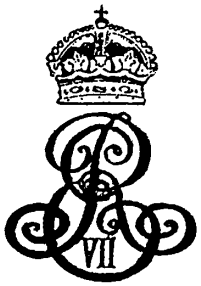

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SCHOLARSHIP

AND THE GROWTH OF NURSING

KNOWLEDGE

Report from a symposium held at the King's Fund Centre
18 February 1986
To celebrate the first ten years of the
Journal of Advanced Nursing

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THE CONTRIBUTION OF THE JOURNAL OF ADVANCED NURSING TO THE BODY OF NURSING KNOWLEDGE

Professor Christine M Chapman, Director of Nursing Studies and Professor of Nursing Education, Welsh National School of Medicine

It gave me great pleasure to be asked to contribute to this conference, celebrating ten years of publication of the Journal of Advanced Nursing. Perhaps the pleasure was enhanced because I remember being asked by the now editor as long ago as 1974 what I thought of the idea and I've been associated with it ever since. At first with a degree of trepidation, wondering whether sufficient articles would be forthcoming to fill the issues and latterly, with a degree of exhaustion as the task of reviewing submitted manuscripts becomes more of an arduous one.

Is publishing enough? It rather depends who asks this question. If it is the publishing firm, then, providing the journal makes a profit, perhaps the answer is 'yes', but for those on the Editorial Board, I feel sure that the answer is 'no'. The reason that we are involved with the Journal is our desire to help nurses proessionally in whatever sphere they may be working and, through them, assist in improving the quality of patient care. To do this, we need to add to the body of nursing knowledge and, in one way, we can confidently say that the Journal has done this. However, just as publishing may not be enough, so the static acumulation of articles is also inadequate. Knowledge is not a static commodity which can be picked up and left in a corner until needed. Instead, it should grow, develop and produce new insights and generate new areas of thought. A course with which I have contact has, as its overall aim:

> **"To enable the students to find, assimilate, use and synthesise knowledge."**

When first approached regarding this conference, it was suggested that I might consider the Journal's contribution to 'academic' knowledge and this ties in with the thoughts on 'synthesising' knowledge.

Initially, I had trouble with the word 'academic' and discovered that it had origins in both Greek and Latin referring to 'institutions of scholars'. I therefore decided to discover what 'institutions of scholars' thought about the Journal.

The best way to do this seemed to be to look at theses written for higher degrees in nursing so I spent a long, fascinating, if rather dusty, day in the Steinberg Collection of Theses in the Rcn Library, looking at theses for the degrees of Magister and Doctor of Philosophy. The Magister degrees on the whole can be said to be using knowledge, while the doctoral degrees should be synthesising new knowledge.

The result of my day's labour was as follows:

> I inspected a total of 111 theses, 36 at doctoral level and 75 at magister level, and counted the number of times articles from the Journal of Advanced Nursing were cited. I only looked at those submitted after 1980, as I considered that earlier candidates would have completed their literature search before the Journal was readily available. The theses were classified as those concerned with Education, Practice (nursing, midwifery and health visiting), Theory (not necessarily nursing theory as such), Management, Research and inevitably, 'Other'. The results are shown in Fig. 1.

In all, there was a total of 269 citations, 95 of these in doctoral theses and 174 in magisters. 35 theses had no citations from the Journal of Advanced nursing, 12 PhD and 23 Magister.

My next step was to see if there was a correlation between the classification of citations and the numbers of articles published in that classification. Fig. 2 shows the numbers published by year, and hence the changes.

It was difficult to be consistent regarding the classification of articles and some dealt with more than one topic. In particular, I had difficulty with the 'Research' heading and, in the end, only classified as such, articles that were primarily concerned with methodology. Because of the possible

inaccuracies in classification, I did not carry out statistical tests of significance, thus giving greater respectability to the findings than they deserve, but a rough correlation indicates that there were twice the numbers of articles published in each category than were cited. However, this statement is also misleading in that in some cases, even though there was a large number of citations, they all referred to a very limited number of different articles. This could be further studied to indicate the influence of specific articles to the development of knowledge.

It is, therefore, possible to conclude that the Journal of Advanced Nursing has made a contribution to the body of nursing knowledge and that it is also 'academically' respectable. This latter point is further supported in that as the articles are subjected to peer review prior to publication, such articles are credited by Universities towards evidence of academic standing, when individuals are considered for tenure and promotion.

One slightly disappointing feature is the rarity with which the Journal is quoted in American nursing publications in relation to the frequency with which UK nurses quote American writers, although I have recently reviewed an American book which cites the Journal of Advanced Nursing as a journal contributing to the development of nursing knowledge and quotes from it extensively.

For the future, it is important that the Journal of Advanced Nursing does not become a publication where authors write for each other but that it remains an influence over the development of nursing knowledge and scholarship, whether by articles describing research findings, or by providing a forum where ideas can be floated and discussed prior to more rigorous scrutiny.

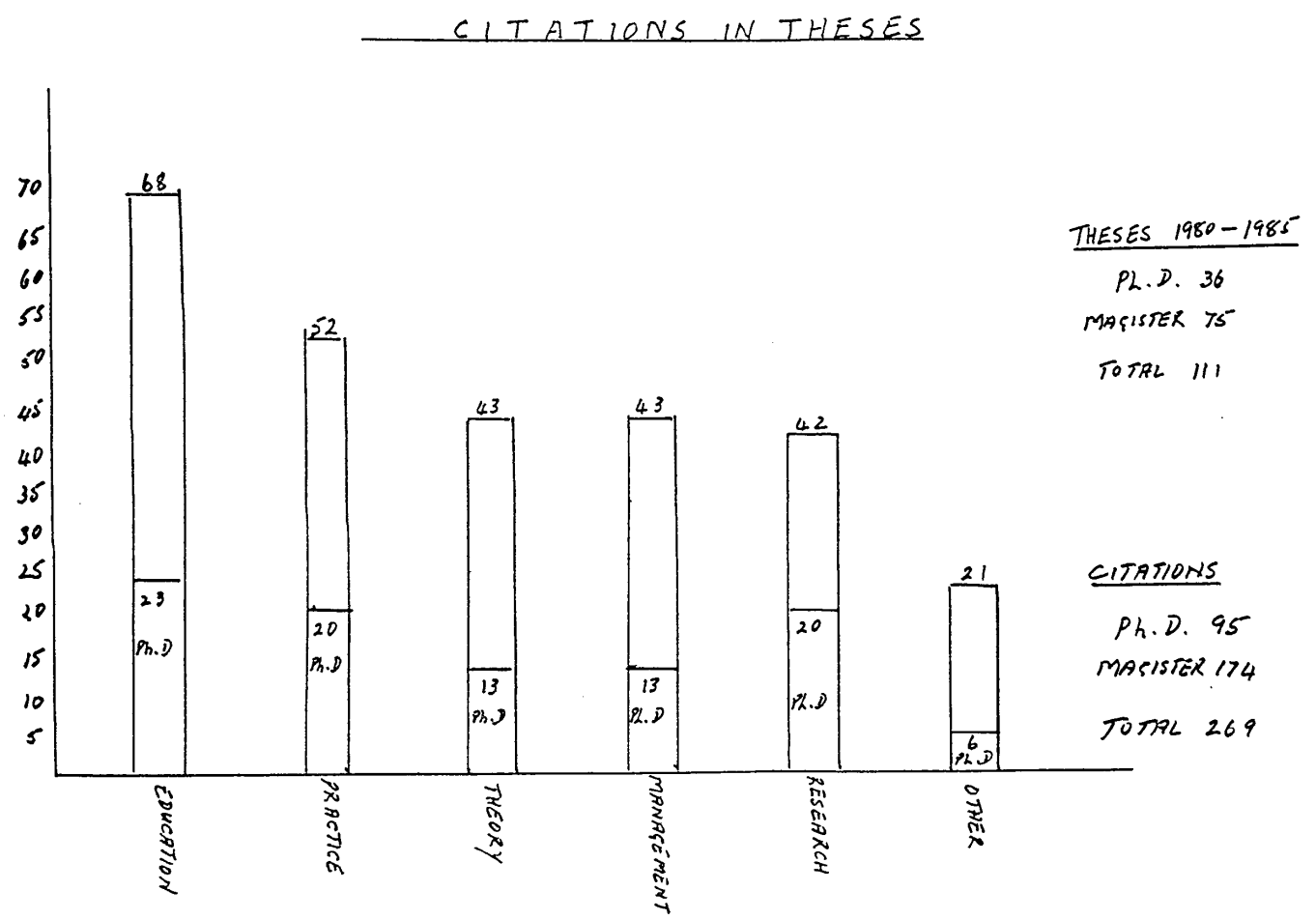
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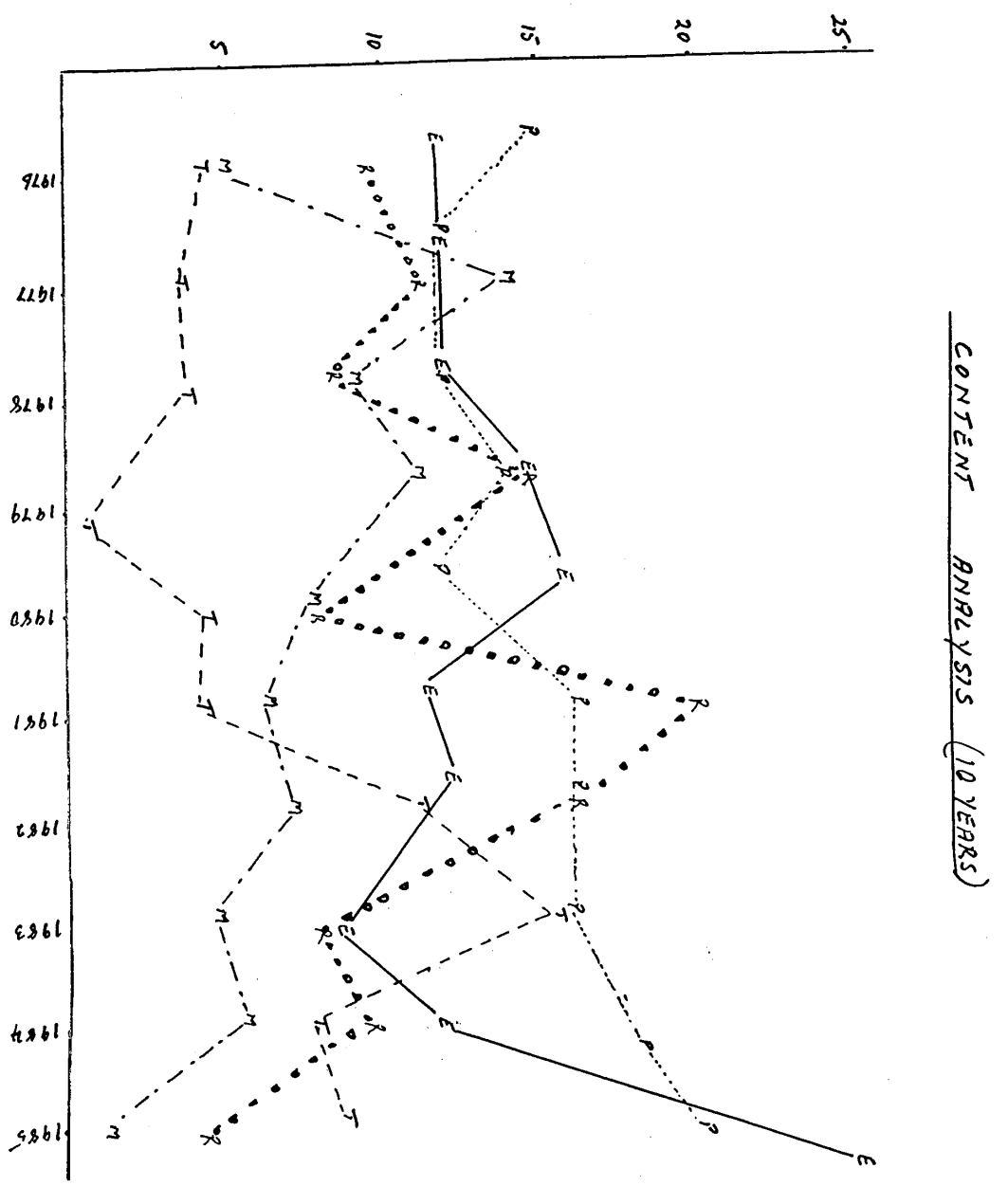
Figure 1.

Figure 2.


CONTENT ANALYSIS (10 YEARS)
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SCHOLARSHIP AND NURSING EDUCATION

Margaret Clarke, Director, Institute of Nursing Studies, University of Hull

Today, many nurses believe that nursing is being threatened in many ways: within the NHS by the implementation of the Griffith's general management proposals and through the operation of limited financial resources; within higher education by increasingly stringent financial cuts. At the same time there are proposals for radical changes within the mainstream of nursing education. One can be forgiven for feeling overwhelmed by the rate at which changes are occurring. Apart from the policy constraints which have been mentioned already, there are other changes which may have equal or even greater impact upon those nurses who are in day to day contact with patients; changes such as privatisation, the introduction of computers, the introduction of Körner; the change in emphasis from hospital to community care; the nursing process; monitoring of quality of care and so on.

These circumstances reveal a great need for nurses who have been exposed to the broadest education possible rather than nurses who have undergone a narrow training in skills which are relevant only to the patients of today. In this paper I wish to suggest that nurse educators should be developing the skills of scholarship within the majority of students of nursing instead of scholarship being restricted to those nursing students within higher education. Scholarship is only one of a number of useful education methods, but it is, nonetheless, crucial both in ensuring a broad education and the ability to cope with change, since coping with change requires self confidence and considerable intellectual resources.

Firstly, I wish to define the word **education** in a broad sense. The education philosopher Peters (1973) has argued that an educated person possesses a considerable body of knowledge, together with a breadth of understanding. He argues that education develops the capacity to reason and the ability to justify one's beliefs and one's conduct. Educated persons, he argues, know the why of things. Above all, their understanding transforms how they see things and makes a difference to the level of life they enjoy. Through education, Peters claims, the whole of experience comes to be organised in terms of systematic conceptual ideas.

Peters goes on to suggest further qualities possessed by the educated person and developed by means of the education he or she has enjoyed.

These are:

1 The capacity of connecting together many different ways of interpreting experience so as to achieve cognitive perspective, and also to avoid being embedded in only one way of reacting to the experiences which are encountered.

2 A readiness to pursue the links between different sorts of understanding.

3 The use of generalisations from social sciences about consequences of behaviour, taking account also of both cultural and legal knowledge in making moral judgements.

4 The ability to explain a particular event in terms of a general principle or where it fits within some more general pattern or framework, thus allowing a higher degree of predictability of events.

5 The ability to argue rationally, through clarity in explanation, elimination of errors, rejection of arbitary assertions, avoidance of irrelevant considerations, and the questioning of generalisation for their evidential basis.

Finally, Peters argues that above all the development of knowledge and understanding permits better control over and utilisation of the natural world for human purposes.

Recently the RCN Commission on Nurse Education has argued for nurses to receive an education rather than training, and the UKCC Project 2000 Paper No. 2 appears to agree with this in these terms:

> "The main thrust of all the reports, articles and discussion in the last four decades is the desire to improve the quality of the total learning environment and ensure that programmes are based on sound educational principles. On this everyone is agreed. Furthermore there has been a shift over time so that there is now greater confidence that the preparation is not best seen as an apprenticeship in which practical skills are paramount but must be more broadly based."

Obviously then this paper is far from revolutionary in arguing for students of nursing to receive an education.

Ruth Schröck in that same UKCC paper, set out some general principles of being a student. By setting out principles of being a student this gets away from the idea that a student exists only within a particular type of institution but that studenthood is much more to do with an attitude towards one's own education. To quote two of these principles: firstly a student should be

> **"self directive to some extent and increasingly so as the educational programme progresses,"**

and secondly, that the student must be

> **"permitted to explore areas of knowledge and skill on an individual basis as well as being part of a larger group"**

Development of the skills entailed in the production of a scholarly paper is a method of education which fulfils these criteria. It is a self directed, student centred method and it permits the exploration of knowledge on both an individual basis as well as within the group.

Definitions of scholarship tend to be static, describing the content of scholarship, e.g. learned, erudite, a profound knowledge of a specific subject gained by extensive reading and study. This has the connotation of a scholar acquiring knowledge in the splendid isolation of an ivory tower. Now in this paper I am not advocating scholarship so that nurses can withdraw from the real world of nursing to acquire knowledge but rather that the knowledge of scholarship can be used to the benefit of nursing practice; this is possible at least in part because of the interdisciplinary nature of nursing.

In the context of nursing the process of producing a scholarly piece of work (called here the Scholarship Process see **page 13**) and the abilities developed within the individual as a result of scholarship is of more interest than the content of scholarship alone. In the table (**page 13**) I have identified the skills used in scholarship. These skills have been set out in a form compatible with the nursing process or the research process since this immediately shows where generalisation of methods of working may occur.

Turning now to the ways in which scholarship can help the individual in terms of intellectual development; these are:

1. Understanding and knowledge are developed (these are the prime purpose of education according to Peters).

2. The ability to identify and define a problem.

3. The person comes to value primary sources.

4. The ability to weigh up evidence both for its soundness and for its relevance to any issue.

5. Clarity of ideas and rationality are developed.

6. A new juxtaposition of areas of knowledge may lead to new ideas: i.e. creativity.

7. Pride in the integrity of one's own work may lead to the development of self confidence and self esteem.

8. The ability to relate one area of knowledge to another area.

9. Since by definition the end product is public this leads to openness in academic work. It also develops a self critical ability and objectivity about one's own work since the writer needs to anticipate the criticisms to which it will be subjected.

10. The ability to use the same language, types of argument and standards of evidence as other disciplines within the NHS or elsewhere.

11. Good habits of neatness and method in documenting and classifying source material.

12. If papers are used for seminar work to which several students contribute it aids sharing and working together.

13. It allows the development through interest of self motivated learning and reading and the acquisition of knowledge which is retained throughout life, transforming the quality of the individual's life.

14. It promotes not just the memorisation and retrieval of knowledge but selection, appreciation, and application in a new way.

15. It promotes good communication skills or at least it should do so.

On this latter point, it is useful to note that the instructions to contributors in journals from different disciplines all emphasise clarity of style and freedom from jargon. In particular the **British Journal of Educational Psychology** is extremely explicit on this point and worth quoting. It states:

> "Papers should be written with the utmost conciseness consistent with clarity. If the editor takes the wrong meaning from or fails to understand a passage, the fault is the author's. Unless the Editor can grasp the meaning of a sentence unequivocally, it cannot be assumed that other readers can."

Having now examined the process of scholarship and the functions it may develop within the individual scholar, scholarship as a method of education is considered next, within the context of traditional vs progressive methods of teaching and learning. Gagne (1967), Rogers (1971), and Bruner (1965) have criticised traditional methods of teaching in which they claim that content is the dominant factor rather than the development of learning skills and processes.

Within nursing itself Gott (1982) has criticised traditional teaching methods. She argues that competing claims on the curriculum, all of which must be covered, leads to a narrow field of knowledge being taught without interconnections being made between related areas. Through this type of teaching, the learners come to expect the knowledge which is transmitted to be narrowly utilitarian. Insufficient time is allowed for learning at the individual's own pace and so inadequate learning may take place. Accepting what Gott says, such tradional teaching maintains the status quo, the idea of routines, and clearly defined subject areas which limits transfer of knowledge. There is a reliance on second-hand knowledge. The teacher comes to be seen as an expert whose knowledge and authority should be accepted without question. This maintains a hierarchial structure in education but also leads to disillusion when the student is in the reality of the ward or community.

On the other hand, scholarship as an educational method can be characterised as student centred. Even if the topic is chosen by the teacher, the student is able to select the areas of literature which will be searched according to interests and ideas of the student's. The student is able to go at his or her own pace, the obligation being to work to a deadline. The process of sifting, evaluating, summarising and then using the literature in a new way aids learning. The balance of control of the learning process passes to the student rather than the teacher. The teacher is less likely to be seen as the authority who is always right, since the student is learning how to analyse and criticise the work of experts, even perhaps the teacher's own work. It is very likely that in some areas of knowledge the student may end up knowing more than the teacher. The teacher becomes a resource for reference material and a person on whom new ideas can be tried out. This changes the nature of the relationship between student and teacher. It becomes more equal and open and this develops the student's self confidence.

By now a good case has been made for scholarship as a method of education, but that does not mean that there are no problems associated with it for nursing. These will be explored briefly.

There are three potentially problematic areas:

1. One area of potential problems is associated with the teacher/student relationship and the teaching process. An obvious problem associated with scholarly pieces of work is that they go hand in hand with a critique of that work. For the newcomer, criticism when writing or giving papers, can be quite devastating, reducing self confidence rather than boosting it. Thus a teacher who is trying to develop the skills of scholarship within a student must handle the weapon of criticism very carefully. Early on the student requires praise for good points and negative aspects of the critique must be introduced only gradually. It is better if the student can gradually be led to criticise his or her own work. However, this approach is time consuming and needs skill and sensitivity if the students are going to be prepared later to take risks in exposing their own ideas on paper or in class, and thus produce worthwhile innovative work. Otherwise they will produce mediocre work full of received ideas through fear of exposing themselves to criticism.

Implicit in what has been said above, the development of scholarship is a long-term process. Students are not going to produce scholarly masterpieces in the first year of a nursing course. It may not happen at all, of course, but usually the best work is not produced until the third or fourth year of a course. How is this going to fit in, for example, with the ENB proposal for an extremely practice-orientated third year of nursing education?

In student centred methods, the teacher does not control the learning process and in producing scholarly work the student works independently. It may be that not all students coming into nursing can cope with this and some may need a great deal of additional help and counselling.

What about the teachers themselves? Will they not feel threatened by students who have learned to look critically at academic work and who in some areas of knowledge know more than the teacher? I believe that the teachers who will feel confident in coping with this are those who have a specialised area of expert and scholarly knowledge themselves. They will know that the student will respect that and they will also realise that no one can have a depth of knowledge in every subject area.

2. A second area where difficulties can be foreseen is that it will be claimed that scholarship is an activity within the domain of theory whilst nursing is essentially a practical activity. Bendall (1973), Gott (1982) and Miller (1985) and others have written about the separation between theory and practice. Indeed, some nurses appear to believe that much theory is irrelevant to practice. This leads to the questioning of the use of scholarship in nursing education. Is it yet another method to drive a wedge between theory and practice; between theoretical nurses and those who actually nurse patients?

In a recent paper (Clarke 1986) I have argued the case for applying the writings of a British psychologist, John Shotter (1975), to the teaching of nursing, since this might overcome the problems of the divorce between theory and practice.

In that paper it is suggested that nursing actions should be the primary unit for the study of nursing. Nursing actions (after Shotter) are defined as comprising both observable behaviour such as history taking, monitoring, social interaction, sensori-motor skill etc., and the reflection upon or explanation of that behaviour. Reflection/explanation may initially come after the behaviour or before it and can take many different forms of elaboration, depth and detail. Shotter claims that it is this explanation/or reflection either to ourselves or others that makes an action both moral and humanistic. It is the explanation/reflection component of nursing action which could come to be the basis of nursing theory, as indeed it already is in many cases.

This has only briefly been elaborated here but it shows, I believe, that scholarship need not inevitably lead to separation between theory and practice. Rather the process of scholarship could arise from the practice component of nursing action. For example there is a wealth of literature available to justify some of the methods used in the prevention and treatment of pressure sores and to explain why others should not be used. This has already provided many scholarly papers on the topic.

At the University of Hull staff expect nursing students to display scholarship in their essays, final year dissertations and nursing care studies and care plans. Nursing care studies tend to become major pieces of work of up to 60 or more pages in length. They allow both the learning of theory relevant to practice and reflection upon practice. The learning which occurs is student centred since students choose which patient they will write about and the aspect(s) of care on which they wish to elaborate. To give two examples from real care studies handed in recently:

> One was a care plan of an elderly patient, aged 88, admitted for falls of unknown origin. Here the student had chosen to include referenced and well researched papers on: the incidence and prevalence of falls; possible underlying pathology and outcomes; confusion; constipation.
>
> A second example is a care plan of a patient undergoing thoracotomy which included a paper on carcinoma of the lung and surgery and one on the prevention of pressure sores.

Pembrey's (1986) paper in this collection reinforces the point that provided there is a clear objective of explaining or reflecting upon practice or the experience of patients/clients, scholarship can be used to the benefit of practice rather than contributing to the separation of theory and practice.

3. The final major potential problem about the use of scholarship within nursing education which will be explored here, arises precisely <u>because</u> it is student centred and allows the student to research some topics in great depth. This means that within the limited time period during which an individual is formally considered to be a student, other topics will be ignored. (One always hopes of course that the person will consider themselves to be a student for life).

Traditionally, nurse training can be characterised as identifying and cataloguing a basic minimum of knowledge and skills which must be covered and on which the student is tested during or at the end of the course. The type of testing used in England at least until the most recent recommendations from the ENB has been based on testing for and checking for one correct answer. To quote the GNC (England and Wales) in 1976/10:

> "One of the main advantages of objective tests over traditional examinations is that answers are asked in such a way that there is only one predetermined answer"

Against this, scholarship suggests that there are a multitude of different approaches, some of which are better than others. The inferred value system behind the traditional nursing training system is that it is indeed possible to identify the skills and the knowledge which are necessary for safety. These can then be tested to ensure that the person is safe. However, that is a model of an unchanging nursing world in which a finite amount of knowledge and skill is needed. This is certainly untrue today if it was ever true. The world of nursing is changing very rapidly and the skills and knowledge required with it.

Therefore, together with knowledge and attitudes the skills an individual needs are the intellectual skills of learning and thinking, which allow coping with change; skills which develop proactivity as well as reactivity; and those which motivate learning throughout life.

I believe that the skills acquired and the intellectual functions developed through scholarship are more useful in coping with today's changing world than is a narrow training based on tutor selected knowledge and the utilitarian set of skills supposedly needed to nurse the patient in today's NHS. To quote a ward sister in Gott's (1982) study on the subject of student nurses:

> "They're taught basic procedures but they're not taught how to adapt to different situations. They don't seem to have initiative; they can't think for themselves. They're taught to do things but not why .....They should reason instead of learning but not understanding."

Scholarship is certainly only one of the methods needed in nurse education but it is the ideal model for developing the truly educated person needed for today's world as opposed to the person with a narrow utilitarian training. In conclusion, it is worth quoting Peters (1973) again. In relation to education in the broadest sense, he says:

> "A strong instrumental case can be made for the passing on of knowledge and understanding. Knowledge is essential to the survival of a community. The development of understanding is particularly important in a modern industrialised society in which the skills required change rapidly. If people are provided only with a specialised skill and only sufficient knowledge to exercise that skill under specific conditions then they will tend to be resistant to change and will become redundant."

Thus the argument in this paper is that scholarship is an essential part of a good and broad and deep education and that paradoxically the best possible education is much more useful for tomorrow's nurses than a narrowly instrumental and utilitarian training.

THE SCHOLARSHIP PROCESS

(Examples refer to a hypothetical paper on **'Institutionalisation in Relation to the Elderly Client of the NHS'**).

Stage 1 - Preliminary definitions of the problem

1. Understand the terms used and their appropriate definitions, e.g. client, elderly, institutionalisation, institutions within the NHS.

Stage 2 - Collection of information

2. Identify the areas of knowledge which may be relevant, e.g. the elderly, institutionalisation as seen in the psychiatric literature; institutionalisation from the sociological point of view; as seen in the psychological literature; behavioural theory; welfare rights; ethics. (This process may be initiated by a list of references from a member of staff if it is a student paper).

3. Carry out literature searches, e.g. by computer; using library catalogue; browsing.

4. Read and collect notes on the literature, making decisions on its relevance. Carefully document and classify all sources so that the information can be retrieved. Summarise literature. Collect quotes.

5. Identify the source material which is centrally important and that which is less central to the topic. Carefully evaluate the academic standing of all source material.

Stage 3 - Define the problem

6. Final definitions of terms in the light of the literature reviewed.

Stage 4 - Plan the paper

7. Usually this will include an introduction; definitions of the terms used and their boundaries (e.g. in this paper I am not going to include short stay wards for the elderly.)

Development of one or more themes, grouping similar topics together (e.g. sociological perspectives may be dealt with before the psychological rather than shifting from one to another).

Interim conclusions will be related to the material providing evidence. All evidence supporting a particular position will be presented and critically evaluated. The same would be done for an opposite position.

A conclusion overall would be drawn in the light of the evidence.

Stage 5 - Write the paper

8. First draft.

9. Critically examine the first draft, checking its logic and rationality. Identify factual descriptive statements as opposed to attitudinal/belief statements making sure that the latter in particular are supported with evidence. Identify any new ideas (creativity), justifying these with evidence or stating how any evidence could be collected to refute or support the idea.

Check that any source material is properly acknowledged to avoid plagiarism. Check for readability, grammar and spelling and ensure that jargon or technical words have been defined and aid clarity rather than obscure it. Check that all sources are properly referenced and cross check with reference list at the end using a standard method of referencing. Check the length of the paper.

10. Final draft.

Stage 6 - Evaluation

Initially this will be by the individual himself or herself. A colleague may be asked an opinion. External evaluation is by the audience reaction, mark, or acceptance by a journal.

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SCHOLARSHIP AND NURSING MANAGEMENT

Miss Anita M Cox, Director of Nursing & Quality Assurance, Hounslow and Spelthorne Health Authority

Introduction

> "We do need to know how to co-operate with the organisation but, more than ever, so do we need to know how to resist it."

William Whyte (1960) wrote this against the mediocrity of an individual enmeshed within an organisation. Perhaps we should consider its application to the nursing profession within the National Health Service at this time.

In January 1985, when this programme for today was planned a question mark, at the very least, hung over the management of the nursing profession. What would the structure of nursing management look like at the beginning of 1986? - and, more fundamentally - would nurse managers exist?

Without doubt this last year has been a traumatic one for nurses and nursing, and for the Health Service as a whole, often because of the threat of the unknown, but also because of the organizational changes which have, in many Health Authorities, removed the management of nursing from a Chief Nurse.

Recognising and accepting that organisational changes have taken, and are taking place within the National Health Service under the auspices of the 'Griffiths' Inquiry (1983); it is within the context of this current environment that nurses continue to provide 50% of the workforce, to spend upwards of 30% of a District's revenue budget, and in which we can consider the relevance of scholarship to nursing management.

Background

A lecturer at one of the better known business schools invariably suggests to a new intake of eager middle managers that:

> 10% of managers, those who are the high fliers, who have an innate and accurate intuitive mechanism and who are going to the very top of the management tree, will not benefit from management education and training.
>
> a further 10% fill only the mediocrity of management posts, have little aptitude for further development and they also will not benefit from management education and training.

That leaves 80%, a large majority, in fact, who will benefit from a programme of learning and self-development in management skills and techniques.

Have 80% of nurse managers benefitted from some form of management training?

More importantly, has a programme been planned to meet the personal development needs of the individual and the development needs of the organisation, be those needs concerned with managing nurse education, managing nursing practice or, indeed, with general management?

Rosemary Hutt's study of the career profiles of Chief Nursing Officers (1985) would suggest that there is no uniformity of opportunity for or attainment of scholarship applied to nursing management following professional qualifications, although the Committee on Senior Nurse Staff Structure (1966) recommended that nurses needed to be educated and trained to achieve the managerial skills levels required for the jobs described in their report.

Two decades later, this recommendation continues to be valid. Although the structure of nursing within the National Health Service has changed three times since that report was published, a nurse continues to progress through the clearly identified phases from managing his/her own learning; managing the care of a patient/group of patients; to managing other nurses and their work, before taking on a wider responsibility and accountability for the profession in one of its many and complex guises.

Many nurses will continue to be engaged directly in the management of nursing at operational level. It is the nurses without that line management control, but with a continued accountability for the profession, who will require a sound knowledge of their management environment in order to move nursing forward in a planned direction. They will require the managerial knowledge, abilities and skills which will enable them to bring their professional influence to bear in the interests of health care provision and future nursing practice.

NHS Management Enquiry

Pre 'Griffiths' the power of nursing within a District Health Authority was evidenced in the hierarchical line management structure (often too vertical); the equality of all disciplines making up the team at Unit and District Level; and the then mode of concensus decision-making giving members the ultimate recourse to veto. Multifarious scholars from managerial, academic and nursing backgrounds have variously described the modes of power evidenced above in terms of autonomy, authority, responsibility and accountability.

Nurses continue to be accountable for the profession, both its presence and its future and though autonomy, authority and responsibility as variously described continue to exist in a lesser form in nursing management, the power of the nurse manager must now focus more strongly on influence. Influence has the power to change people and things; to change the behaviour and attitudes of individuals through to changing the plans and objectives of whole organisations.

Handy (1976) conversely describes 'power as a source of influence' rather than 'influence as a source of power' and in the event of influence and power not being used in the best interests of health care provision, he also suggests ways in which influence can be resisted.

Pragmatically, it is the application of scholarship which is paramount. Scholarship which is fostered as a knowledge base for an elitist erudite group without application, can be seen as both arrogant and wasteful in today's economic climate within the National Health Service. Post 'Griffiths', however, it is the scholarship of nursing practice, education and management which is the nurse manager's power base and the application of that scholarship which can influence the future.

The Management Inquiry Team raised issues in their report (1983) which it behoves the nursing profession to address forthwith and comprehensively if it wishes to facilitate the work of the clinical manager and to enhance the nursing care of patients/clients in the hospital and the community.

The team recommends a management budgeting approach which 'relates workload and service objectives to financial and manpower implications'.

It recommends that optimum nurse manpower levels are determined for different types of unit, having regard to the local situation and the maintenance of professional standards.

Drawing on the experiences of industry and applying the similarities to the National Health Service, the report suggests that managers below Board level are concerned with the quality of the product, meeting budgets, productivity, motivation and rewarding staff and research and development.

The team identified dissimilarities between industry and the National Health Service in the lack of continuous evaluation of performance against agreed criteria, in the minimal amount of evaluation of clinical practices and, more rarely still, any economic evaluation of these practices.

The report declares that the driving force behind its advice is the concern to secure the best deal for patients and the community within available resources.

The issues selected from the report do not refer to nursing per se but their total relevance to nurse managers is indubitable. Moreover, they are issues which can rightly be pursued through the Regional, District and Unit review system. Faced with such issues, the profession cannot uniformly and unitedly account for itself at this point in time.

The Need for Information

In order to address the managerial issues identified by Griffiths, the nurse manager requires information appropriate to the decisions which need to be taken. A nurse at the bedside, with a responsibility and an accountability for the pre and post operative surgical nursing care of a patient, less than adequately fulfils this role unless she can apply her comprehension of the aetiology of ill health, her knowledge of the social and emotional factors affecting this particular patient's recovery, and has relevant information regarding the support services available in the community, following transfer from hospital.

A nursing care model

Individualised care plans incorporating the processes of indentifying the needs, planning and carrying out the care and then evaluating that care given, is well recorded as an invaluable tool for the clinical nurse. Less well evidenced is the use of those same care plans as a management tool. First and foremost what are the outcomes of the process? Miller (1986) describes the application of the 'process' to the 'process' in order to evaluate and review its effectiveness.

It should be possible to aggregate care plans, probably using a computerized data base package to monitor patient care and the nursing care process against previously agreed criteria.

Workload measurement

We have long understood that it is not the number of beds available nor those occupied, which determines the need for nurses. Rather it is a combination of the dependency of the patient, the time it takes to perform care tasks and the skill level required to carry out those tasks. This equation is then modified to take account of the learning and supervisory needs of learner nurses and non nurses, the support services and facilities available and the geography of the ward.

It is not surprising, given these complexities that, as yet, we have not got a universally credible tool, although excellent studies have been undertaken on patient dependency and establisment setting systems. Some of these have been modified to meet local needs, and yet more studies are being undertaken in this country or being imported from the States.

It would seem that it is time to draw this work to a conclusion. A report of the Operational Research Department of the DHSS (1985) summarizes some of the available systems and draws comparisons of methodology, resource input and, more significantly, the outcomes. Unfortunately this is not comprehensive and, in particular, omits some of the more recent studies.

Deploying nursing manpower

It is not in dispute that the Ward Sister's/Charge Nurse's primary responsibility is the clinical nursing care of patients, preferably against set standards and a monitored process. It also lies within the responsibility to provide an appropriate total care environment for nurses and non nurses. He/she is the ultimate ward manager. This responsibility comes into dispute when the tools to do the job are not available and maximum time is spent on those tasks which are only indirectly involved in patient care.

One of these tasks is the deployment of nurses, preferably against an agreed and/or identified workload. At worst, a time consuming and laborious manual system rosters nurses against off duty requests, taking little heed of the number of nurses or of the skill mix required. At best, it is perfectly possible to utilise a ward terminal with links into the personnel and finance systems, not only for the 'computer to take the strain' but for the best skill mix to be obtained against a cost effective option. This system would also enable time out to be monitored, staff to be paid against the hours worked and due consideration to be given to working pattern preferences. A link into a Patient Administration System also enables the daily and/or weekly workload to be managed against manpower availability.

Manpower Planning

Given a patient dependency system and a deployment system, such as has been briefly described, both nurse manager and general manager can be satisfied that the process can achieve the most cost effective short term solution to the problem probed by Abel, Farmer, Hunt and Ship (1976) "to provide nurses with the right skills in the right place at the right time, appropriate to the clinical educational and managerial activities to be carried out." The process also addresses the criticisms concerning the inefficient deployment of nurses in the Auditor General's Report (1985).

This describes a detailed process at micro level, however, which can only be satisfied by manpower planning at a macro level. The Regional review system now demands a manpower profile up to 1994 to accompany the strategy for service provision. In the absence of a dynamic manpower profile of the present situation, a manpower plan for the next ten years becomes impossible. Moreover, service plans may be ready to identify reductions in acute beds and shifts to the community, but the evidence of plans for alternative models of care, for the elderly for instance, is still embryonic even though the client group has been steadily increasing to problematic proportions for well over a decade.

Also when one considers that from the same population is derived the product, the consumer and the workforce, it is important to remember that the changing age structure affects not only the receiver of the service but the giver as well.

Data to develop a current manpower profile is usually available, but often manually collected and not collated in a manner appropriate to the projection of trends on sources of supply and destination of leavers, retention and turnover patterns and the factors which govern them, and although service planning is primarily progressed on a care group basis, comprehensive manpower data has not always been stored in these categories.

Although the question has been asked on numerous occasions over the past decade, and we are now planning for the 1990s. We are still unable to answer the question:

> "How many nurses should we train?"

Scholarship must continue to be applied to this issue but of paramount importance is the credible and profession-wide application of that scholarship to the service.

Management Budgeting

Just as information, and a credible manpower plan are the tools and the power bases of nurse managers, so to is management budgeting. Management budgeting is aimed at identifying and structuring the management process and tailoring a budgeting system to complement and enhance the process as described by Abbott (1986). The focus of the management inquiry team was on the clinicians, as the main users of financial resources:

> "to involve them in the management process, consistent with clinical freedom and practice."

There can be little doubt as to the appropriateness of intent as the clinician, by action or prescription, influences all other expenditure.

Prescription, however, initiates further action and it is the nurse at this point, who makes the professional decision, for which she is accountable, regarding the nursing care requirement which she is then responsible for implementing, for monitoring and for evaluating.

The nurse manager in her budget plan will expect to respond to agreed changes in the service plan, changes in medical technology and prescribed care, and changes in nursing care patterns. She controls the use of manpower, bedlinen and dressings, and she influences or maybe uses catering, cleaning and portering services. He/she is responsible for implementing the budget plan for monitoring expenditure and for evaluating expenditure against the outcome of the plan.

This budgeting process should regularly and systematically force creativity and innovative and alternative ways of delivering the same service at less cost, or greater service at the same cost. This was the declared intent of one of the four management budgeting pilot districts. Management budgets should be about the appraisal of options for staffing levels, skill mix and patterns of medical and nursing care and the process should be adapted to fit the needs of the user.

Purely on the basis of value judgement, it seems fair to say that, to date, nurse managers have been reactive rather than proactive in the implementation of cost improvement programmes and option appraisal features only rarely as a basis for agreeing operational and budget plans.

The essential criteria for successfully monitoring and controlling a budget is that information should be:

- timely
- agreed with the user as being critical to decision-making
- in a format which is readily understood and easy to produce, and
- credible

Budgeting information cannot stand alone as a management control system. It is irrefutably linked with information about workload and about manpower. Critical information for the nurse manager would therefore be derived from data held on each of:

- a patient administration system
- a patient dependency system
- a nurse deployment system
- a budgeting and finance system and
- a personnel system

It is vital that the General Managers and those responsible for planning the technical and technological environments should understand the management process which will enable the nurse manager to monitor and control professional standards.

Quality

Kemp (1986) states, in a descriptive article on quality assurance, the need as never before:

> "for nurses to question their practice, seek advice and use research findings that will enable them to plan and implement some method of evaluating the care and support given to patients and staff"

Of such methods 'Monitor' developed from the Rush/Medicus System has received much publicity.

Brooten (1985) broadens the field by suggesting that management of nursing should lead to an examination of professional goals, of leadership styles and of values.

Quality must be about the whole of the organisation. it is an umbrella under which management and financial systems are examined, standards of patient care are set and the clinical practices of the professions are audited. Quality Assurance, as defined by the Department of Trade and Industry for their National Quality Campaign (1984), means all the actions planned and taken which will secure for the benefit of the consumer a standard of service which is fit for its intended purpose.

Quality assessment and the setting of quality standards is not new to nursing and is evidenced by nursing care plans and documented clinical procedures, by learning objectives and curriculum plans and by management audit such as that development in Doncaster (1976). Application over the years has demonstrated that a procedure must not be too detailed, otherwise it will not be readily understood. Procedures shoulld be written by managers who are familiar with the activities covered. They should be within agreed policy and they should be capable of producing the required results. Essentially any procedures within a quality system, be that system related to clinical practice, education or management, should be capable of answering six questions about an activity:

Who does it?
How is it done?
What is done?
When is it done?
Where is it done? and
Why is it done?

To ensure uniformity, ready recognition and ease of reference throughout the organisation, there would need to be a procedure for writing procedures; this being the practice employed by at least one consultant firm when setting up quality management systems in Industry.

Quality control is yet another phrase in the new culture. It can be said that all employees gain more satisfaction from a high quality product and a high level of service; a nurse gets more satisfaction from high quality care, from a student well taught and a budget well planned, albeit the standards have first to be set. The quality of output and outcome would seem to be the least well tested area of our patient/client processes. Quality control doing its proper job helps those applying the process to achieve the outcome objectives. Price (1984), refutes industry's conventional wisdom that high productivity and high quality are mutually exclusive. There could be a direct correlation if his thinking were applied to the health service where quality control in helping to increase activity and output can also achieve higher quality outcomes.

A nurse manager responsible for the total patient care environment and together with other relevant disciplines, can begin to apply the theory of quality management systems to the support services. Tracing supplies, catering, domestic services, linen, maintenance, portering and drugs from source to ultimate delivery to the patient and documerting the necessary processes, not only achieves quality care for the patient, but also delivers quality to the nurse who has to carry out that care, and should something go wrong, ensures that the fault in the system is readily traceable and corrected.

One further process may be worth considering in pursuit of quality and that is the process of using quality circles which originated in Japan in 1962. This process has already been used successfully in the Health Service. Hutchins' (1985) definition of a quality circle is:

> "a small group of between three and twelve people who do the same or similar work, voluntarily meeting together regularly for about an hour per week in paid time, usually under the leadership of their own supervisor, and trained to identify, analyse and solve some of the problems in their work, presenting solutions to management, and where possible, implementing the solutions themselves"

There are numerous studies on motivation at work, but certainly in this participative style of management, with good communications systems and a framework of close interpersonal relationships, one can see the derivation from studies as early as the classic 'Hawthorne' in the 1920s and also of Maslow in the 1940s.

Conclusion

Motivation and rewarding staff are ingredients which enhance every industry. In a labour intensive industry like the National Health Service where from the same population, as previously stated, is derived the workforce, the consumer, the product and the resource, they are essential elements. Quality is everybody's business, all employees are consumers, not necessarily as patients, but as receivers of a service which another department is providing. If the service to all consumers is to be of a high standard, employees must individually and jointly own the organisation and as a service industry, the ownership should extend into the community.

If nurses as indiviuals and as a professional group are to participate fully in this industry, ongoing clinical, educational and managerial development programmes must be planned with care. Have we the ability to select the high flying leaders of the profession from today's student and staff nurse population and send them on the National Development Programme for Nurses, which is about to select its second intake, or to select tomorrows General Managers and send them on the General Management Development Scheme with its first intake scheduled for the next academic year? Do managers of nurse education always attend educational development programmes or are some persuaded that a general management course or a business degree is equally or maybe more important to the profession and the organisation?

Charles Handy writing for the Times on the 9th January 1986 described a Shamrock Organisation in which one leaf of the shamrock was a core of key managers, professional technicians and skilled workers who embodied the organisational knowledge, giving that organisation identity and added value. Nurse managers are part of this core with the power to influence the organisation in which they work.

John Thackeray writing in Management Today in February 1986, suggested that the development of a 'corporate culture' was now in vogue in the States and had superceded the well-tried theories of 'synergy', 'management by objectives' and 'management of change'. He suggests that, where corporate culture exists, top managers are capable of altering the strength, direction, values, symbols, language and even the myths of an organisation. Nurse managers and the nursing profession have equity of opportunity to influence this culture where there is scholarship and a comprehension of the environment.

The scholarship of nursing management must be seen to be focussed on the improvement and development of health care provision. This will be synonymous with the interests of the profession. The profession can apply this scholarship by co-operating with the organisation and also by challenging it when it is necessary to do so, to achieve the modifications appropriate to the fulfilment of its overall objectives.

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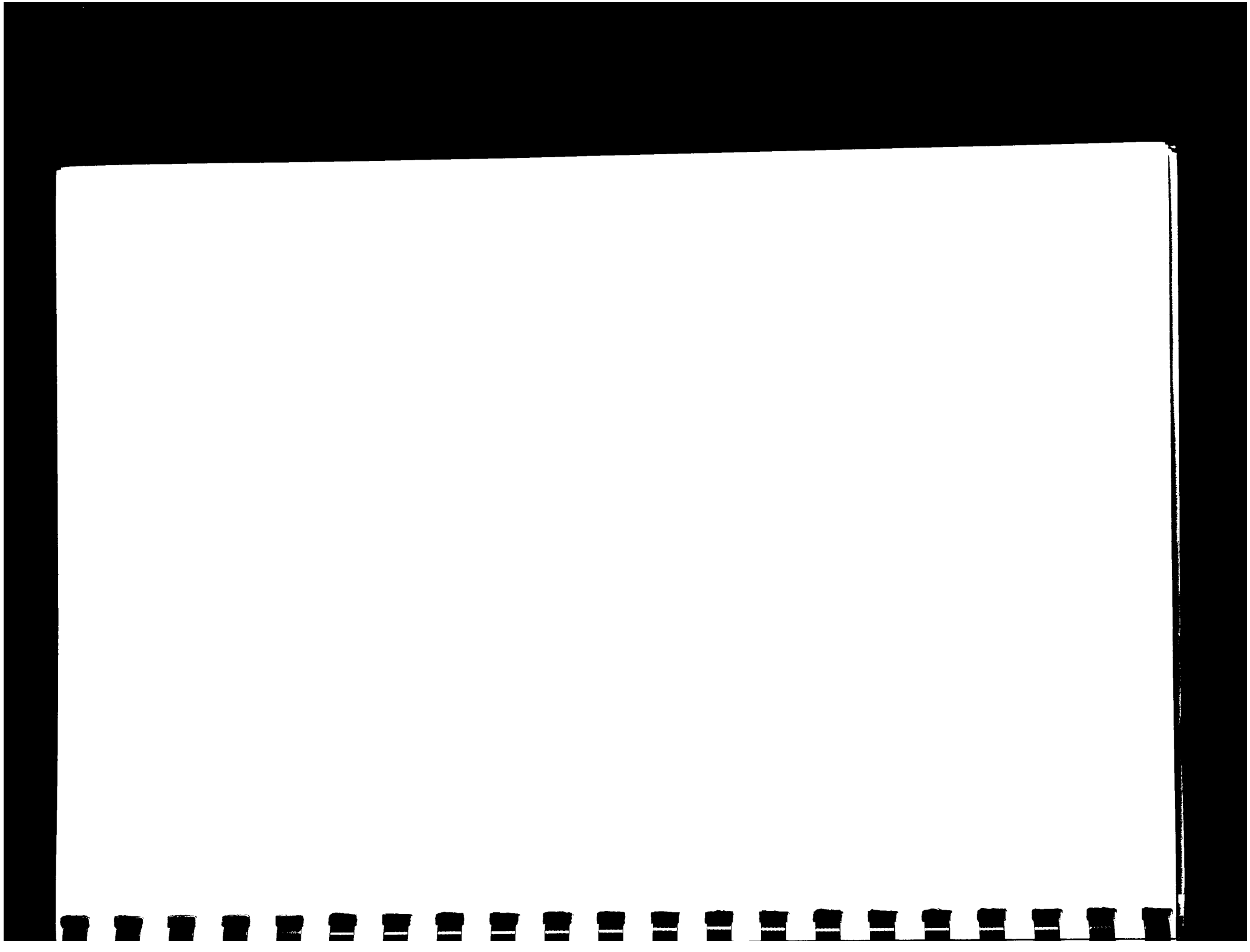

SCHOLARSHIP AND NURSING PRACTICE

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Introduction

This paper was presented to the Symposium by Sue Pembrey. It is based substantially on the work of Alison Binnie the co-author. It is hoped that the full text of Alison Binnie's study will be published in due course.

I am honoured and happy to celebrate with everyone here the 10th anniversary of the Journal of Advanced Nursing. In the course of the day I am sure it will become clear the debt we owe the Journal of Advanced Nursing for its contribution to scholarship and to the growth, communication and use of nursing knowledge and also what a special position the Journal has established since 1976.

I have been asked to address the subject of Scholarship and Nursing Practice. I plan to do this through a study of the nursing of a patient, because there are two elements I want to explore; the growth of nursing knowledge and its application to clinical practice.

There is no doubt that during the last ten years there has been an encouraging growth in nursing knowledge and scholarship. This development has been led predominantly by those nurses who have had experience of higher education, and their markedly more scholarly approach to learning and nursing has influenced a huge number of able nurses who, through no fault of their own, have never experienced scholarship. Given the opportunity, sometimes at the beginning by seeing scholars at work in nursing, many of these nurses have become interested and excellent scholars themselves.

The Journal of Advanced Nursing both reflects and contributes to this growth in nursing knowledge and a scholarly approach; it now contains many articles relating to clinical practice, some good analytical work and some rigorous research, including experimental work which can provide prescriptions for nursing care. However, many would argue that scholarship is still for an elite - and that the elite are not much use to practical nursing anyway; that there is a lot of rubbish thought, talked and written (Journal of Advanced Nursing referees perhaps know of some!) and that scholars live in an incomprehensible, irrelevant world, far removed from daily practice.

So the relationship of scholarship to nursing practice does need to be addressed. Can scholarship be applied to a practice discipline such as nursing? How has scholarship affected nursing practice? In nursing the effects of scholarship need to be demonstrated, not only in the approach to learning, but also in the application of learning to the nursing of patients. The application of learning can and must be measured in terms of the effects on patients, and this is what I now intend to do through a study of the nursing of one patient.

This study was presented for the new Diploma in Nursing of London University and is titled "A critical review of the nursing management of one patient's pain." This work was done by Alison Binnie, a senior sister in Oxford and a non-graduate. It is chosen because it demonstrates scholarly learning and the application of scholarship to nursing, as well as graphically describing some non-scholarly nursing which took place in the ward. I leave the audience to decide whether the difference is important.

Chambers 20th century dictionary describes a scholar as a student - in time of less widespread education one who could read and write. A scholar is also one whose learning is extensive and exact; one whose approach to learning is scrupulous and critical.

It is hoped to demonstrate first, the evidence of extensive and exact previous learning, precisely described and applied. Second, that the actual nursing of the patient also demonstrates the process of scholarship, that is scrupulous and critical learning.

It is only possible to highlight aspects of the study which draws on a large number of theories and disciplines. Aspects that will be explored include the nature of nursing, the nature and management of a therapeutic relationship, communications theory and practice, knowledgeable helping of the patient who is undergoing protracted diagnostic tests and, in particular, the nursing management of pain, including aspects of assessment, knowledge and use of pain therapies and systems of evaluation.

The author, Alison Binnie, chose to write in the first person:

> "I have departed from my usual pattern of writing assignments in the impersonal academic style which adopts the third person. My relationship with the patient whose case is discussed and my own approach to pain management strongly influenced the way the case was handled. Writing in the first person has allowed me to include these important influences and present a complete and realistic picture."

The Patient

"Mrs Hall was admitted to a surgical ward with a two month history of dull, constant pain in the right side of her abdomen and back. During this period she had also developed dark urine, increasing constipation, diminished appetite and had lost half a stone in weight. Over the two weeks prior to her admission, her sleep was being disturbed by pain and by night sweats, and she was getting intermittent fever. The symptoms suggested either an infection or a malignant disease process.

I first met Mrs Hall three days after her admission. I found her a warm kindhearted person who enjoyed conversation and took a great interest in everyone around her. She talked readily and openly about herself, but she was not a woman to complain and tended to pass lightly over her own problems and illness.

By the second week of her stay in hospital, aware that the doctors had still not found the cause of her illness Mrs Hall was, not surprisingly, beginning to show signs of anxiety, though she did her best to maintain her brave, cheerful exterior. Her continuing pain, increasing worry, and regular drenching night sweats allowed her little sleep, in spite of night sedation and the quiet of a single room. Mrs Hall was becoming physically and mentally worn down and the strength it was becoming increasingly likely she would need to face up to an eventual diagnosis of malignancy, was being drained away.

As a result, I made a conscious effort to build upon the spontaneous friendly rapport I had established with Mrs Hall and to lay the foundations of a therapeutic relationship, which I hoped might help her to cope with what lay ahead. I aimed at building trust, at showing openness and nonjudgemental acceptance of her feelings and behaviour, and at conveying empathy. In practical terms this meant making time for Mrs Hall. Every day I was on duty, I planned fifteen to thirty minutes of uninterrupted time to be with her. I made a point of making sure Mrs Hall knew what tests were planned for her and exactly what they involved, and then made sure I followed up afterwards, letting her tell me about the tests, explaining the results and letting her express her frustration or fear.

I tried to make her feel that irritation, impatience, fear, fatigue and even doubt about the doctors' competence were all legitimate feelings in her situation and I would not deny or disapprove of them if she expressed such feelings. I tried to describe to her what I could see her going through, so she would feel that I understood the exhausting cycle of building herself up to face another investigation, trying to be brave and patient, wondering what it would be like; putting up with the inconvenience, discomfort or indignity that may be involved; then worrying about the result, simultaneously wanting and dreading an answer; finally the frustration of an inconclusive result and the prospect of starting the whole process again.

As the uncertainty about her diagnosis continued and as treatment with antibiotics for a possible infective process failed to produce an improvement in her symptoms, Mrs Hall began to talk about the possibility of there being 'something sinister' at the root of the problem, then openly about the possibility of cancer. Again I responded to her openly and directly, acknowledging that her fear was realistic. This allowed her to explore her feelings about cancer and to seek information from me, and it enabled me to discover and correct some mistaken notions she had about the disease.

I have sketched just the key elements of the relationship I built up with Mrs Hall during the two and a half weeks preceding the laparotomy that the surgeons eventually decided was necessary to establish a diagnosis. Whilst we waited for a diagnosis, I attempted to establish a relationship with Mrs Hall through which I could help her cope with the suffering we were failing to relieve. I did not fully appreciate, at the outset, how important this relationship would be in the subsequent management of a much more severe pain control problem that presented postoperatively.

At laparotomy a diagnosis was made of inoperable carcinoma of the pancreas with metastases.

When Mrs Hall returned to the ward after her operation, she was cared for by a third year student nurse, but I was on duty for the first six hours and closely supervised the assessment and management of her post-operative pain during this period. The following table summarises nursing activity in relation to pain control during this initial post-operative period.

SCHOLARLY MANAGEMENT OF PAIN ON THE DAY OF DIAGNOSTIC LAPAROTOMY

Time	Observation	Actions
10.15	In recovery Dept. - prescription for PETHIDINE 50-100 mg IM 4 hrly	given 100 mg PETHIDINE IM
11.30	Returned to ward: Drowsy, but aware of surroundings. Lying very still. Face muscles tense, pulse 68/min. BP 110/70mm HG. Says she is in severe pain.	House surgeon contacted. Analgesia prescription changed to MORPHINE SULPHATE 10 mg IM 3 hrly prn.
11.45		First dose MORPHINE 10 mg given
12.00	Says pain is no better	Helped to change position slightly. Instruction in muscle relaxation.
12.15	Still drowsy: not wanting to talk. Says pain is still severe. Physical signs unchanged. Unable to relax.	Assured that analgesia would continue to be given until she was comfortable. House surgeon contacted again - agreed low pain tolerance to be expected in view of stressful pre-op period.
12.30		Agree to try intravenous analgesia. MORPHINE 2.5 mg IV given by doctor.
12.45	Face and body less tense. Says she feels more relaxed, but pain still present, unbearable on slightest movement.	2nd dose MORPHINE 2.5 mg IV given by doctor.
13.30	Says pain is now easing slightly but deep breathing and movement very uncomfortable. No change in conscious level. No respiratory depression. Pulse 84. BP 115/70 Resp. 28/min.	Telephoned house surgeon and suggested 3rd dose IV MORPHINE - agreed.
14.05		MORPHINE 2.5 mg IV given by doctor. Analgesia prescription changed to MORPHINE 10-20 mg IM 3 hrly. prn.
14.30	Looking relaxed. Says she is more comfortable. Feeling sleepy. Pulse 84, BP 115/70 Resp 24	
15.00	Sleeping. Vital signs stable.	
15.30	Comfortable. Moved with only mild discomfort. Sleepy.	Helped to turn onto right side.
16.00	Sleeping.	
17.00	Sleepy. Relaxed. Passed urine. Says getting onto bedpan was very uncomfortable. Wound 'beginning to feel sore again'.	Helped onto bedpan.
17.15		MORPHINE 10 mg IM given. Positioned comfortably on left side.

I next saw Mrs Hall on her fourth post-operative day. I learned from doctors and nurses in the ward that she had not been told about her operation findings: apparently she had not asked. I was surprised and concerned, so at the earliest opportunity I made some time to spend with Mrs Hall.

I let her direct the conversation: she kept it cheerful and superficial, mostly away from herself or focused on the positive, successful aspects of her post-operative recovery. I allowed pauses to make it clear I was not in a hurry and to allow her to change the subject if she wished, but the subjects remained on safe ground. This pattern continued for about fifteen minutes, then suddenly out of the blue, she said:

"Have I got cancer then, Sister?

I replied:

"Yes you have."

I did not say any more; she was controlling the conversation and I wanted it that way, but I continued to look at her directly to indicate that I was prepared to follow her lead. Slowly, in her own time, she questioned me about the operation findings and I answered simply and honestly, sticking to the particular point she raised. Occasionally I made a comment about what it seemed to me she was going through and this appeared to help her express what she felt about this expected yet much dreaded news. Eventually Mrs Hall thanked me warmly for telling her and this seemed to indicate she had talked enough, but I wanted to raise one point and the moment felt right - why had she not asked sooner? Surely she had known the doctors well enough? Her reply appalled me:

"The pain has been so dreadful I just couldn't think of anything else. I never imagined it would be so bad."

UNSCHOLARLY MANAGEMENT OF PAIN ON POST-OPERATIVE DAYS 1, 2 AND 3

Given Morphine 10 mg (10-20 mg, 3 hourly, prescribed)
Intervals nearly always over 4 hours.
On day 1, there was a gap of 12 hours between mid-day and midnight when Distalgesic tablets only were given.

Nursing Record

"Morphine given for pain"
"Morphine given as necessary"
"Still requiring analgesia - last given at 13.00 hrs"

After the disclosure about her post-operative pain problem, I made a conscious decision to supervise Mrs Hall's pain management very closely myself.

During this period I helped a student nurse to try out a pain rating scale with Mrs Hall (none of the ward nurses had encountered these simple instruments in practice before, though one student had read about them). Mrs Hall's first score of 8 out of 10 (where 10 = "pain as bad as I can imagine"), during the trial of Temgesic tablets, genuinely shocked the nurses and prompted some interesting discussion about psychological influences on pain tolerance and about nursing assessment and management of pain. A second recording of 6 out of 10, 24 hours after starting morphine solution, led the student and I to instruct nurses to increase the morphine from 10 to 15 mg (the prescription allowed up to 20 mg) and to be more punctual with the 3 hourly doses - we noted intervals of up to 6 hours between doses during the preceding 24 hours. Over the next two days, the oral morphine was increased again, until, by the third day, Mrs Hall was receiving 25 mg 3 hourly. In spite of this, constant pain persisted (score between 4 and 6) and her general condition was deteriorating rapidly.

We were clearly failing to relieve suffering that I knew we should be able to control. I had talked with the senior medical staff and beyond increasing the morphine, they had nothing more to offer. It was unanimously agreed that as a team we needed expert advice. That same day a consultant from the local pain clinic came to see Mrs Hall. His visit marked a dramatic turning point in the course of events.

During his first visit I sat with the consultant while he spent about fifteen minutes listening very carefully to Mrs Hall as she talked about her illness and described her pain. At the end of this assessment the doctor interpreted to Mrs Hall what he had understood from her description. He said there appeared to be five different pain problems:

1. Musculo-skeletal pain round lower part of right rib cage, possibly including a small rib fracture.

2. Muscular pain spreading across her right shoulder blade from a precisely located trigger point half way across the top of the shoulder blade.

1 and 2 - both probably initially caused by the vigorous painting, decorating and furniture moving of a few weeks previously, now aggravated by inactivity.

3. Muscular pain in outer aspect of right thigh, following a precise nerve distribution - a recognised feature of enforced inactivity.

4. Abdominal distension and constipation pain aggravating residual wound pain.

5. Slight tumour pain.

Of all the different pain problems only tumour pain and wound pain would have been helped by morphine (or any related drug). The other, in this case far more significant pains, the doctor described as 'morphine non-responsive pains'. These pains would be likely to respond to regular doses of Aspirin.

When we left Mrs Hall, I spent time with the consultant analysing where the ward medical and nursing staff had gone wrong with Mrs Hall's pain management and he discussed the use of oral morphine for cancer patients with me in some detail. It seemed that while the aims and attitudes in our approach to the problem had been appropriate at this stage, inadequate assessment of the pain and inadequate knowledge about the use of morphine had led to inappropriate prescribing.

When I saw Mrs Hall the next morning she was rather drowsy, but very relaxed. She had slept without interruption for seven hours. She said it was the best night's sleep she had had for months; she was immensely pleased.

I felt we had reached an important turning point. She had been near to despair, now there was a glimmer of hope. I wanted to capitalise on this, to help restore her damaged self-confidence, to build a feeling that she would be able to cope with her illness with dignity. I was also anxious to produce some visible evidence for her family that we were gaining control of her problems. I decided that simple nursing measures, carefully executed, might prove very effective.

I suggested to Mrs Hall that as getting out of bed had been so much easier, she might like to have a bath; she clearly felt that it was rather an ambitious suggestion. I was gently persuasive, describing how she could sit in the hoist chair so that no effort would be required on her part and I pointed out the beneficial effect the warm water would have on her muscular pains. I said I would bath her myself. She was still uncertain, but agreed to try.

The bath was a great success. Mrs Hall thought the hoist was a marvellous contraption; she felt wonderfully refreshed - with all the sweating she said she had never felt really clean after just a wash; and the hot water did soothe her pains. As she was not too tired by the bath, I also washed and dried her hair and set it in heated rollers. The result was quite a transformation, psychologically as well as physically. The look of surprise, relief and delight on her son's face confirmed that my efforts had been worthwhile and well timed and confirmed Mrs Hall's obvious sense of achievement. Over the previous few days our relationship had felt strained now we were working together again. During her last few days in hospital I continued to give Mrs Hall an uninterrupted 15 to 20 minutes of my time each day I was on the ward. She how needed very little physical nursing care, but it was precisely at this point, as her physical pains were at last under control, that she had more profound psychological pain to face.

My role in this phase of Mrs Hall's illness was simply to listen with concern, interest and emphathy and to watch her emotional state.

After five and a half weeks in hospital, Mrs Hall was discharged home to her own new bungalow and the care of her devoted son and daughter, with support from her general practitioner and district nurse.

Mrs Hall's pain remained well controlled, with only slight increase in her morphine required during the last few days of her illness. She died two weeks after leaving hospital, in her own home with her children, as she had wished."

A scholarly evaluation

Alison Binnie then carefully reviews the nursing management of this patient:

Education for professional work requires the acquisition of knowledge, skills and attitudes that will lead to effective practice. A sound philosophical framework and an appropriate system of organising work also make an important contribution to the maintenance of good practice. Pain management is a complex nursing activity and in striving towards excellence in this sphere of their work I believe that nurses need to:

- examine their own attitudes to pain

- increase their skill in assessing patients' pain

- extend their knowledge of the mechanism of pain and of pain therapies

- develop systems of organising nursing work within which accountability for pain management is clearly identifiable

- ensure that models for nursing practice are devised and interpreted in a way which helps nurses to focus their attention upon relief of suffering and promotion of well-being.

In relation to Mrs Hall I:

- gave time and attention at frequent intervals, indicating availability of open and empathetic communication

- sought and accepted verbal descriptions of pain

- watched for and noted behavioural and physiological indicators (but was not misled by stable vital signs)

- consciously took account of factors likely to influence Mrs Hall's pain tolerance.

- failed to explore in enough detail the nature of her post-operative pain

- was misled by assumption that the pain was due to the presence of a surgical wound and an invasive malignant tumour

Succeeded in:

- establishing open communication about the pain

- exploring the pain experience

- identifying the effects of the pain

- considering factors that influenced her pain experience

Failed to:

- focus in enough detail upon characteristics of the pain sensation, particularly its location, quality, onset and duration.

Conclusion

We hope we have demonstrated that scholarship is required in nursing, that it can be applied, and that a scholarly approach of scrupulous and critical learning during practice generates good nursing and new knowledge. A lack of scholarship - a lack of extensive and exact learning and a lack of a scrupulous and critical approach - fails to meet patients' nursing needs.

Scholarship is still rare in nursing practice but it is developing. We are grateful to the Journal of Advanced Nursing for its vital contribution in promoting that development and we look forward to its continuing contribution in the years ahead.

RESEARCH: ITS RELATIONSHIP TO PRACTICE AND REPRESENTATION IN THE JOURNAL OF ADVANCED NURSING

Dr Jenifer Wilson-Barnett, Director, Department of Nursing Studies, King's College (Chelsea Campus)

Delightedly I accepted James Smith's invitation to become a member of the Journal of Advanced Nursing Editorial Board in 1982. Since which time I have enjoyed reviewing one or two papers each month. This, of course, has contributed to my own research knowledge. The Journal has certainly not been produced as an exclusively research publication (exclusive but not in just research). Yet a review of research reports demonstrates that these reflect several very important trends in our research tradition. Changes in the proportion of research reports to other articles, the subject matter and the methods and designs can be traced throughout the ten years. This facinating activity of reviewing research in this way obviously indicates a mature profession - when we can afford to do research on research!

Now, without invading the territory of the next speaker I would also like to consider the effect of various trends in nursing research on practice (which have been reflected in this review). One can always select individual projects or areas which have been recognised as important and even some that have really altered practice. As an overall account however, one has to agree with many others, notably Jenny Hunt (1984) that research has not really touched most nursing practice. For many reasons even the Journal of Advanced Nursing has not been able to make findings sufficiently accessible or applicable to nurses. We all know that many studies have had to explore rather than test aspects of care. However, I would now claim that there is a greater awareness among the profession that research may have value for the future. More realistic ideas of its potential contribution are held by nurses now than ten years ago.

Research may have contributed more to a questioning approach rather than a scientific one (they are often not synonymous). Absence of reliable, replicated and representative studies in many areas probably prevents most interventions being based on hard evidence. Despite this or possibly because of this more debate occurs and is often accompanied by a lack of confidence. This spirit of questioning and criticism exists in many

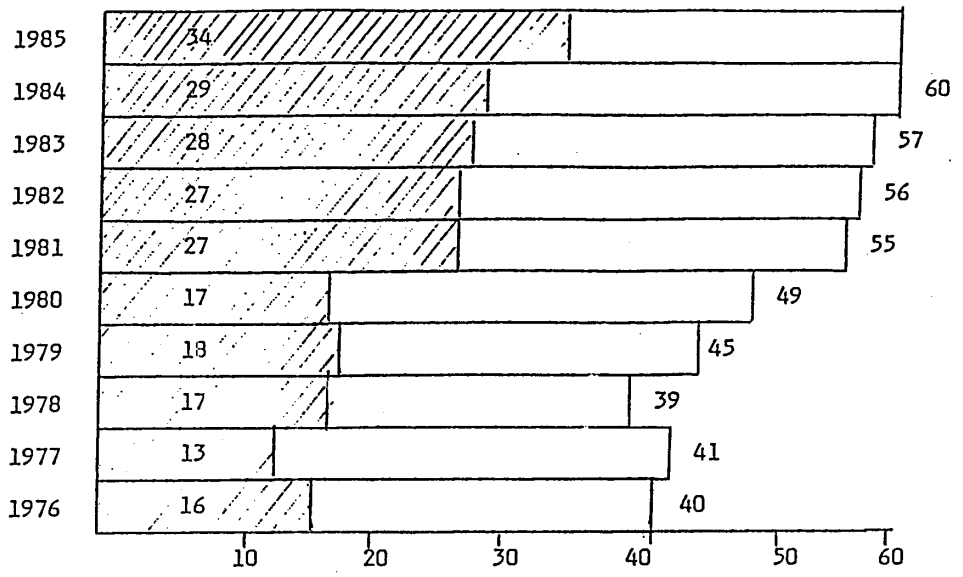
settings or can easily be kindled with trained and untrained staff. The focus extends beyond nursing to other's care too. However, this need not create dissatisfaction or conflict, in contrast it can be seen as a new and creative motivation which should be channelled. Journal clubs, research interest groups and ward teaching sessions have really sprung up over this last decade and I for one am always impressed by the enthusiasm of participants.

What is so apparent to me is the way the journal has so closely represented changes in nursing research. Of course this may seem an obvious development, indeed, it would seem strange if this were not so. To demonstrate, this paper will attempt to present some of these trends and elaborate on why they have occured, much of the rationale and influences coming from practice. Contrary to research influencing practice, the strongest pressures have flown in the opposite direction!

Several judgements were made during this exercise. For instance, only those articles in the main body of the journal were considered, although in the early days, specific research reports were summarised at the back of the journal, reflecting their importance to the advancement of knowledge. Only articles which explicitly presented research data in a formal structured and systematic way were classified as research reports. Those which selected one portion of data as an example to discuss an issue were excluded. Also, research reviews, (explicitly claimed as such, rather than a well referenced discussion), seven in all, becoming more frequently latterly, 3 in 1984, were excluded. Many theoretical discussions on the nature of research, its relationship to practice, knowledge and education, which obviously explored research knowledge, were not included, either.

The first impression from this review was that research understanding is more sophisticated, that practical problems are discussed more, recently, and that research has increased over the years. From 1976, for 5 years half the papers were research reports. In the last five years they constituted at least half.

Figure 1.



Research reports* as a proportion of J.A.N. articles.

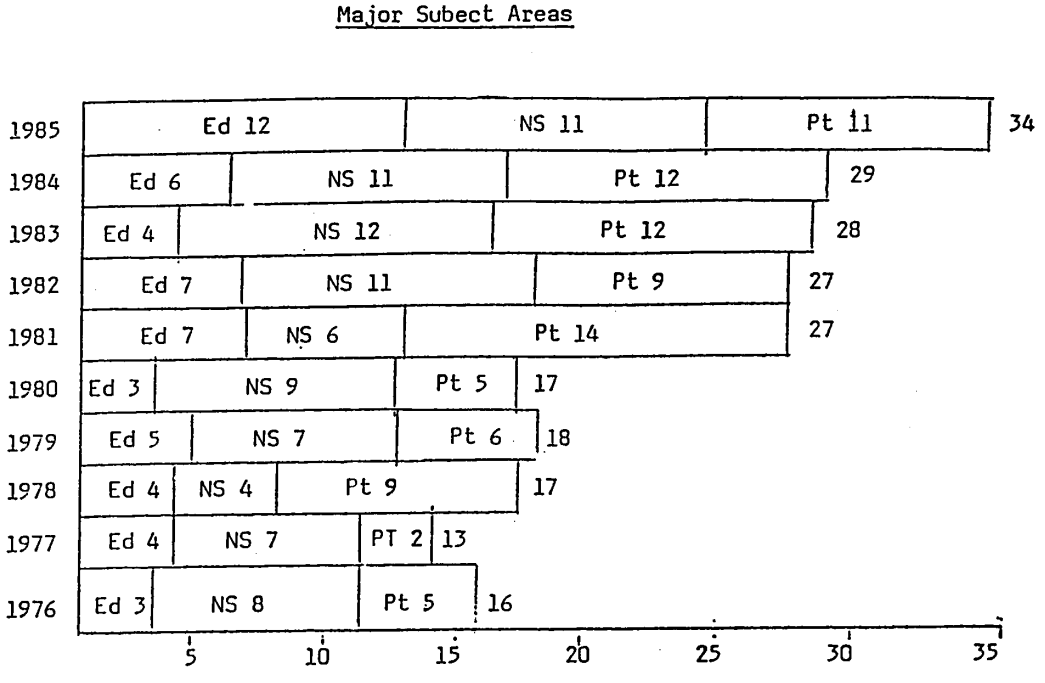
* Definition of Research report
- Systematic reporting of systematically collected representative data.

This trend is encouraging to me as I definitely considered such reports to have potentially more original value to add to our body of knowledge than other papers, however erudite. Of course both are valuable and complementary. As a reviewer I also feel much happier with material in which there are conventional objective rules by which to judge their merit. However, there has never been a policy to dichotomise and publish more or less proportional to submissions, their increase is thus reflective of more research being done and written up for publication.

Improvements in the general level of education of nurses, in public expenditure levels in higher education and in the number of potential nurse researchers have all affected the volume of research in nursing. Successful civil servants at the DHSS created a discrete budget, fostered the research studentships (in my view one of the most fundamental contributions to nursing research) and helped to persuade senior nurse managers that they needed researched data to succeed in the post Salmon era. Social scientists and educationalists were eager for new subjects (in all senses of the word) and their own ethos of the seventies supported applied work. They supervised and spawned many projects. The birth of the Journal of Advanced Nursing coincided with this tide, and incidentally with the creation of the second generation of university departments of nursing.

Topics or the focus of research has definitely shifted in the last ten years towards patient related studies. Majorie Simpson's (1971) famous review on the occasion of the Nursing Mirror lecture in 1971 demonstrated the earlier paucity of patient or consumer-orientated research. Our heritage from origins in higher education in disciplines of sociology and education is obviously reflected in the large number of studies in education and administration or organisational topics. However, it could be said that it is both practically and possibly intellectually easier to study nurses than patients. This contentious statement is of course supported by the evidence on this histogram. Once more I find the trend encouraging.

Figure 2.

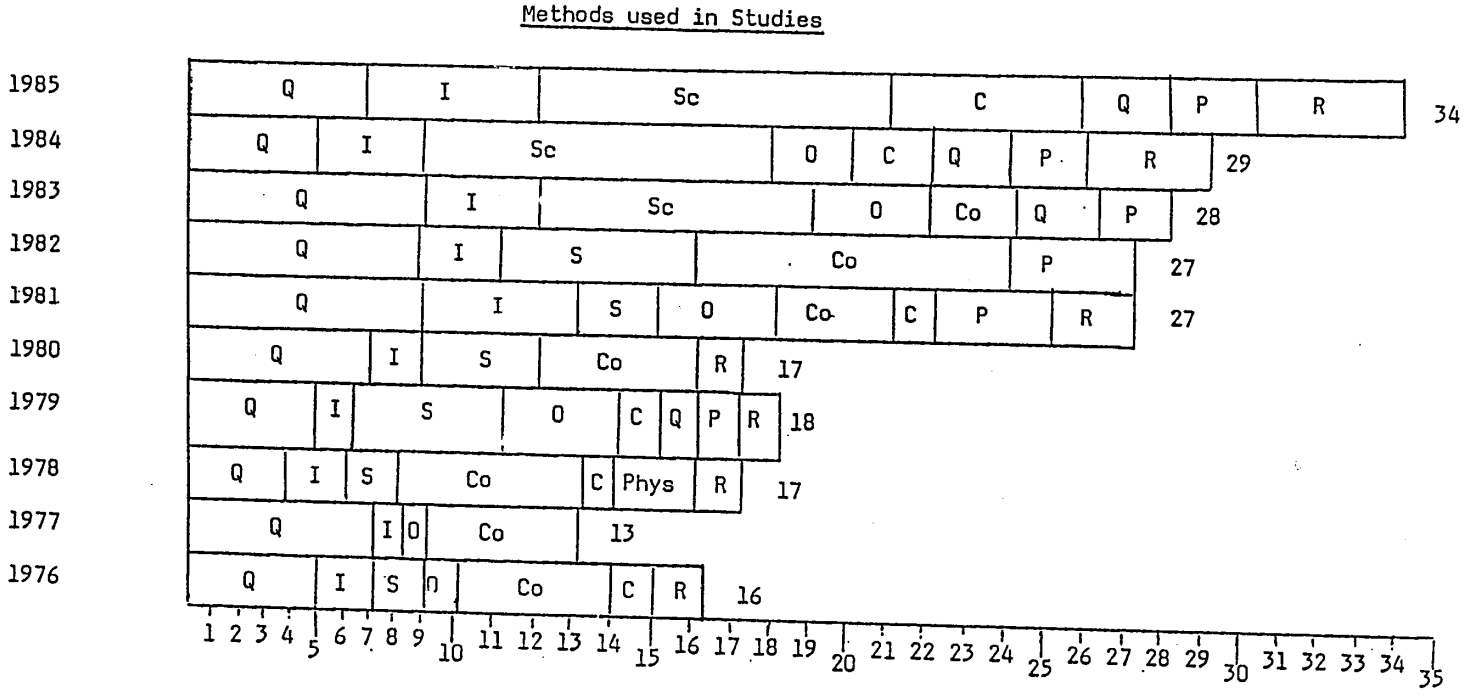


Key Ed = Education of Students or Nurses/test of knowledge.
NS = Nurses opinion/attitudes and work.
Pt = Studies affecting patients.

Nursing knowledge must be our first priority, so many of the studies on education and the work situation could benefit other disciplines more than nursing. It would be interesting to evaluate this more thoroughly. Although a diversion from the main theme and one which will be revisited, nurses exploiting such areas as education or organisational theories should surely reciprocate by publicising their work to those audiences as well as nurses. With well-founded confidence in the standard of research published in the Journal of Advanced Nursing, certainly over the last few years, our own discipline will grow in respect when this occurs.

From the start of the eighties there was a definite (possibly one should not use the work significant) rise in the proportion of studies affecting patients. This could reflect a greater confidence amongst nurses to tackle real problems, those of relevance to the care they gave, and it could be explained by the crest of the wave of awareness amongst practitioners. This may have been encouraged by nurses asking researchers questions, by their challenges, which we can all remember. My own study on the work of the nursing officer (published before the time of the Journal of Advanced Nursing) did not fire the enthusiasm of the bulk of nurses or the researcher! Whereas studies on pain management, promoting recovery and wound healing usually do. Hence it is easier to justify clinical or patient care studies to nurses although not always easier to win funds. A search for more appropriate and meaningful methods to study patients has therefore also been encouraged, somewhat indirectly by professional pressure.

Parallel developments in the methods used to collect data show interesting and quite subtle and complex changes. Questionnaires are the most popular tool, especially when they can be sent out to respondants who have been well socialised and are obedient as nurses. How glorious for the researcher to do it all from her desk. Quite properly the image of these nurse researchers is one who gets everyone else to do the work!



Key

Q = Questionnaire
I = Interview
S = Scale
O = Observation (structed)
Co = Combination
Q = Qualitative (obs & int.)
C = Care Study
P = Physical measures
R = Records/Content analysis

Figure 3.

With very careful analysis one can also find a relative, but small increase in the use of standardised scales for measuring attitudes, knowledge and more recently behaviour. This could be seen as progress consequent on several years of testing exercises with a greater number of reliable instruments. Although it seems that many researchers are reluctant to rely on one method of data collection, preferring a combined approach, usually questionnaire and interview and sometimes also observational techniques. Efforts to design all these tools usually reflect a team of researchers attempting to gain more confidence in their findings through triangulation.

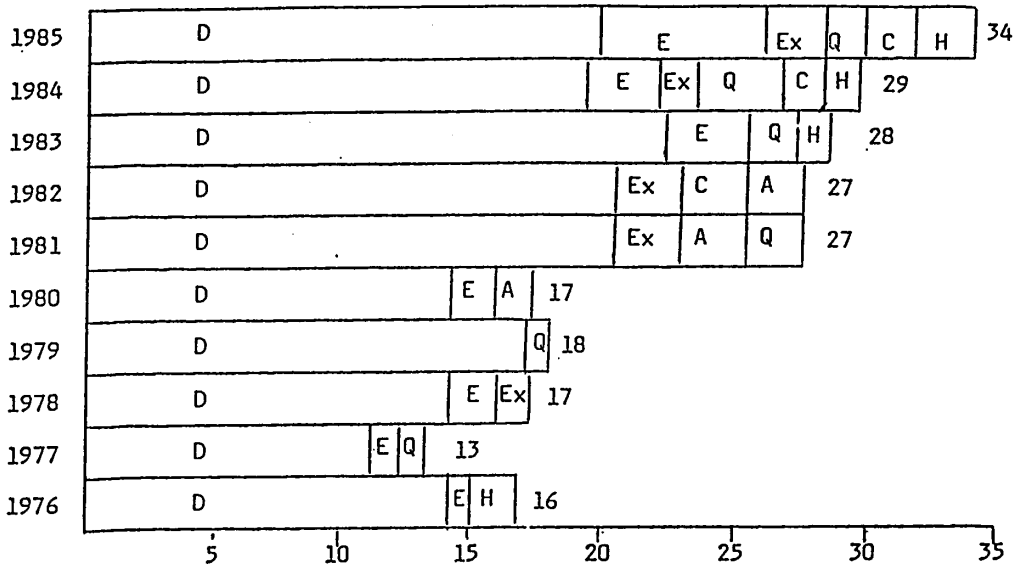
Physical measuring techniques are also being more represented and refined in nursing research reports, as are the use of observation and case study or less structured approaches. Overall from this review I would conclude that a greater variety of methods has been employed of late with a more equal spread across the range than was represented in the 1970s.

This wide selection of methods could signify an attempt to become more independent of one or two disciplines and exploit more. Certainly it seems to be those studies which aim to explore or change practice which use combined approaches, physical measures, case studies or less structured tools. Confidence or courage to do this may have come from a comfortable base in a sociology or social policy department or alternatively from a firm base in a clinical setting, explicitly defined as practice research - home grown (or should I say hospital grown).

Despite the plethora of research methods or instruments employed our youth as a research discipline is probably best demonstrated by the next figure, showing that descriptive studies predominate. It is not an unfamiliar picture for a developing subject. Nursing is not so unusual that it has a deviant research history. Mainstream phsychology, medicine and physics were all based in systematic empiricism, describing phenomena repeatedly until a pattern emerged, questions about influences, changes and causes coming much later.

Figure 4.

Research Design



Key:
- D = Description
- E = Evaluation
- Ex = Experimental
- C = Comparative
- A = Action
- Q = Qualitative
- H = Historical

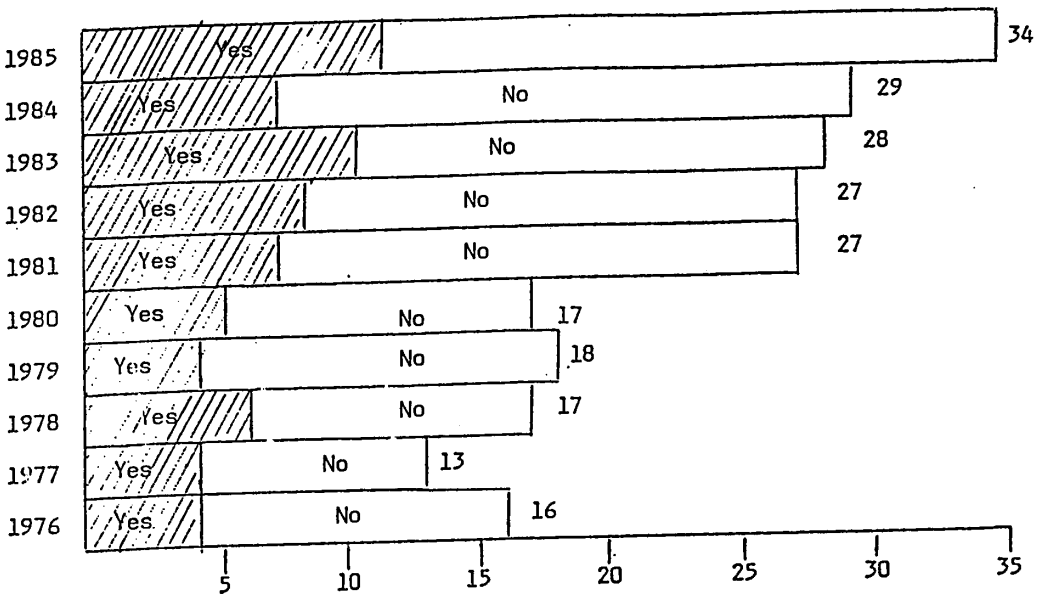
Describing opinions, events, experiences, attitudes and situations occupied the majority of the researchers publishing in the Journal of Advanced Nursing. They tended to use structured tools although some seemed to become more eclectic in the last few years. There are also several excellent articles on the merits and appropriateness of qualitative methods for nursing, yet few such studies reported. It would have been exciting if, as I had hoped, a greater proportion used these less conventional approaches.

Action research, evaluative studies and experiments are becoming more common. All three are related to assessing the effects of an intervention and this involves a degree of manipulation - something which may not have been possible before nurses were more independent and influential themselves. With reference to that last statement I am proud to claim publication of the first experimental research report among these articles (on the subsequently popular topic of barium x-rays).

Contributions from evaluation of change are potentially very great and could be seen as indicating guidelines for practice and future improvements in service to the public. Their power to explain and predict is usually limited prior to replication and wide representativeness, yet they are often more motivating and interesting than the descriptive accounts on which they should of course be based. Certainly and not surprisingly nurses at patient care level seem to favour research which positively demonstrates better treatments rather than descriptive studies which tend to highlight deficiencies in practice, without constructive suggestions. Lisbeth Hockey (1982) is a firm believer in description but not in the liberty of prescription. Correctly, researchers should not assume they have the solutions, without demonstrating the efficiency of their suggestions. Many have perhaps been over-confident in this direction. Practitioners have to be convinced of such projected improvements. This may explain why action research and evaluative studies are cited, even used sometimes, but are also supported more by practitioners than descriptive work, further testament of their influence in research. However, this also provides some indication that research can impress practitioners. Clearly proven guidelines for practice would of course herald the science of nursing. Indeed, when practice is research based this frequently involves experimental work.

Figure 5.

Link with Previous Research and Thearetical Issues



Definition: Discussion of research findings in the context of previous results, ideas and theories ; placing it in the context of the present state of knowledge.

Key

Yes explicit links

None

Finally, the essential element of whether research contributes to a body of knowledge to the extent that findings are discussed, compared and explained in the light of the existing body of knowledge. Intellectually this may be the most challenging aspect of research and as such it is often the most poorly executed of any research report.

Assessing the extent of such integration is also challenging, reliability of my judgement in this was not tested. One would predict that researchers have matured sufficiently to at least attempt some synthesis in recent years and with highly optimistic vision an increase in such attempts can be seen in the 1980s. Studies using qualitative or evaluative approaches certainly seem to lend themselves to this more easily.

With reference to this, the most crucial index, that of the quality of research, has been too problematic and undiplomatic to apply to these articles. Everyone has very different criteria for assessment and it is my impression that there are more good reports lately, as might be expected as the overall volume increases. Certainly the smallest sample of 8, divided into two groups randomly, published in 1978 would now be unlikely to slip through the editors, not unless the underlying purpose was truly brilliant.

Perhaps what impresses a reader most is the breadth of subjects and research strategies employed by nurses and the extent to which these are represented in the Journal of Advanced Nursing. Patient welfare and care is starting to occupy its rightful important place. Nurses are becoming confident enough to use less tried techniques as well as exploiting those which are tried and proven. It is now certainly appropriate for many authors to contribute to other disciplines by sharing their findings and thoughts. Despite all these encouraging results the weakness of presentations to locate, integrate and improve or modify theoretical debate and evaluate knowledge is evident. It would seem to negate the purpose of so many of the papers. Literature reviews should not be seen as something one completes prior to commencing 'the real stuff' of the research, to prove you have read the big names in the area.

Pertinent work should be compared and reassessed in the light of new findings which should also, where possible, be discussed with reference to mainstream thought on the subject.

On a final note, the interaction or relationship between practice and research is becoming established. Correctly this should be a two-way exchange. Problems identified by practitioners are often extemely challenging but most vital. Research should not be a repetitive, routinised, activity it should be enriched by our inability to find immediate strategies and search for really meaningful data. No longer should post-graduates stick to the most do-able projects (a previous tendency). In order for research to affect practice it must study patient care and service problems. Practitioners have been saying this long enough and we have sufficiently good minds in nursing to follow this advice, many of these practitioners also should practice what they preach!

These comments have to be seen in the context of an impressive body of papers. So much progress has been made within the last decade that we should be grateful to all the contributors who have worked so hard. Internationally, the Journal of Advanced Nursing is, perhaps, put on a higher pedestal, while in the UK our natural modesty prohibits a forecast for even greater achievement in the next ten years. However, optimisim is usually encouraged and, in this case, founded on very strong evidence from these research reports.

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Nursing practice

Nursing management

nursing education & training

scholarship