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The utilization of the medical and surgical nursing care studies to measure the extent of integration of the basic aspects of rehabilitation nursing in a basic collegiate program

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THE UTILIZATION OF THE MEDICAL AND SURGICAL NURSING CARE
STUDIES TO MEASURE THE EXTENT OF INTEGRATION OF THE BASIC
ASPECTS OF REHABILITATION NURSING IN A BASIC COLLEGIATE
PROGRAM

by
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CHAPTER 1

INTRODUCTION

Rehabilitation is not a new concept. The works of Hippocrates, the Father of Medicine (Circa 460 B.C.) reveal that attempts to treat deformity and disability were made even in that era. The modern concept of rehabilitation, however, has only recently been clearly stated and generally accepted. Herbert Whiting¹ says:

Of comparatively recent origin is the harnessing of the separate forces of physical medicine and the psycho-social and vocational counseling services -- into a... team, and the projection of this concept into dynamic activities that will restore the individual to a self-sufficient, self-supporting, and self-respecting individual.

Physical medicine and rehabilitation offers some of the oldest therapies utilized by medicine, yet it is the newest medical specialty recognized by the Council on Medical Education and Hospitals of the American Medical Association.²

There are a number of definitions of this new specialty. The definition of the National Conference on Rehabilitation is as follows:

Rehabilitation means the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.³

¹ Whiting, Herbert "Classification of Rehabilitation Potential" Journal of Rehabilitation 16: 7, November-December, 1950.

² Morrissey, Alice, Rehabilitation Nursing, foreword, p. ix.

³ Terry, Florence J. etal, Principles and Technics of Rehabilitation Nursing, p. 10.

Mary Switzer, Director of the Office of Vocational Rehabilitation, defines the newest of the medical skills thus:

Rehabilitation is a bridge spanning the gap between uselessness and usefulness, between hopelessness and hopefulness, between despair and happiness.⁴

It is estimated that, today in the United States, twenty eight million individuals are handicapped because of chronic illness, orthopedic defects, or disorders of vision and hearing. This estimate includes all age groups, children and adults.⁵

Each year about 250,000 men and women are so disabled by injury or disease that they become incapable of holding a job or of enjoying a normal life. A large majority of them can be helped through restorative medical care, vocational training, and other services to take their place as productive members of their communities.⁶

What is the impact, then, of this growing field upon the nurse and the role she is to assume in the rehabilitative process? An inspection of the indices of the American Journal of Nursing reveals that prior to the year 1937 there is only one article relating to rehabilitation listed; in the Cumulative Index for the years 1941 to 1945 twenty references are listed under the Rehabilitation heading; the years 1946 to 1950 contain thirty one references; and the 1950 to 1955

⁴ Terry, op. cit., p. 14.

⁵ Ibid. p. 17.

⁶ Ewing, Oscar R., The Nation's Health, A Ten Year Program, p.

Cumulative Index has sixty nine references.

The fourth edition of the basic nursing text The Principles and Practice of Nursing by Bertha Harmer and Virginia Henderson reveals no reference to rehabilitation in the index, whereas the fifth revised edition of this text not only devotes a specific chapter to rehabilitation but also discusses rehabilitation in relation to every aspect of basic nursing care.⁷

The nursing literature, then, serves as one of the barometers of the developments in the field of rehabilitation and rehabilitation nursing which have taken place in recent years. In August of 1954 Congress enacted the Vocational Rehabilitation Act of 1954 (Public Law 565, 83rd Congress), which was designed to carry out the President's recommendation to strengthen and expand the nation's resources for the rehabilitation of handicapped persons. It recognized that a major obstacle to extending rehabilitation opportunities to a greater number of disabled persons is the insufficient supply of trained personnel which includes those of the nursing profession. Consequently, traineeship awards were made available in order to augment the number of personnel trained in the rehabilitation field. As regards traineeships for nurses the Office of

⁷ Harmer, Bertha, and Henderson, Virginia, Textbook of the Principles and Practice of Nursing, p. 515.

Vocational Rehabilitation states in part:⁸

If the (rehabilitative) principles in nursing are to be part of all patient care, then each hospital and health agency should have at least one nurse sufficiently oriented to rehabilitation to be able to teach those principles to the other nurses in the same institution.

The writer, a recipient of a traineeship aware in rehabilitation nursing from the Office of Vocational Rehabilitation, intends to return to the X School of Nursing where one of her major responsibilities as a clinical instructor will be concerned with providing for more extensive integration of the basic principles of rehabilitation in the medical and surgical nursing clinical area.

STATEMENT AND JUSTIFICATION OF THE PROBLEM

Implicit in the statement of purpose to "provide for more extensive integration" of the basic aspects of rehabilitation is the fact that integration of these aspects is currently being done in the Medical and Surgical Nursing Clinical area of the X School of Nursing. The problem which presents itself, then, is the measurement of the extent to which these principles and aspects are being integrated and the means by which the integration can be evaluated.

The writer, then proposes to:

1. Identify those components of nursing care which are

⁸ "Rehabilitation Traineeships in the Field of Nursing", U. S. Dept. of Health, Education and Welfare, Office of Vocational Rehabilitation, Washington, D. C., August, 1955.

distinctive of rehabilitation nursing.

2. Ascertain to what extent these components appear in the medical and surgical nursing care studies written by forty two basic collegiate students at the school with which the writer is associated.

3. Test the hypothesis that certain differences will exist between those students who wrote care studies considered to contain a good awareness of the basic aspects of rehabilitation, and those students whose care studies indicate limited awareness of the basic aspects of rehabilitation. These differences will lie specifically in the areas of:

- a. The purpose in the selection of a patient - whether motivation was patient centered or disease centered.
- b. The extent of communication with resource personnel.
- c. The extent of contact with the patient's family.
- d. The length of time assigned for comprehensive care of the patient.

As a result of the study it is hoped that both the weaknesses and strengths in the present clinical teaching program as it relates to rehabilitation can be identified and recommendations can be made.

SCOPE AND LIMITATIONS

The study places reliance on the data obtained from the medical and surgical nursing care studies of forty two basic

collegiate students enrolled in a four year program which will lead to the degree of Bachelor of Science as well as a diploma in nursing. Eighty four nursing care studies - forty two medical and forty two surgical - written during the first medical and surgical nursing clinical rotation were analyzed. These care studies represent all of the studies written by the class during their first experience in the hospital setting in the third or junior year of the program. Of the forty two students, twenty or forty eight per cent of the group were interviewed in order to clarify and to gain more information regarding the findings of the analyses of the case studies and to obtain data to test the hypothesis.

A major limiting factor to the study is that reliance is to be placed to a large degree on the written word. It is impossible to ascertain to what extent the interpersonal interaction occurring between nurse and patient enhanced or deterred the therapeutic plan of nursing care. This last could only be determined by direct observation of each student-patient contact as it occurred. Peplau⁹ states that "Progressive identification of needs takes place as nurse and patient communicate with one another in the interpersonal relationship." The nursing care study provides an opportunity to record those needs recognized as such by the student but some of the needs expressed by the patient in an interpersonal relationship may not

⁹ Peplau, Hildegard, Interpersonal Relations in Nursing,
p. 84.

be recognized by the student nurse, and therefore may not be recorded in the care study. Conversely, it is also quite possible that the student recognized and identified the basic needs expressed by the patient but did not record them as part of her nursing care study.

PREVIEW OF METHODOLOGY

The literature on rehabilitation nursing from rehabilitation and nursing arts textbooks, articles from nursing journals and pamphlets, and reports of special conferences listed in the bibliography were used as a basis for identifying what some of the basic aspects of rehabilitation nursing might be. Ideas from these sources have also been incorporated into the statement of philosophy which guides the study. The author's definition of the aspects was presented to and discussed with the professor who directs the rehabilitation nursing program at Boston University and with six graduate students currently enrolled in the rehabilitation nursing program at the University. They concurred with the author's definition.

Eighty four nursing care studies written by forty two basic collegiate nursing students were analyzed as to the degree and frequency in which the identified components of rehabilitation nursing were present.

Twenty of these nursing care studies were then submitted to two clinical instructors in the field of medical and surgical nursing. They analyzed them as to the degree in which the rehabilitation components of nursing care were present. The

findings of the clinical instructors were then compared to those of the writer as a test for reliability.

A focused interview was held with twenty students, ten of these showed a good awareness and incorporation of the rehabilitation aspects in the care study, while the care studies of the second ten indicated a limited awareness of these aspects, according to the criteria established by the writer.

SEQUENCE OF PRESENTATION

Chapter II deals with the theoretical frame of reference for the study, and includes both a review of the related literature and an underlying philosophy of the study. Chapter III consists of a detailed consideration of the methodology. In Chapter IV the data will be presented and analyzed. A summary, conclusion and recommendations based on the study will be presented in Chapter V.

CHAPTER II

THEORETICAL FRAME OF REFERENCE

It is the belief of the writer that while the nurse, student or graduate, plans for and administers comprehensive nursing care to meet the specific needs of a patient, she is also intimately concerned with the rehabilitative aspects of good nursing care. What is good nursing care? Frances Kreuter¹ states that the understanding of a person and the establishment of mutual trust are essential to the goodness of nursing care. The goodness of this care is controlled by the independent operations of ministrations and communications. Ministrations refer to those nursing measures from which all other nursing operations draw comfort. The basic ministrations in nursing care are concerned with the comforting measures that contribute to a sense of well-being and are the means by which a sense of mutual trust and confidence is established between patient and nurse. The second operation, communications, is essential in a comprehensive care plan. This operation involves communicating with the patient, with members of the allied professions, and other professional workers and with the patient's family.

The patterns of patient care in the span of a decade or so have undergone a change in emphasis from a scientific and technical approach to one which is more and more concerned with that of total or comprehensive nursing care.

¹ Kreuter, Francis R., "What is Good Nursing Care?", Nursing Outlook 5: 302, May, 1957.

Nursing strives to improve its own administration and to design its education to the end that the practitioner of the art may achieve the objectives of the art meeting the needs of each patient comprehensively, and forwarding the physicians purposes in therapy, rehabilitation or prevention.²

The Joint Commission for the Improvement of the Care of the Patient presented the following statement to the Board of Trustees of the American Medical Association, The American Hospital Association, and the Board of Directors of the American Nurses' Association and the National League for Nursing:

Comprehensive nursing care should be designed to provide physical and emotional care for the patient; care of his immediate environment; carrying out the treatment prescribed by the physician; teaching the patient and his family the essentials of nursing that they must render; giving general health instruction and supervision of auxiliary personnel.³

Implicit in this statement of a concept of nursing care which is the right of every patient are the rehabilitative aspects of nursing. The rehabilitation process begins at the onset of illness and includes not only the cure of illness, but also, the methods of preventing further disability, the management of the convalescent period, and the ultimate return of the individual as a self-sufficient member of the family and the community.⁴

² Leone, Lucille P., "The Art of Nursing", The Yearbook of Modern Nursing, p. 6.

³ The Joint Commission Recommend, Nursing Outlook 1: 15⁴, March, 1953.

⁴ Hartigan, Helen "Nursing Responsibilities in Rehabilitation", Nursing Outlook 2: 650, December, 195⁴.

Ole Sand⁵ in the progress report of the study in basic nursing education at the University of Washington records the following statement concerned with the needs of patients in the content area - The Plan of Care for Individual Nursing Care:

The health needs of people were analyzed, resulting in seven sub-areas of content: Physical needs of the patient, including the need for comfort, cleanliness, sleep and rest, physical activity...., emotional need... including the need for belonging and acceptance; social and economic needs...; integrative needs of the patient referring particularly to the need to relate oneself to something beyond oneself...; therapeutic needs... such as needs for medications and treatment; the patient's need for learning, including the need to care for oneself and one's family during minor illnesses, chronic illnesses and convalescence, and the need to know how to keep well and to prevent illness and injury; and the intellectual needs of the patient.⁶

This plan for individual nursing care also recognizes that the needs of people for rehabilitation are an integral part of all other needs, namely, the physical, emotional, social-economical, integrative, therapeutic, learning, and intellectual.⁷ Emphasis on any of these health needs may change from day to day, and since no two persons are the same, modifications in meeting these needs must be made according to the individual patient. Factors which will influence modification include the patient's age, his social background, his personality, the medical plan of care, and the particular health situations and

⁵ Sand, Ole, Curriculum Study in Basic Nursing Education, p. 36.

⁶ Ibid. p. 37.

⁷ Ibid. p. 37.

problems which arise out of the illness and which the patient has to face.

The close relationship and correlation between comprehensive nursing care and rehabilitation has been further expounded by the Work Conference Committee on Teaching the Rehabilitative Aspects of Nursing.³ Some of the basic beliefs as identified by the conference members regarding the rehabilitative aspects of nursing are as follows:

1. Rehabilitation is a point of view based on the belief in our culture that all persons should be helped to maintain or retain their best possible physical and mental health rather than a body of specific skills. This point of view should be developed in the basic programs.
2. Rehabilitation is a goal of comprehensive patient care accepted by all members of the health team and as such is an integral part of good nursing.
3. Comprehensive nursing is one part of the rehabilitation process. Much of the effectiveness of what the nurse does depends upon her interchange with other disciplines in helping the patient to rehabilitate himself.
4. Nursing in the rehabilitation process begins when the nurse first meets the patient and his family and continues in all settings in which this relationship exists ----.
5. There are many components of comprehensive patient care which are initiated by the nurse and which make definite contributions to rehabilitation. These include ... rest, comfort, recreation, emotional support, health teaching and nutrition.

³ Report of Work Conference Committee--Teaching the Rehabilitative Aspects of Nursing, (National League for Nursing), October 15, 1956.

Therefore, it is evident that comprehensive nursing care and the rehabilitative aspects of nursing are intimately bound.

In the execution of the total or comprehensive plan of nursing care the nurse is concerned with the rehabilitation process which involves the consideration of the patient as a unique individual, his total needs, and the means and plans by which these needs may be met. Both the comprehensive and rehabilitative approach to nursing require that each patient be recognized as a person and not a case. Because of this certain fundamental attitudes are basic to comprehensive care, and therefore to rehabilitation. These attitudes are particularly concerned with the recognition of the worth of every individual and his right to be different.⁹ This implies that the nurse along with other members of the team assumes the responsibility of finding out how the patient feels about his illness, his likes and dislikes, and the implications the illness has for him and his family. It requires a knowledge of his home, his family, the community and the resources available both within and without the hospital setting which will hasten the restoration of an individual to his rightful place in society.

Hartigan¹⁰ states that within simple nursing procedures there is much that can be done to set the patient well along the road to rehabilitation. These include the encouraging of

⁹ Report of Work Conference Committee Meeting, op. cit., p. 5.

¹⁰ Hartigan, op. cit., p. 650.

the patient to help himself; positioning of the patient in ways to prevent deformity and to promote normal function; helping the patient maintain normal range of joint motion; encouraging him in the use of self-help devices; counseling the patient and his family in order to help him live with his existing capacities rather than his disabilities.

Another major nursing contribution to the successful rehabilitation of the patient is teaching the patient, his family and others.¹¹

Working with other disciplines to provide the best possible services to meet the patient's needs is another major area where the nurse contributes. This implies that the nurse should be completely familiar with available resources. Since the nurse is responsible for patient care over a longer period of time than any other member of the health team, the provision for follow-up and carry-over of treatment and motivation falls to her. It is therefore essential that she be familiar with the types and aims of the treatment provided by the other disciplines.

Rehabilitative or comprehensive nursing care cannot be accomplished solely by one individual or profession. It involves understanding, teamwork, and recognition of the fact that the most important discipline or worker at any one time is the one for whom the patient at the time has the greatest need.

¹¹ Hartigan, op. cit., p. 650.

The above discussion has been in essence the philosophy and concept of rehabilitation and the comprehensiveness of patient care. In the basic nursing education program at X School of Nursing an effort to unify the students' thinking in a "total care" program has been brought about in the development of the course in Comprehensive Medical and Surgical Nursing. This all-inclusive course integrates the principles and practices of medical and surgical nursing, the dietary, pharmacologic, therapeutic, and the social and health aspects of nursing. At the X School of Nursing selected clinical practices and the closely associated integrated experiences are carried out in a large general teaching hospital. A background body of knowledge is offered so that students may acquire an understanding of the major disease conditions of the body systems, which are a result of alterations in normal physiology; the methods by which she may assist the physician in making a diagnosis; the role she plays in carrying out with others the effective plan of immediate and long-term medical and surgical care for a patient which should lead to his optimum rehabilitation and prevent him from complications or from becoming a patient again.

Resource people who participate include the diet-therapist, the social worker, rehabilitation experts, the university interpersonal relations expert, the university and hospital spiritual advisors and various clinical experts. These assist the instructors in high-lighting the different aspects of complete patient care so that the nurse can see how to plan

and carry out comprehensive nursing care to meet the socio-economic, physical, integrative, intellectual, emotional, and any other needs of an individual who becomes a patient.

To give flavor to this learning experience as well as a broader and deeper understanding of continuing total patient care the students visit a few selected official or voluntary health agencies to which patients may have been referred or from whence patients come.

The delegation of responsibility for the curriculum in nursing is to the faculty of the collegiate school. Clinical instruction, assignment of time, assignment to patients, rotation of clinical experiences, and the evaluation of student growth and progress in the clinical situation are a collegiate responsibility.

At the beginning of the selected clinical practice, the assignment of patients is done with a view toward choosing a patient with problems which are being considered in the classroom. This patient would have problems creating needs which would be within the scope of the student's ability to meet without frustration at the time. A plan of care for the patient is prepared in this beginning experience. The student consults all available source materials in preparing the plan. She reviews all aspects of his history thoroughly, notes the physician's plan of care, searches out pertinent information concerning his drug and diet and other forms of therapy from resource people and the literature. She talks with the patient

and speaks with the family during visiting hours. After the plan of care is written the student reviews the plan with the instructor. Then the plan of care is administered, and it is during this time that she sees the patient as a person and establishes a good relationship with him; she anticipates his needs, modifies and carries out safe, comfortable, therapeutic nursing measures; she observes, reports, and records any pertinent observations; she utilizes available opportunities to teach the patient and his family; she accompanies the patient to any other hospital department where he will receive care and treatment such as the X-Ray department, operating room, physical therapy department, etc.

The second phase of the clinical experience is a continuation of the first. Assignments during this time are made with the purpose of allowing the student to participate in the care of patients who present problems which are more complicated and require more thought and action for solution than those for whom she cared during the first part of the course. Whenever possible the student participates in the inter-agency referral plan when the patient is being discharged. If it is possible she meets the patient again when he returns to the out-patient department.

Since nursing is an interaction between the patient and the nurse which requires a period of time to develop, the student gives continuous care to a particular patient for a period of one to four weeks. Total care, involving as it does

the responsibility of helping the patient through the immediate stress situation to recovery and ultimate discharge to his home and community, takes more than brief contacts involving only physical care.

The clinical teaching program is patient-centered. The main approach is by the use of such techniques as patient presentation, problem solving, and case method. The student attends and participates with others in physicians and nurses "rounds", bed-side clinics, and reports of on-going research projects, group conferences and demonstrations of special procedures.

A major learning assignment during this period is the writing of the nursing care study. Two care studies are required - one to be concerned with the nursing care needs of a medical patient and the other to focus on the nursing needs presented by a patient with a surgical condition. The nursing care study, by definition, is "a thoughtful record of the patient, his needs, his problems, the care given him and the attempts made to help him solve his problems and meet his needs."¹² The study is made as the care is being given and shows the adjustments which can be made to meet the changing needs of the patient. It is intended to emphasize the patient as an individual personality. Through showing the patient as a whole, the nursing care study can provide the student with one

¹² Petry, Lucille, The Encyclopedia of Nursing, p. 652.

of the best means to see herself in a nursing role.¹³ The student's concept of nursing care may strongly influence her attitude towards nursing. Social scientists generally agree that the status and scope of a profession depends largely on the views which the members of the profession have of themselves.¹⁴ In the curriculum, the care study provides the major opportunity for the student to show that even though she shares with others in the care of the patient she can manage to merge isolated elements of nursing care into a meaningful whole - the total or comprehensive nursing care of the patient.

Since comprehensive care is one part of the rehabilitation process¹⁵ and the needs of people for rehabilitation are an integral part of all other needs¹⁶ considered in total patient care, then, the nursing care study can provide one of the best means of evaluating the extent to which the rehabilitative aspects of nursing are integrated in the basic medical and surgical clinical area upon analysis of the extent to which the patient's needs were met.

¹³ Mauksch, Ingeborg and Hans Mauksch, "The Value of the Nursing Care Study", The American Journal of Nursing, 50: 44-46, January, 1950.

¹⁴ Ibid. p. 45.

¹⁵ Work Conference Committee, op. cit., p. 5.

¹⁶ Sand, op. cit., p. 37.

STATEMENT OF THE HYPOTHESIS

HYPOTHESIS

Certain differences will exist between those students whose studies, according to criteria, indicate a large degree of integration and those whose studies show a limited degree of integration of the basic aspects of rehabilitation nursing. The chief focus for the differences will be the student's approach to the study, that is, whether it is a patient-centered approach, concerned mainly with an individual and his specific needs, or a disease-centered approach, which is concerned mainly with the technical or medical aspects of a particular disease or condition. These differences would be specifically in the areas of:

- a. The purpose in the selection of a patient - whether motivation was patient-centered or disease-centered.
- b. The extent of communication with resource personnel.
- c. The extent of contact with the patient's family.
- d. The length of time assigned for comprehensive care of the patient.

It is hypothesized that the students who obtained a high score in the integration of the basic aspects of rehabilitation in the care studies will: have a patient-centered motivation in the selection of the patient for the care study; show a greater amount of contact with resource personnel and the family; and will have had a longer period of time in assignment to the patient.

The hypothesis has been based upon the following

premises:

Comprehensive nursing care is concerned with the nurse helping to meet the needs of people who are ill and convalescent. These needs including the physical, emotional, social and economic, the integrative, the therapeutic, the intellectual, and the learning needs, are basic health needs of all people, but during illness may assume greater importance.

The needs of people for rehabilitation are an integral part of all the other needs, namely, the physical, emotional, socio-economic, integrative, therapeutic, learning and intellectual. The nursing care study is a thoughtful consideration of the patient as an individual, his total needs and the plan for how these needs might be met. The core of the philosophy of rehabilitation and comprehensive care is the concept of the patient as a united entity - a whole person.

It would seem that an analyses of the nursing care studies written by basic collegiate students about patients to whom they have been assigned to administer comprehensive nursing care will provide an effective means of measuring the success of the integration of the basic rehabilitative aspects of nursing.

CHAPTER III

THE METHODOLOGY

The method employed in investigating the problem and testing the hypothesis was based on the need to:

1. Identify the basic aspects of rehabilitation nursing.
2. Determine to what extent these aspects were present in the eighty four medical and surgical nursing care studies written by forty two basic collegiate students.
3. Ascertain the differences, disclosed by interviewing, between those students who showed a high degree of integration of the basic aspects of rehabilitation in the care studies and those whose care studies indicated a limited degree of inclusion of these aspects.

IDENTIFICATION OF THE BASIC ASPECTS OF REHABILITATION NURSING

A review of the literature reinforced the writer's belief that in the execution of the assignment aimed to render comprehensiveness of care, the elements of the rehabilitative aspects were closely interwoven and interrelated. The rehabilitation potential may be found in all areas of nursing and does not require a special setting.^{1, 2, 3} The rehabilitative components of nursing care are not only associated with severely disabled patients who require the gamut of special services and

¹ Hartigan, op. ci., p. 650.

² Sand, op. cit., p. 37.

³ Work Conference Committee, op. cit., p. 5.

therapies, but also are a vital part of the care and treatment of any patient, regardless of his diagnosis.

In nursing care, seven needs basic to the health of all individuals are identified, namely, the physical, the emotional, the social and economical, the integrative, the intellectual, the learning, and the therapeutic. Some specific rehabilitative aspects which are an integral part of the above broad health needs are also identified.

After identification of these needs and the specific rehabilitative aspects of the broad health needs, the writer submitted them for recommendations to a member of the faculty associated with the rehabilitation program at Boston University and six graduate nurses enrolled in the Rehabilitation Nursing Program at the University.

The group approved the utilization of the seven basic health needs as criteria for the evaluation of the care studies.

The revised list of the specific rehabilitative aspects of nursing is as follows:

1. The preventive and supportive aspects of nursing.
2. Recognition of the contributions of other professional personnel - the physical therapist, the social worker, the vocational counselor, the speech therapist, etc.
3. Recognition of the need and the provision for continuity of care - the community resources available to the patient following discharge.
4. Recognition of the services of the hospital follow-

up out-patient department, tumor clinic, or physical medicine department.

5. Recognition of the nurse's role in the coordination of the plans for the patient's discharge - including participation in the inter-agency referral system and the cooperation of the family.

6. Encouragement of the patient to help himself in attaining maximum independence.

Each nursing care study was appraised in relation to the extent in which the seven basic needs and the specific rehabilitative aspects of nursing appear.

ANALYSIS OF NURSING CARE STUDIES

Eighty four nursing care studies written by forty two nursing students enrolled in a basic degree program at X School of Nursing were read and analyzed. These care studies were written as a major assignment as part of the educational and clinical program during the six month period of assignment to the medical and surgical clinical division described previously.

The students at the time of their writing the care studies were not aware that these would be utilized in a study. The customary orientation and explanation as to the writing of the care study was given by the clinical instructors prior to the selection of the particular problem for study by the writer. A guide for writing the nursing care study was utilized as it had been in previous years. The writer requested that all the

nursing care studies written by the class be retained rather than be returned to the students, as was customary, upon completion of the clinical experience.

Next, the eighty four nursing care studies were read and analyzed in order to ascertain to what extent the needs and rehabilitative aspects of care appeared in the care studies. Since a review of the literature as to how best these studies could be evaluated and relative weights given revealed no standard process which would lend itself conveniently to evaluation, the following were arrived at in the evaluation of each of the seven basic needs in the care studies of each student. (See Appendix)

- 3 - Indicates a good awareness of the need.
- 2 - Indicates a fair awareness of the need.
- 1 - Indicates a poor awareness of the need.
- 0 - Indicates no awareness or mention of the need.
- (-) - Symbol utilized in those cases where a particular need could not be met for the patient at the time the student was administering the care.

Each nursing care study averaged 750 to 1000 words and the task of reading these could become tedious and tiring, a factor which was considered in the interest of accuracy. It was found that by limiting the number of care studies read at one sitting to five, the task could be accomplished with a greater degree of efficiency and dispatch.

A factor which aided in the evaluation process was the

familiarity of the writer with the majority of the patients about whom the students wrote. The writer had been employed as a part-time clinical instructor for this particular group of students and consequently was acquainted with the patients and some of their problems. The writer was familiar with thirty four of the thirty six patients selected for the surgical care study. Six students, having been assigned to a particular ward at different times, had selected a patient previously studied by a classmate.

Of the thirty four patients about whom medical care studies were written the author was acquainted with twenty eight. Eight students had patients previously studied by a classmate.

By knowing the patients, the writer was more likely to know whether a problem was present or not and could ascertain with a greater degree of reliability the student's awareness of it.

Because the writer was also familiar with the former achievement and the personality of the students a factor to be considered as a probable cause of bias is that which is called the "halo effect".⁴ This is a tendency to permit judgement of an individual on a specific trait to be influenced by judgement of her as a whole or by our like or dislike of her.⁵

⁴ Thorndyke, E. L. "A Constant Error in Psychological Ratings," Journal of Applied Psychology 4: 26, March, 1920.

⁵ Symonds, Percival, Ph.D. "Eliminating Bias in Evaluating the Student's Achievement", The American Journal of Nursing 52: 611, May, 1952.

This halo effect is fostered by interpersonal relationships, and it is more likely that an instructor will note an error or fault in a student about whom she has built unfavorable impression and feelings than in a student whom she likes and admires.⁶

In order to eliminate the above factor the student's name on the care study was obliterated and a number was assigned to the study.

As a further check for bias twenty care studies selected at random were submitted to two clinical instructors who held a major responsibility in the clinical teaching program at the X School of Nursing. The same precautions were taken to eliminate the possibility of the "halo effect."

A conference was held with the two clinical instructors in order to explain and clarify the method of evaluation and to arrive at mutual agreement regarding the interpretation of the basic needs and the specific rehabilitative aspects arising from these needs. After the evaluations of the twenty care studies were completed another conference was held with the clinical instructors in order to compare their findings with those of the writer.

The reliability check disclosed agreement with one instructor ninety seven per cent of the time. With the second instructor agreement occurred ninety two per cent of the time.

⁶ Symonds, op. cit., p. 611.

THE FOCUSED INTERVIEW

The focused interview was utilized to secure more information and to clarify the data obtained in the evaluation of the care studies. This tool was also used to gain data to test the hypothesis that students whose care studies showed a good awareness of the basic aspects of rehabilitation differed in certain respects from those whose care studies indicated a limited awareness of these aspects.

Merton and Kendall⁷ have outlined the characteristics of this type of interview as follows:

1. The persons interviewed are known to have been involved in a particular concrete situation.
2. The hypothetically significant elements, patterns and total structure of the situation have been previously analyzed by the investigator.
3. On the basis of this analysis, the investigator has fashioned an interview guide, setting forth the major areas of inquiry and the hypotheses which locate the pertinence of data to be obtained in the interview.
4. The interview itself is focused on the subjective experiences of persons exposed to the pre-analyzed situation. The array of the reported responses to this situation enables the investigator to test the validity of hypotheses to this situation which will give rise to new hypotheses.

⁷ Jahoda, Marie, Deutch, M. and Cook, S, Research Methods in Social Relations, p. 176, quoting R. K. Merton and P. L. Kendall, "The Focused Interview," American Journal of Sociology, 1946, pp. 541-547

THE INTERVIEW SCHEDULE

The interview schedule contained the following questions:

A. Questions aimed at getting further information arising from the analysis of the care studies in relation to the ability or inability of the students to meet the patient's basic health needs and identification of specific rehabilitative aspects were as follows:

1. What were some of the factors which you feel enhanced your ability to understand (patient's name) needs?
2. What were some of the factors which you feel prevented you from meeting (patient's name) needs?

Rewording of these two questions was frequently necessary in the initial interviews. The interviewees would question the interviewer as to just what was meant. Rewording the questions in subsequent interviews elicited a more spontaneous response.

The rephrasing of the questions resulted in the following: As you look back, what are some of the things which either helped or hindered you in giving comprehensive care to the patient and helped or prevented you from understanding and meeting the needs of (patient's name)?

3. You have (have not) mentioned or included (specific need) of your patient in the care study. Would you

like to comment upon this?

B. Questions aimed to obtain data to test the hypothesis regarding differences evident between two selected groups of students included:

1. Why did you select (name patient) for your nursing care study?
2. For what period of time did you give nursing care to (name patient)?
3. Was (period of time) long enough for you to administer comprehensive or total nursing care?
4. How long had you known (patient's name)?
5. To what extent did you make an attempt to contact resource personnel or talk with them about any special concern you had about (name patient)? Who were the persons you contacted?
6. Were you acquainted with the patient's family? How well did you get to know the family?
7. Did you enjoy the experience of caring for (name patient)? Why?
8. How do you feel about the nursing care study as a learning experience?

Ten of the students who were interviewed had written care studies which represented a good awareness of the rehabilitative aspects of nursing care. These students averaged a point value of 2.5 or more against a perfect point value of 3.0 in their ability to recognize and meet the patient's seven basic

health needs and had included four or more of the six specific rehabilitative aspects associated with comprehensive care in their study.

Ten of the students who were interviewed had written care studies which revealed a limited awareness of the rehabilitative aspects of care. The point value average of these students for meeting the patient's basic needs was at 1.5 or lower. These students included three or less of the six rehabilitative aspects of nursing in their studies.

In both cases the accessibility of the students was a determining factor in selection. Some students who met the above criteria in both categories were not available due to an out-of-state clinical assignment at the time when the interviews were taking place.

Contact with the students was made by letter. The purpose of the interview was explained and a more complete explanation was given at the time of the interview. The students were asked to arrange for a convenient time when all would be available. After determining the time and place the class representative contacted the investigator by letter or telephone to verify the details of the appointment. In one instance, at the writer's request, the university clinical instructor at the affiliating agency notified the students regarding the interview and made satisfactory arrangements as to time and place for both the interviewees and the interviewer.

All of the students contacted were available on the

designated time and date with the exception of one who was ill at home. Another student whose care study showed a similar point value average was available and consented to be interviewed in the place of the absent student.

Each student was interviewed individually, the interview lasting from thirty to forty five minutes on the average. Throughout the process of interviewing the investigator recognized her function as being primarily to serve as a catalyst to a comprehensive expression of the student's feelings and beliefs and of the frame of reference within which her feelings and beliefs take on personal significance.⁸ To achieve this result the interviewer attempted to create a completely permissive atmosphere in which the student was free to express herself without fear of disapproval or dispute and without advice from the interviewer. The fact that the instructor was previously acquainted with each of the students served to facilitate rapport and the creation of a friendly informal atmosphere.

⁸ Jahoda, op. cit., p. 177.

CHAPTER IV
PRESENTATION

This chapter is concerned with a presentation of the data obtained from an analysis of eighty four medical and surgical nursing care studies written by forty two basic collegiate students and the focused interview held with twenty selected students. It contains the findings relevant to the assumption of the investigator that the extent to which the components of rehabilitative nursing appear in the care studies can be ascertained; and that certain differences will exist between those students whose care studies show a good awareness of the basic aspects of rehabilitation and those whose studies reveal a limited awareness of these aspects. The result of this study will be presented as follows: (1) The findings of the analysis of eighty four care studies, (2) The results of the focused interview with twenty selected students.

ANALYSIS OF NURSING CARE STUDIES FOR BASIC HEALTH NEEDS

Each nursing care study was examined and a weighted value was given for each basic health need; 3 indicates a good awareness of the need; 2 indicates a fair awareness of the need; 1 for a poor awareness of the need; 0 was used when there was no mention of the particular need; the symbol (-) was used when the need for the particular patient could not be met at the time when the student was responsible for the comprehensive care of the patient. A mean was obtained for each health need appearing in each care study, and a total mean was computed for each

TABLE 1

THE RANK ORDER AND MEAN SCORES OF HEALTH NEEDS IN THE MEDICAL AND SURGICAL NURSING CARE STUDIES

Basic Health Need	Mean Score Medical Care Study	Rank Order	Mean Score Surgical Care Study	Rank Order	Mean Score Combined Medical and Surgical Studies	Rank Order
Physical	2.55	1	2.33	2	2.44	1
Socio-Economic	2.40	4	2.42	1	2.41	2
Emotional	2.50	2.5	2.20	3	2.35	3
Therapeutic	2.50	2.5	2.14	4	2.32	4
Learning	2.17	5	1.94	6	2.06	5
Intellectual	1.88	6	2.02	5	1.95	6
Integrative	1.73	7	1.40	7	1.57	7

need in the eighty four care studies combined.

Table 1 indicates the mean scores and rank order of each basic health need as found in the medical and surgical care studies. It is evident that the four basic health needs, the physical, therapeutic, socio-economic, and emotional needs, while not having the same rank order in both medical and surgical categories, have the higher means and rank among the first four for both medical and surgical categories. Three basic health needs, the learning, the intellectual, and the integra-

tive are among the lowest in rank order. The integrative need is the lowest in both the medical and surgical categories.

The means obtained for each health need for the total number of care studies reveal that the physical, socio-economic, emotional, and therapeutic needs rank in order among the first four, learning and intellectual rank fifth and sixth respectively, and the integrative needs rank the lowest.

Since the investigator is primarily concerned with the over-all inclusion and integration of the basic health needs in both the medical and surgical care studies, the mean scores and ranks of the health needs for the combined medical and surgical care studies will be discussed in detail.

The ability of the students to recognize and meet the patient's physical needs ranks first with a mean of 2.44. This high score may be attributed to the fact that the beginning student's initial prolonged contact with patients is concerned with such physical measures as provision for the patient's comfort, cleanliness, rest, and sleep, proper posture and body mechanics; prevention of deformity or pressure ulcers, and the like. These measures are those which are planned for and carried out regularly and are the ministrations commonly associated with nursing functions.

The ability of the students to recognize the socio-economic needs of patients ranks second with a mean of 2.41. This score indicates that a high degree of integration of the principles relating to the social sciences and health aspects

of nursing has been affected. The high ranking of this need might be attributed to the general hospital setting in which the student finds herself - a large municipal hospital located in a teeming slum area, having a large census of indigent patients.

The ability to recognize and meet the emotional needs of the patient averages 2.35. This indicates a relatively high degree of integration of this need which is concerned with the need of the sick individual for belonging and acceptance by the family, nurse, and other hospital personnel. It also involves the recognition and interpretation of how the patient attempts to solve emotional conflicts and stresses which are presented by his illness. The guidance of the university interpersonal relations instructor and the orientation of the clinical instructors in the interpersonal relations principles might account for the relatively high mean obtained.

The ability to meet and understand therapeutic needs ranks fourth having a mean of 2.32. Although ranking among the first four, one might have expected this particular factor to have ranked higher. The medical and surgical areas to which the students are assigned are staffed by medical schools which carry on an active research and therapeutic program in which the students frequently participate. Attendance at medical conferences, medical ward rounds, and a free exchange of information is afforded due to the close proximity of the service laboratories and teaching areas to the clinical divisions where the stu-

dents are practicing.

The extent of integration of the need for learning is fifth with a mean of 2.06. This need is concerned with the requirements for a person to care for himself or for his family during illness and convalescence, and the need to know how to keep well and to prevent future illness or injury. The ability of students to recognize or meet this need is somewhat low. The focused interview brought out some pertinent facts as to some of the reasons why this need could not be met. (See Table 4).

The ability to meet the patient's intellectual needs ranks sixth with a mean of 1.95. This relatively low standing may be attributed to the inadvisability and the impracticability of fostering the interest of the acutely ill patient in intellectual or recreative pursuits. (See Table 4).

The ability to meet the patient's integrative needs ranks seventh and lowest with a mean of 1.57. This basic need particularly refers to the need to relate to something beyond oneself, including a philosophy of life, religion and the aesthetics. That this need ranked lowest is surprising when viewed in terms of the background knowledge in philosophy and theology which forms an integral and vital part of the curriculum at X School of Nursing. During the freshman and sophomore years of the college program each student is required to complete twelve credits in philosophy and six credits in theology.

The spiritual advisor to the school of nursing, in a conference with the investigator, expressed the opinion that the

particular hospital setting where the student is receiving experience may account for the low rank of the integrative needs. A full-time complement of Catholic, Protestant and Jewish chaplains minister to the religious needs of patients, and thus the nurse may find that in a situation such as exists at X Hospital, her responsibility in recognizing this need is somewhat lessened.

Table 2 was prepared so that the skewness exhibited by the frequency distribution of the mean scores of eighty four nursing care studies might be indicated.

TABLE 2
FREQUENCY DISTRIBUTION OF MEAN SCORES

Range and Scores	Frequency	Per Cent of Care Studies
2.6-3.0	21	24
2.1-2.5	29	35
1.6-2.0	15	18
1.1-1.5	14	17
0.6-1.0	5	6
Total	84	100%

Analysis of Table 2 indicates a range of scores from a low of 0.6 to a high of 3.0. In the highest range of 2.6-3.0 fall twenty four per cent of the care studies. In the range 2.1 to 2.5 fall thirty five per cent of the studies. If the care studies falling within the range of 2.1 to 3.0 are considered to be those containing a good awareness of the patient's basic needs, then fifty nine per cent of the studies are included.

Eighteen per cent of the care studies fall in the range 1.6 to 2.0. This range includes studies which are considered to incorporate a fair degree of integration of the patient's basic needs. The range 0.6 to 1.5, containing studies showing a limited degree of integration of the basic health needs, includes twenty three per cent of the care studies. It is regrettable that in a curriculum which emphasizes total or comprehensive patient care that this percentage of care studies fall in the last two ranges.

Further exploration of some of the factors which either enhanced or hindered the student's ability to meet or understand the patient's needs was done in the focused interview with twenty students.

The question utilized to obtain the data was: "As you look back, what are some of the things which either helped or hindered you in giving comprehensive care to the patient and either helped or prevented you from understanding or meeting the needs of (patient's name)?"

In some instances a follow-up question was employed. This question was stated thus: "You have (have not) mentioned or included specific need of your patient in the care study. Would you like to comment upon this?"

Tables 3 and 4 record the data collected in answer to the above questions. It is significant that prolonged contact with the patient and the ability to establish good rapport were factors mentioned by forty per cent of the twenty interviewees as conducive to meeting all of the patient needs.

TABLE 3

STUDENTS OPINIONS REGARDING FACTORS WHICH ENHANCED THEIR ABILITY
IN MEETING BASIC NEEDS

Factor	Basic Need	Number of Students N = 20	Per cent of Students
Prolonged contact	All	8	40
Establishment of good rapport	All	8	40
Conference with doctor	Therapeutic Socio-economic	7	35
Conference with instructor	Physical	4	20
Patient's record	All	3	15
Receptivity to teaching	Learning	3	15
Conference with classmates*	Physical Emotional	3	15
Library research	Physical Therapeutic	3	15
Family contact	Socio-economic	2	10
Patient-Care Conference	All	1	5

* Previously assigned to patient

TABLE 4

STUDENT'S OPINIONS REGARDING FACTORS WHICH HINDERED THEM IN MEETING BASIC NEEDS

Factor	Basic Need	Number of Students N = 20	Per cent of Students
Inability to establish good rapport	Learning Intellectual Emotional	11	55
Patient's condition	Learning Intellectual	7	35
Mental retardation	Learning	2	10
Need not expressed	Integrative	2	10
Insufficient time	Learning Intellectual	1	5
Difficulty in family contacts	Learning	1	5

Inability to establish good rapport was mentioned by fifty five per cent of the interviewees as being a major factor in the inability to meet all of the learning, intellectual or emotional needs of the patient. The patient's condition was mentioned by thirty five per cent of the students as a factor in their inability to meet the patient's learning and intellectual needs. In the majority of cases the patient was considered to be too seriously ill at the time the care was given, and nursing efforts were concentrated mainly in the attempt to meet the patient's physical and therapeutic needs. Of the six factors mentioned which in the opinion of the students prevented the meeting of the patient's needs, the learning need was mentioned most frequently as a specific need which could not be met. Of interest in Table 4 is the non-appearance of those needs which received the highest mean scores and ranks, namely the physical, emotional, socio-economic and therapeutic. In contrast, Table 3, except when all needs are specified as met, lists the needs which received the highest score and rank, with the exception of the learning need, which ranked fifth,

Prolonged contact with the patient, and the establishment of good rapport and relationships with the patient were considered by forty per cent of the interviewees to be major factors in their ability to meet all of the patient's basic needs. (See Table 3) Conferences with the doctor were mentioned by thirty five per cent of the interviewees, as a factor which increased their ability to meet the patient's socio-economic and

therapeutic needs. Conferences with the clinical instructor were limited to being a factor in meeting the patient's physical needs, twenty per cent of the students mentioning this in the interview.

Only one student felt the patient-care conference aided her in the understanding of the patient's total needs. Since the main objective of a patient-care conference is to aid the student in seeing the individual patient in a comprehensive plan of care, this item is rather puzzling in that more students did not mention it as a factor in increasing their ability to meet the patient's needs.

ANALYSIS OF CARE STUDIES FOR SPECIFIC REHABILITATIVE ASPECTS OF NURSING

Each nursing care study was examined for the frequency of the inclusion of the specific rehabilitative aspects of nursing care. Table 5 contains the frequency of recognition by the students of these aspects.

In order of rank, it is interesting to note that aspect number one, which is concerned with the preventive and supportive aspects of nursing, is first and is included in eighty one per cent of the care studies. This aspect is related primarily to the ability to meet the physical needs of patients. It will be recalled that the physical needs received the highest mean score of the seven basic needs. The rehabilitative aspects which comprise this category are intimately and closely related to the degree and ability with which the physical needs of patients are met.

Aspect number three, which is concerned with the need and the provision for continuity of care and the community resources available after discharge, is included in forty nine or fifty seven per cent of the care studies. This appears to be a somewhat low rating. A factor to be considered is that eleven patients at the time of study were seriously ill and definitive plans for their discharge could not be made. A variety of community resources and agencies were named. These included visiting nurse association, rehabilitation centers, Alcoholics Anonymous, various veteran's services, hospitals for the chronically and terminally ill, and nursing homes.

Fifty per cent of the care studies included aspect number five, the third in rank order. This aspect is concerned with the recognition of the nurse's role for the coordination of plans for the patient's discharge, including participation in the inter-agency referral plan. All of the studies which included this aspect elaborated on the vital role of the family in the rehabilitation program both before and after the patient's discharge.

Aspect number two, the recognition of the contributions of other professional personnel, including the physiotherapist, the occupational therapist, the social worker, the vocational counselor and the speech therapist, ranks fourth. Thirty seven per cent of the studies made reference to this specific rehabilitative aspect.

The social worker was the professional worker most frequently mentioned as a contributor to the comprehensiveness of patient care. This might be attributed to the fact that opportunity for contact and exchange of information with this professional worker is frequently and conveniently brought about on the hospital ward setting.

The speech therapist was mentioned twice, once in conjunction with a patient who had had a laryngectomy and once in reference to a patient who had had a radical neck dissection. The services of a speech therapist were not mentioned in conjunction with four patients whose diagnosis was cerebral vascular accident with manifestations of aphasia. This lack of inclusion

TABLE 5

RANK ORDER OF FREQUENCY OF RECOGNITION BY STUDENTS OF THE SPECIFIC REHABILITATIVE ASPECTS OF NURSING CARE

Specific Rehabilitative Aspect	Recognition of Aspect in:			Per Cent	Rank
	Medical Studies N = 42	Surgical Studies N = 42	Total		
Preventive and supportive aspects of nursing	38	30	68	81	1
Recognition of need and provision for continuity of care	21	28	49	57	2
Recognition of nurse's role in coordination of plans for discharge-inter-agency referral, etc.	17	25	42	50	3
Recognition of contributions of other professional personnel	10	21	31	37	4
Recognition of services of hospital follow-up out-patient department, tumor clinic, physical medicine	17	11	28	33	5
Encouragement of the patient to help himself in attaining maximum independence	6	16	22	26	6

of the speech therapist in the plan of care for the last named patients might be attributed to the practice of the particular medical service which does not utilize the services of a speech therapist. Most patients with aphasia who are discharged from this medical service are referred for therapy at another hospital which provides this particular rehabilitative service.

The physical therapist was included twice in the care studies, both times in conjunction with the therapy plan for patients following a cerebral vascular accident. A physical medicine department is a part of the hospital services but at the time the studies were written this service was not being extensively used by the particular medical service. In the total rehabilitation program for any patient, the team of workers can progress only as far as the medical authorities will permit, for it is they who assume the responsibility for the direction of the plan of care. As the medical staff increases the utilization of special services, the student nurse may be able to develop a more acute awareness of the functions of the physiotherapist in the total program in the medical and surgical setting.

The occupational therapist and the vocational counselor were included once in reviewing the plans for the discharge of a patient to a local rehabilitation center. The low incidence of the inclusion of these last named members of the team might be attributed to the fact that their services are not an integral part of the service provided by the hospital, which is geared primarily for the care and treatment of the acutely ill patient.

In addition, since many of the patients were acutely ill at the time the studies were written, the plans for future employment may have had to be deferred until stabilization of the patient's condition occurred.

Thirty three per cent of the studies showed cognizance of the services of the follow-up out-patient department, the tumor clinic or the hospital physical medicine department . There are no figures or information immediately available for this study as to the number of patients from the particular medical and surgical wards who would ordinarily be referred to these services. Thus, no definite conclusions can be drawn from this figure.

The sixth and last basic aspect in rank order is present in twenty six per cent of the care studies. This aspect is concerned with the nurse's encouragement of the patient to help himself toward attaining maximum independence. A major factor to consider in regard to the small percentage of care studies in which this aspect appeared is the diagnoses and conditions of the patients at the time the studies were written. Sixteen patients had a diagnosis of myocardial infarction or congestive heart disease, conditions in which the major responsibility of the nurse is to spare the patient any unnecessary motion or exertion. Six patients were either unconscious or disoriented at the time of study, and, therefore, the nurse was unable to initiate a program which would ultimately lead to maximum self-help and independence on the part of the patient.

The number of care studies in which these specific aspects were identified appears to be somewhat low. The conditions of the patients might be the major contributing factor. Many of the patients at the time of study were acutely ill and definite plans for discharge or rehabilitation were still in doubt.

RESULTS OF THE INTERVIEW

Analysis of the data obtained in the focused interview is based on the purpose of the interview, namely to gain data to test the hypothesis that students whose care studies contained a good awareness and degree of integration of the basic aspects of rehabilitation differed in certain respects from the students whose care studies showed a limited degree of integration of these aspects. Hereafter, in the presentation of data the students in the group showing a high degree of integration will be referred to as Group I, and students whose care studies indicated a limited awareness of the patient's basic needs will be known as Group II. The students in Group I had mean scores of 2.5 or higher and had included four or more of the specific rehabilitative aspects in the care study; the students in Group II had mean scores of 1.5 or lower and had included three or less of the specific rehabilitative aspects in their studies.

It will be recalled that the hypothesis contained four specific parts. Findings on each of these will be discussed.

Part I

Students in Group I selected the patient for study from a patient-centered point of view and students in Group II were

primarily motivated by a disease-centered focus in the selection of the patient.

In order to gain data to test this part of the hypothesis the interviewees were asked the following question: "Why did you select (name patient) for your nursing care study?" Table 6 indicates the types of response made by the two groups.

TABLE 6

MOTIVATION OF STUDENTS IN SELECTION OF PATIENT FOR CARE STUDY

	Patient-Centered	Disease-Centered	Both Patient and Disease Centered
Group I	6	2	2
Group II	3	5	2

Examples of patient-centered responses are as follows:

"I felt I could help him the most. He was an immigrant - my grandfather was too. Because of this I felt I could understand the different customs. He was old-fashioned like my grandparents and he was afraid of hospitals - the same as mine would be I felt sorry for him as he was the only older man in a room with younger patients. He was for the most part ignored by them."

Another student made this comment:

"He was a challenge to me. He came to the ward with a pre-diagnosed personality - 'not a good patient'. I overheard a graduate nurse from the ward where he was transferred say he

was 'repulsive'. I wanted to try to help the patient as best I could. Maybe he wasn't as bad as they said."

Examples of disease-centered responses follow:

"Well, I took care of four patients while I was on Medical 4. Two of them were selected by other students, the other one was not worthwhile - she was in mainly for senility - and so Mrs. C. was the only one left. I got interested in Hodgkin's Disease."

One student made this comment: "Disease was so different and unusual, something I didn't know much about."

Another commented thus:

"I scrubbed in on the case the last week I was in the O.R. and I was interested in the surgical procedures - for example, wangensteen drainage and that special gall bladder drainage apparatus they had rigged up."

An example of a patient-centered and a disease-centered response is as follows:

"Well, I was interested in the final diagnosis, and I had him for a patient most of the time. When I got to know him better, I found him to be a challenge, especially because of the mental aspects. He was very depressed at first, and I found I gained a good deal of satisfaction in helping him accept his illness."

On the basis of the data obtained, there is evidence that students in Group I were more apt to approach the care study from a patient-centered view than students in Group II. A Chi-

square on the table was not significant but the trend is in the right direction.

Part II

It was hypothesized that students in Group I were assigned to the patient for a longer period of time than students in Group II. To obtain data to test this part of the hypothesis the interviewees were asked the following questions: "For what period of time did you give comprehensive nursing care to (name patient)? Was the period of time long enough for you to administer total or comprehensive care?"

Students in Group I had a time range of zero to twenty one days in assignment to a patient. The average length of time devoted to the comprehensive care of the patient was 8.1 days. The student with no days of care had not actually been assigned to the patient about whom she wrote the study but was "interested in Mrs. A as she had terminal carcinoma and she knew it. I used to talk with her a lot about how she felt about it and what it meant to her and her family. She was quite independent and attended to her own physical needs. What she really needed was someone to talk to - emotional support - and I had time to give it."

Students in Group II had a time range of three to twenty one days in assignment to the patient selected for the care study. The average length of time of assignment to the patient for these students was ten days.

Eight students in both groups felt that the time assigned

was sufficiently long for the administration of comprehensive nursing care, while two in each group felt that more time would have been helpful. The students in Group I who desired more time were concerned with the problems relating to more fully understanding and meeting the needs of the individual patient. The students in Group II desired more time in order to learn more about certain apparatus, i.e., suction type drainage. It is interesting to note that the students who wished more time had been assigned to the patient for periods ranging from seven days to fourteen days, while those students who had been assigned to the patient from zero to six days felt that this period of time was adequate.

These findings indicate that there is no appreciable difference between the groups in the length of time assigned to the patient and the ability to meet and recognize the patient's basic needs.

Part III

It was hypothesized that students in Group I would score higher in the frequency of communications with resource personnel than students in Group II.

Table 7 includes the findings obtained in response to the questions: "To what extent did you make an attempt to contact resource personnel or talk with them about any special concern you may have had about (name patient)? Who were the persons you contacted?"

TABLE 7
 COMMUNICATIONS WITH RESOURCE PERSONNEL BY STUDENTS

Personnel	Group I N = 10	Group II N = 10
Doctor	8	9
Clinical Instructor	8	6
Social Worker	4	0
Head Nurse	3	3
Dietician	2	0
Chaplain	2	0
Medical Student	2	0
Speech Therapist	1	0
Staff Nurse	3	1

Group I shows a total of thirty three contacts with nine different categories of personnel. Group II made nineteen contacts with four different categories of personnel.

Students in Group I made contact with some personnel who are not frequently located on the hospital ward, whereas Group II contacts are those easily accessible on the hospital ward.

Of special interest to the investigator is the relatively small number of students in both groups who communicated with the head nurse in relation to getting help or information in administering nursing care. The head nurse in view of the position she occupies is the key person between the patient and the hospital, between the doctor and the patient and his family, and between

the student and the patient and the community.¹ It is logical and reasonable, then, that she is one of the most important sources of information to the young student nurse. Some exploratory questions were asked of the group and the answers elicited were that: the head nurse on one division was not approachable; the clinical instructor or doctor were able to supply the needed information or help.

These findings indicate that there is a marked relationship between the ability to meet the patient's needs and the amount of exploration and communication which takes place on the part of the nurse.

Part IV

It was hypothesized that contact with the patient's family would contribute to a greater awareness and recognition of the patient's basic needs.

The following data were obtained in response to the questions: "Were you acquainted with the patient's family? How well did you get to know the family?"

Students in Group I revealed a range of zero to ten contacts with the patient's family and a total of thirty four contacts. Three students had no contact with the family as the patients had no known relatives or friends. Almost all of the contacts with the family took place during regular hospital visiting hours. Four students in this group expressed the

¹ Jensen, Deborah, Principles and Practice of Clinical Instruction, p. 41.

opinion that it would be more helpful if visiting hour time were kept free from classes in order to increase the student's opportunity to meet and talk with the patient's family.

In Group II the range of contact with the family was zero to six. Three students had not had any contact and one student had six. The total number of family contacts was twenty two. Two students in this group spontaneously remarked that they had been handicapped in fully understanding the socio-economic needs because they had not met the family.

It is evident then that increased family contact to some degree is related to the ability to understand the patient's basic needs.

In summary, Group I differs from Group II in the following respects: The motivation of the students for the selection of the patient in Group I is more frequently patient-centered than disease-centered; the number of contacts with resource personnel is greater for Group I; and the number of contacts with the patient's family is more frequent for Group I. There is no appreciable difference between the two groups in relation to the length of time assigned to an individual patient.

EXPLORATION OF THE STUDENT'S OPINIONS REGARDING THE NURSING CARE STUDY AS A LEARNING EXPERIENCE

At the time of the focused interview the investigator was interested in exploring the students' feelings about the value of writing a care study as a learning experience.

Since the interview in this regard was primarily of an

exploratory nature this data will be reported for the combined groups. Fourteen of the twenty interviewees felt that the writing of a care study was a good learning experience, six felt it was of negligible value.

Eight students felt that the writing of a care study gave them an opportunity to develop some skills in research; eight felt that it made them more aware of the needs to be met; three stated that it aided them in the analysis and evaluation of their nursing care; and two felt that the writing of a care study aided them in the organization of thought.

The comments of the six students who felt that the writing of a care study contributed little of value as a learning experience are as follows:

"They should not be made into such a big project. Every day experience with the patient means more than what is down on paper. I did not like the outline . . . too much on text book picture and too little emphasis on individual aspects of care."

"An oral care study would have been better . . . less of a grind . . . and less apt to put it off until the last minute."

"I have a hard time writing things. For example, I was aware of Mrs. B's needs . . . she certainly presented enough problems . . . especially emotional . . . and I'm surprised I didn't get the idea across in the study. Guess I just can't express myself well on paper."

"Special projects such as taking one aspect, for example patient teaching, would prove more valuable."

"Silly to have to write what you have already done and are aware of, and the instructor is aware of, too. I feel it benefits the instructor more as she can use it as a means of evaluation."

"Oral, better than written. It's frustrating to write on things I know and the instructor knows. Not a challenge, I'd say."

These negative comments are significant in that they point out the need to make the writing of a case study more interesting and creative. Four students who felt that the writing of a case study was a good learning experience did criticize the outline guide as being too rigid and would have preferred to develop their own studies without a guide. Five students felt that the outline over-emphasized the insignificant details; these details were identified as the recording of admission temperature, pulse and respiration, the type of curve formed by the vital signs during acute illness, laboratory tests, and the textbook discussion of the disease condition.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

This study, in line with the purpose of the investigator to provide for more extensive integration of the basic aspects of rehabilitation in a basic collegiate medical and surgical program, has been undertaken in order to measure to what extent these principles are integrated at present in the program. It was hoped that as an outcome of this study the particular strengths and weaknesses might be pointed out and recommendations made for future implementation. Eighty four medical and surgical nursing care studies written by forty two basic collegiate students were read and rated for the degree in which the rehabilitative components of nursing care appeared. The results of the evaluation of the studies were further utilized in order to test the hypothesis that certain differences exist between those students whose care studies included a good awareness and understanding of the basic aspects of rehabilitation, and those whose care studies indicated a limited awareness of these aspects.

Seven basic needs were identified as basic components of rehabilitation. These needs are the physical, emotional, socio-economic, therapeutic, intellectual, learning and integrative.

Six specific rehabilitative aspects of nursing which are an integral part of the above mentioned needs were also identified. These specific aspects are: (1) the preventive and supportive aspects of nursing; (2) recognition of the contribution

of other professional personnel who comprise the health team; (3) recognition of the need and provision for continuity of care, including the community resources available to the patient after discharge; (4) recognition of the services of the hospital follow-up out-patient department, tumor clinic or physical medicine department; (5) recognition of the nurse's role in the coordination of the plans for the patient's discharge, including participation in the inter-agency referral system and the cooperation of the family; and (6) encouragement of the patient to help himself in attaining maximum independence.

These basic health needs and the specific rehabilitative aspects which are considered a part of these needs were presented to the university director of the rehabilitation nursing program and six colleagues who concurred with the writer's definition.

The two nursing care studies written by each student were examined for the degree to which these aspects and needs were present. A weighted value was given for the presence or absence of each need. A mean score was determined for each study and a total mean score for each need in the eighty four care studies was obtained. The specific rehabilitative aspects of care were identified by number if they appeared in the care study and the total number of each aspect mentioned in the eighty four studies was determined.

A reliability check was done on twenty care studies, selected at random, by two clinical instructors. Their agreement

with that of the investigator averaged ninety four per cent.

Twenty students were selected for a focused interview. Data from the interviews were collected to gain additional information regarding the factors which in the students' opinion either enhanced or prevented their ability to meet the patient's basic needs. In addition, data were obtained through this medium in order to test the hypothesis that the students whose care studies showed a good recognition of the patient's basic need differed from those whose studies did not in the following respects:

1. Motivation in the selection of the patient for care study was a patient-centered approach versus the disease-centered focus.

2. Length of time assigned to administer comprehensive nursing care to the patient.

3. The number of contacts with resource personnel.

4. The number of contacts with the patient's family.

One group of ten students selected for interviewing had a mean score of 2.5 or higher, and had included four of the six specific rehabilitative aspects in their care study. The second group of interviewees consisted of ten students who had a mean score of 1.5 or lower and had included three or less of the specific rehabilitative aspects in the nursing care study.

CONCLUSIONS

Analysis of the eighty four nursing care studies revealed that the ability of the students to recognize and meet the patient's physical needs received the highest mean score of 2.44; the socio-economic need ranked second with a mean score of 2.41; the emotional, third, with a score of 2.35; and the therapeutic was fourth, having a mean score of 2.32. When the scores attained in the ability to integrate and recognize these needs in the nursing care study are compared with the highest possible score of 3.0, then these needs may be said to be most successfully integrated in the medical and surgical curriculum at X School of Nursing.

The learning needs of patients received a mean score of 2.06. In the focused interview, factors which were recognized by the student as preventing them from meeting this need were most frequently mentioned. The condition of the patient at the time that comprehensive care was being administered accounted for the majority of the reasons why the learning needs of the patient could not be met.

The ability of students to recognize and meet the intellectual needs of the patient was sixth in rank order with a mean score of 1.95. Data obtained in the focused interview revealed that some of the students were not able to meet this need primarily because of the acutely ill conditions of the patients.

The integrative needs of the patient received a mean score of 1.57 ranking seventh and last. This last was a surprising

finding when viewed from the standpoint of the background and knowledge in philosophy and theology of this particular group of students. Is it a possibility that the integrative needs of patients are interpreted by the students as concerned merely with specific religious needs rather than in a broader sense that involves those intangibles concerned with a philosophy of life and the aesthetics?

The specific rehabilitative aspects in order of rank of frequency in recognition in the care studies are as follows:

1. The preventive and supportive aspects of nursing (Aspect No. 1).
2. Recognition of the need for and the provision for continuity of care, including the community resources available to the patient (Aspect No. 3).
3. Recognition of the nurse's role in the coordination of plans for the patient's discharge, including participation in the inter-agency referral system and the cooperation of the family (Aspect No. 5).
4. Recognition of the contributions of other professional personnel who form the health team - the social worker, the physical therapist, the speech therapist, the vocational counselor, etc. (Aspect No. 2).
5. Recognition of the services of the hospital follow-up out-patient department, tumor clinic, or physical medicine department. (Aspect No. 4).
6. Encouragement of the patient to help himself in the

attainment of maximum independence (Aspect No. 6).

The analysis of the care studies reveals areas of strength in the ability of students to meet the physical, therapeutic, socio-economic and emotional needs of patients. Weak areas apparently lie in the ability to meet the patient's learning, intellectual and integrative needs.

The chief area of strength in the specific rehabilitative aspects of nursing appear to be in the preventive and supportive aspects. The frequency in which the remaining five aspects appeared in the care study was relatively low. A possible factor contributing to the low frequency of recognition of the specific rehabilitative aspects numbered two, three, five and six might be attributed to the acutely ill conditions of some of the patients selected by the students. The remaining weak area is in the recognition of the contributions of other professional personnel.

The focused interview with twenty selected students revealed data that suggest there is some degree of relationship between the students who received a high score in the ability to meet the patient's needs and who had a patient-centered approach to the selection of the patient for study. Those receiving a low mean score were more apt to approach the care study from a disease-centered focus. There was no relationship between high and low scorers in length of time assigned to the care of the patient. The high scorers communicated more frequently with resource personnel, both in number of communications and different types of

workers, than those who had low mean scores in the ability to recognize or meet the patient's basic needs. Students obtaining high mean scores in the attainment of the patient's basic needs also showed greater extent of contact with the patient's family than those with low mean scores.

RECOMMENDATIONS

Recommendations indicated by the general findings are as follows:

1. Future assignments to patients be made so that the students will be better able to meet the patient's integrative, intellectual and learning needs.

2. Increased utilization of the physical therapist, vocational counselor and speech therapist in the clinical teaching program during the period of time the studies are being written in order to focus upon the contributions of these members of the health team.

3. Assignments be arranged so that students may participate to a greater extent, within the framework of the policies of the institution, in the inter-agency referral plan.

4. Field trips to rehabilitation centers and other community agencies be placed during the second phase of the comprehensive medical and surgical teaching program as well as in the first.

5. The clinical nursing care study guide be revised in order that students may be allowed more opportunity to focus on the particular problems presented by a patient and to foster more freedom and creativity in expressing their ideas rather than relying on a rigid outline.

6. That communications between the students and the head nurse be encouraged as a means of obtaining guidance and information relative to meeting the basic needs of patients.

7. A similar method of analysis as employed in this study be utilized for the evaluation of nursing care studies.

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Appendix A

ANALYSIS OF FORTY TWO SURGICAL NURSING CARE STUDIES

Student	Diagnosis or Surgical Treatment of Patient	Physical Needs	Emotional Needs	Socio-Economic Needs	Integrative Needs	Therapeutic Needs	Learning Needs	Intellectual Needs	Average	Specific Rehabilitative Aspects	No. Rehab. Aspects
1	Hernia - Intestinal Obstruction	1	3	3	3	2	3	3	2.5	1, 3	2
2	Herniorrhaphy	3	1	3	0	3	2	2	2.0	1, 4, 2, 5	4
3	Malignant Melanoma	3	3	3	3	3	3	2	2.8	1, 2, 3, 4, 5, 6	6
4	Pyelonephritis Aphasia	2	2	3	1	3	2	1	2.0	1, 3	2
5	Breast Abscess	3	3	3	3	3	3	1	2.7	1, 3, 5, 6	4
6	Cholecystectomy	2	0	3	0	2	0	1	1.1	3, 4	2
7	Cholecystectomy	3	3	3	2	3	3	3	2.8	1, 3, 4	3
8	Cholecystectomy	2	2	3	1	2	3	3	2.3	1	1
9	Cholecystectomy	2	2	3	1	2	1	3	2.0	1, 3	2
10	Cholecystectomy	2	3	2	3	1	3	3	2.4	1, 3	2
11	Cancer of Mandible	2	3	3	0	1	2	3	2.0	2, 3, 6	3
12	Cholecystectomy	2	2	2	3	3	0	3	2.1	3	1
13	Diverticulitis	2	2	3	3	2	3	3	2.5	1, 3, 4, 5	4
14	Diabetes - Cellulitis	3	2	3	1	3	3	3	2.5	1, 2, 3, 4	4
15	Cancer of Stomach	2	2	2	1	2	0	1	1.4	3, 5	2
16	Cholecystectomy	3	3	3	3	2	3	3	2.8	1, 2, 3, 5, 6	5
17	Carbuncle- Laryngectomy	3	3	3	3	3	3	3	3.0	1, 2, 3, 5, 6	5
18	Pelvic Exenteration	3	2	3	0	2	3	3	2.3	2, 3, 5, 6	4
19	Abscess - Karso- choff's	3	3	3	2	2	(-)	3	2.5	1, 2, 3, 5	4
20	Second and Third Degree Burns	3	3	3	3	3	3	3	3.0	1, 3, 5, 6	4

21	Cancer of Rectum	2	2	3	0	2	0	2	1.5	1,3	2
22	Cancer - Breast	3	3	3	3	3	3	3	3.0	1,3,4,5,6	5
23	Cancer - Breast	3	0	2	0	3	0	2	1.4	2,3,5,6	4
24	Cancer - Breast	3	3	3	0	2	3	2	2.3	1,3,6	3
25	Cancer - Jaw	2	1	1	0	1	2	2	1.3	1	1
26	Trans-Med. Amputation	2	3	2	1	2	0	1	1.5	1,6	2
27	Diabetes-Amputation	2	1	1	0	2	1	1	1.1	1,4	2
28	Diabetes-Amputation	2	1	3	0	1	1	0	1.1	1	1
29	Gangrene - Toe	3	3	3	3	2	(-)	(-)	2.8	1,3,5,6	4
30	Carcinoma - Stomach	1	2	3	3	1	(-)	(-)	2.0		0
31	Cancer of Colon	2	3	2	3	3	0	3	2.3	1	1
32	Colostomy	3	2	3	3	2	2	0	2.1	1	1
33	Abdomino-perineal Resection	3	3	3	1	2	3	2	2.4	3,4,5,6	4
34	Mid-thigh Amputation	1	1	1	0	1	(-)	(-)	0.8	1	1
35	Abdominal perineal Resection	2	2	3	0	2	1	0	1.4	1,3,4,5	4
36	Mid-thigh Amputation	2	1	2	3	2	2	2	2.0	1,2,4	3
37	Mid-thigh Amputation	3	2	3	0	3	3	0	2.0	1,2,6	3
38	Mid-thigh Amputation	2	2	2	0	2	2	1	1.5	3,5	2
39	Mid-calf Amputation	2	2	2	0	1	1	2	1.4	1,3,6	3
40	Ileostomy	2	2	3	0	2	1	2	1.7		0
41	Colostomy	2	3	3	3	2	3	1	2.8	2,3,5	3
42	Colostomy	2	3	2	0	2	3	3	2.1	1,6	2

Appendix B

ANALYSIS OF FORTY TWO MEDICAL NURSING CARE STUDIES

Student	Patient's Diagnosis	Physical	Emotional	Socio- Economic	Inte- grative	Thera- peutic	Learning	Intellectual	Average	Specific Rehabili- tative Aspects	No. Rehab. Aspects
1	Myocardial infarct	3	3	3	2	3	3	2	2.7	1,3,5	3
2	Auricular Fibrillation	3	2	3	0	1	2	1	1.7	1,5	2
3	Myocardial infarct	3	3	2	1	2	2	3	2.3	1,4,5	3
4	Myocardial infarct	3	(-)	2	0	2	2	(-)	1.8	1,5	2
5	Congestive heart failure	2	1	1	1	2	0	0	1.0	1,3,5	3
6	Congestive heart failure	1	2	1	0	3	0	0	1.0	1,5	2
7	Myocardial infarct	3	2	2	0	3	2	1	1.9	1,2,3,5	4
8	Arterioscle- rotic heart dis.	3	3	3	1	3	3	2	2.5	1,3,4,5,6	5
9	Myocardial infarct	3	3	3	3	3	3	2	2.8	1,3,4,5,6	5
10	Congestive heart failure	3	2	2	2	3	3	1	2.3	1,4,5	3
11	Cardiac Decom- pensation. Dia- betes	2	2	3	3	2	1	1	2.0	1,4,5	3
12	Diabetes	3	3	3	3	3	3	3	3.0	1,2,3,4,5	5
13	Myocardial infarct	2	2	3	3	2	2	1	2.1	1,5,6	3
14	Subacute Bact. Endocarditis	2	2	3	3	2	2	2	2.3	1,4	2
15	Myocardial infarct	3	2	3	1	2	3	3	2.4	1,3,4,5	4
							3	3	3.0	1,2,3,4,5	5
16	Myocardial infarct	3	3	3	3	3	3	2	2.3	1,5	2
17	Brain tumor	3	3	2	2	1	(-)	(-)	1.5	1	1
18	Brain tumor	3	(-)	0	0	3	(-)	(-)			

20	Hodgekin's disease	3	(-)	2	3	3	(-)	(-)	2.7	5	1
21	Cancer of stomach	3	3	3	3	3	3	3	3.0	1,3,5,6	4
22	CA of sigmoid Congestive heart failure	2	1	2	3	2	1	0	1.5	1	1
23	Hodgekin's disease	1	(-)	1	(-)	1	(-)	(-)	1.0		0
24	Metastatic carcinoma-spine	3	3	3	3	3	2	3	2.8	1,2,3,4,5	5
25	Pneumonia	1	0	0	0	2	(-)	(-)	0.6		0
26	Anemia	2	3	3	2	2	2	2	2.3	2,3,5	3
27	Parkinson's disease	3	3	3	3	3	1	2	2.5	1,5,6	3
28	Pneumonia	3	3	3	2	2	0	2	2.1	1	1
29	Leukemia	3	3	3	3	3	(-)	3	3.0	1,3,4,5	4
30	Cor-pulmonale Asthma	2	2	2	0	2	1	0	1.4	1	1
31	Leukemia	2	2	3	1	3	(-)	(-)	1.8	1	1
32	Cerebral vascular accident	3	3	3	3	3	3	3	3.0	1,2,3,4,5	5
33	Congestive heart failure Diabetes	3	3	3	3	3	3	2	2.8	1,2,4,5	4
34	Cerebral vascular accident	3	(-)	1	3	3	(-)	(-)	2.5	1,2,3	3
35	Peptic ulcer Alcoholism	2	3	2	2	3	2	2	2.3	1,3	2
36	Diabetes Arteriosclerosis	2	3	3	3	3	3	3	2.8	1,2,3,4,6	5
37	Diabetes Arteriosclerosis	2	3	3	0	2	2	2	2.0	1,4	2
38	Trichinosis	2	3	3	3	3	3	3	2.8	1,3,4	3
39	Contractures and Dermatitis	3	1	2	1	2	3	3	2.0	1,3	2
40	Duodenal ulcer	3	3	3	0	3	3	0	2.1	1,3	2
41	Duodenal ulcer	3	3	3	0	3	3	3	2.5	1,3,4	3
42	Duodenal ulcer	2	3	2	2	3	2	1	2.1	1,3	2