

A DOCTORATE IN NURSING AND ITS IMPACT ON CLINICAL PRACTICE

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This paper deals with how a doctorate in nursing centered in human care can impact and change clinical practice. An account of the evolution of nursing education in Venezuela within a persisting context involving social, cultural, economical and political factors is discussed as well as the philosophy of our educational programs. Drawn from our nursing experience, a quality management process integrating three phases of analysis into participatory processes of evaluation is outlined. The ultimate purpose is to promote nursing research and the integration of academic knowledge, sound clinical principles and patient care needs and values into our professional practice.

EVOLUTION OF NURSING EDUCATION

From 1940 Venezuela began to offer a three-year educational program in national schools of nursing. Such program focused on both theory and practice and trained technical nurses who received a "Professional Nurse" degree from the Ministry of Education. At the same time the Ministry of Health and Social Welfare was offering a one-year educational program towards becoming "auxiliary nurses". The professional nursing program with some curriculum changes was in effect until 1985. In 1966, nursing studies were developed and offered in two national universities.

In this evolutionary process, it is important to highlight that from 1983 there have existed seven (7) schools of nursing at university level offering two levels of studies: a three-year program conferring the title of "Advanced Nursing Technician". To this program can be added another two school years towards the degree of "Bachelor in Nursing". The latter educates generalist nurses to offer nursing in all clinical areas such as maternity-infancy, surgery, administration of services, community health, gerontology, psychiatry, primary care, intensive care, occupational care and applied research as well as theoretical instruction in biological, medical and social sciences.

Since the beginning of the 1980's, there has been an economic, political and social crisis in Venezuela which has manifested itself in various ways including the reduction of assigned budgets to finance basic services, deficit expenses, poor problem solving competence, inadequate handling of problems, and increase of the population's unmet basic needs. This situation has improved, but it is still present and has generated a dramatic impact in the health field.

To the analysis of the crisis mentioned above must be added the previously existing fragmentation of actions, lack of coordination among health team members, identified needs of the population and measures taken from an individualistic management perspective focused on healing and clientele oriented. Other factors affecting health services include unmotivated human resources with a loss of collective humanistic solidarity, a decrease of quality of services, a strong tendency towards privatization, and a management style economically hard on the ordinary patient-user.

Given above situation, the Ministry of Health and Social Welfare as the Rector of health in Venezuela together with its decentralized state institutions initiated a process of reorganization and reformulation of its policies. Then, it was created the General Regional Division of Research and Education and the structure of Regional Development Units. At this point, there is the emergence of the development of decentralization policies and of Human Resources with a focus on strategic administration fostering preventive measures and the promotion of equity in order to improve the levels of health in the society at large.

Since nursing is the largest social group within the health sector, it became imperative in 1988 for National Universities, as the only institutions educating nursing human resources, to create an area of graduate studies. This is how the University of Carabobo in Valencia decided to develop a master degree program with activities and courses focusing on deep and systematic analysis of specific knowledge areas and on methodological training in research as the only essential strategy conducive to finding solutions to emergent problems inherent in the practice of nursing.

Thus, the development of the first Master program in the country initially only offered at the University of Carabobo was an answer to the growing demand of nursing as a profession which was to educate qualified teachers of nursing who would be proficient in research methodology and capable of offering up-to-date clinical training at undergraduate, graduate and postgraduate levels. Likewise, the program sought to meet the demand for male and female nurses with high qualifications to manage health services due to the fact that since the 23rd of July 1987 a law was approved governing the National Health System. The said law encompassed decentralized services at increasing levels of complexity with the participation of members from various health disciplines with the purpose of improving the quality of public health. This mandate required as well the development of clinical research specialized in knowledge areas specific to professional practice.

Presently, the Master program is offered in three national universities with specializations in Administration of Health and Nursing Services, Reproductive Health, Medical-Surgical Nursing, Critical Adult Care and Gerontology and Geriatric Nursing.

Both the teaching staff and the students of the Master of Nursing have had a scientific production which has led to consolidating important knowledge both in clinical research and research-based knowledge which constitute the theoretical and practical framework for the accomplishment of graduating assignments and practicum. Such

research specialization areas include "Professional Practice and the Organizational Climate of Nursing Services", "Professional Nursing Practice and "Promotion of Sexual and Reproductive Health of Adolescent Females and Males", "Nursing Care and the Critically ill Patient with Cardiovascular and Politraumatism due to Transit Accidents" and "Female and Male Elders in the Community and Nursing Practice".

Equally worthy of mention is the production of knowledge gained through nursing research conducted by both teachers and students at the undergraduate level in Schools of Nursing of National Universities. Their input has served to consolidate the conceptual base of nursing and to improve human care practice.

In 1998, the seven national universities formed a network and made a Strategic alliance nursing with the purpose of developing the first and still the only Doctorate of Nursing in Venezuela offered since then at only one location, the Universidad of Carabobo. All seven universities provide support and all necessary resources. Students must come from across the country to follow the only program which is offered at our university. Our Doctorate of Nursing is a single-disciplinary program emphasizing research on Health and Human Care. According to the classification made by Grace Helen (1990, p. 153) our doctorate program fits her model of the "Professional Doctorate" for reasons stated below.

After the Bachelor degree, the candidates to the Doctorate Program in Nursing must do a Master in an area of knowledge specific to nursing with emphasis on clinical research within the chosen area of studies; only subsequently may candidates be admitted to our single-disciplinary doctorate program. We seek informed and validated knowledge from Doctors in Nursing capable of conducting research to generate new and relevant knowledge in order to offer the best care of human health. The knowledge gained, in turn, serves to consolidate the theoretical foundation proper to nursing which represent an important and essential contribution to human, scientific and technological development.

Our doctorate fits the philosophy and policies established by the "Rector of Education in Venezuela". This orientation determines that doctors be educated to generate new knowledge in order to help solve problems in the corresponding area which in our case is nursing.

The development of our nursing resource with high academic standards is founded on a set of beliefs and values which sustain the university community and specially nursing professors who seek to form doctors capable of bearing the mark of their role within a social profession and of yielding significant contribution towards the care of health and of human experience. These professionals in their human interactions within a harmonious climate will carry out functions, perform actions, use a diversity of dynamics which may act as producers and protectors of health and life in different social, spatial and time frames and may eventually transform realities. Their well-thought actions will be the product of a process of promotion and development of sustained, factual research using various methodological approaches. Lastly, the pursuit of our program is also the education of researchers-protagonists of their own personal and

professional development who take care of themselves, of others, and of their ecological, geographical and cosmic environments.

NURSING EXPERIENCE: *WHY NURSING PRACTICE IS ESSENTIAL*

This question has been addressed many a times in terms of its necessity, content, extent and quality. We believe that nursing is a practice discipline. As such, the practice of nursing becomes a living model exerting a manifold effect on both care receivers and providers. We may see nursing as a phenomenon because it can be experienced, observed, analyzed, described, explained, replicated and modified. *Broadening our understanding of nursing as a practice discipline requires seeing a genuine patient-nurse relationship as its cornerstone.*

The basis of such a relationship is the moral commitment of a nurse to his/her patient. This moral character of nursing practice then becomes the moral foundation underlying a bond or link necessary to the exercise of mutual trust, responsibility and accountability in nursing practice. These building blocks reflect themselves in the humane and disinterested way of performing a nurse's duties namely to care and seek the welfare of patients while demonstrating respect for human dignity in the pursuit of professional development and excellence (Pellegrino & Thomasma 1988).

In addition to above moral foundation and commitments characterizing all health professions, nurses are also expected to seek meaning in their clinical practice, to increase their awareness and knowledge of people, health and their environments, to address the emotional needs of patients, to be present for their patients in ways which foster healing, wholeness and to help them recover to the best of their abilities. Thus, the full understanding of the meaning and significance of a patient-nurse relationship both individually and collectively is only gained by nurses as they engage themselves wholeheartedly in such relationships. As it has been documented, "Caring, attending and the four modes of being present (physical, therapeutic, holistic and spiritual) can only happen through nursing practice" (Easter 2000).

An example of this living experience is also described as a daily journey in which the nurse plays the role of the enabler of pregnant adolescent girls deprived economically, in knowledge and in life skills necessary for carrying out the responsibilities of motherhood and child care. In order to be successful at fulfilling a nurse's commitments in terms of planning, teaching, research and care practice, it is crucial to know and understand this phenomenon experienced in the nurse-client relationship (Cody, 1996). Again, the full meaning of care and caring is only comprehended by being present at four levels physically, therapeutically, holistically, and spiritually in a nursing relationship.

Thus far, most of the literature documents that a nurse's capacity to help his/her fellow men requires specific types of knowledge dealing with the physical sciences such as physiology, pathophysiology, conditions covering medical, social, and cultural

elements interrelated to the physiological conditions in question. Consequently, the nurse must be present with respect to the whole situation: the importance of being knowledgeable and competent in all of these areas of life and experience is undeniable, but secondary and subject to being applied in a meaningful relationship with the person whom we are attending. Therefore, nurses must pursue excellence through the acquisition of greater knowledge combined with a meaningful, empowering contact and caring. These two essential ingredients to wholeness must be integrated and can only be gained and offered in relationships established while responsively engaged in nursing practice.

WHAT IS THE INTERRELATION BETWEEN NURSING PRACTICE AND RESEARCH?

Nursing practice experience allows the identification of critical areas requiring attention and further study. (Schoenhofer, 1993). By observing nursing as a process, the identified critical areas are turned into questions which constitute the object of further research. In order to benefit from research findings, these must be interpreted and understood in the light of the patient's condition (Phillips, 1995). Furthermore, the interpretation of nursing research data and findings must be done within a theoretical nursing framework; and it must acknowledge nursing practice in order to promote reliability, validity and freedom from misconceptions and conclusions. Thorne and Jillings (1996) have rightly stated that nurses are in favorable positions, by the nature of their role, to engage themselves in all research phases which include data gathering through observation, listening and making sense of the nursing experience in most areas of clinical nursing research but most importantly in quality of life research.

STRATEGIC QUALITY MANAGEMENT

As described by Varo (1996, p. 4), strategic management of quality in health services is considered as the operational application of quality policy which means that quality is demonstrated through the action it generates. According to Varo, the management of quality includes three processes: planning, organization and control. On the other hand, Lopez (1997) highlights that *management of quality makes of people the cornerstone of the whole system*. The practice of management quality stimulates and articulates a participatory orientation which translates into the consequence of quotas of personal and institutional development through continuous improvement and permanent learning. Motivation constitutes the people's motor which becomes the factor capable of mobilizing energies and individual capacities to their maximum potential.

CLINICAL QUALITY MANAGEMENT (CQM) PROCESS

Clinical Quality Management (CQM) is the process which makes it possible to attain changes in institutions. It implies the adoption of participatory strategies which allow the personnel from different departments or organizational sectors to work in groups in order to analyze the situation, plan, execute and correct the direction of proposed actions towards seeking permanent adjustments of processes, products and services to meet explicit demands and needs emerging from clients or beneficiaries. It is a process which requires changes in management style, internal use of human and material resources, changes in relationship style and in decision making, and alliances with other actors who influence the quality process.

The authors of this article advocate that a Clinical Quality Management (CQM) Process must be introduced into clinical settings in order to achieve more clarity in relevant research findings, and to facilitate generating more research practice-based questions. Moreover, the CQM process also facilitates enlarging the focus of research and developing systematic strategies to ensure that research findings are applied to clinical practice which result in continuous quality improvements of relevant and related outcomes in terms of patient, staff and health care (King and Teo, 2000).

Clinical Quality Management (CQM) Process follows several phases including *situation analysis, planning, and implementing alternatives*; all of which serve to measure, compare, and evaluate outcomes, and to make relevant changes towards attaining quality improvements.

Clinical Quality Management (CQM) Process begins with the development of a *clear definition and the measurement of the problem* in question from various points of view. This phase known as situation analysis serves to identify the best course of action which is also referred to as "best practice" through a collective construction process of a future vision and comparing our own organizational practice to the "best practice" which is seen as the golden rule or standard. (Mohr et al., 1996). In the process, measurable relevant indicators are identified for comparison purposes. Once empirical evidence generated by the research is identified, it is applied to clinical practice and outcomes. This means that practice patterns and patient outcomes are measured.

A *comparison* either through *observation* or *statistics* is then made between the "in house" data and practices and the data obtained from the external research entity through the application of what has been identified as "best practice". Results of this comparison may indicate poor referral practices. For instance, there could be found a discrepancy between the percentage of patients presenting a medical condition receiving referrals to specialists in the field within the in-house sample with respect to the same number of patients being referred to specialists by the external source. In this example, when observation is used as measurement, it is noted that the institution keeps blank referrals in personal medical files which are handed out as part of a routine assessment of cardiology patients. On the other hand, when statistics is the measurement norm by both the in-house and external sources, the ratio of referred patients as opposed to non-referred patients presenting similar medical conditions in both settings is computed in terms of percentage. "(i.e., institutions that have high rates of referral to cardiac rehabilitation

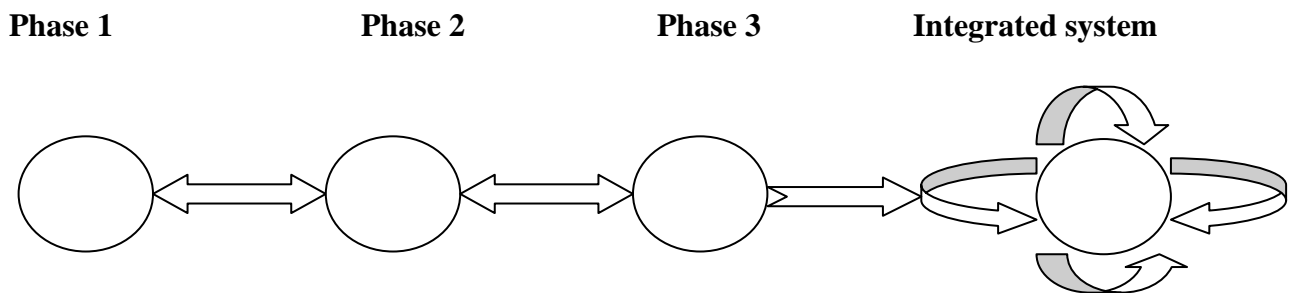
have referral forms attached to health records, whereas our institution has no such practice) or statistics (i.e., experts believe that up to 80% of patients following heart attack, bypass surgery, and percutaneous transluminal coronary angioplasty should be referred to cardiac rehabilitation programs, whereas only 24% of these patients from our institution have any such referral)."

The *next phase* involves *planning and implementing alternatives* with the purpose of improving nursing practice and outcomes. It has been recommended that all professionals delivering care participate in this phase to promote the effective widespread application of findings and to enhance patients' benefits. The selected planned interventions reflect the integration of findings made through the benchmarking phase. Their effective application will fulfill their purposes which are to enhance the nursing care process, to better the use of current best evidence, and to ultimately influence clinical decision making. This process will, in turn, identify, gaps in research practices and generate further research-based questions.

Ongoing assessment of outcomes is crucial to the CQM process. The assessment focuses on the immediate effects of the intervention versus the effectiveness of new interventions on a longer term basis. These component phases of the overall Clinical Quality Management (CQM) Process constitute an *integrated system of ongoing participatory processes of evaluation* in which professionals are constantly engaged in an ever *progressive spiral process of further analysis situation, planning, and implementing alternatives* towards continuing to generate practice-based and research-based questions. (King and Teo, 2000).

Illustration 1

**PARTICIPATORY PROCESSES FOR ASSESSING A SITUATION,
PLANNING AND IMPLEMENTING ALTERNATIVES
(Seen separately but in interaction)**



Phase 1 : Situation analysis.

Phase 2: Planning and implementing alternatives

Phase 3: Evaluation of out comes and carrying out changes.

CLINICAL QUALITY MANAGEMENT UNITS: CURRENT EXPERIENCE

In 1999, five out of seven schools of the nursing doctoral network, in the Central-Western Region of Venezuela made a coalition to form *potential leader groups* to support the establishment and maintenance of Clinical Quality Management Units (CQMU) in health organizations where participants in of undergraduate Nursing Studies undergo clinical practice training.

The potential leader groups were formed by members of the Professional Nursing Federation, nursing faculty members, clinical nurses, graduate and postgraduate students. Two out of five potential leader groups also included members from other disciplines. However, *only doctoral nursing students were retained as mentors* with the responsibility to direct the leadership preparation program which consists of six 3-day workshops being held over the period of three months. The *contents of the program* offers theoretical and practical themes of leadership as well as the elaboration and achievement of standards to be integrated into nursing education, practice, and research in the light of needs arising from the contextual factors previously stated (cf. p. 1-3) which are predominant in the country and surround the exercise of the nursing profession.

The *focus of this leadership preparation program* is to provide opportunities for an interactive, exchange of ideas, values, knowledge and experience to be integrated into the participants' own research and clinical practice. Participatory processes of quality management enable nurses to reflect about what they do, to identify strengths, weaknesses, opportunities and liabilities. Likewise, as nurses engage themselves in the phases of the participatory processes of quality management, they prioritize problems and develop strategic action plans including the identification and description of specific problems, the *collective construction of a future vision* and the production of strategic planning which ultimately generates further relevant practice and the development of research objectives towards achieving greater competence in performing the various tasks implicit in the processes.

WORK IN PROGRESS AND A FUTURE VISION

In practice, our work follows a *6-step-standard pattern* proper of *action research*: First, it starts with some questions listed below; second, it examines current relevant practice; third, it implements target-changes; fourth, it gathers data; fifth, it assesses the utility of target-changes; and sixth, it plans the next action. In summary, this comprehensive approach starting with the analytical assessment of a situation in question at any given moment allows nurses to identify and follow a plan of action appropriate to the situation and to the environmental characteristics and limitations.

Our *problem solving strategy* while integrating research and clinical practice would generate new knowledge. As this new knowledge is applied, it would, in turn, inevitably change clinical practice. Thus, nurses engage themselves in an ever

progressive spiral process towards the construction of new knowledge, and the attainment of greater degree of quality leading towards an ever increasing mastery of our professional practice. Ultimately, this comprehensive approach promotes and support continuous research that would enable nurses to carry out the evaluation of their own clinical practice; and through participatory processes of quality assessment and improvement, they would also construct and validate alternatives that would enable them to embrace academic knowledge and clinical care with patient's needs and values.

PARTICIPATORY PROCESSES FOR ASSESSING A SITUATION, PLANNING AND IMPLEMENTING ALTERNATIVES.

Illustration 2: Phases 1, 2 & 3 seen as an integrated spiral system of operations in constant interaction

Illustration 3: Phases 1, 2 & 3 and its components seen as an integrated spiral system of operations in constant interaction

ILLUSTRATION 2

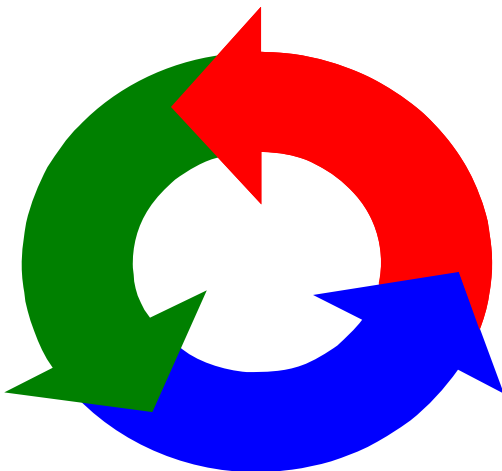
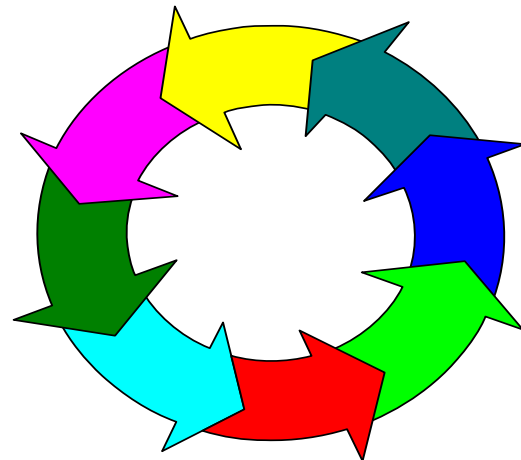


ILLUSTRATION 3



Phase 1 : Situation analysis.

Phase 2: Planning and implementing alternatives.

Phase 3: Evaluation of outcomes and carrying out changes.

ROUTINE QUESTIONS

The following questions form part of our practical strategic methodology:

1. Which are the characteristics of nursing practice?
2. Which are the main functions of the clinical nurse?
3. What kind of research is conducted in nursing?
4. How does research benefit nursing practice?
5. What should we change in nursing practice?
6. What nursing practice do we currently offer in specific settings?
7. What nursing practice
 - a. should we develop?
 - b. can we implement?

in specific settings in order to achieve our goals: i) to overcome our weaknesses; ii) and to contribute to improve: - the conditions affecting the health status of the population; - the quality of our standards guiding our practice, research and nursing education; - the quality of health practice in the light of a future vision which seeks the empowerment of our clients through life-style changes involving health care habits (a future vision);

8. As nurses, how do you think you can achieve that vision? (strategic planning and action).

FINDINGS MADE THROUGH CLINICAL MANAGEMENT UNITS

Three out of five potential leader groups identified the following problems:

- weak nursing leadership;
- lack of effective integration among health team members;
- weak integration of nursing practice, research and teaching;
- lack of effective nursing participation in decision making based on practice observation;
- interventions centered on illness rather than health and quality of life;
- predominance of administrative functions over nursing practice;
- limited research and poor clinical relevance;

ACHIEVEMENTS MADE

Since the onset of the leadership preparation program in 1999, trained leaders have developed as previously outlined their own *Clinical Quality Management Units (CQMU) philosophy and standards*. *Leaders promote CQMU process of organization* by paying visits to interested institutions; by offering seminars and by disseminating information through handing out official brochures, pamphlets and making slide-show presentations.

Furthermore, upon completion of the first CQMU leadership preparation program, leaders began to hold *support meetings* with the cooperation of hospital management staff and university professors.

CLINICAL QUALITY MANAGEMENT UNITS' FUTURE VISION

Our CQMU intend to foster communication first within the different components of each local CQMU, and subsequently among regional CQMU. We also envision the creation of a CQMU National Board. In so doing, we seek the promotion of professional development; the follow-up and integration of the various phases of the CQMU process towards redressing our national health status and quality of human care, and continuing to share our vision and progress in nursing practice as a discipline throughout the world.

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