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The Status of Cancer Nursing Research in Canada

Comportements du couple âgé à domicile et stratégies d'intervention de l'infirmière centrées sur le système conjugal

The Teaching of Systematic Physical Assessment in Baccalaureate Nursing Programmes in Canada

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Pediatric Nurses' Perception of Pain Experienced by Children and Adults

Positive Effects of Education on Nursing Students Attitudes toward Death and Dying

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AN EDITORIAL

The time has come. It is not enough to be merely socially legitimate as a discipline. Nursing has always been so. It is time that a critical proportion of our membership meet the criteria of a science discipline. It is time that we identified our model or models of nursing research. Just as we are struggling to develop and manage the various models of nursing practice; just as we have had to struggle (and continue to do so) to demonstrate our legitimacy as a discipline of applied science, we will also struggle to articulate, validate and defend the model(s) of nursing research before review committees and our peers.

Use of a model or models of nursing research would increase the probability of our discipline's movement to explanation, prediction, and prescription in nursing science in terms of the major focus of attention of nursing practice. Model(s) of nursing research are not a denial of classic experimental investigation. Nor is it a rejection of cohort analysis of Epidemiology and quasi experimental designs born in Psychology. Particular methodological designs are shared by all (or nearly all) the health related disciplines. Rather, the point is how these designs are related to the mission of research that is nursing.

It is appropriate that a scholarly journal address the vehicle(s) as well as the method and content of the expansion of the discipline's horizons.

Marian McGee

ÉDITORIAL

Le moment est venu. La légitimité sociale des soins infirmiers en tant que discipline ne suffit plus. Cette légitimité n'a jamais été contestée. Il est temps désormais qu'une proportion critique de nos effectifs satisfasse aux critères d'une nouvelle discipline scientifique, les sciences infirmières. Il est temps d'identifier notre modèle ou nos modèles de recherche en sciences infirmières. Tout comme nous luttons pour mettre au point et mettre en oeuvre les différents modèles de pratique infirmière, tout comme nous avons dû lutter et continuons de lutter pour légitimer les sciences infirmières comme discipline scientifique appliquée, nous lutterons également pour énoncer clairement, valider et défendre le(s) modèle(s) de recherche en sciences infirmières auprès des comités d'étude et de nos collègues.

L'utilisation d'un ou de plusieurs modèles de recherche en sciences infirmières nous permettrait très probablement de faire évoluer les sciences infirmières et, par le biais de l'explication, de la probabilité et de la prescription de faire reconnaître les sciences infirmières comme discipline scientifique. Le(s) modèle(s) de recherche en sciences infirmières ne renie(nt) pas la méthode de recherche expérimentale classique. Il(s) ne rejette(nt) pas non plus l'analyse des cohortes de l'épidémiologie et les conceptions quasi expérimentales de la psychologie. Les conceptions méthodologiques particulières sont le fait de toutes les disciplines (ou presque) liées à la santé. Il s'agit plutôt de définir de quelle manière ces conceptions se rapportent à la mission de recherche de la profession d'infirmier(ère).

Il convient qu'une revue professionnelle se penche sur les moyens autant que sur les modalités d'élargissement des horizons de la discipline.

Marian McGee

THE STATUS OF CANCER NURSING RESEARCH IN CANADA

Lesley F. Degner

Over the past several decades nurses have demonstrated their commitment to the generation of knowledge which will improve both the long-term survival and the quality of life for people with cancer. As the medical specialty of oncology emerged in the 1950's, nurses became involved in the management of biomedical research. Their efforts were directed toward maintaining the integrity of the research design, given the constraints of the clinical setting, and to recruiting patients in an ethically sensitive manner. The psychosocial support provided by these research nurses to patients enrolled in particularly toxic therapeutic trials has probably reduced problems with attrition and subsequent evaluation of the therapeutic effectiveness of different treatment regimens.

The past decade has seen the development among nurses of another type of commitment to the scientific enterprise with the emergence of cancer *nursing* research. Clinicians and academics have identified priorities within this field of research (Oberst, 1978), and are generating an increasingly impressive body of literature (Grant and Padilla, 1983). Scientific inquiry in cancer nursing has tended to focus on the interactions between physical/biological processes and psychosocial responses and adaptations (Benoliel, 1983).

If Canadian nurses are to contribute to this scientific enterprise, it is essential that they have arenas within which they can compete for research funding. Two questions might be posed:

1. What types of cancer research are Canadian nurses currently conducting?

2. What funding sources are nurses approaching to support their research?

A decision was made to conduct a limited survey of Canadian nurses to determine the answers to these two questions.

Lesley Degner, R.N., Ph.D., is associate professor, School of Nursing, The University of Manitoba, Winnipeg.

Review of Literature

Benoliel (1983) traced the development of cancer nursing research within the United States. She identified three forces which have shaped this development. First, nursing's traditional interest in the care and comfort of people has defined the nature of investigations within the field of cancer nursing research. For example, many projects have studied the assessment of distress and discomfort associated with cancer and its treatment, as well as nursing interventions designed to alleviate this distress and discomfort. Second, the movement of large numbers of nurses into graduate study for clinical specialization introduced them to the process and methods of science. This education enabled nurses to frame questions of clinical interest so that they could become "researchable" problems. Third, the clinical experiences of cancer nurses have influenced the specific problems they have selected to study. Nursing observations of the difficulties experienced by patients and families have frequently provided the stimulus for establishing research programs.

Grant and Padilla (1983) recently reviewed studies published in the field of cancer nursing research since 1970. They found that the past three years have witnessed the most rapid growth of oncology nursing studies. Grant and Padilla reported the following distribution among the 275 nursing studies they reviewed:

1. The majority of all studies (148 or 54.2%) were classified under the concept of health-illness continuum, revealing an overall priority for research of clinical problems.

2. The second largest group of studies (92 or 33.4%) related to the individual and his family, with the largest cluster of studies related to psychosocial responses and nursing interventions.

3. Less frequent areas for cancer nursing research were the community and the environment (19 or 6.9%), and the health care system (15 or 5.4%).

Grant and Padilla recommended that the strong clinical emphasis in cancer nursing research continue.

Conceptual Framework

The framework for development of the survey questionnaire was provided by McCorkle and Lewis (1980). These investigators distinguished between nursing involvement in the conceptual stage and in the empiric stage of research. Nurses are frequently involved in the empiric stage of either biomedical or cancer nursing research in their familiar roles as data collectors. However, nursing involvement in the conceptual phase of research has been less conspicuous. This

issue is a significant one since the formulation of research questions is profoundly influenced by the professional background and academic preparation of the investigator. In this survey, a decision was made to focus on nurses as principal investigators involved in the conceptual phase of cancer nursing research.

The framework for analysis of the types of cancer nursing research ongoing in Canada was provided by Oberst (1978). She identified priorities for cancer nursing research using the Delphi technique. This technique elicits collective opinion or consensus through repeated individual questioning of persons knowledgeable in a particular area. A list of 1800 researchable items was generated from data supplied by an initial panel of 575 nurses. A final list of 101 items were ranked according to their impact on patient welfare and their value for practising nurses. The ten items Oberst ranked most highly with respect to their impact on patient welfare were selected as the primary framework for analyzing ongoing cancer nursing research in Canada.

The Survey Questionnaire

A simple two page questionnaire was designed to identify nurse principal investigators conducting research in which cancer patients and/or their caregivers were the subjects. The questionnaire requested a variety of information, including: names of co-investigators; academic degrees of principal and co-investigators; whether the research was being completed for a degree; and questions about funding sources. The title and abstract of the study was requested, as well as onset and projected completion dates of the research. The data base generated by this questionnaire was judged to be sufficient to make preliminary statements about the status of cancer nursing research in Canada.

Methods

During the summer of 1983, the survey questionnaire was mailed to all cancer centers, University Schools of Nursing, and Victorian Order of Nurses (V.O.N.) agencies in Canada. A total of 121 institutions were surveyed, with an overall response rate of 42.9 per cent (see Table 1). However, response rates for schools of nursing (at 60 per cent) and cancer institutes (at 64 per cent) were considerably higher. All questionnaires returned prior to October 1, 1983, were included in this analysis.

Data Analysis

A total of 32 or 61.5 per cent of responding institutions returned questionnaires uncompleted because they were not currently conducting cancer nursing research (see Table 2).

Table 1

Cancer Nursing Research Questionnaire

Returns by Type of Institution

Institution type	Questionnaires sent	Questionnaires returned
V.O.N.	71	21 (29.6%)[a]
Schools of Nursing	25	15 (60%)
Cancer Centers	25	16 (64%)
Totals	121	52 (42.9%)

[a]Row per cent

Table 2

Cancer Nursing Research Projects

Identified by Type of Institution

Institution Type	Ongoing Research		Number of Projects
	No	Yes	
V.O.N.	19	2	2
Schools of Nursing	5	10	22
Cancer Centers	8	8	16
Totals	32	20	40

The greatest level of research activity (on both an institutional and per project basis) was in schools of nursing with 10 schools reporting at least one ongoing project in cancer nursing research. Fifteen projects submitted by cancer centers were omitted from the analysis because 10 were biomedical in nature and 5 were completed prior to 1983.

The remaining 40 projects were categorized according to Oberst's framework using their titles and, where available, study abstracts. The following categorization sequence was implemented. First, an attempt was made to categorize each project into one of the ten research items ranked as having the highest "impact on patient welfare". If this categorization failed, an attempt was made to classify the project into one of the ten research items ranked as having the highest "value for practicing nurses". If this categorization failed, an attempt was made to generate a category name appropriate to the research project. A total of 36 of the 40 projects could be categorized using this system.

Table 3

Cancer Nursing Research Projects Categorized by Oberst's Priorities for "Impact on Patient Welfare"

Item	Schools of Nursing	Cancer Centers	V.O.N.
3. Establish discharge planning and follow up programs	5	0	0
4. Identify nursing interventions which assist patients and families to cope with grief	1	0	0
5. Find effective ways to prevent and/or treat stomatitis	0	1	1
7. Delineate modifications in physical plant, nursing care program, and policy which promote comfort and dignity for the dying	2	1	1
9. Develop more effective methods of psychological support for patients and families	9	0	0
10. Clarify the dying person's rights to make decisions about his health care	1	0	0
Totals	18	2	2

The distribution of ongoing projects in cancer nursing research by Oberst's priorities for impact on patient welfare is illustrated in Table 3. The single most frequent category for study is "develop more effective methods of psychological support for patients and families at various stages of diagnosis and cancer treatment". The second most frequent category is "establish discharge planning and follow up which effectively mobilize patient, family and community resources". All of these studies are occurring in schools of nursing. While 18 of the 22 school of nursing projects could be classified according to Oberst's primary framework, only three of the 16 cancer center projects could be so classified. Table 4 illustrates projects identified by Oberst as having the highest value for practising nurses.

Table 4

Cancer Nursing Research Projects Categorized by Oberst's Priorities for "Value for Practising Nurses"

Item	Schools of Nursing	Cancer Centers	V.O.N.
1. Assess the psychological impact on the nurse of sustained exposure to the problems which cancer imposes upon patients and families and develop appropriate emotional support systems for staff	0	1	0
2. Establish effective educational and support systems to assist nurses in planning care for the dying and in coping with their own feelings of grief, loss, and frustration	1	0	0
3. Identify and determine the best approach to meeting specific learning needs of nurses in various settings regarding the nature of cancer, major treatment modalities, and specific nursing techniques	0	1	0
Totals	1	2	0

Only three studies were classified according to this framework. The majority of studies being conducted within cancer centers required additional categories to facilitate their classification (see Table 5). The two categories most frequently identified in projects being conducted within cancer centers were: "determine effects of patient education materials/methods"; and, "assess quality of life of cancer patients".

Table 5

Cancer Nursing Research Projects
by Additional Categories

Item	Schools of Nursing	Cancer Centers	V.O.N.
Determine effects of patient education materials and methods	1	3	0
Assess quality of life in cancer patients	0	3	0
Determine the effectiveness of relaxation therapy	0	2	0
Survey staff attitudes	0	2	0
Other	1	2	1
Totals	2	12	1

Of the 40 projects analyzed in this survey, 17 were supported by funding in addition to the salaries of the principal investigators. Table 6 illustrates the sources of funding by type of institution. The provincial research boards of the four western provinces have been the most frequent sources of funding for cancer nursing research, with approximately $160,000 allocated to ongoing projects during the past two years. Two nurse respondents indicated that they had been unsuccessful in obtaining funding in a National Cancer Institute of Canada competition.

Table 6

Sources of Funding for Cancer Nursing Research Projects by Type of Institution

Sources of Funding	Schools of Nursing	Cancer Centers
Provincial Research Boards	3 (3)[a]	3
University Research Boards	3	0
National Health Research and Development Program	3	0
Local Cancer Institute	1	0
Local Foundation	1	0
Totals	11 (3)[a]	3

[a]Funds applied for but not yet granted.

Thirteen of the 40 projects analyzed were being conducted to satisfy requirements for a degree. Three of these projects had received external funding, while 10 had not. Projects which were not being conducted to satisfy the requirements for a degree had nurse principal investigators who were, for the most part, prepared with Master's degrees.

Discussion

The findings of this survey must be examined in light of the low overall response rate to the questionnaire (42.9 per cent). Because institutions not involved in cancer nursing research were considered to be less likely to return the questionnaire unanswered, the findings may under-represent the number of cancer nursing research projects ongoing in Canada. Institutions other than those surveyed, such as hospitals and psychiatric institutes, may also be initiating cancer nursing research. However, the 40 projects identified in this survey provide a starting point for understanding the developing field of cancer nursing research in Canada.

The major institutional settings in which cancer nursing research is being conducted in this country are university schools of nursing. Not surprisingly, these nurse principal investigators are conducting research on types of psychological support for cancer patients, and on

discharge and followup programs for patients in the community. Studies on clinical problems of more immediate relevance to clinic nurses are noticeable through their absence. No studies were identified in areas highest ranked by Oberst and relating to relief of nausea and vomiting and relief of pain. Until nursing research within cancer centers becomes a more frequent phenomenon, it is unlikely that this type of research will be developed with a nursing conceptual framework.

The emphasis within cancer centers is on development of patient education methods and materials, and on assessment of the quality of life of cancer patients. Other studies relate to the relief of stomatitis, the evaluation of the effectiveness of relaxation therapy as a nursing intervention, and surveys of staff attitudes. Perhaps because of the variety of pressing clinical problems perceived by the nurse principal investigators, the nursing research being conducted within cancer centers was less focussed on only a few categories of research.

Most cancer nursing research is not externally funded. Nurses are being successful in obtaining funding from the western provincial research boards, with additional support coming from university research boards and the National Health Research and Development Program. The fact that few nurse principal investigators are prepared at the doctoral level is probably a disadvantage in seeking national funding.

Recommendations

A number of general recommendations for the development of the field of cancer nursing research are found in the literature. These include:

1. The development of sound conceptual frameworks which are relevant to practice and integrated from a variety of related disciplines (McCorkle & Lewis, 1980).

2. The development of more rigorous designs that have validity, generalizability, sensitivity and efficiency (Grant & Padilla, 1983).

3. The development of programatic research (Degner, 1983).

4. The development of collaborative research efforts (Hilkemeyer, 1982).

Implementation of each of these recommendations is of critical importance to the development of cancer nursing research in Canada. As increasing numbers of Canadian nurses are prepared with doctoral degrees, the opportunities for joint appointments between schools of nursing and cancer centers should be pursued to facilitate the develop-

ment of research proposals with the greatest impact on patient welfare and the greatest value for practising nurses. The formation of a collaborative cancer nursing research group at the national level would also facilitate this process.

Summary

This survey of the status of cancer nursing research in Canada has revealed a small number of ongoing studies. These studies were analyzed and categorized using Oberst's (1978) framework for research which is identified as having the highest impact on patient welfare. Current sources of funding for cancer nursing research were discussed, and recommendations for future directions within Canada were formulated.

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RÉSUMÉ

L'état de la recherche infirmière sur le cancer au Canada

Les infirmières participent à la réalisation de la recherche biomédicale sur le cancer depuis plusieurs décennies, mais le domaine de recherche *infirmière* sur le cancer est récent. Un sondage a été effectué auprès des écoles de sciences infirmières au sein des universités, des centres de recherche sur le cancer et des agences d'infirmières visiteuses afin de déterminer le type de recherche infirmière sur le cancer en cours au Canada et de savoir quelles en sont les sources de financement. Ces travaux ont été réalisés auprès de 121 établissements et le taux de réponse globale a été de 42,9%. Le plus haut niveau d'activité de recherche a été observé au sein des écoles de sciences infirmières. Les 40 projets signalés ont été analysés à l'aide de l'échelle d'Oberst, les priorités de la recherche infirmière sur le cancer. Les catégories le plus souvent identifiées ont été "élaborer des méthodes plus efficaces d'appui psychologique" et "établir des programmes relatifs aux congés des malades." Dix-sept des quarante projets ont été subventionnés par des sources extérieures. Des recommandations au sujet du développement du domaine de la recherche infirmière sur le cancer au Canada font l'objet d'une discussion.

COMPORTEMENTS DU COUPLE ÂGÉ À DOMICILE ET STRATÉGIES D'INTERVENTION DE L'INFIRMIÈRE CENTRÉES SUR LE SYSTÈME CONJUGAL

Francine Ducharme

Problématique

De nombreuses préoccupations sont à l'origine de cette étude. Parmi celles-ci se retrouve d'abord la tendance, dans notre système de distribution des soins, au maintien à domicile des personnes âgées. Face à cette situation et devant un vieillissement incontesté de la population, l'infirmière oeuvrant à domicile, se retrouve de plus en plus confrontée avec des adultes âgés dans son travail quotidien. De plus, les données statistiques révèlent au Canada une proportion croissante de personnes âgées habitant à domicile avec leur conjoint. L'importance de ce nombre de couples âgés amène l'infirmière, bien souvent, à intervenir non seulement auprès d'un individu vieillissant affecté par des problèmes de santé mais également auprès d'un système conjugal affecté, d'une part, par son vieillissement, et d'autre part, par ses problèmes de santé. Or, les données factuelles et les recherches concernant la dynamique de ces couples vieillissants sont toutes fins utiles inexistantes. Enfin, des difficultés observées chez l'infirmière à tenir compte dans son intervention à domicile de l'interaction existant entre des conjoints faisant partie d'un système conjugal en processus d'adaptation fut l'une des contestations importantes qui contribua à la réalisation de ce projet d'exploration des comportements des couples âgés et à l'élaboration de stratégies d'intervention de l'infirmière centrées sur le système conjugal.

Théoriquement, l'infirmière possède un rôle qui lui est reconnu auprès de la famille et de ses sous-systèmes. Néanmoins, en pratique, elle dispose de peu d'informations concernant la situation du système conjugal vieillissant et conséquemment, de peu d'outils d'intervention.

Francine Ducharme, inf., M.Sc., est professeur adjoint, Faculté des sciences infirmières, Université de Montréal.

Suite à ces considérations, deux buts se dégageaient de l'étude soit celui d'explorer la situation de vie du couple âgé habitant à domicile affecté par des problèmes de santé et celui d'élaborer, suite aux résultats obtenus, une forme d'intervention de l'infirmière centrée sur le couple en tant que système conjugal.

Orientation théorique

L'orientation théorique de l'étude a principalement témoigné des aspects relatifs au système conjugal ainsi que des effets du processus de vieillissement et des problèmes de santé sur l'adaptation individuelle et conjugale.

Approche systémique

La théorie générale des systèmes de von Bertalanffy (1955), les travaux de Watzlawick, Helmick-Beavin et Jackson (1972) sur la communication, ceux de Minuchin (1979), de Satir (1971) et de Guttman (1977) sur le système familial ont particulièrement inspiré l'étude en ce qui concerne l'approche systémique de l'infirmière auprès du couple âgé.

Il est en effet possible d'appliquer les concepts de base de la théorie générale des systèmes définie par von Bertalanffy à l'étude des phénomènes interactionnels du couple et de la famille. Le couple, en tant que système social vivant, constitue un système ouvert en ce sens qu'il réagit à un échange constant de matière, d'énergie et d'information avec son environnement et est caractérisé par les propriétés de totalité, son corollaire étant la non-sommativité, de rétroaction et d'équifinalité.

Guttman, en se basant sur les travaux d'Epstein, Sigall et Rakoff (1968) et de Minuchin (1979) a décrit les fonctions sociales, socio-psychologiques et psychologiques du système familial. Les fonctions sociales retenues dans cette étude ont été principalement la capacité du couple à identifier et à solutionner ses problèmes instrumentaux et affectifs et la distribution des rôles entre conjoints, rôles pouvant être également qualifiés d'instrumentaux et affectifs. Parmi les fonctions socio-psychologiques, la capacité d'expression des émotions et des sentiments de bien-être tels la tendresse et l'amour, et des sentiments d'urgence tels la rage, la peur, la colère et la solitude fut retenue. Quant aux fonctions psychologiques, le respect de l'individualité et de l'intégrité de chacun des membres du système conjugal fut privilégié.

Finalement, dans le but de répondre à ses multiples fonctions, le système conjugal doit être structuré, et Minuchin (1979) mentionne que la structure familiale est le réseau indivisible d'exigences fonction-

nelles qui organise la façon dont les membres de la famille interagissent. L'organisation du système en sous-systèmes, la délimitation des sous-systèmes à l'aide de frontières, l'exercice du pouvoir et les règles régissant les modes de transactions entre les membres sont tous des éléments de la structure conjugale qui furent considérés dans la présente étude.

Adaptation au vieillissement

En ce qui concerne le vieillissement conjugal, le concept d'adaptation aux pertes bio-psycho-sociales fut privilégié dans cette recherche.

Dans une perspective systémique, Watzlawick et al. (1972) soulignent clairement que toutes les pertes affectent la dynamique conjugale lorsqu'ils affirment que les liens qui unissent les éléments du système sont si étroits qu'une modification de l'un des éléments entraîne une modification de tous les autres. Ainsi, suite à une recherche sur l'impact des problèmes de santé d'un client sur son conjoint, Klein, Dean et Bogdonoff (1967) ont découvert que les niveaux de symptômes et de tensions interpersonnelles augmentent chez le client manifestant des problèmes de santé et également chez son conjoint.

Deutscher et Cavan (1974) précisent que de nombreux changements hors du contrôle des époux s'effectuent à partir de l'âge moyen. Parmi ces changements se retrouvent principalement, selon Peterson (1970), le départ des enfants et la retraite. Cet auteur parle de périodes d'adaptation cruciales où temps, énergie et rôles doivent être réorientés. Pour Plamondon et Plamondon (1980), une transformation des pratiques de communication au sein du couple doit s'opérer lors de la mise à la retraite. Enfin, Bier (1974) affirme que le défi du couple âgé réside dans l'affrontement des pertes accompagnant le vieillissement, dans l'accomplissement de tâches de développement correspondant à cette période de la vie et dans la redéfinition constante des relations mutuelles dans le but de faire face aux changements internes et externes. Au terme de cette phase, Mucchielli (1973) souligne qu'il y a possibilité de crise suite au bilan des années écoulées ou fuite devant le vieillissement commun.

Intervention de l'infirmière

Pour ce qui est de la deuxième partie de cette étude soit celle de l'élaboration d'une intervention centrée sur le système conjugal, l'orientation théorique a d'abord témoigné des notions inhérentes à toute intervention de l'infirmière auprès des personnes âgées. Les conditions d'apprentissage essentielles à la personne âgée telles que des tâches significatives tenant compte des expériences antérieures, la clarté et la concrétisation des informations, un vocabulaire adapté, un

rythme lent, une augmentation du stimulus auditif, la proximité physique, un environnement calme, la formulation d'objectifs, conditions mentionnées entre autres par Woodruff et Walsh (1975) et Burnside (1976) furent donc d'importants points de départ pour l'élaboration de l'intervention.

En ce qui a trait plus précisément au système conjugal, des notions concernant l'apprentissage ont également été considérées. Minuchin (1979), mentionne que le seul fait d'entrer comme intervenant auprès du système produit un changement donc une occasion d'apprentissage; en facilitant l'usage d'autres modalités de transaction entre les membres du système, il est possible d'offrir de nouvelles conditions de vie.

Modèle conceptuel

Par ailleurs, toute l'étude s'est inspirée d'un cadre de référence propre à la profession infirmière soit du modèle conceptuel de Callista Roy (1976). A partir de la théorie du niveau d'adaptation d'Helson (Adaptation Level Theory, 1964), Roy a développé son modèle dans lequel l'adaptation est définie comme étant une réponse positive de l'homme à son environnement changeant. Roy voit l'homme comme un être bio-psycho-social qui répond selon quatre modes aux stimuli auxquels il doit faire face, soit les modes physiologique, concept de soi, fonction de rôle et interdépendance. Le mode physiologique est fondé sur le besoin d'intégrité biologique de l'homme et comprend les besoins physiologiques de base. Le mode concept de soi repose sur le besoin d'intégrité psychique et comprend le soi physique et le soi personnel. Le mode fonction de rôle repose sur le besoin qu'a l'homme de savoir ce que les autres attendent de lui dans ses divers rôles afin de pouvoir agir. Enfin, le mode interdépendance se réfère au besoin de réalisation de soi, au besoin d'être aimé et d'être lié aux autres ainsi qu'à celui d'être autonome. Les modes fonction de rôle et interdépendance visent à maintenir l'intégrité sociale de l'individu. Enfin, selon Roy, une réponse positive aux stimuli constitue un comportement adapté et contribue à conserver l'intégrité bio-psycho-sociale de l'individu.

Dans l'optique de Roy, l'infirmière est un agent d'adaptation en regard des quatres modes du client et le but de la profession est de faciliter l'adaptation relativement à la dimension santé-maladie. L'intervention de l'infirmière consiste donc à manipuler les stimuli auxquels l'homme est exposé en les augmentant, diminuant ou maintenant dans le but d'obtenir des comportements adaptés maintenant l'intégrité bio-psycho-sociale.

Ces aspects de l'orientation théorique s'avéraient très importants, les questions de recherche, la méthodologie et l'ensemble des résultats étant teintés particulièrement de cette conception des soins infirmiers de même que des notions théoriques reliées aux systèmes d'interaction.

Ainsi, les principales questions de recherche étaient les suivantes:
- quels sont les comportements adaptés et non adaptés des couples âgés?
- quels sont les stimuli qui peuvent contribuer à ces comportements?
- quelles stratégies d'intervention centrées sur le couple peuvent être utilisées par l'infirmière suite à l'identification de ces comportements et stimuli?

Les comportements adaptés et non adaptés des couples âgés ont été définis respectivement dans cette étude comme des réponses ou réactions observées chez l'individu ou le couple ou rapportées par l'individu ou par le couple conservant ou ne conservant pas l'intégrité bio-psycho-sociale de l'individu ou l'intégrité du système conjugal. Quant aux stimuli, ces derniers ont été définis comme des facteurs dans l'environnement interne ou externe contribuant à un ou des comportements.

Méthodologie

Instruments

Afin de recueillir des données sur la situation de vie des couples âgés en dégageant les comportements adaptés, non adaptés ainsi que les stimuli pouvant contribuer à ces comportements, une entrevue-questionnaire composée de 65 questions ouvertes et fermées et structurée en fonction des quatre modes d'adaptation de Roy (1976) fut élaborée. Les avis de cinq juges compétents permirent d'assurer la validité nominale de l'instrument. Quant à la validité de contenu, les observations cliniques, les écrits théoriques ainsi que certains questionnaires déjà élaborés dans des recherches utilisant le modèle de Roy (Farkas, 1980; Richard, 1980) ou portant sur le système familial (Roberts, 1979; Robidoux, 1978) permirent de construire le contenu de l'entrevue-questionnaire.

En ce qui concerne l'intervention de l'infirmière centrée sur le couple, celle-ci fut élaborée et appliquée à partir d'un guide constitué de stratégies d'intervention. La validité de ce guide vient principalement du fait que ce dernier est issu directement de l'analyse des données et donc basé sur les résultats dégagés lors de la première étape de l'étude. Par ailleurs, le contenu du guide a été élaboré à partir des écrits reliés au processus de vieillissement et au fonctionnement du couple ainsi qu'à l'expérience de l'auteur. La troisième étape permettant d'assurer

la validité du guide a consisté en l'application de ce quide auprès de couples âgés. De plus, un questionnaire permit de recueillir la perception des conjoints sur le contenu de l'intervention.

Milieu et sujets

Les sujets furent sélectionnés parmi la clientèle d'un programme de visites préventives en vigueur au sein d'un Département de santé communautaire (D.S.C.) d'un centre hospitalier universitaire de la région de Montréal. Les critères d'inclusion des sujets pour l'entrevue-questionnaire étaient les suivants:

- couple habitant à domicile;
- conjoints ayant entre 70 et 80 ans;
- au moins un des conjoints présentant un problème de santé, c'est-à-dire une limite ou une incapacité d'ordre physique ou psychologique excluant les états grabataires et de confusion;
- niveau socio-économique moyen.

Tableau 1

Tableau synthèse des caractéristiques des sujets

N = 20 couples — 40 sujets

Moyenne d'âge: N = 40	75.6			
Nombre moyen d'années de mariage — N = 20	46.7			
Degré de scolarisation N = 40	Primaire Collégial	:11 :13	Secondaire Universitaire	:14 : 2
Source de revenus N = 20	Pensions du gouvernement Pensions et revenus de placements			:11 : 9
Types d'habitation N = 20	H.L.M. Logement	: 3 :11	Appartment Maison unifamiliale	:3 :3
Problèmes de santé N = 40	Problèmes de mobilité articulaire Problèmes circulatoires et cardiaques Problèmes pulmonaires Problèmes d'ordre émotif			:12 :16 : 4 : 7
Services reçu à domicile N = 20	Aide à domicile Soins à domicile	:4 :2		

Vingt couples furent sélectionnés pour cette première étape de l'étude. En ce qui concerne la deuxième partie de l'étude ou, plus précisément, l'application du guide d'intervention, quatre couples parmi les vingt interviewés furent retenus. Par souci d'éthique, les couples manifestant les difficultés d'adaptation les plus importantes furent choisis pour l'intervention. De plus, tous les couples furent assurés de la protection de leur identité et de la confidentialité de leurs réponses à l'entrevue-questionnaire. Le tableau 1 met en évidence les principales caractéristiques des sujets.

Déroulement de l'expérience

Les entrevues-questionnaires visant à recueillir les données concernant la situation de vie des couples âgés s'effectuèrent au moyen de rencontres de 90 à 120 minutes chacune, au domicile des couples sélectionnés. Les couples étaient avisés de façon protocolaire par téléphone de la visite de l'infirmière. Une fois ces entrevues terminées, l'analyse des données fut effectuée et le guide d'intervention complété. L'application du guide se réalisa à raison d'une visite de 90 minutes par semaine pendant cinq semaines consécutives au domicile des quatre couples choisis ayant accepté de participer à l'expérience.

Résultats

Entrevue-questionnaire

A partir des données brutes issues des 65 questions de l'entrevue-questionnaire, trois juges ont identifié les comportements adaptés et non adaptés des couples ainsi que les principaux stimuli ou facteurs pouvant contribuer à ces comportements.

Le processus de classification des comportements en comportements adaptés ou non adaptés ainsi que la détermination des stimuli furent effectués en fonction de critères précis, soit les suivants:

- les connaissances actuelles sur le processus de vieillissement et le fonctionnement du couple;
- le respect de la perception des couples;
- le jugement clinique des consultants quant à l'importance et à la fréquence des réponses obtenues à l'entrevue-questionnaire ainsi qu'aux facteurs pouvant être reliés aux comportements déterminés;
- une analyse de l'ensemble des données en fonction des stimuli pouvant contribuer aux comportements;
- les possibilités d'intervention de l'infirmière pour solutionner le problème;
- les comportements adaptés ou non adaptés déjà relevés dans les écrits de Callista Roy (Riehl & Roy, 1980; Roy, 1976) et dans une

recherche sur l'opérationnalisation du modèle de Roy auprès des personnes âgées en institution (Lévesque, 1980).

Le tableau 2 représente les divers comportements adaptés des couples âgés identifiés par les juges. Ces comportements sont subdivisés d'après différents éléments du fonctionnement du système conjugal.

De façon générale, très peu de comportements adaptés ont été dégagés chez les couples âgés à partir des critères déjà mentionnés. Ainsi, en regard des rôles, il apparaît évident à la lumière de l'analyse des données brutes que la gratuité des gestes et le sentiment d'utilité créés par le rôle parental apparaissent très significatifs. Néanmoins, en ce qui concerne les prises de décisions, les couples se considèrent autonomes et peu influencés par les divers agents extérieurs y compris

Tableau 2

Comportements adaptés des couples

N = 20

COMPORTEMENTS
Rôles:
— Privilégient les rôles de parents et de grands-parents
Communication:
— Expriment des émotions et des sentiments envers les enfants et les petits-enfants
Prise de décision-résolution de problèmes:
— Face aux influences extérieures, se considèrent autonomes en tant que couple dans leur prise de décision
— Se consultent lorsqu'il s'agit d'importants problèmes
Individualité:
— Privilégient autonomie et initiative de chacun de façon très marquée. Respectent l'individualité
Sécurité physique:
— Se disent en sécurité dans leur domicile

les enfants. Ils s'accordent pour affirmer que les décisions doivent être prises au sein de leur domicile. De plus, une consultation semble s'effectuer entre les conjoints lorsqu'il s'agit d'importantes décisions telles qu'un déménagement ou un placement éventuel.

Un des comportements prédominants découvert au moment de cette étude fut le respect très marqué de l'individualité des conjoints au sein des couples. Chaque conjoint rapporte qu'il vaque à des activités autonomes avec peu de contraintes exercées par le partenaire. En dernier lieu, il est indispensable de mentionner que malgré leurs problèmes de santé et leurs difficultés quotidiennes, les couples âgés se perçoivent en sécurité physique et désirent demeurer au sein de leur domicile.

Le tableau 3, également subdivisé d'après différentes fonctions du système conjugal, collige les comportements non adaptés des couples âgés. Il est intéressant de souligner qu'un grand nombre de comportements non adaptés a pu être dégagé. Une absence de souplesse est d'abord remarquée dans la distribution des rôles. Une importance démesurée est accordée aux rôles instrumentaux traditionnels. Les conjoints étant surtout engagés dans des relations complémentaires et très rarement dans des relations symétriques, la substitution des rôles perdus, suite à la retraite ou aux problèmes de santé, par de nouveaux rôles adaptés à la vie quotidienne, est vécue très difficilement par les conjoints. Par ailleurs, le respect de l'individualité se manifeste souvent à un point tel que les conjoints expriment être peu engagés en tant que couple. Ces derniers disent avoir peu d'intérêts, d'activités ou de projets en commun.

En ce qui concerne le processus de prise de décision, il apparaît clairement que les couples identifient avec plus de difficulté les problèmes d'ordre affectif et concentrent leur attention sur le plan instrumental. De plus, les conjoints avouent faire peu de compromis lors de la résolution de problèmes quotidiens. Les décisions sont fréquemment prises par un seul des deux conjoints et, très souvent, l'épouse avoue être maître de ces décisions.

De façon générale, il est possible de dire que les couples perçoivent leur système conjugal de façon négative. Ces derniers ont effectivement manifesté beaucoup de difficultés à témoigner des aspects positifs et enrichissants de la vie commune au moment de l'entrevue-questionnaire. Les données recueillies démontrent également un manque d'intérêt à communiquer entre les conjoints et les déficiences sensorielles sont abondamment utilisées par les couples comme prétexte à cette pauvreté de communication. Les conjoints justifient aussi leurs difficultés dans leur relation par leur état de santé qui se détériore

graduellement et leur âge avancé. Globalement il est constaté que les couples manifestent énormément de difficulté à parler de leur relation et de leur communication et, par conséquent, ont de la difficulté à métacommuniquer. Les conjoints expriment davantage des sentiments de colère et de désapprobation que des sentiments de tristesse; ils sont réticents à identifier et à exprimer des sentiments de bien-être et de tendresse. Quant aux contacts physiques reliés à la tendresse et à l'affection, les couples rapportent que ceux-ci sont évités ou très absents de leur vie conjugale quotidienne. La sexualité constitue une zone obscure dans la vie des couples âgés. En dernier lieu, il s'avère intéressant de noter, en ce qui concerne la communication, le désir des conjoints d'éviter de discuter entre eux de leur séparation éventuelle et de la mort.

TABLEAU 3
COMPORTEMENTS NON ADAPTÉS DES COUPLES
N = 20

COMPORTEMENTS

Rôles:

— Démontrent de la rigidité dans la distribution des rôles
— Conjoints ne se sentent utiles que dans la maîtrise des rôles instrumentaux traditionnels d'époux et d'épouse
— Accordent peu d'importance aux rôles socio-affectifs
— Sont surtout engagés dans des relations complémentaires
— Substituent difficilement les rôles perdus pour de nouveaux rôles adaptés à la situation quotidienne

Engagement et individualité:

— Ressentent de l'ennui et de la solitude
— Conjoints se sentent peu engagés en tant que couple:
  • peu d'intérêts en commun
  • peu d'activités communes
  • pas de projets communs
  • peu de plaisir à effectuer des activités communes

Prise de décision et résolution de problèmes:

— Identifient difficilement les problèmes d'ordre affectif
— À l'intérieur du couple, les conjoints font peu de compromis face à la résolution de problèmes quotidiens (instrumentaux et affectifs)
— Ont tendance à prendre des décisions unilatéralement

Concept de soi:

— Perçoivent leur système conjugal de façon négative
— Ont de la difficulté à témoigner des aspects positifs et enrichissants de la vie commune
— Privilégient le sous-système parental au détriment du sous-système conjugal
— Ne favorisent pas l'apprentissage ou la confirmation de l'estime de soi:
  • conjoints manifestent de la difficulté à reconnaître le vécu du partenaire et se discréditent mutuellement
  • éprouvent de la difficulté à se supporter, s'entraider et à se motiver en tant que conjoints

Communication:

— Ne trouvent pas d'intérêt à communiquer
— Utilisent leurs déficiences sensorielles (diminution de l'acuité visuelle et auditive) pour limiter leur communication
— Justifient par leur état de santé et leur âge certaines de leurs difficultés dans leur relation afin de maintenir leur mode de relation
— Ont de la difficulté à parler de leur relation de couple: difficulté métacommuniquer.

Expression des attentes, des émotions et des sentiments:

— Conjoints ont de la difficulté à exprimer leurs attentes l'un envers l'autre
— Face à l'autre, les conjoints expriment surtout des sentiments de colère et de désapprobation et sont incapables d'exprimer leurs sentiments de tristesse
— Manifestent de la difficulté à identifier et à exprimer des sentiments de bien-être et de tendresse.
— Ne recherchent pas de contacts physiques affectueux — Conjoints ne recherchent pas affection et attention
— Ont de la difficulté à vivre une forme de sexualité satisfaisante pour les deux partenaires
— N'abordent pas le sujet de la mort et expriment difficilement leurs sentiments à la séparation éventuelle
— N'identifient pas leur besoin d'aide sur le plan relationnel ou hésitent à rechercher l'aide nécessaire à l'extérieur.

La liste des principaux stimuli contribuant aux comportements adaptés et non adaptés des couples identifiée par les juges, apparaît au tableau 4.

Tableau 4

Stimuli contribuant aux comportements adaptés et non adaptés des couples

Stimuli
• valeurs culturelles traditionnelles
• la relation:
— structure du système conjugal
• - règles
• - sous-systèmes
• - frontières
• - répartition du pouvoir
— fonctions du système conjugal
• - distribution des rôles
• - capacité à identifier et à solutionner des problèmes
• - individualité et engagement
• - capacité à identifier et à exprimer émotions et sentiments
• estime de soi du couple
• connaissances relatives au fonctionnement d'un couple
• motivation à explorer de nouvelles alternatives de fonctionnement conjugal

En plus de tous les facteurs individuels connus dans les écrits tels que l'âge, l'état de santé, la qualité de l'environnement extérieur, cinq stimuli principaux reliés aux comportements des couples ont été dégagés. Un important facteur agissant sur toute la situation étudiée est certainement l'influence et la perpétuation des valeurs culturelles traditionnelles chez les couples âgés. Les différents aspects reliés particulièrement aux rôles, aux modes et aux règles de communication ainsi qu'à l'expression de la sexualité sont des comportements influencés étroitement par ces valeurs culturelles traditionnelles.

Néanmoins, les principaux stimuli reliés aux comportements des couples concernent la relation conjugale sous ses différents aspects. En effet, la rigidité des règles influe sur les rôles, sur les modalités de communication, sur le processus de résolution de problèmes tandis que l'absence de frontières claires entre les sous-systèmes contribue à privilégier le sous-système parental et à diminuer l'importance de la communication au sein du couple. La répartition du pouvoir est un stimulus important affectant, quant à lui, différentes zones dont les prises de décision, l'entraide et le support entre les conjoints.

Enfin, le degré d'accomplissement plus ou moins grand des différentes fonctions du système conjugal de même que l'apport de connaissances des couples concernant les différentes alternatives de fonctionnement possible au sein d'un couple et le degré de motivation des conjoints face à leur engagement et à l'exploration de nouvelles avenues de fonctionnement conjugal sont également des stimuli à retenir, ces derniers pouvant être manipulables à l'intérieur de l'intervention de l'infirmière.

Intervention de l'infirmière — description du guide d'intervention

Les principaux résultats cités précédemment furent considérés pour élaborer le guide d'intervention. L'expression des différentes réactions des conjoints face à leur vieillissement est l'un des éléments qui a pris de l'importance au sein de ce guide d'intervention. Amener les conjoints à s'exprimer sur leurs rôles, leurs responsabilités, leurs attentes mutuelles et à clarifier ces aspects de leur vie conjugale, aider le couple à identifier son processus de prise de décision et de résolution de problèmes, favoriser chez les conjoints l'identification et l'expression des opinions et des sentiments tant d'urgence que de bien-être et aborder avec les conjoints la dimension de la séparation et de la mort furent les principaux points inclus au sein de ce guide.

Chacune des rencontres avec les couples était alimentée d'objectifs. Néanmoins, le guide d'intervention était un instrument flexible et la place assignée aux contenus pouvait varier en fonction des priorités de chaque couple. Les objectifs généraux des rencontres étaient d'accompagner le couple dans sa démarche d'identification de ses problèmes d'adaptation et de recherche de solutions à ses problèmes et, également, de faire participer le couple à l'élaboration de son propre plan de soins. En effet, dans le but de favoriser la participation des couples, une feuille de plan de soins devait être utilisée et rédigée avec l'aide des conjoints.

En ce qui concerne le déroulement de l'intervention, l'infirmière devait d'abord, lors de la première rencontre, établir un contrat avec le couple où la fréquence des rencontres, la durée de celles-ci ainsi que les objectifs étaient précisés. Cette première rencontre servait à établir un climat de confiance entre l'infirmière et le couple et permettait principalement de favoriser l'expression des réactions des conjoints face aux différents aspects bio-psycho-sociaux du vieillissement. Les rencontres subséquentes servaient principalement à travailler la dimension relationnelle entre les conjoints. Au cours de l'avant-dernière visite, un moment était réservé afin de préparer la fin de la relation avec le couple. Enfin, lors de la dernière rencontre, il était prévu de voir comment l'expérience que les conjoints venaient de vivre pouvait leur être utile ou comment ils pouvaient transférer l'apprentissage qu'ils venaient de faire à d'autres situations.

Application du guide

En ce qui a trait plus précisément à l'application du guide, une feuille de rappel de l'intervention permit de respecter le même contenu auprès des couples sélectionnés. L'application mit clairement en évidence les difficultés des couples âgés relativement à la communication et à la distribution des rôles. En effet, l'expression des opinions, émotions, sentiments et attentes entre conjoints ainsi que la communication sur des sujets tels que la séparation et la mort apparurent plus difficiles pour les couples. Quant aux rôles, une cristallisation et une difficulté de substitution des rôles entre les conjoints furent constatées malgré les changements dans le rythme de vie des couples occasionnés par l'avènement de la retraite et des problèmes de santé.

En ce qui concerne le processus même d'intervention, il est opportun de mentionner certains points. Ainsi, l'importance de faire appel aux réminiscences avec le couple âgé apparaît incontestable. Les bons souvenirs de la vie conjugale alimentent les possibilités ou les alternatives de fonctionnement possible s'offrant au couple ayant des difficultés relationnelles tout en se reliant à des aspects concrets du vécu. Egalement, souligner la contribution positive de chaque conjoint au bien-être de son partenaire ainsi que les forces du couple fut particulièrement important.

Certains phénomènes ont pu être remarqués au cours de l'application du guide et méritent une attention particulière. Lors des premières rencontres, une tendance des conjoints fut observée soit celle de communiquer des faits, des opinions ou des émotions à l'infirmière plutôt qu'au partenaire. L'importance de réorienter l'interaction entre les conjoints fut alors constatée. Au cours des deux premières rencontres,

la participation égale des conjoints masculins et féminins fut notée. Néanmoins, lors des rencontres subséquentes, les femmes s'exprimaient davantage et leur partenaire avait la tendance à se retirer de l'interaction. Ces dernières exprimaient indirectement à leur conjoint ce qu'elles ressentaient en recherchant une alliance avec l'infirmière. Le fait que l'investigatrice soit une femme peut être une des explications à cette recherche d'alliance. De plus, l'expression de l'agressivité semblait facilitée du fait qu'une tierce personne pouvait tempérer la situation. Certains sujets tels que la sexualité et la mort s'avéraient moins menaçants en présence de l'infirmière. Enfin, dans le but de dénouer cette alliance recherchée par les femmes, impliquer les conjoints masculins dans la discussion et leur donner un rôle important dans l'interaction fut primordial.

Opinions des conjoints sur l'intervention

De façon générale, les réponses au questionnaire d'opinions sur les rencontres confirment le bien-fondé d'un tel type d'intervention pour l'infirmière. L'ensemble des rencontres furent jugées très aidantes par les sujets. L'écoute, le respect, la compréhension et la possibilité de s'exprimer sont les principaux points qui furent soulignés par ceux-ci.

Discussion et recommandations

L'adoption d'un modèle conceptuel en sciences infirmières permit de tenir compte de toutes les dimensions bio-psycho-sociales du système conjugal, tant au niveau du développement de l'entrevue-questionnaire que de l'intervention. Dans cette optique, le modèle de Callista Roy apparaît une base conceptuelle très appropriée pour intervenir auprès d'un système; en effet, trois des quatre modes d'adaptation inclus dans la conceptualisation de l'homme faite par Roy sont d'ordre psychosocial et se relient facilement aux différentes fonctions d'un système.

La forme d'entrevue utilisée est particulièrement significative et elle peut expliquer certaines différences avec les résultats obtenus par Roberts (1979). En effet, contrairement aux résultats qu'il a obtenu aux Etats-Unis au sujet des éléments significatifs de la relation des couples âgés, l'engagement mutuel, la camaraderie, l'intimité émotionnelle manifestée par le toucher et la proximité physique ne sont pas des éléments caractéristiques de la vie conjugale des personnes âgées retrouvés dans la présente étude. Il est vrai que l'entrevue-questionnaire fut effectuée uniquement auprès de 20 couples. Néanmoins constituée surtout de questions ouvertes impliquant un élément de discussion avec l'infirmière, l'entrevue-questionnaire fait beaucoup moins appel au concept de désirabilité sociale très marqué dans le questionnaire à questions fermées utilisé par Roberts.

Les différentes constatations issues de l'analyse des données sont une indication supplémentaire de la pertinence qu'il y avait à explorer la situation de vie des couples âgés avant d'entreprendre l'élaboration de toute forme d'intervention. De véritables difficultés de communication entre les conjoints ont pu être observées, celles-ci pouvant aller jusqu'à de la souffrance au sein du système conjugal. Ce phénomène peut vraisemblablement s'expliquer à la lumière des valeurs culturelles québécoises de cette génération. Le nombre considérable d'enfants, la rigidité dans la distribution des rôles instrumentaux entre mari et femme, l'influence de la religion, les mythes associés à la sexualité et l'impossibilité de dissoudre l'union entre les conjoints sont autant de facteurs culturels qui peuvent expliquer certains résultats de l'étude.

Il apparaît enfin évident qu'avec l'évolution actuelle et les changements dans les valeurs, le profil de la situation de vie qui se dégage devrait se modifier avec les générations. Il est toutefois pertinent à l'heure actuelle de s'interroger sur ce profil; avec un nombre plus élevé de sujets et un milieu socio-économique différent, ce profil de vie se maintiendrait-il?

En ce qui concerne l'application du guide d'intervention, l'utilisation d'une formule de plan de soins et la détermination de tâches pratiques reliées à la vie quotidienne furent les moyens qui suscitèrent de la motivation et encouragèrent la participation des couples. Il est toutefois important de rappeler ici que l'application du guide s'est effectuée uniquement auprès de quatre couples. Le nombre restreint de sujets constitue effectivement une limite. Cependant, cette partie était davantage considérée comme une des étapes de validité du guide d'intervention. Il va de soi que l'habileté et la personnalité de l'infirmière sont également des aspects non négligeables qui peuvent avoir influencé tant le déroulement des entrevues que les rencontres avec les couples lors de l'intervention.

Enfin, compte tenu de l'immense besoin des conjoints relativement à la communication et de l'importance des valeurs culturelles traditionnelles, un plus grand nombre de rencontres serait indispensable lors de l'intervention. Par ailleurs, il est opportun de mentionner que la liste de stimuli énoncée dans la présente étude n'est pas exhaustive. Compléter cette liste pourrait permettre d'ajouter certains aspects à l'intervention de l'infirmière auprès de cette population.

Cette étude permit enfin de réaliser l'importance de privilégier les couples âgés au même titre que les personnes âgées seules en tant que population à risque dans le système de distribution des soins. Compte tenu du fait que les couples vivent de nombreux problèmes d'adapta-

tion relativement à leur relation conjugale, il serait souhaitable que dans une perspective de maintien à domicile et d'amélioration de la qualité de vie des personnes âgées, l'infirmière favorise l'adaptation des couples en travaillant particulièrement au niveau de la communication entre conjoints et de la distribution des rôles. L'intervention devrait être entreprise dans une optique de clarification de la communication et de décristallisation des rôles ne répondant plus à la vie quotidienne des couples âgés faisant place à des problèmes de santé et à des problèmes dans l'organisation du temps depuis la retraite et le départ des enfants.

Suite aux résultats obtenus, une étude expérimentale où deux variables dépendantes de l'intervention de l'infirmière seraient précisément la communication entre conjoints et la distribution des rôles, serait à recommander. La même étude reprise auprès d'un plus grand nombre de sujets choisis aléatoirement, au sein de milieux socio-économiques différents et d'un autre territoire permettrait aussi de généraliser certains résultats.*

Dans leur pratique quotidienne, les infirmières devraient intervenir, tout en ayant des sessions de supervision, auprès des systèmes conjugaux ayant des difficultés d'adaptation. Il serait également souhaitable que dans une optique de prévention primaire des problèmes concernant les rôles et la communication, elles entreprennent des interventions auprès de groupes de conjoints préalablement à la retraite. Il apparaît enfin que les programmes de formation des infirmières orientés de plus en plus vers le concept de la famille, produiront des infirmières capables de tenir compte de tout le système familial lors de la dispensation des soins et sensibilisées à la dimension interactionnelle existant entre les membres d'une famille.

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* Cet article fut soumis à *Perspectives en nursing* en juillet 1982; une étude subséquente auprès de 56 couples provenant de milieux socio-économiques et de territoires différents fut effectuée par l'auteur et terminée en janvier 1984, grâce à une subvention du Comité d'attribution des fonds internes de recherche de l'Université de Montréal. Les résultats de cette étude apparaissent dans un rapport de recherche; les personnes intéressées à ces résultats peuvent communiquer avec l'auteur.

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ABSTRACT

Nursing interventional approach and behaviour of the aged couple living at home

The purpose of this study was to explore the everyday situation of the aged couple living at home and coping with health problems, and thereafter to elaborate a nursing intervention wherein the couple is viewed as a system of interactions.

To this end, an interview-questionnaire, based on Callista Roy's conceptual model, was submitted to 20 couples (40 subjects) between the ages of 70 and 80. The data so obtained permitted identification of certain "adaptive and maladaptive" behaviours of the couples on a bio-psycho-social level, and isolation of factors that may contribute to such behaviour. The results have clearly demonstrated the importance of an interactional approach for aged couples. It was found that a negative perception of the conjugal image, a marked individuality of spouses, and, above all, difficulties inherent to communication and to substitution of social roles within the couple are important aspects of married life of the aged following retirement and health problems.

From these results, a guide to nursing intervention, primarily taking into account the relationship within the couple, together with the psychosocial dimensions and the physiological needs related to aging, were elaborated. The application of this guide, through one interview per week for five consecutive weeks, permitted confirmation of the merits of having based intervention on the existing relationship of the couple, and has clearly underlined the difficulties encountered by the spouse when communicating and when changing roles with the partner. This study has therefore facilitated the identification of certain variables within the framework of an experimental study.

PEDIATRIC NURSES' PERCEPTION OF PAIN EXPERIENCED BY CHILDREN AND ADULTS*

Patrick McGrath • Carolanne Vair • Mary-Jean McGrath
Elvera Unruh • Robert Schnurr

Pain is a frequent experience during childhood but our understanding of the experience of pain in children is extremely limited (Eland & Anderson, 1977; Jeans, 1983). There is evidence that children are, in comparison to adults, undermedicated for post operative pain. Eland and Anderson (1977) compared 25 children between the ages of 5 and 8 years with 18 adults who had undergone the same operation. The 25 children received a total of 24 doses of analgesics, of which 11 doses were narcotics. The 18 adults received 671 doses of analgesics of which 372 were narcotic analgesics. Similarly, Beyer, DeGood, Ashley and Russell (1983) found that 50 children (age 1 day to 14 years) who were undergoing open heart surgery were prescribed, and received, far fewer potent analgesics than adults who were undergoing similar surgery.

The reasons for the discrepancy between the amount of medication given to children and the amount of medication given to adults following surgery are not at all clear. Among the reasons that have been suggested is that adults, and nurses in particular, do not perceive the pain experienced by children to be as serious as the pain experienced by adults.

Although in previous studies there has been no positive evidence that nurses regard the pain experienced by children as less serious than the pain experienced by adults, this myth has been widely accepted.

Patrick McGrath, Ph.D., is a senior psychologist at the Children's Hospital of Eastern Ontario and an adjunct professor at Carleton University.
Carolanne Vair, M.Sc.N., is Nursing Director, Children's Hospital of Eastern Ontario.
Mary-Jean McGrath, B.A., Elvera Unruh, B.A., and Robert Schnurr, M.A., were research assistants at Children's Hospital of Eastern Ontario.

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Few studies have attempted to measure how people perceive the pain experienced by others. Davitz and Davitz (1981) in a series of studies, examined nurses' inferences of patients' pain and psychological distress by means of a series of vignettes, portraying patients of different ages and with different types of problems. Nurses were asked to rate how much pain and how much psychological distress they thought the patients would feel in each situation. The findings of systematic differences across diseases and groups of nurses lends credibility to the vignette methodology.

The age and sex of the patients in the vignettes was not systematically varied and consequently it was not clear if there was any difference in nurses' inferences of pain because of the age or sex of the patients.

Petrovich (1957) describes a test of pain perception that uses a series of pictures to elicit estimates of how much pain respondents think the person in the picture is feeling. Since all pictures depict an adult male no differential estimates of perception of pain experienced by children or adults is possible using this test.

The purpose of this study was to investigate nurses' perceptions of the pain experienced by males and females in two age groups: children aged 9-12 years and adults aged 30-45 years. Pain situations were presented in vignettes and the nurses' perceptions of the pain was measured from two perspectives: 1) a judgement of what action the person in pain should take and 2) a rating of the severity of the pain experienced.

Method

Subjects

Graduate staff nurses working at a 300 bed pediatric teaching hospital were contacted by a nursing director who asked if they wished to participate in a study investigating nurses' responses to pain. The true nature of the study was not revealed to the subjects until after completion of the study. One hundred and seventeen nurses (115 females and 2 males) completed and returned the vignette questionnaire and a brief demographic face sheet on their own time. Responses were anonymous. The average age of respondents was 34.4 years (range 22-54 years). Thirty (25.6%) had graduated from community college programs; 66 (56.4%) had graduated from Hospital programs and 21 (17.9%) had completed University nursing programs.

Instrument

Four sets of sixteen vignettes describing commonly experienced pain situations were developed. Each situation described pain for which no serious medical sequelae would be expected. Table 1 contains examples of the vignettes. Each set had four vignettes in which the character was an adult male (30-45 years), and four in which the character was an adult female (30-45 years). Similarly, four vignettes in each set featured a male child (9-12 years) and four a female child (9-12 years). The order of vignettes was randomized in each set. Each of the sixteen vignettes appeared in each set and each vignette was equally represented in all four age-sex combinations.(1)

(1)Complete copies of the vignettes are available from the senior author.

Table 1

Examples of Vignettes Depicting Pain

As she was bicycling back from the park, Patricia age 36 lost her balance when her front wheel hit a stone. She fell on the pavement scraping her legs and arms badly.
Kevin, age 43 was building a doghouse. Little splinters were left in his arm and hand from the rough board he was carrying. When the splinters were removed, it left his arm red and sore.
While moving to her new home, Cathy, age 9, strained her back lifting a box. The next day her back hurt enough to make her change her plans to go shopping.
While spending the day on the family boat, 9 year old Billy got a bad sunburn. His burn is very red, hot to touch, and there are tiny white water blisters on his arm and nose.

Each subject in the study was given one set of sixteen vignettes and asked to answer, "What should this person do to relieve the pain he/she is experiencing?". The subjects were also assured that the person in the vignettes did not have any serious medical problem. Each response was coded using a Behavior Response Code (Table 2) in which possible behavioral responses were rated for their seriousness. The values assigned to each of the behavioral responses were determined by the rankings of the items in the Code assigned by three independent health professionals (agreement was 100%). In order to assess inter-rater reliability of this coding, twenty of the subjects'

questionnaires were independently recoded. A rate of 88% agreement was registered. If more than one response was given by a subject, only the most serious response was coded.

Table 2

Behavior Response Code

Value	*Description*
1	The person in pain should help himself without medicine, for example, try not to think about it or do something to keep their mind off the pain.
2	The person in pain should use a home remedy like drinking herbal tea or using a hot water bottle or ice pack.
3	The person in pain should seek advice or assistance from a friend or family member.
4.5	The person in pain should take a non-prescription pain reliever.
4.5	The person in pain should take a non-prescription medication that relieves the symptom but is not an analgesic.
6	A doctor, clinic or hospital should be consulted by phone.
7	A doctor, clinic or hospital should be visited, or prescription medication should be administered.

Subjects were also asked to rate the severity of pain experienced in each of the sixteen vignettes, using Davitz and Davitz's seven point scale.

Results

The scores on the Behavioral Response Code and the pain severity rating were initially analysed to determine any differences among subjects that were attributable to the age, sex or education of the respondent nurses. No differences were found, and consequently, the data from all groups of nurses were collapsed.

The scores on the Behavior Response Code and the pain rating were calculated for each of the four types of character in the vignettes: adult male, adult female, male child, and female child (Tables 3 and 4). Analysis of variance was applied to determine if the age or sex of the vignette character was of significance. Analyses yielded no significant

(alpha = .05) differences in the perception of pain by nurses for any of the character types as measured by the Behavior Response Code and the pain severity rating.

The assessment of the amount of pain experienced by the vignette characters was closely related to what was suggested the vignette character do. The Pearson correlation of the scores on the severity scale and the Behavior Response Code was $r = 0.78$ ($p < .001$). This provides evidence for the validity of the vignette format in that nurses suggested more radical treatment for pain that was more severe.

Table 3

Behavior Response Scale Rating by Nurses of Vignettes

Character in vignette	Mean rating	Standard deviation	N
Male child	3.72	0.99	117
Adult male	3.83	1.21	117
Female child	3.69	1.13	117
Adult female	3.73	1.14	117

Table 4

Pain Rating by Nurses of Vignettes

Character in vignette	Mean rating	Standard deviation	N
Male child	3.89	0.66	110
Adult male	3.87	0.70	110
Female child	3.83	0.72	110
Adult female	3.84	0.79	110

Discussion

In this vignette study, pediatric nurses regarded pain arising from everyday activities, experienced by 9-12 year old children to be as serious as similar pain experienced by adults. The nurses perceived the pain of children as severe as adult pain and they suggested similar classes of action to alleviate the pain. Similarly no differences were apparent in the perceived pain of males and females.

This finding suggests there is no underlying overall prejudice that would affect nurses' perception of pain in children. Such a prejudice would be apparent in common everyday pain as well as in post-operative situations. It is not possible to determine whether or not nurses would react differently to children and adults portrayed as being hospital patients, or if they would react differently to younger children. As well, the limitations of all analogue studies apply to this study. Real life behavior may not be identical to responses on a questionnaire.

Explanations for differential use of analgesics by children and adults in post operative pain must be attributed to factors other than a global prejudice on the part of nurses to diminish pain experienced by children. These factors might include the children's inability or unwillingness to communicate their pain; the lack of adequate methods to measure pain, especially in young children; or factors specific to the medical situation such as the health professional's fear that children may experience negative side effects from potent analgesics, or other specifics of post surgical pain.

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RÉSUMÉ

Les douleurs ressenties par les enfants et par les adultes telles que les perçoivent les infirmières pédiatriques

Il existe des preuves à l'effet que les enfants ne reçoivent pas suffisamment de médicaments pour soulager leur douleur. Le phénomène pourrait s'expliquer notamment par le fait que les infirmières accordent moins d'importance à la douleur chez l'enfant qu'à une douleur comparable chez l'adulte. On a effectué une étude analogue dans le cadre de laquelle on a demandé aux infirmières de lire seize vignettes décrivant des personnes souffrantes; on leur a ensuite demandé de proposer des moyens de soulager la douleur de chaque personne et d'évaluer l'insensibilité de cette souffrance chez chacune d'elles. L'âge (9-12 ans ou 30-45 ans) et le sexe des caractères des vignettes variaient systématiquement. Les résultats ont révélé que les infirmières de notre échantillon trouvaient que les douleurs de l'enfant justifiaient un traitement similaire et étaient tout aussi pénibles que celles que présentaient les adultes. Bien que cette étude présente des limites importantes, elle offre cependant une première indication du fait que la manière dont les infirmières perçoivent la douleur d'une personne ne serait pas nécessairement influencée par l'âge ni par le sexe du malade.

POSITIVE EFFECTS OF EDUCATION ON NURSING STUDENTS' ATTITUDES TOWARD DEATH AND DYING

Suzanne Caty • Deborah Tamlyn

Introduction

Death is a universal experience which none can escape. Nevertheless, in North American society death is still a topic which many avoid because of conscious and unconscious fears and attitudes which are frequently fueled by superstitions, myths, and taboos. Health professionals are not immune to these fears and attitudes. Nurses, as the primary care givers for dying patients and their families, are frequently ill equipped to assist individuals and families in handling the human experience of dying.

The pioneering work of Quint (1967, 1969) and Kubler-Ross (1969, 1972) helped nurse educators to recognize the importance of including death education in nursing curricula, and recent surveys indicate that this is now happening in many nursing schools (Trush, Paulus, & Trush, 1979; Caty & Downe-Wamboldt, 1983). This article describes the results of a study which measured the death attitudes of third year baccalaureate nursing students.

Literature Review

Many educators have recognized the need to evaluate, in an objective and systematic way, the effect of death education on learners' attitudes toward death and dying (Watts, 1977; Miles, 1980; Gow & Degner, 1980; Benoleil Quint, 1982; Eddy & Alles, 1983). Some research findings point to a positive impact of education on attitudes (Quint, 1969; Snyder, Gertler & Ferneau, 1973; Yeaworth, 1974; Hopping, 1977; Watts, 1977; Gow & Degner, 1980; Miles, 1980; Tamlyn & Caty, 1983), while others found no effect (Martin & Collier, 1975; Swain & Cowles, 1982), or a delayed positive effect (Murray, 1974; Laube, 1977).

Suzanne Caty, R.N., M.Sc., and Deborah Tamlyn, R.N., M. Ed., are assistant professors, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

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The literature indicates that a variety of approaches, educational designs, content, and strategies are used in death education (Trush, Paulus & Trush, 1979; Gow & Degner, 1980; Benoleil Quint, 1982; Eddy & Alles, 1983; Caty & Downe-Wamboldt, 1983). However, the relationship between educational design and its effect on attitudinal changes still remains unclear.

This study was undertaken to measure the effects of a two-day death education seminar on attitudes of baccalaureate nursing students toward death and dying.

The research questions were:

1. Do nursing students' attitudes toward death and dying change significantly after a death education seminar?

2. After completing a death education seminar, do nursing students who have experienced the death of an immediate family member register a more significant attitude change than nursing students who have not experienced the death of an immediate family member?

3. After completing a death education seminar, do nursing students who have nursed dying patients demonstrate a more significant attitude change than nursing students who have not nursed a dying patient?

Methods and Materials

Subjects

Two groups of subjects participated in this study; an experimental group of third year nursing students, and a control group of third year physiotherapy students, both attending the same university. All students in these two classes were invited to participate in the study.

All potential participants were informed that the research project had received ethical approval. The purpose of the study was explained, as were the facts that involvement in the study was voluntary, that anonymity was guaranteed, and that a decision not to participate had no effect on their student status.

Thirty-three of the nursing students (83%) and 22 of the physiotherapy students (88%) participated in the first measurement. The percentages of participation in subsequent measurements were 73% and 78% for the nursing students, and 72% and 84% for the physiotherapy students. Only data from subjects who had participated in measurement one and at least one subsequent measurement were included in the study.

Research Design

A quasi-experimental research design was employed. The two groups were tested prior to, and 3 months and 14 months following the seminar. Only the nursing students experienced the death education seminar.

The first measurement was done two weeks prior to the death education seminar, before the experimental group were informed of the objectives and suggested readings for the seminar. Longitudinal measurements were done in order to determine the effect of time on death attitudes. Other researchers have also recommended the need for longitudinal study in this area (Murray, 1974; Hopping, 1977; Laube, 1977).

Instrument

A variety of instruments have been developed for measuring attitudes toward death and dying (Snyder, Gertler & Ferneau, 1983; Martin & Collier, 1975; Hopping, 1977; Watts, 1977; Miles, 1980; Swain & Cowles, 1982). We elected to use the "Questionnaire for Understanding the Dying Person and his Family" (Winget, Yeaworth & Kapp, 1979) because it was developed for health professionals and has been used extensively with nurses. Its items are congruent with the objectives of our death education seminar, and it has been successful in detecting attitudinal differences in baccalaureate nursing students. Its developers have reported a discriminant validity of $t = 8.69$ for mean scores ($p < 0.001$) and a co-efficient alpha of .72.

The questionnaire has three parts. The first part consists of fifty Likert-type items related to death to be answered using a 5 point scale. Seventeen of the items are fillers. A scoring key has been developed and scores can range from 33 to 165 points: the lower the score, the more open and flexible the attitude. The second part of the questionnaire collects information which deals with the respondent's personal and professional experiences with death. The third part collects demographic data such as age, sex, marital status, religion, and perceived intensity of religious beliefs.

Analysis of Data

Data from the completed questionnaires were analyzed using the Statistical Package for the Social Science (Klecka, W.L., Nie, N.H., Hull, C.H., 1975; 1982), and included: 1) descriptive statistics to describe and summarize the data and mean scores of the three measurements; 2) t-tests on the differences between mean scores for the three measurements for each group; 3) analysis of co-variance to compare the experimental and control group mean scores, taking into

consideration the possible initial differences in the group; 4) stepwise multiple regression analysis to examine the correlations between the mean scores and the independent variables, experience with death of a family member, and experience with a dying patient. Because of the distribution of responses for the variable intensity of religious belief, it was decided to include this variable in the multiple regression analysis. Level of significance was set at $p \leqslant 0.05$.

Treatment

The two-day (16 hour) required death education seminar was incorporated into a third year baccalaureate nursing course which focuses on the nurse's role in helping clients, i.e. individuals and families, adapt to living with a chronic health problem. In their clinical experiences students are exposed to clients at different stages of the life cycle who are coping with a variety of chronic illnesses. Many students have direct or indirect contact with dying patients and their families.

Knott (1977) contends that students in death education courses must be given opportunities to examine their feelings and values as knowledge alone cannot bring about the desired attitudinal and behavioral changes. This belief guided us in the development of the following learner objectives for the seminar:

— to become more aware of personal feelings and attitudes towards death and dying

— to recognize how one's feelings about death and dying can influence nursing care.

— to understand the nurse's role in caring for the dying patient and his family.

A variety of resource people and teaching strategies were used to optimize conditions for the accomplishment of the objectives (Table 1). The resource people included local faculty, and two nurses and a chaplain from a local hospice unit. We believe it is important that all these people be comfortable with their own feelings about death and dying. Personal experiences of faculty members enabled them to develop sensitivity to these issues.

Before the seminar, the students received a packet which described objectives, suggested readings and relevant questions to consider. The activities of small groups and of the entire group played an integral part in the seminar. Small group learning activities encouraged discussion and provided opportunities to share ideas, feelings, and experiences. In the activities of the entire group, the emphasis was on sharing feelings, ideas, and experiences rather than only on transmitting information. For example, faculty members shared their personal

experiences in the death of family members. Self-disclosure on the part of the faculty prompted the development of an atmosphere of trust that encouraged the students to be open as well.

Each day of the seminar had a special focus: day one, "Death and Me"; and day two, "Death and Nursing" (Table 2). We believe that students ought to examine their own feelings and attitudes about these topics before they discuss their professional roles. The initial sessions are quite emotional for the students, and the group leader's role is key to helping the students deal with their feelings. On the second day of the seminar, the hospice nurses shared with the students how they use their professional skills to help the dying and their family members. During these sessions, much time was spent on improving communication skills primarily through role playing.

In contrast, the control group had no formal required course or planned content on the topic of death and dying. The topic may have been discussed in clinical situations or in some theory courses but it was not assured that all students would receive this information.

Results

Characteristics of the subjects at measurement one are presented in Table 3. The majority of the subjects were single females, 20-25 years old, who considered themselves to be religious. In both groups of subjects, at least 68% had experienced the death of an immediate family member, i.e. parent, step-parent, sibling, spouse, or child.

In the experimental group, many of the students (73%) stated that they had nursed a dying patient prior to the seminar. At the time of the final measurement, 13% reported they had not nursed a dying patient; this meant they would probably not have this experience during their nursing programme.

At measurement three, 62% of the subjects in the control group stated that they had worked with a dying patient during a clinical field experience. Forty-seven percent (47%) of the control group subjects reported, at the third measurement, that they had never studied the topic of death and dying in a course.

The lowest score obtained by the experimental group was 48 and the highest was 87. In contrast, in the control group, the lowest score was 60 and the highest was 104.

Statistical Findings

The mean score of each measurement obtained by the two groups of subjects is presented in Table 4. In the experimental group, statistical significance was found between the difference in the means of

measurement one and of measurement three ($t = 3.02$, $dF = 30$, $p = 0.005$); no statistically significant difference was found between the means of measurement one and measurement two. In the control group, the difference between the mean scores of t_1, t_2, and t_3 was not statistically significant.

The difference in the mean scores of the nursing students and the physiotherapy students at measurement one was statistically significant ($t = 3.17$, $dF = 53$, $p = 0.003$). Further, statistical analysis used an analysis-of-covariance in which the mean score at measurement one was the covariate. This was employed to control for any differences in the groups which might confound differences in the mean scores in measurement two and three. The analysis of covariance produced no significant difference between the adjusted mean scores of the experimental and the control group at measurement two, but did reveal a significant difference between the adjusted mean scores of the groups at measurement three (Table 5).

The stepwise multiple regression analysis for both groups indicated no significant correlations between the mean scores and the independent variables (experience with death of a family member, intensity of religious beliefs, and experience with a dying patient).

Discussion

The homogeneity of the two groups is probably a consequence of the fact that the nursing and physiotherapy professions are still predominantly female professions. The high percentage of subjects in both groups who had experienced the death of an immediate family member was surprising, considering the relatively young age of the subjects. In an earlier exploratory study (Tamlyn & Caty, 1983), only 25% of nursing students had experienced such a loss.

It was noteworthy that over 80% of the subjects rated their intensity of religious belief as average or strong. This was also found in an earlier study (Tamlyn & Caty, 1983); however, the relationship between intensity of religious belief and mean scores was not statistically significant in either group. Leming (1979-80) surmises that intensity of religious belief may serve to increase anxiety about death as well as decrease it. Lester (1970) reported that college students with low intensities of religious belief held less inconsistent attitudes than students with high intensities of religious belief. Further study in the role of religiousness in attitude formation would be worth pursuing.

A majority of the students in the experimental group reported nursing dying patients before the seminar. Similar majorities have been reported in other studies (Martin & Collier, 1975; Tamlyn &

Caty, 1983). Educators need to question the potential detrimental effect when students nurse dying patients before they have had an opportunity to examine their own feelings and attitudes, and to acquire the nursing skills for their care.

The lack of significant difference between the mean scores of measurement one and two in the experimental group is a different finding from other studies (Watts, 1977; Miles, 1980: Tamlyn & Caty, 1983). This may, in part, be explained by the low mean score on measurement one (69.0). Yeaworth (1974), in her study with nursing students, found a mean score of 78.8 for the same measurement with freshman students, and Gow & Degner (1980) found that sophomore nursing students had a mean score of 75.04. Professional socialization may have been an influencing factor, as, at the time of the first measurement the nursing students had been in the nursing programme for two and a half year.

In contrast, the significant difference between mean scores on measurement one and measurement three in the experimental group supports the premise that attitudes change over time. It also illustrates the necessity for doing longitudinal studies (Hopping, 1977; Gow & Degner, 1980; Miles, 1980; Tamlyn & Caty, 1983). As time passed, a greater number of students in the experimental group displayed a more open flexible attitude toward death and dying. Measuring the students' attitudes a few days after the seminar might have given us a better understanding of the influence of the seminar on death attitudes.

The statistically significant difference in mean scores between the two groups in the first and third measurement is an important finding. The difference in mean scores on the initial measurement is remarkable considering the apparent homogeneity of the two groups. The initial mean score of the control group (76.27) is very similar to the freshman and sophomore students' scores found in the Yeaworth (1974) and the Gow & Degner (1980) studies. Once again, one needs to consider the influence of professional socialization, educational experiences, and the focus of different programmes on attitude formation. Sundin, Gaines, and Knapp (1975) suggested in their study comparing death attitudes of dental and medical students that their attitudes toward death may be affected by professional experiences.

The statistical significance between the difference in the adjusted mean scores of the two groups at measurement three is encouraging, and lends some support to the value of this two day seminar. We believe that the positive attitude changes demonstrated by the nursing

students occurred because the two-day seminar is incorporated into an integrated programme that has an emphasis on helping relationships, communication and, family centered nursing.

In summary, the results of this study suggest a two-day death education seminar may exert some influence on attitudes toward death and dying. Nurse educators considering inclusion of death education in their programme, need to examine their present curriculum in order to determine whether learning would be increased by incorporating such a seminar into an existing course or by adding a separate death education course to the curriculum.

This project has raised many research questions that may offer direction for future study. We offer the following:

1. What is the relative effect of different educational designs on death attitudes?

2. What is the relationship between death attitudes and subsequent clinical behaviours?

3. What is the role of professional socialization in attitude formation?

4. When and where should death education be placed within a nursing curriculum?

Table 1

Death Education Seminar

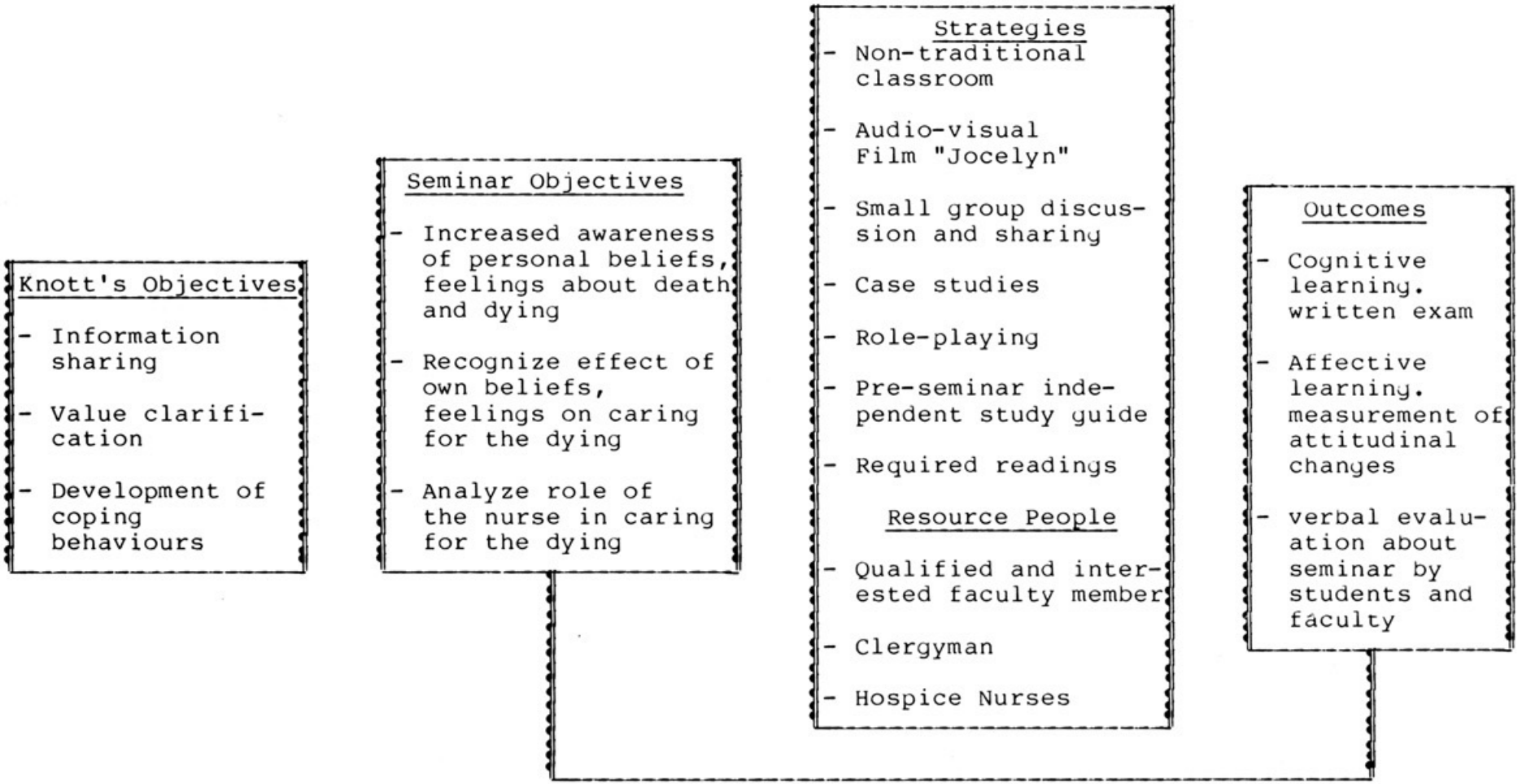

Table 2

Outline of Death Education Seminar

Day One — Death and Me		
Introduction	—	Review of objectives
	—	Introduction of resource people
	—	Death and Dying in North America. Where are we now?
Whole Group	—	Loss and grieving
	—	Faculty share own personal experience with death and dying and how this loss has influenced their nursing practice.
Small Group	—	Exploration of feelings and experiences about death and dying.
		Lunch
Large Group	—	Spiritual aspect of death and dying
	—	Film "Jocelyn"
	—	Discussion Film
Small Group	—	Sharing of feelings and experiences
	—	Follow-up discussion on topic presented in large group
Large Group	—	Review of day
Day Two — Death and Nursing		
Large Group	—	Hospice movement and nursing
Small Group	—	Sharing of professional experiences
	—	Exploration of feelings
	—	Discussion on previous presentation
		Lunch
Large Group	—	Communicating with the dying and their families
	—	Role playing
Small Group	—	Practicing communication skills
	—	Role-playing
	—	Case studies
Large Group	—	Review of day
	—	Evaluation of seminar

Table 3

Characteristics of Subjects At Measurement 1

	Experimental Group (n = 33)		Control Group (n = 22)	
Characteristics	N	%	N	%
Age 20-25	32	97	20	90.9
26-30	1	3	2	9.1
Sex Female	33	100	21	95.4
Male			1	4.6
Marital status: single	32	97	20	90.9
married	1	3	2	9.1
Religion: Catholic	11	33.3	9	40.9
Protestant	18	54.5	12	54.5
Other	4	12.2	1	4.6
Intensity of Religious Beliefs: Poor	2	6.1	3	13.6
Fair	4	12.1	1	4.6
Average	20	60.6	11	50.0
Strong	7	21.2	7	31.8
Attended a funeral: no	5	15.2	4	18.2
yes	28	84.8	18	81.8
Death of an Immediate Family Member: no	10	33.3	7	31.8
yes	23	69.7	15	68.2

Table 4

Death Attitude Mean Scores At Measurement 1, 2, 3

Experimental Group					Control Group			
Measure-ment	N	Range	$\bar{x}$	SD	N	Range	$\bar{x}$	SD
1	33	48-86	69.06	7.65*	22	65-104	76.27	9.10
2	29	51-83	67.79	8.23	18	67-86	75.94	6.00
3	31	48-87	63.06	9.37*	21	60-97	73.80	8.28

*p = .005

Table 5

Analysis of Variance of Death Attitude Mean Scores of Test 2 and 3 by Group Type with Mean Score of Test 1 as the Covariate

Source	d.F.	M.S.	F
Mean score test 2 / by group type	1	169.416	3.817*
Error	41	44.386	
Total	43	74.983	
*p = .058			
Mean score test 3 / by group type	1	272.540	4.402*
Error	41	61.910	
Total	43	92.957	
*p = .042			

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RÉSUMÉ

Effets positifs de la formation sur les attitudes des étudiants infirmiers face à la mort

Cette étude a mesuré les attitudes face à la mort des étudiants infirmiers en troisième année du programme de bacalauréat avant et après un séminaire de deux jours sur la mort. On a utilisé une conception quasi expérimentale auprès d'un groupe expérimental qui avait participé au séminaire et d'un groupe témoin d'étudiants de physiothérapie de troisième année qui n'avaient pas été exposés à cette formation. Des évaluations des attitudes avant le séminaire ainsi que 3 mois et 14 mois après cette rencontre ont été effectuées auprès des groupes à l'aide du "Questionnaire for Understanding the Dying Person and His Family" (Questionnaire visant à comprendre le mourant et sa famille) de Winget.

La différence au niveau du score moyen d'attitudes face à la mort chez les étudiants infirmiers, entre la première et la troisième évaluation a été significative sur le plan statistique ($P = 0,005$). Dans le groupe témoin, le changement des résultats moyens n'était pas significatif sur le plan statistique. Les différences de résultats moyens avant le séminaire entre les étudiants infirmiers et les étudiants physiothérapeutes étaient significatives sur le plan statistique à P 0,003. Une analyse de co-variance dans laquelle les résultats moyens d'avant le séminaire ont servi de co-variés n'ont fait apparaître aucune différence significative sur le plan statistique entre les résultats moyens lors de la deuxième évaluation mais des différences importantes ont été notées entre les résultats moyens lors de la troisième évaluation ($P = 0,042$). Les étudiants infirmiers ont démontré une attitude plus souple et plus ouverte face à la mort tout au long de la période d'évaluation. Ces observations semblent indiquer que le séminaire de deux jours pourrait avoir joué un rôle en améliorant les attitudes face à la mort.

ARTICULATION AND BACCALAUREATE ENTRY TO PRACTICE

Ruth Gallop

The Canadian Nurses Association has resolved that, by the year 2000, the minimal educational requirement for entry into the practice of nursing should be a baccalaureate degree in nursing (Canadian Nurses Association, 1982). This resolution emerged from recognition by the nursing association of the actuality that changes in health care concepts require that the nurse be educated in the university setting. Six provincial organizations have endorsed similar resolutions; the remaining four provinces are developing position papers. These resolutions parallel a similar resolution by the American Nurses Association. This proposal has important implications for the nursing profession and will require significant changes and adjustments in the educational process.

Currently, professional organizations and nursing educators across Canada are considering how to implement this change. The position and purpose of hospital schools of nursing and of community college programs will have to be reconsidered. Designed as terminal programs, it is not clear what, if any, role these schools will have in the future education of nurses.

The Registered Nurses Association of Ontario (RNAO) has responded with an initial position paper on entry to practice (1982). The recommendations of the RNAO point to many of the issues that must be nationally addressed if the entry-to-practice resolution is to be implemented in a manner truly beneficial to the development of a nursing discipline.

The RNAO paper endorses the CNA resolution and attempts to look at the mechanics of implementation of the proposal. Two major recommendations made by the RNAO identify grandfathering and temporary articulation as important and necessary steps for the changeover to baccalaureate education. Alberta's position paper makes similar suggestions (1979). Grandfathering would provide protection of status for all existing diploma educated registered nurses. A cut-off date has not been proposed by the provincial organization. Articulation refers to a specific educational process that would enable the diploma graduate to upgrade to a baccalaureate level.

Ruth Gallop, R.N., M.Sc.N. is a lecturer in the Faculty of Nursing, University of Toronto.

This paper will examine the use of articulation as a valid, even if temporary, educational alternative for the preparation of a baccalaureate registered nurse. First the writer will review briefly the rationale for baccalaureate education in nursing. Problems in curriculum design that may arise as a consequence of dual methods of preparation will be addressed. Finally, the writer will suggest that important benefits fundamental to the discipline of nursing may be derived from a unified approach to education.

Rationale for Baccalaureate Education

Placing all nursing education firmly within the university setting is not a new idea. As early as 1914, Falconer, then President of the University of Toronto and heading a committee on nursing education, recommended that training should take place in a university setting. The Weir Survey of Nursing Education (1932) made similar recommendations. However, it was not until 1942 that a university nursing program possessing complete control of the educational experience of the students was established. Until the late 1960's most nursing education programs were under direct hospital control. In the 1980's nursing education, for the most part, has been removed from hospital control and placed within the general education system.

The CNA resolution is a clear attempt to address the expanding complexity of nursing. In the past, nurses' primary function has been the delivery of "bedside" care to the ill. Over time, with changing societal patterns of illness and health, the nurse's area of practice has expanded to include the attainment, maintenance, and recovery of health of the clients (Flaherty, 1980). Fundamental to the CNA proposal is the belief that the appropriate location for this nursing education is the university. Kramer (1981) identifies the broad goal of baccalaureate education: "To prepare a liberally educated person to function as a professional nurse in a variety of nurse roles and health care settings" (p. 224). By exposing the student to the arts and humanities as well as biological science the student acquires a rich foundation for self growth. Ideally the nursing student will have an opportunity to acquire the ability to think in complex patterns, to problem solve, to tolerate ambiguity, and to pursue knowledge for its own end. The baccalaureate program should encourage cognitive development that will prepare the nurse more fully for problem solving and decision making in the ever increasing complexities of nursing practice.

Concomitant to the ideal of a liberally educated nurse is the belief in a discipline of nursing. For nursing to be identified as a professional discipline, there must exist a body of knowledge unique to nursing,

that is constantly being expanded and explored in a scientific manner. The CNA proposal accepts the notion of a discipline of nursing and stresses the need for preparation in nursing to be "undertaken within a university context if research is to be integral to nursing practice" (p. 29). For the baccalaureate student this research helps provide a "scientific basis for nursing practice" (p. 29), and the educational process encourages the application of this knowledge in practice.

The CNA resolution is an attempt to define nursing as a profession. A profession is: "An occupation whose incumbents *create* and explicitly utilize systematically accumulated general knowledge in the solution of problems posed by the clientele" (Moore, 1970, 53-54, my italics). The CNA position defines nursing practice as having a discipline base and, like the traditional professions, requires that the educational process occurs in the university setting.

The Process of Articulation

Articulation in nursing education is a comparatively recent phenomenon. In its broadest sense articulation can be seen as "building upon previously learned content," however, it is usually seen as one program building upon particular lower level program content (Stevens, 1981). In nursing, articulation usually refers to a 2 years baccalaureate program building upon a diploma level program. Examples may be found in Ontario and Western Canada. In Ontario, the degree program at Ryerson Polytechnical Institute is designed to articulate with its own diploma program. Entrants to the degree program must be Ryerson graduates or have specific equivalence. In the United States baccalaureate programs for registered nurses or "second step" programs have become a major movement in nursing. A dramatic increase of such programs during the 1970's was identified in a survey by Church, Brian, and Searight (1980). Of the 75 true "second step" programs identified, 86% admitted their first students between 1973 and 1978.

Debate about the quality and validity of articulated programs has been carried on primarily in the American nursing literature. For simplicity, in examining some of this literature, the associate degree program existing in American community colleges will be considered equivalent to the diploma programs within the general education system.

Perhaps because of the youth of articulated programs, the writer was unable to find any research literature comparing the professional practice of graduates of an articulated program with that of graduates of a generic baccalaureate program. The debate appears to be largely

philosophical and founded upon concerns about the nature of the initial nursing education experience.

The practice of articulation is based upon the assumption that what has gone before is a valid knowledge base for what must come after. It is this assumption that is being questioned. According to Kramer (1981), there are two different kinds of nurses: a professional nurse (baccalaureate) and a technical nurse (associate degree or diploma). Research offers some support for the suggestion that there is a difference in the orientation of the students of baccalaureate and associate degree programs. The findings of Bullough and Sparks (1975) suggest that baccalaureate senior students focus more on caring for patients, while associate degree students are more oriented to curing their illnesses. Hover (1975) compared diploma and degree nurses and found that, as education increased, "Nurses showed greater preference for active patients," and, "were more interested in providing teaching and supportive care" (p. 685).

When the associate degree programs were established in community colleges, they were described as semi-professional or technical (Montag, 1951). The aims of these programs were terminal and designed to provide a standardized level of technical competency. The distinction between technical and professional nursing has never been clearly differentiated by the employers of nurses nor by the consumers of their services. This situation is paralleled in Canada.

McClure (1976) believes that this lack of distinction is inevitable since nursing cannot be compartmentalized into isolated bits. Nursing is a practice profession and while "the professional nurse may delegate some of the technical aspects of care to another level these aspects remain an integral part of the professional nurse's total responsibility" (McClure, 1976, p. 95).

If one agrees with McClure, as this writer does, one cannot support the building of professional nursing education upon a base of technical competencies. Technical competencies must emerge from a broad-base educational experience and be placed within the context of the discipline. The two-year community college program has the dual purpose of training a nurse to provide basic bedside care, and of preparing the student to write registration exams. During a short period the student must absorb and acquire numerous technical skills; they begin to confront issues of enormous moral and ethical consequence: abortion; death with dignity; the right to refuse treatment; the right of the individual to make choices that run counter to the health professional's belief system. To be able to consider these and other issues in a complex manner requires the ability to think in a relativistic

manner (Perry, 1968). The student in a two-year program has not had the opportunity to acquire these cognitive skills. The very nature of the program may require the student to view issues as simply right or wrong. One of the important benefits of a university environment is the luxury to struggle with moral and ethical issues within a relatively risk-free environment. This experience is not inherent in the community college setting. Professional education must build upon a liberal education base. While this may be done through concurrent educational experience as in current generic nursing programs, it cannot be done in reverse.

According to Stevens (1981), articulation programs tend to exist in a model of upward planning. In this model, the upper level program adjusts to the limitations of the lower level curricula. Hence, the quality and integrity of the baccalaureate program may have to be compromised if it is to fit the lower level educational experience. As a consequence the product of these baccalaureate programs may be of "inferior" quality to the product of a generic program. Montag (1980) suggests that this emphasis on mobility between levels makes the acceptance of the technical programs suspect because the original intention of the associate degree was that it possess an integrity of its own.

The task of upper level programs is not simply to enlarge the nurse's knowledge base, but, as well, to expand cognitive functions that will help in dealing with the increasing complexities of nursing. In the initial educational experience the diploma graduate has been socialized into a nursing role that is based upon technical competencies. The task of changing this basis may be too arduous for the "second step" programs, if the graduate is to meet Kramer's definition of a baccalaureate nurse.

Curriculum Design and Articulation

"Curriculum structure, pattern or design refers to the arrangement of courses within given time periods" (Bevis, 1982, p. 178). Within curriculum design, three major elements emerge: 1. the concepts, skills, and values identified as behavioral objectives for the students, 2. specific subjects broadly identified as organizing structures, 3. organizing principles such as chronological order and increasingly broad application of knowledge (Tyler, 1956). The first of these elements tends to determine the content and sequencing of the curriculum design (Bevis, 1982). Chater (1975) would identify this element as the conceptual framework and indicate three sources of input: the setting, the student, and the subject. While all three sources are relevant to the point-of-entry proposal, this paper will address issues concerning subject and setting.

Temporary articulation to allow registered nurses with diplomas to upgrade will be a tempting prospect for all provinces. The schools already exist. The RNAO position paper stresses the temporary nature of these programs: "Temporary measures must be very clearly just that; it would be defeating to design an 'aberration' that becomes permanent" (p. 14). The report does not however, indicate a cut off-date for community colleges to cease to be valid routes for entry to nursing. One must assume it to be, at the latest, 2000. The report states that neither baccalaureate nor diploma programs should make major curricula changes unless the changes in the baccalaureate programs are "desirable in themselves." Suggestions are made to facilitate conditions for articulation. Recommendations are made that would require modifications in both the diploma and baccalaureate level. For example, the brief recommends that behavioral and biological science courses in the diploma level be made equivalent to those offered in a baccalaureate program, in order that credits be transferable. Further it suggests that university faculties examine their curricula for possible adjustments "without altering the integrity of the curricula;; (p. 15). The report states that it does not support or advocate a "ladder approach" (two plus two), however, the conditions for articulation just cited are both philosophically and practically consistent with such an approach.

When the position papers of the CNA and the RNAO are compared, fundamental differences in concepts and values in nursing appear to emerge. I don't believe the position paper of the CNA supports the notion of articulation. The CNA paper strongly endorses the notion of a discipline of nursing and that, "It is crucial that the degree be undertaken within a *university* context if research is to be integral to nursing practice" (p. 29). The concept of a discipline of nursing requires a totally integrated professional discipline approach. If the university does not have control over the entire educational experience, this is not possible. However, the RNAO paper lacks any reference to the discipline of nursing. It provides a functional model of nursing, listing nursing functions and identifying the scope and complexity of practice. It is this functional approach that distinguishes the RNAO paper from the CNA paper. A functional approach to nursing can rationalize a nursing program that is focused upon specific competencies in the first two years. This would be the case if the current diploma programs were to articulate with upper level programs. One could expect community college programs to become feeder programs for a specific university. This outcome would disregard the fact that the lower level programs were designed as terminal programs and never meant to articulate with upper level programs. Curriculum at

the university would have to be modified to "fit" the community college. Not only would the integrity of the upper level program be compromised but the upper level would be building upon a conflicting curriculum design.

In an articulated program the curriculum design would reflect diploma values at the first level. Subjects and sequencing for the first two years would tend to favour a functional approach. The next phase would be an attempt to switch to baccalaureate values, subjects, and sequencing. If one develops a curriculum design based on baccalaureate or disciplinary values, from the beginning at the community college level, then one assumes that a community college is equivalent to a university, and sequencing is not a critical issue in curriculum design. Kramer and Tyler imply that sequencing is an important issue. For Kramer it is a fundamental issue in the education of the baccalaureate nurse.

A Unified Approach to Baccalaureate Education

The CNA point of entry resolution represents a profound change for nursing. Currently, a nurse may choose one of three entry points to begin to practice. The point of entry resolution states that a nurse will be a baccalaureate prepared person. As such, the proposal allows for a commonality of language within the definition of professional nursing.

If "temporary" articulation is implemented a vast mechanism will be set up to accomplish the task. Once this machinery is in place, interest groups will make its dismantling very difficult. Diploma programs will have been modified rather than phased out. Universities will have geared their programs to accommodate large numbers of applicants. Nursing education will once again be creating more that one kind of nurse: a generic baccalaureate nurse and an articulated baccalaureate nurse. Questions of equivalence will arise.

If the leaders in nursing education truly support the need for a "liberally educated nurse," then the use of articulation even as a "temporary" measure becomes inconsistent with attempts to professionalize nursing. Articulation is a means by which nursing looks over its shoulder and tries to make up for past mistakes. It is natural and appropriate that concern exist for those nurses who have not acquired a baccalaureate degree; however, the recommended methods would upgrade diploma programs and look for common areas in learning experience between diploma and degree. These methods are not consistent with the aims of a liberal education in the university setting. The suggestion to "upgrade" a community college course to university level requires that the educator ignore the objectives of a university education. Similarity of content does not mean equivalence of ex-

perience. Nursing must take a clearly defined position — setting a date for grandfathering and for placing nursing education firmly within the university setting.

A unified approach to nursing does not imply that each university setting will be a duplicate of any other university setting. Unity will be reflected in the fundamental belief that nursing is a professional discipline. The varied expressions of that belief will influence the uniqueness and experiences of the faculty and students in the programme. Universities must be prepared to expand the number of spaces for professional education. New programmes will need to be developed. Practising registered nurses, while insured the right to continue to practise, must have the opportunity to enter generic programmes, using challenge exams to establish advanced standing when appropriate.

If nursing is to progress, it must go forward boldly and take its position as a professional discipline. As MacFarlane, the President of Nova Scotia's Registered Nursing Association stated, when discussing concerns about the practice of current practitioners:

> But we must go far beyond that, beyond our self interests, to make decisions that will profoundly affect the quality of life for generations of nurses and their clients.
>
> (RNANS bulletin 1982)

Articulation may undermine the very concept of a professional discipline approach. Integrity of curriculum is compromised by the need to adapt to lower level experiences and to semi-professional training based on non-baccalaureate objectives. It is an attempt to correct nursing's past errors in the educational process. The time for all nursing education to be firmly rooted in the university is long overdue. Nursing will benefit greatly from a unified and professional discipline approach.

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RÉSUMÉ

Articulation et admission à l'exercice de la profession après le baccalauréat

La résolution relative à l'admission à l'exercice de la profession votée par l'Association des infirmières et infirmiers du Canada a des implications majeures pour la profession infirmière et pour l'enseignement des sciences infirmières au Canada. Dans le présent article, on examine les recommandations formulées par certaines organisations provinciales concernant les modifications à apporter à la formation des infirmières. Faisant appel notamment aux recommandations de l'Association des infirmières diplômées de l'Ontario, l'auteur examine la recommandation visant la mise sur pied de programmes articulés de sciences infirmières, soit temporaires soit permanents, pour augmenter le nombre d'infirmiers détenteurs d'un baccalauréat. Si les sciences infirmières s'inscrivent comme une discipline distincte, alors l'articulation pourrait avoir des conséquences importantes sur le plan de la conception des programmes et l'apparition des soins infirmiers comme profession reconnue.

THE TEACHING OF SYSTEMATIC PHYSICAL ASSESSMENT IN BACCALAUREATE NURSING PROGRAMMES IN CANADA

Edna M. Wallhead

In 1982 a survey was undertaken for the purpose of describing the direction that Canadian university nursing programmes are taking toward teaching physical assessment and health history skills.

Over the past decade in Canada there has been much emphasis on the expanded role of the nurse and on primary health care functions. The skills that are the focus of study in the physical assessment courses are fundamental to this area of practice.

Literature Review

Nurses have practiced in an expanded role in Northern Canada for many years. During the 1960's and early 1970's, in response to evidence that a great need existed for nurses' educated for roles in primary care, special programmes were designed and implemented (Witter DuGas, 1974). In 1972 the Boudreau Report gave even greater impetus to the educational movement by suggesting that basic nursing education be altered to reflect a broadened concept of nursing practice and, thus, to facilitate the preparation of nurses for primary care. Paralleling this change was a shift in emphasis from illness care to health care.

Many authors have considered the preparation and role of the nurse in primary care, and have made reference to the teaching of physical assessment and health history skills in basic programmes (Awtrey, 1974; Fagin & Goodwin, 1972; Jones & Parker, 1974; McGiven, 1974). Also noted in the literature are a number of Canadian schools which have incorporated these skills into their baccalaureate programmes (Logan, 1974; Roach, 1974; Witter DuGas, 1974). Research investigating the acceptance and use of these skills by nurses in traditional and expanded roles also has been conducted in Canada (Buckley-Poichuk, 1977).

Edna Wallhead, R.N., M.Sc.N., is associate professor, School of Nursing, Lakehead University, Thunder Bay, ON.

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Little, however, has been written about the actual teaching of physical assessment and health history skills. Apart from some discussion concerning whether nurses should teach physical assessment or whether physicians should (Fagin & Goodwin, 1972; McGiven, 1974; Parker, 1977), only two articles have been found that consider other curriculum matters.

Hagopian and Kilpack (1974) discussed learning experiences, the ordering of content, faculty preparation, and concurrent course material. Quarto and Natapoff (1979) reported on a survey done in New York State that noted learning experiences, required equipment, hours allotted to the skills and the maintenance of faculty competence.

The survey that is the subject of this paper was conducted to provide a description of the situation in terms of Canadian baccalaureate nursing education.

Design Sample

A questionnaire was developed with a combination of closed and open-ended questions. It was sent to the dean or director of the eighteen English language generic baccalaureate nursing programmes across Canada. An accompanying letter requested that the questionnaire be forwarded to an appropriate person on faculty for completion. Eighty-nine percent of those completing the questionnaire were faculty members who actually taught the skills of physical assessment.

Each of the eighteen schools completed and returned the questionnaire, and consented to participate in the survey. Anonymity was assured to the participating schools.

To facilitate clarity, the following terms were defined: systematic physical assessment (SPA); a head-to-toe physical examination including the skills of inspection, palpation, auscultation, and percussion that is carried out in a systematic manner; skill, the aspect of judgment or assessment of findings as well as psychomotor abilities.

Limitations

There are three limitations to the study. The first is that French-speaking schools were not included. The second is that the questionnaires did not inquire into what physical assessment equipment the student was required to purchase, what equipment was provided by the schools for their use. The third limitation is that students themselves were not surveyed.

A pre-test was not carried out. However, face validity and the clarity of questions were addressed by colleagues who teach health history and physical assessment skills.

The Findings

Of the eighteen schools involved in the survey, fifteen (83%) teach systematic physical assessment. Of the three schools which do not, the programme of one is currently under revision and the faculty has yet to decide if SPA is a basic skill. A second school teaches physical assessment skills, but feels it is not providing SPA in the purest sense because of the organization of the course content. The third school teaches numerous screening tests, many of which are found within SPA; however, on the assumption that routine physical examinations are no longer recommended this third programme does not include SPA.

It should be noted that both the second and third schools mentioned in the preceeding description answered only those questions that related to their teaching of assessment skills. In addition three of the schools that teach SPA also teach additional physical assessment skills in their programmes.

Eight of the schools teaching SPA (fourteen respondents) stated that it is being taught in order that the nursing process be implemented, and six viewed teaching SPA as a trend in baccalaureate education for preparing nurses to function in primary care.

A great variety of subject material is taught concurrently with SPA. Such material includes therapeutic communication, maternal-child nursing, community nursing, acute care nursing, nursing process, and basic psychomotor skills.

Of the sixteen programmes teaching physical assessment skills, SPA seems to be taught most commonly in Year Two (eight schools), while four other schools present the material throughout the four years of the programme (see Table 1). Fifty percent of the schools teaching SPA in Year Two introduce first year students to some of the skills. Eight programmes also re-introduce SPA in later years for varied reasons; for example, for a focus on pathological findings, for greater depth, for orientation to specific clinical areas, and for review purposes.

In ninety-four percent of the schools SPA is focussed on identifying "normal" and "variations from normal" findings. Only one school includes pathological findings along with normal and variations from the normal. Each of the sixteen schools uses laboratory demonstration and supervised practice to teach physical assessment. Five of these schools also use independent study.

Eleven of the seventeen schools (65%) use written assignments to facilitate the learning of assessment skills. Eight of those eleven schools use a written report of the assessment findings with six of the eight schools also incorporating a health history. Nursing diagnosis assignments and nursing care plans are utilized in other programmes.

Only two schools employ a physician, in addition to a nurse educator, to teach SPA. As of 1983, one of these schools will discontinue the use of the medical doctor.

Fourteen of the seventeen respondents (76.5%) stated that faculty involved in teaching SPA regularly use these skills themselves.

Schools tend to teach SPA after the study of anatomy, concurrently with or after the study of physiology, and prior to the study of pathophysiology (see Table 1).

Table 1

The Teaching of SPA in Relation to

Anatomy, Physiology and Pathophysiology

	Year in Which SPA is Taught														
	Yr. 1			Yr. 2						Yr.3		Yr.4		All 4 Yrs.	
SCHOOLS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
ANATOMY:																
Prior to its study																
Concurrent with its study	X									X			X	X	X	X
After its study		X	X	X	X	X	X	X	X		X	X			X	X
PHYSIOLOGY:																
Prior to its study			X													X
Concurrent with its study	X			X			X		X	X			X	X	X	X
After its study		X			X	X		X			X	X			X	X
PATHOPHYSIOLOGY																
Prior to its study	X	X	X	X	X	X	X		X		X				X	X
Concurrent with its study								X		X					X	X
After its study												X	X			

The hours set aside for teaching SPA vary tremendously — anywhere from twenty-four to ninety hours. For some schools it is difficult to identify the specific hours used to teach health history, and thus these hours are included in the time used to teach SPA. Of the twelve schools reporting specific hours for teaching physical assessment, five schools allot between thirty and fifty hours and three schools between fifty-one and seventy-one hours. These twelve schools also reported varying periods of time for the teaching of health history. The range was from one to eighteen hours, with the most frequent answer (three schools) being four hours.

In an attempt to shed some light on the depth of assessment taught, schools noted whether or not students were expected to assess five particular areas as noted in Table 2.

Table 2

The Teaching of Funduscopic and Specific Cardiovascular Assessments by Individual Schools

	Schools														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
VISUAL ASSESSMENT																
Retinal Structures								X			X	X	X		X	X
CARDIOVASCULAR ASSESSMENT																
Physiological Split of S_2		X		X	X				X		X	X	X	X	X	X
S_3 sounds										X					X	X
S_4 sounds										X					X	X
Murmurs				X	X				X		X	X		X	X	

These areas were chosen as they are finer aspects of assessment, that may be viewed as being more difficult to develop skill in.

Fifteen of sixteen schools teaching physical assessment have a required textbook. For the sixteenth school, a recommended text is optional. *A Guide to Physical Examination* by Barbara Bates is by far the

most popular text with eight of the fifteen schools using it. Two other programmes include Bates in a selection from which students may choose.

In three of the sixteen schools, 100% of the faculty who supervise students clinically have studied SPA. In the remaining thirteen schools the percentages vary widely from none (one school) to 71% (one school). The mode was 25% (two schools). At least 50% of the faculty who supervise students in clinical areas in eight schools are skilled in SPA.

Methods used to assess student skills are itemized in Table 3. Most schools assess each of these areas. Observation of clinical performance and the use of written examinations and testing practicums are the most common methods used for assessments.

Variation of from no time limit to twenty-four hours for a head-to-toe examination, and from fifteen minutes to two hours for a randomly chosen system were reported. Some responses were difficult to interpret because, in some instances, it appeared that an entire block of clinical experience was being referred to as a practicum.

Grading practices also vary tremendously, although each of the ten programmes reported that a particular grade is required to pass the practicum. Nine of the ten schools seem to have grading designations that would likely be viewed as requiring a pass level, i.e. pass/fail, C, 51, 60 and 65. The remaining school requires 90% on the demonstration of a head-to-toe examination with a two-hour time limit.

After SPA is taught, students from thirteen of the seventeen programmes, are expected to use the skills routinely. Three programmes require students to use only those skills that are relevant to their patient's problems. Fourteen of the seventeen programmes expect students to carry out health histories routinely after they have been taught. Five respondents state that a health history on an adult medical/surgical patient would be taken, another five that a nursing history relating to the presenting problem would be taken, and the remaining six require either a health or nursing history.

Four respondents state that a head-to-toe examination would be completed and twelve indicate a partial examination would be done to assess the person's presenting problem(s).

Thirteen of the sixteen respondents state that a student's skill in physical assessment is assessed in clinical performance subsequent to the teaching of SPA. For nine of these, clinical observation is the method of evaluation.

Table 3

Methods Used to Assess Student Skill in Health History taking Knowledge of SPA and Skill in SPA

Methods	Schools															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Oral examination										x						x
2. Written examination	x	x	x	x		x*		x	x*		x		x		x*	x
3. Discussion												x				
4. Study questions													x			
5. Laboratory practice			*					x*	x*							
6. Observation of clinical performance	x*	x*	x*		*	x*		x*	x*			x*				
7. Recorded practice on lab. partner			x				+									
8. Simulation												x*				
9. Critique of taped interview														+		
10. Videotape of an interview															+	
11. Nursing care plan				*												
12. Recorded history on a client		+	+					+	+	+	+					
13. Role playing					x*											
14. Clinical paper						+										
15. Assignment	+								x*							
16. Practicum: randomly chosen system		x*			*	x*				x*	*				x*	
head to toe examination							x*	x*				x*		x*		*

NOTE: Code — + - skill in health history x - knowledge in SPA
* - skill in SPA

Discussion of Findings

Although it is somewhat unusual to make reference to the significance of a survey in a report, it seems that the findings of this survey will be of particular interest to Canadian nurse-educators because every school in the sample consented to participate.

The findings from the survey form an interesting profile of the teaching of systematic physical assessment in the generic programmes across Canada.

The survey indicates that the knowledge and skills for systematic physical assessment and for health history are considered to be fundamental to the education of generic baccalaureate nurses. Forty-three percent of the schools state that nurses require these skills for roles in primary care, and fifty-seven percent assert that the skills are essential to the implementation of the nursing process.

Systematic physical assessment is taught concurrently with almost any conceivable nursing subject. In some programmes it is taught with other health oriented subjects such as community health and health promotion. In other programmes it is taught concurrently with acute care nursing where illness rather than health is the orientation. However, in the case of either orientations, 94% of the programmes focus on normal findings and variations from the normal. Laboratory demonstration and supervised practice are used by each school, and one-third also incorporate independent study.

It is difficult to draw any specific conclusions with regard to the depth to which assessment is taught. It would appear that most programmes place reduced emphasis on funduscopic examination, and the identification of S3 and S4 heart sounds. However, the identification of physiological splitting of S2 and the identification of heart murmurs are taught in about two of every three programmes.

The skills of systematic physical assessment and health history seem to be firmly in place in baccalaureate programmes. However, to what extent these skills are emphasized and applied clinically is unclear. One factor may relate to whether the skills in question are perceived to be basic to the assessment of any individual or specific to the assessment and screening of individuals of a particular group such as would be seen in primary care.

Ruth Zarnow (1977) described five levels of content related to the expanded role. These are: basic nursing, assessment, screening, management, and diagnostic. From the findings of this survey (indicating that students primarily carry out partial physical examination and histories relevant to the person's presenting problem), it would

seem that most students practice the skills at level two, the assessment level. Here more indepth assessments and more accurate descriptions of the person are encouraged. As Zarnow states, at this level the nurse is experiencing a change not in role, but in function.

This alteration in function would be more appropriate to the health needs of individuals. Perhaps faculty are caught in the transition from illness oriented to health oriented care. It is difficult to teach what is not generally practised and, likewise, it is difficult to acquire and maintain new skills. Conceptually, faculty might be assisted by considering Newman's (1979) assumptions underlying the concept of health where illness is seen to be part of health. Illness care then becomes only one part of health care; the latter being the focus of nursing. Certainly discussion and debate will continue on this matter.

For now, it appears that systematic physical assessment and health history skills are part of an inventory of competencies basic to the baccalaureate nurse in Canada.

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RÉSUMÉ

L'enseignement de l'évaluation physique systématique dans les programmes de baccalauréat en sciences infirmières au Canada

On a effectué une étude des programmes de baccalauréat en sciences infirmières au sein des universités anglophones du Canada afin d'obtenir des renseignements concernant l'enseignement des démarches d'évaluation physique systématique et d'anamnèse. L'étude à laquelle toutes les écoles ont participé a révélé que cette démarche était enseignée dans le cadre de 15 des 18 programmes. Bien que certains répondants aient noté au niveau de la formation du baccalauréat une tendance à enseigner aux infirmiers les démarches fondamentales de soins de base, un plus grand nombre ont cependant souligné la nécessité de maîtriser ces compétences afin de donner suite à la démarche infirmière.

On a noté des similitudes dans les programmes, notamment pour ce qui est de l'accent sur les observations normales, l'enseignement dispensé par les professeurs de nursing, l'utilisation obligatoire d'un manuel d'évaluation physique ainsi que l'obligation pour les étudiants d'effectuer des examens physiques partiels en rapport avec le problème que présente le malade. On a observé de très grandes différences au sein des programmes en termes d'heures consacrées à l'enseignement de ces compétences, au niveau de la formation des professeurs, au niveau des méthodes d'évaluation utilisées, des délais accordés pour effectuer les examens sous forme de travaux pratiques et les sujets de sciences infirmières enseignées concurremmnent. Bien qu'il existe des différences en termes d'apprentissage et de conditions, il semblerait que l'enseignement des aptitudes relatives à l'évaluation physique systématique et à l'anamnèse ait été généralement incorporée dans les programmes fondamentaux de baccalauréat en sciences infirmières au Canada.

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Are the ideas developed logically? Are they expressed clearly? Is the length appropriate to the subject? Does the number of references or tables exceed what is needed?

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La revue *Nursing Papers/Perspectives en nursing* accueille avec plaisir des articles de recherche ayant trait aux sciences infirmières et aux soins de la santé. Veuillez adresser vos manuscrits à la rédactrice en chef, *Nursing Papers/Perspectives en nursing*, Ecole des sciences infirmières, Université McGill, 3506 rue University, Montréal, P.Q., H3A 2A7.

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L'auteur développe-t-il ses idées de manière logique? Les exprime-t-il clairement? La longueur de son article est-elle appropriée au sujet abordé? Est-ce que le nombre de notes ou de tableaux dépasse le strict nécessaire?

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Length of program

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

Language of study: English

Further information from:

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