were devised with subcategories of behaviours created under each main category. The system was then used in a simulation study investigating the relationship between perceived empathy and nurses' communication.

In each of the studies reviewed, the content analysis system that was developed appeared to have limitations when applied to the analysis of verbal communicative behaviours of nurses in interactions focused on helping patients explore themselves and their problems. As a result

of the literature review, the first purpose of this study was construction of an analysis system to provide for the coding of verbal behaviours of the nurse, which were facilitating or blocking to patient self-exploration.

The second purpose of the study involved two parts: the use of the system by trained coders to code the verbal behaviours nurses used in videotaped interactions focused on helping patients self-explore; and an analysis of the particular verbal behaviours nurses used in these interactions, including a comparison between the amount of facilitating and blocking behaviours employed.

METHOD

Subjects

In a Post-R.N. class of 35 students, 31 agreed to participate in the study. They had at least one year of nursing experience and were enrolled in a Post-R.N. Bachelor of Science in Nursing program. Currently they were completing a required course in communication skills, which included an assignment of videotaping an interaction with a patient they had selected and who had consented to the taping. One nurse's videotape was disqualified because of sound problems. This reduced the sample to 30 nurses.

Materials

The videotape recording equipment and set-up allowed the operator to be in a different room from the nurse and patient. Videotaping also allowed for a clearer presentation of the interaction and hence more accurate coding.

Procedure

Each nurse and the selected patient participated in a 30 minute interaction which was videotaped. The use of therapeutic communication techniques which would encourage the patient's own self-exploration and problem-solving was the focus of the interaction for the nurse. The videotapes were later viewed by two trained coders who coded each verbalization of the nurse according to the communication analysis system constructed for this study.

Communication analysis system. The system was constructed by identifying from the literature those verbal behaviours perceived to facilitate or block patient self-exploration (Brammer, 1979; Concept Media; 1970; Egan, 1975; Eriksen, 1977; Stetler, 1977). Operational definitions and examples were provided for each behaviour. A panel of scholars reviewed the system, made suggestions, reviewed the

system again and judged it to be adequate. The categories of the communication analysis system constructed for the study consisted of the following:

Facilitating Verbal Behaviours

1. Broad opening statements/questions: allows patients to set the direction of the conversation and focuses the conversation on the patient. e.g., "You may have questions to ask me" or "where would you like to begin?"

2. General leads: encourages patient to continue by indicating interest and understanding of what patient is saying. e.g., "Go on" or "uh-huh".

3. Reflecting: all or part of the patient's statement is repeated or slightly rephrased to encourage continuation. e.g., Patient: "I don't know how I feel." Nurse: "You're not sure how you feel?"

4. Sharing observations: verbalizing perceptions with patient which may focus on patient's physical or emotional state and which invite patient to verify, correct or elaborate on nurse's observation. e.g., "I notice you turn away when I mention going home."

5. Acknowledging patient's feelings: acceptance of how the patient feels is conveyed irrespective of whether the nurse feels or thinks the same way; encourages patient to continue expressing feelings without a judgment placed on them. e.g., "You feel your doctor doesn't care about you."

6. Recognizing: acknowledging patient's presence. e.g., "Good morning, Mr. Smith."

7. Giving information: answers questions, dispels misconceptions, gives facts patient wants or needs to know; decreases anxiety and establishes trust. e.g., "Your wound is healing well."

8. Clarifying: nurse makes meaning clearer or requests patient to make meaning clearer; prevents ambiguity or misunderstanding and motivates patient to continue. e.g., "Do you mean . . ."

9. Verbalizing implied thoughts and/or feelings: nurse voices what patient has hinted or suggested rather than what has been said; helps patient to become more aware of thoughts and feelings and helps nurse to verify impressions. e.g., "It seems you are not sure about having the operation."

Blocking Verbal Behaviours

1. Reassuring clichés/stereotyped comments: trite comments given automatically and tending to convey to the patient nurse's disinterest or lack of understanding or own anxiety. e.g., "Everything will be fine."

2. Advising: taking over patient's decision-making by imposing own opinions and solutions rather than assisting patient to explore arriving at conclusions. e.g., "You should do this."

3. Approving/agreeing: comments and opinions which shift focus to nurse's values, standards or feelings, imposing on free expression from the patient. e.g., "It's good you are out of bed."

4. Requesting an explanation: asking patient to immediately analyze and explain feelings or actions; often involves "why" questions which can be intimidating to patient. e.g., "Why do you feel that way?"

5. Disapproving/disagreeing: negative judgment placed on patient's actions, thoughts, or feelings and introducing nurse's values which may intimidate patient, prompting conformity for nurse's approval. e.g., "It's not good for you to worry about that."

6. Belittling: indicating that patient's experiences are not unique or important; a shift of focus away from the patient. e.g., "This operation is nothing compared to major surgery - you're lucky."

7. Defending: protecting or making excuses for rather than allowing patient to express own opinions and feelings. e.g., "This hospital has a fine reputation."

8. Changing the subject: introducing a new or unrelated topic and taking the lead in the conversation from the patient who may not make a further attempt to make his needs known. e.g., Patient: "I'm tired this morning." Nurse: "It's a lovely day."

9. Closed questioning: focusing on "yes" or "no" questions which may limit patient's response and suggest nurse's quest for a specific answer. e.g., "Did you eat everything on your tray?"

Each verbalization of the nurse was coded. The coder chose the single subcategory or behaviour that best described the verbalization. Tonal cues as well as patient response were used in making the decision. The unit for coding was defined as a verbalization without pause. In the event of multiple statements or questions made by the nurse, the last question or statement verbalized was coded. Carkhuff and Berenson (1977) point out that clients generally respond to the last part of the helper's verbalization.

Training of coders. Training of the coders in the use of the analysis system was conducted by the author and included both formal sessions and independent study. Initially the coders were introduced to the analysis system and given detailed descriptions and examples of each verbal behaviour. Training videotapes of nurse-patient interac-

tion similar to the actual data were used for study and testing. When the coders proceeded to the actual data, 90 percent agreement in coding had been obtained on a test videotape.

Limitations

1. Only verbal communication of the nurses was examined in the study. The context of the nurse-patient interaction was specific, namely patient exploration of self and problem.

2. While content validation of the communication analysis system was provided, further validation of the system is necessary.

Analysis

Intercoder reliabilities on the actual data were determined using the following formula:

$$\text{Percentage Agreement} = \frac{\text{Agreed upon codings}}{\text{Agreed and disagreed}} \times 100$$

Three videotapes were randomly selected from the total of 30 and intercoder reliability was determined in regard to the two categories of facilitating and blocking behaviours. The 27 remaining videotapes were randomly and equally assigned to the two coders.

To assess the validity of individual coder competency, intracoder reliability was determined on three randomly selected tapes and calculated according to the formula above.

The percentage of occurrence of each verbal behaviour in the communication analysis system was calculated for the sample. As well, the percentage of facilitating and blocking verbal behaviours was determined for the sample.

RESULTS

Intercoder reliabilities on the actual data, reported in Table 1, show a range of 95.04 to 95.23 percent for the facilitating verbal behaviour category and a range of 62.50 to 90.47 percent for the blocking verbal behaviour category. A mean percentage of 87.66 on the communication analysis system represented a very adequate level of reliability.

Intracoder reliabilities ranged between 82.60 and 100 percent with a mean percentage of 96.11 for coder 1 and 87.45 for coder 2. These percentage agreements indicate individual coder consistency and competency.

Table 1

Intercoder Reliability for Facilitating and Blocking Verbal Behaviour Categories

Tape	Verbal behaviour	Number of codings Coder 1	Coder 2	Percent agreement
1	Facilitating	63	60	95.23
	Blocking	16	10	62.50
2	Facilitating	60	63	95.23
	Blocking	21	19	90.47
3	Facilitating	101	96	95.04
	Blocking	7	8	87.50

A percentage breakdown of each verbal behaviour, presented in Table 2, revealed that nearly 45 percent of all verbal behaviour of the 30 nurses consisted of general leads. Within that sub-category, the most frequent response by far was "uh-huh" which, while facilitating, represents a low level of verbal communicative skill. It was for this reason that a percentage breakdown excluding the general leads sub-category is also presented in Table 2. With this exclusion the most frequent verbal behaviour of the nurses became closed questioning, a blocking response, which comprised approximately 22 percent of the verbal behaviours. An analysis of the overall verbal behaviours of the nurses revealed that 80 percent were facilitating. With the exclusion of the general leads sub-category, 64 percent of the nurses' verbalizations were facilitating. One blocking verbal behaviour, defending, was not used by any of the nurses.

Table 2
Percentage of Verbal Behaviours With and Without General Leads Sub-category

Verbal behaviour	Percent	Percentage excluding sub-category
Facilitating		
General leads	44.77	—
Clarifying	10.22	18.51
Broad opening statements/questions	8.55	15.49
Giving information	5.53	10.02
Sharing observations	4.26	7.71
Reflecting	2.59	4.69
Recognizing	1.62	2.94
Verbalizing implied thoughts	1.39	2.52
Acknowledging feelings	1.31	2.38
Blocking		
Closed questioning	12.04	21.80
Advising	2.75	4.97
Approving/agreeing	2.16	3.92
Changing the subject	1.54	2.80
Requesting an explanation	0.81	1.47
Reassuring clichés	0.65	1.19
Expressing disapproval	0.27	0.49
Belittling	0.19	0.35
Defending	0.0	0.0

DISCUSSION

With either the inclusion or exclusion of the general leads sub-category, the nurses' verbal communication with patients was consistently more facilitating than blocking. These results, more positive than those of Beanlands and MacKay (1981) and Clark (1981), may be due to the skills acquired by the nurses in the current communication course and/or the use of a coding system which allowed for the coding of all verbal behaviours. Closed questioning, the most commonly used blocking behaviour by the nurses in this study and the use of few reflecting statements (less than 3 percent) were results consistant with Clark's findings.

The communication analysis system, which appears to be a reliable and workable system for coding nurses' verbal behaviours with patients, requires further validation. One method of validating the system could involve the use of an independent measure for comparison.

The system has potential usefulness as a tool for the assessment and development of nurses' verbal communication skills when the focus of the interaction is on patient self-exploration and problem-solving.

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RÉSUMÉ

Analyse de la communication verbale des infirmiers avec les malades

Cette étude est axée sur l'élaboration et la vérification d'un système d'analyse des communications qui permet le codage de la communication verbale entre infirmiers et malades. Trente et une infirmières qui terminaient un cours obligatoire en communication, ont consenti à se laisser filmer sur bande vidéo au cours d'une entrevue de 30 minutes avec un patient de leur choix. Deux codeurs qualifiés ont regardé les bandes vidéo et ont codé chacune des interventions des infirmières, les classant dans l'une des 18 catégories de comportements qui favorisent ou inhibent les rapports verbaux dans le système d'analyse des communications. Le test de fiabilité intercodeur et intracodeur donne des résultats de concordance de 87 et 91 pour cent respectivement. Les résultats ont révélé qu'environ 80 pour cent des comportements verbaux des infirmiers favorisaient les rapports et 20 pour cent étaient des interventions inhibitrices.

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DESCRIPTION DES RÉSISTANCES AU CHANGEMENT DANS UN PROJET D'AMÉLIORATION DE LA QUALITÉ DES SOINS INFIRMIERS

Fernande Hébert

Tout changement, qu'il soit planifié ou non, entraîne chez les individus des réactions de résistance (Klein, 1969), la résistance étant définie par Lewin (1975) comme une force qui empêche le système de changer. Ce phénomène a été observé lors de l'exécution d'activités planifiées à l'intérieur d'un projet de recherche visant la "Formation par l'évaluation de la qualité des soins infirmiers" (FEQSI)* dans un service de soins à domicile. La résistance des praticiens** a été diminuée grâce à des moyens prévus à cet effet dans le projet. Consécutivement, des modifications dans la pratique ont pu être observées. Le but de cet article est de décrire le projet de recherche FEQSI, les changements qu'il occasionne, la résistance rencontrée, et les moyens utilisés afin de favoriser les changements de comportement nursing.

LE PROJET FEQSI

Le projet FEQSI a été conçu à la suite d'une demande des membres de l'administration et des praticiens d'un département de santé communautaire (DSC) pour répondre aux besoins d'un programme de maintien à domicile. Ces besoins étaient en termes d'évaluation de la qualité des soins infirmiers dispensés d'une part et de formation en cours d'emploi d'autre part. La responsable de ce programme travaillait depuis déjà quelque temps avec les praticiens à l'élaboration de moyens visant l'amélioration des soins dispensés. Leurs efforts étaient concentrés surtout sur les aspects techniques des soins, et la participation à des conférences et à des cours offerts dans la région.

L'idée d'un projet qui définirait les critères de qualité avec lesquels les praticiens pourraient comparer leur pratique et par la suite apporter des actions correctrices afin d'améliorer cette pratique, fut accueillie favorablement par l'administration.

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*Ce projet est subventionné par le Ministère des Affaires sociales. Ce projet est sous la direction de l'auteur, avec la collaboration de E. Côté, J. Tremblay, S. Suissa, et C. Varin.

**Ce terme désigne les infirmières et les infirmiers.

L'introduction d'actions correctrices par les praticiens a été envisagée comme possibilité d'éducation continue. Des études suggèrent (King et Cheung, 1978) que les intervenants y gagnent davantage lorsque les actions correctrices proviennent d'eux-mêmes ou du groupe de pairs. Ce méchanisme a l'avantage de s'adresser simultanément au groupe et aux individus qui le composent, sans que l'on sorte du milieu habituel. Un autre avantage, c'est qu'il permet l'interfécondation de la pratique et de la théorie, dimension qu'il est difficile de vivre dans les cours offerts à l'extérieur du service.

Tenant compte de ces aspects et du fait que les soins infirmiers représentent le service le plus important quantitativement dans les programmes de maintien et de soins à domicile (Ministère des Affaires sociales, 1979), les chercheurs ont élaboré un projet de recherche visant l'objectif général suivant: Implanter et évaluer un programme d'assurance de qualité de soins infirmiers à domicile.

Le projet FEQSI est un projet de recherche quasi-expérimental s'échelonnant sur une période de trois ans, de janvier 1981 à décembre 1983. Ce devis est appliqué au sein de deux DSC où 30 praticiens dispensent des soins infirmiers à domicile. Les praticiens de ces deux DSC vivent l'expérience des activités du FEQSI à des moments différents de sorte que les deux groupes se servent mutuellement de contrôle (Cook et Campbell, 1976). L'expérience relatée dans cet article a été vécue par un de ces deux groupes de praticiens.

Le projet FEQSI favorise la formation des praticiens par l'évaluation des activités effectuées à l'intérieur du processus nursing et regroupe des activités similaires à celles que l'on retrouve dans le processus d'évaluation de la prescription médicale connu sous le nom de Révision de l'utilisation médicamenteuse (Stolar, 1979; Tremblay, 1979, 1981). Dans le projet FEQSI, nous retrouvons ces activités dans les trois étapes suivantes: 1) l'élaboration des critères de qualité; 2) l'évaluation de l'adhésion à ces critères; et 3) les séances collectives de rétroaction.

L'élaboration des critères de qualité fut effectuée à l'aide de la méthode Delphi, version modifiée par Tremblay (1979, 1981). Le but de la consultation auprès des praticiens était de valider les critères élaborés à partir de la littérature, en regard des soins dispensés à domicile, et d'obtenir un consensus quant à leur usage quotidien. L'élaboration de critères, *première étape du projet FEQSI*, a nécessité trois jours de consultation d'avril à juillet 1981. La responsable des soins à domicile organisa les horaires de façon à accorder aux praticiens le temps nécessaire pour remplir les questionnaires, soit deux heures et quart en moyenne pour chacun des trois jours de consultation.

La deuxième étape du projet FEQSI, l'évaluation de l'adhésion aux critères, comprend les activités suivantes: l'élaboration de nouvelles formules, l'observation de l'adhésion aux critères, et la rétroaction sur la pratique individuelle.

L'élaboration de nouvelles formules fut jugée nécessaire après l'analyse sommaire des formules utilisées dans le service. Cette analyse démontra que la majorité des critères de qualité élaborés ne faisait pas l'objet d'observation.

Les nouvelles formules sont au nombre de quatre: l'évaluation à l'admission, la note d'évolution, le plan de soins et les fiches de visite. Les trois premières formules sont une modification des formules déjà existantes. Les fiches de visite sont de nouvelles formules préparées par les chercheurs; elles furent présentées aux praticiens en septembre 1981 pour discussion et prétest, et acceptées un mois plus tard, après modifications quant à la formulation et à la présentation.

L'observation de l'adhésion aux critères de qualité sert à déceler des situations de non adhésion aux critères dans les formules remplies par les praticiens suite aux visites à domicile. Cette observation a commencé en février 1982 et se continuera jusqu'à octobre 1983, à raison d'une observation par mois.

La rétroaction sur la pratique individuelle se fait par un comité de révision par les pairs (CRP) à qui les chercheurs transmettent les résultats de l'observation mensuelle du dossier. Ce comité formé de trois praticiens est élu par le groupe à chaque mois. Le CRP est chargé de faire avec les praticiens une révision en profondeur des situations identifiées de non adhésion aux critères. Les rencontres d'un membre du CRP avec un praticien permettent de discuter des comportements potentiellement "déviants" et de proposer les actions correctrices. Les activités de révision par le CRP s'échelonnèrent de mars 1981 à septembre 1982.

La troisième étape du projet FEQSI est celle de l'organisation de séances collectives de rétroaction par le CRP auprès du groupe des praticiens. Durant ces séances, les membres du CRP prennent note des résultats positifs de l'analyse de la pratique collective et discutent avec les praticiens des situations les plus fréquentes de non adhésion aux critères. Ces séances renseignent les praticiens sur l'état de la pratique du groupe et leur permettent d'apporter des suggestions d'actions correctrices pour améliorer la qualité des soins. Durant les activités d'analyse et de rétroaction, les chercheurs agissent comme personnes ressources auprès du CRP et des praticiens afin de les aider à trouver

des solutions aux problèmes rencontrés. Les séances de rétroaction sur l'analyse de la pratique collective ont commencé en mai 1982 pour se terminer en octobre 1982 à raison d'une rencontre par mois. Ces séances constituent le changement pour cette étape.

Comme nous venons de le voir, plusieurs modifications aux pratiques établies ont été apportées au cours du projet FEQSI. Ces modifications provoquèrent de la résistance chez les praticiens, surtout l'introduction des nouvelles formules et en particulier celle des fiches de visite. Dans les prochains paragraphes nous décrirons quelles ont été les réactions et comment elles se sont manifestées.

LES RÉACTIONS DE RÉSISTANCE

Les réactions de résistance perçues chez les praticiens ont évolué selon un cycle semblable à celui que décrit Watson (1969). Ce dernier identifie cinq étapes à travers lesquelles évolue la résistance perçue lors de l'introduction d'une innovation. Au début du cycle, la résistance apparaît massive et non différenciée. Ensuite, les forces pour et contre le projet deviennent plus identifiables. Alors, la résistance s'organise afin de contrer l'implantation de l'innovation proposée. Après l'opposition qui marque cette troisième étape, les défenseurs du projet sont en majorité et la résistance qui persiste est alors perçue comme une nuisance tenace. Vers la fin du cycle, des activités d'implantation du changement apparaissent.

Au cours du projet, des étapes similaires ont pu être reconnues pendant lesquelles les praticiens ont exprimé leur résistance aux changements proposés, sous forme de réactions émotives, sociales et cognitives ou rationnelles (Klein, 1969; Lippitt, 1966; Schuman, 1972; Tessier, 1973; Watson, 1969).

Au début du projet, soit pendant la période d'élaboration des critères, quelques praticiens seulement ont pris le programme au sérieux. A ce moment, la résistance apparaissait non nuancée. C'est surtout durant la période de prétest et de discussion des nouvelles formules que les forces pour et contre le programme se sont davantage exprimées ouvertement. Cependant, ce sont surtout les opposants au projet qui se faisaient entendre. Cette réalité est exprimée dans une réflexion qui a circulé parmi les praticiens, "certains y tiennent à mort et pour d'autres c'est un cauchemar." Les réactions socio-émotives ont été les premières à se manifester; elles mettaient en cause les normes et les valeurs du groupe. Certains y voyaient une modification de leur pratique et une atteinte à leur autonomie; d'autres voyaient la partie évaluative du programme comme une menace. Plusieurs ont associé le projet FEQSI avec le système de gestion Projet de recherche en nursing

(PRN), instrument d'évaluation quantitative des soins infirmiers. Ce système est actuellement utilisé dans certains hôpitaux de la région et contesté dans d'autres milieux, dont le milieu à l'étude. Des praticiens portaient des macarons symbilisant le refus du système PRN. La majorité envisageait l'utilisation des nouvelles formules comme un surcroît de travail survenant dans la période de coupures budgétaires, période où les craintes de pertes d'effectifs infirmiers étaient grandes. Dans une telle atmosphère, les promoteurs d'une innovation peuvent être étiquetés comme des personnes visionnaires ou des personnes aux idées extravagantes (Klein, 1969). Une praticienne nous a ramené à sa réalité: "Si l'on s'interrogeait sur votre grand projet . . . . Parler de qualité quand on conteste la quantité." Des résistances intellectuelles sont aussi apparues. Des praticiens se sont opposés à l'emploi du modèle nursing d'Orem, au profit d'un autre modèle de soins infirmiers.

Le projet FEQSI qui proposait des changements, par exemple l'inclusion de nouvelles formules au dossier du bénéficiaire, était perçu comme une ingérence dans le travail de professionnels qui se percevaient comme compétents. La notion de changement entraîne l'abandon d'une chose à laquelle on croit et que l'on valorise. Le changement met en évidence l'inadéquation des comportements ou de la pratique actuelle avec la pratique souhaitée, conclusion que les individus sont naturellement portés à rejeter (Schein, 1969). Ces réactions de résistance coïncidant avec l'augmentation des admissions dans le service, déclenchèrent un mouvement de rejet du projet. Pendant ce temps, les réseaux de communication informels apparurent plus actifs que jamais. Les relations entre les praticiens et les chercheurs étaient difficiles. Un climat de méfiance régnait. Les opposants signifiaient aux défenseurs du projet qu'accepter celui-ci voulait dire trahir le groupe: "Vous êtes des 'scabs'." Ceux qui jugeaient le programme nécessaire trouvaient inconcevable tous les efforts que les opposants déployaient à écraser le projet. A certains moments cette situation de conflit fut perçue par des praticiens comme une situation dans laquelle les énergies étaient déployées pour gagner une cause plutôt que pour résoudre des problèmes, sentiment qui n'est pas rare dans ces situations (Klein, 1969). Cette période est donc critique car elle signifie la mort ou la survie d'un projet (Watson, 1969). La survie dépend alors des moyens employés pour faire face aux résistances. Nous y reviendrons lorsque nous décrirons ces moyens.

Après toutes ces difficultés nous nous retrouvons avec les défenseurs du programme qui sont en majorité. Ils ont accepté les nouvelles formules, se sont pliés à l'observation de l'adhésion aux critères de qualité, et ont participé à l'évaluation par les pairs des soins

dispensés, activités faisant partie de la deuxième étape du projet FEQSI (p.60). Durant cette période, le danger de volte-face demeure réel (Watson, 1969). Toute évidence d'échec peut mobiliser une opposition latente chez ceux qui semblent accepter le projet. L'alliance de ceux-ci avec les opposants pourrait suffire à renverser le projet. Toutefois, les défenseurs du projet entreprirent de nouvelles activités; ils consultèrent soit leurs pairs, soit les chercheurs en vue d'améliorer leurs comportements en relation avec les critères élaborés. Ces changements sont exprimés par une participante dans l'extrait suivant:

Prendre conscience
Sans perdre patience
Virer mon psy. dans tous les sens
Trouver mes torts
Péter les scores.

Les praticiens étaient curieux de savoir si les recommandations qu'ils avaient faites au sujet des nouvelles formules, au cours des rencontres avec le CRP, seraient prises en considération par les chercheurs.

Finalement, vers la fin du cycle de résistance, les adversaires sont moins nombreux qu'au début et moins nombreux aussi que les défenseurs du projet. Puisque cette période coïncide avec la dernière étape du projet — les séances collectives de rétroactions (p.60) — il y a de fortes chances que les forces en faveur du projet réussissent à influencer les derniers résistants. Nous nous retrouvons donc dans la situation où ceux pour lesquels le projet FEQSI était un cauchemar au début, deviennent maintenant les défenseurs de ce même projet. Comme le dit une participante:

Au nom du Pair
Et à vous tous intervenants
Qu'on se le dise dès maintenant
Je ne suis pas un correcteur
Je suis bien plus qu'un précurseur
Que vous cochiez ou omettiez
Je me retrouve sur le même pied
J'aurai un jour la qualité
Et du même coup la sainteté.

La résistance s'est manifestée tout au long des activités du projet FEQSI, mais surtout lors de l'introduction des nouvelles formules faisant partie du dossier des bénéficiaires. Les principes de changement tels qu'ils sont décrits par Lewin (1975) sont utiles pour expliquer le phénomène de résistance et les moyens que nous avons utilisés au cours de ce processus de changement.

Le niveau d'équilibre d'une organisation est maintenu par des forces incitatrices et des forces de résistance qui s'opposent entre elles (Lewin, 1975). Les forces incitatrices, qui peuvent être des objectifs à atteindre, sont des éléments de l'organisation qui vont dans la direction du changement, tandis que les forces de résistance, comme les peurs, empêchent le système de changer. Le déséquilibre entre ces forces produit le changement; changement qui selon Lewin est le passage d'un niveau d'équilibre à un autre. Ce passage s'effectue en trois étapes: la décristallisation, le déplacement de niveau, et la recristallisation. La décristallisation consiste à modifier le niveau de quasi-équilibre déjà existant dans les attitudes et les valeurs. On peut modifier ce niveau d'équilibre soit en exerçant des pressions en faveur du changement, soit en diminuant les forces de résistance, ou finalement en utilisant une combinaison de ces deux stratégies. En général, si la première stratégie est la seule employée, il se produit une augmentation de tension dans le système qui rend les employés plus fatigués et plus agressifs. Par contre, en diminuant les forces de résistance, il se produit un mouvement vers un changement plus durable et plus stable et ceci avec un minimum de stress. Un moyen suggéré par Lewin pour diminuer la résistance reliée aux normes du groupe en rapport avec une activité, serait l'emploi de procédures visant à minimiser la force de ces normes ou la perception que les individus en ont. Si les normes du groupe sont diminuées, la résistance qui est due à la relation entre l'individu et les normes est éliminée. Les activités de rétroaction organisées dans le projet FEQSI visent cet objectif. L'information transmise aux praticiens par le CRP les met en présence de ce qui se fait en réalité et ce qu'ils cherchent à défendre. Suite aux premières séances de rétroaction, plusieurs praticiens se sont engagés davantage dans les acticités du programme.

Des conflits peuvent survenir entre les individus durant le processus de changement et des rencontres sont nécessaires afin d'orienter les énergies. Des observations faites lors de l'emploi de certaines méthodes de formation (Fortin, 1973; Lewin, 1975) démontrent que des rencontres de sous-groupes sont souvent nécessaires afin d'éviter ces conflits. Plus le changement est accepté en petit groupe, plus les résistances diminuent entre les individus et le reste du groupe.

Des rencontres de tous les praticiens ont été organisées avant chacune des trois étapes du projet FEQSI dans le but d'expliquer le déroulement des activités et de demander leur participation. Lors de ces rencontres, les praticiens ont été mis au courant des moyens préconisés pour protéger leur intégrité professionnelle. Ces moyens leur furent expliqués en termes d'objectivité, de neutralité et de confidentialité (Tremblay, 1981). Entre autres, les practiciens étaient

assurés que la non conformité de leur pratique aux critères élaborés serait le seul motif de révision en profondeur de leur pratique; que l'activité d'évaluation ne favoriserait pas l'acquisition d'un pouvoir organisationnel ou individuel puisque le processus ne s'appliquerait qu'à ceux et celles qui feraient l'objet d'une révision de leur pratique. Et finalement, les praticiens étaient assurés de la même confidentialité qui existe entre un professionnel et son client et qu'aucune sanction ne pourrait être imposée pour la non adhésion aux critères.

Des réunions de groupe et de sous-groupe ont été nécessaires durant les activités de la deuxième étape du projet, période où les forces de résistance se manifestèrent le plus. Ces réunions ont fourni aux praticiens l'occasion d'exprimer leur opposition; ceux-ci étaient encouragés à apporter leurs arguments et étaient aidés à prendre position face aux changements proposés. Les résistances socio-émotives ou rationnelles furent écartées progressivement. Nous étions conscients à ce moment-là que les arguments en faveur du projet ne servaient qu'à augmenter la tension dans le groupe. Les rencontres de sous-groupe rassemblaient quatre ou cinq praticiens et un chercheur et portaient particulièrement sur l'utilisation des nouvelles formules et sur l'interprétation des critères. Les chercheurs se sont également rendus disponibles pour des consultations individuelles avec les praticiens qui le désiraient. Ceux-ci ont apprécié ces rencontres, non seulement parce qu'elles ont permis d'apporter des éclaircissements sur les nouvelles formules et de préciser les objectifs du projet, mais aussi parce qu'elles ont fourni l'occasion de mieux se connaître et d'échanger des idées sur les pratiques nursing.

Ces moyens ont eu pour effet de diminuer les résistances et de favoriser la décristallisation des attitudes. Une fois l'équilibre bouleversé et les individus motivés à changer, ceux-ci deviennent réceptifs et cherchent les informations nécessaires afin de modifier leur comportement. Ils décident d'expérimenter les changements suggérés, déplacent le niveau de leur pratique actuelle et connaissent une recristallisation qui maintient le niveau atteint. Les expériences mentionnées à la fin du cycle de résistance démontrent que les praticiens tentent de nouveaux comportements de pratique. Les observations mensuelles nous permettent actuellement de constater ces changements et nous permettront de vérifier si ces changements demeurent durables.

La permanence du changement est attribuée selon Lewin (1975) aux décisions prises en groupe et aux mesures mises en place dans le système pour renforcer la décision. Les décisions prises en groupe semblent avoir un effet "cristallisant" parce que, d'une part, l'individu a tendance à respecter la décision qu'il a prise et, d'autre part, parce

qu'il s'engage vis-à-vis des autres. Les séances collectives de rétroaction organisées par les pairs sont de nature à favoriser les décisions de groupe. L'utilisation des nouvelles formules au dossier et du plan de soins est une mesure de renforcement des décisions prises antérieurement.

CONCLUSION

Des forces de résistance se sont manifestées durant les trois étapes du projet FEQSI, surtout pendant la deuxième étape: l'évaluation de l'adhésion aux critères. Au cours de cette période, un changement majeur fut introduit: les nouvelles formules servant à évaluer l'adhésion aux critères de qualité de soins. Les phénomènes de résistance au changement sont fréquents au niveau tant de la pratique clinique que de la recherche en soins infirmiers. Il semble donc pertinent de mettre en relief les principes du changement et la théorie du champ de forces de Lewin qui furent utiles pour expliquer le phénomène de résistance et guider les chercheurs sur les moyens à utiliser pour diminuer les effets de la résistance.

Cette description souligne aussi l'importance de planifier en même temps que les stratégies nécessaires à l'implantation d'un nouveau projet, des mécanismes visant à diminuer le pouvoir des forces de résistance. Les activités de rétroaction individuelle et collective intégrées au projet FEQSI atteignaient cet objectif. De plus, une observation attentive de la dynamique du groupe au cours de l'implantation s'avère essentielle afin de discerner les oppositions latentes et de choisir des moyens appropriés pour diminuer ces oppositions. Dans le cas du FEQSI, les rencontres de groupe, de sous-groupe, la disponibilité sur place des chercheurs, surtout durant la deuxième étape, ont aidé à créer un climat de confiance. Ces moyens ont favorisé la motivation et l'action dans la direction du changement.

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ABSTRACT

Description of resistance to change in an experimental project to assure quality nursing in home care

This article describes an on-going continuing education project: "Formation par l'évaluation de la qualité des soins infirmiers" (FEQSI), the changes it seeks, the resistance observed and the strategies used to modify resistance. The project seeks to improve and assure quality nursing in home care. In the first stage of the project, the modified Delphi method was used with the nurse practitioners to validate criteria for assessing the quality of nursing in home care and to obtain group consensus on these criteria. Following this stage, changes in the procedures to record nursing were proposed to take the agreed-upon criteria into account. Of most importance was the development of a home visit check list.

After discussion and pretest of these procedures, modifications were made and agreement reached for their implementation on an experimental basis. This step was followed by verification by the research team using on-site observations to measure levels of adherence to the criteria. These results were then used by a committee elected by the practitioners in feedback sessions to the group. In spite of precautions to protect professional integrity, the practitioners developed emotional, social and intellectual resistance to the project. The dynamics of the resistance were evaluated and action in the form of small group consultation taken to minimize gaps in communication and understanding. By these measures, the research team was able to transform the resistance into support for the goals and methods of the project.

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