

VALUES AND VICISSITUDES OF THE SCIENTIST NURSE

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NURSES have always known that newborns could see. They acted on this belief, in spite of the fact that authorities told them that newborns could not see. Why didn't some nurse study the question of visual development of the infant, and refute the authorities? Why did it wait for the psychologist Robert Fantz to produce the studies that refute the authorities(1)?

There are probably several answers to this question. Until recently, there have been very few nurses with the skill to investigate the question. Secondly, nurses, in the main, have not valued careful, systematic investigation, especially if it should require subjecting newborns or other dependent people to special testing or strange devices. Probably more importantly, the question of whether babies could see or not was not a problem for the nurse. In spite of the words of the authorities, she could act on her own beliefs; she, and the mother and baby, could ignore the authorities' claims, with no consequences. They did not need to pay attention to what scientists said about the infant's vision.

The advent of increasing numbers of scientist nurses should make it more likely that something such as the visual development of infants *would* be studied by nurses. Such scientist nurses, however, will differ from other nurses in the kind, amount, and extent of their formal education. Consequently, they will differ from other nurses in their knowledge, skills, interests, perceptions, and attitudes. Will they differ from the majority of nurses in their values? It seems likely that they will. If scientist nurses are to contribute to the development of nursing, however, there must be some values which scientist nurses and other nurses continue to hold in common. It is to be hoped that one such value would be service to society, expressed as concern and action for health welfare, and the care of the sick.

The route to becoming a scientist nurse, or a career as a scientist nurse, contains experiences and costs which may impede direct expression of this value. Some nurses trained as scientists may even adopt values which supplant the service to society value which underlies nursing. This would

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not be surprising. A value of knowledge for the sake of knowledge is one that is commonly expressed.

Consider the costs of becoming a nurse scientist through education in some specific discipline. For an appreciable number of years a nurse becoming a scientist usually is removed from daily encounters with a community of nurses, and from living in the environment in which nursing occurs. There is the cost of loss in some nursing skills from disuse, or from the lack of opportunity to keep abreast in a rapidly changing world of nursing practice. There is also the cost in the loss of other learning. While one focuses on learning one discipline, one cannot master others equally important for nursing. The costs affect not only the nurse scientist herself, but may contribute to some estrangement of the nurse scientist from the active nurse practitioner, or to an altered perception of the nurse scientist as a nurse by practicing nurses.

The potential for estrangement is probably related to the motivation underlying a nurse's election of a nurse scientist program or career. Why do nurse scientists choose to bear the costs? The seeking of answers, of knowledge, of status or prestige, of power or influence, of enjoyment, or of special skills are motivation for some. There are probably many more motives, such as avoidance, each with a different potential for producing estrangement from the nurse practitioner.

Whatever the motive for pursuing the career of a nurse scientist, the pursuit is a commitment to a pattern of thought, and of behavior, for years to come. It behooves the nurse scientist to consider how her values relate to those underlying nursing, and to those commonly held by the practitioner in nursing.

The orientation of the nurse scientist to nursing, and to the practice and practitioner in nursing, is

essential, if one wants to use the word "nurse" to modify "scientist," or to use the word "nursing" to modify the word "research." Pressures for some discontinuity with nursing can occur in the process of a nurse becoming a scientist.

To truly learn any discipline, one must develop an identity with that discipline. The structures for developing this identity, the spatial or territorial arrangements, and the work relationships, differ somewhat from academic discipline to discipline. Becker and Carper, in an analysis of physiology, engineering, and philosophy found three significant factors in the development of identity with an occupation(2). These are the informal peer group, the apprenticeship relationship with professors, and the formal academic structure.

In physiology, the vast world of problems yet to be tackled is the perspective. A careful, building block approach through laboratory studies is the mode. Laboratory groups are the vital work and social orientations. The laboratory is the site for peer group interactions. A major professor as a sponsor, a mentor, and perhaps as a life time reference seems the norm. It is not uncommon to find the question "With whom did you study?" to be one of the first questions to be asked of the newcomer physiologist. The answer may influence how the newcomer is perceived or placed. A student typically will select for his investigation some problem specific to the special competence and interest of his mentor. The student will enjoy a close working and social relationship with this mentor which is apt to continue beyond the student's graduation. He spends his time in the same territory as his mentor, and does work with or like that of his mentor. He is physically close to the actual working of his fellow students, has frequent opportunity to observe them in action.

The student in a department of philosophy does not have the specific problem focus, the building block rigor, the laboratory work, the laboratory group, or the same sort of professor-student contacts, characteristic of physiology. The professor does his work secluded in his office. The student may consume the completed work, but he rarely can observe the processes, as his professor works on a philosophical problem. Rarely does the student significantly share in these work processes.

Physiology and philosophy probably represent two extreme models, with other disciplines having models more like one or the other, depending on their "hardness" as science.

The process of acquiring identity with and from an academic discipline cannot help but alter the nurse who lives for a significant number of years, as a graduate student, in that academic environment. There may be some tensions during the period if the expected identity with others in an academic discipline fails to mesh with identity as a nurse. Identity as a nurse may impair the perceptions of significant others as they judge the nurse student against the specifications of the discipline identity. The nurse may find some difficulty in accepting the trappings of the academic acolyte, if these are at odds with the nurse identity.

Acquiring full identity with the discipline may make one marginal and suspected in nursing. Failure to acquire the identity makes one marginal and suspected in the discipline. How painful is marginality, and what does one do about it? The answers lie in one's values and primary loyalties, which each one must discover for himself. From the disciplines there is the weight of the problems, the ideologies, the fellows, and the sponsors, from that discipline. There is the burden of loyalty to remain what one has become, so as not to let down the sponsor. For a nonnurse disciple, or the nurse whose primary loyalty is to some discipline, this can have important consequences for career opportunities. It can affect the choice of problems or activities one pursues. For the nurse disciple whose nursing orientation remains a primary loyalty, there is greater freedom to the extent that one may move beyond discipleship more rapidly, because there are few masters in nursing. One may lose some security as one moves somewhat away from a discipline sponsor or colleagues, but one can gain a wide freedom of choice of activities, or problems to pursue. Nursing is not currently characterized by sponsorship, or by loyalty to unique or particular ideologies, as essentials in career development.

To be identified with nursing, the nurses need only exhibit a loyalty to the ethos of nursing. Koltzoff, in writing about the nurse scientist, speaks of old traditions of service in new ways(3). It is clear that to be identified as a nurse one must retain the nursing tradition of service to man, though one can exhibit allegiance to the tradition in a variety of new ways, based on the knowledge and skills acquired in advanced study. Marginality and suspicion can be overcome, it need not be painful, if the nurse scientist has experienced the satisfaction and enrichment that accrues to the professional in nursing, and finds in these the sources for continued willing adherence to the valuable traditions of nursing. In this is a source for renewal through meaningful work. In this is the source for meaningful relationships with practitioners in nursing.

Such sources would dictate that the problems which scientist nurses choose to study, and their perceptions, attitudes, and values, would be those relevant to nursing. They would be those relevant to a special service to man. The nurse, in contrast to some scientists, would ask "Why?" when she starts a search for knowledge, and the answer to why should contain a relevance or reference to nursing.

One should learn from history or the experiences of others. Medicine is today experiencing some dilemma about the orientation and location of its basic sciences or scientists. Some medical school faculty oriented to clinical practice are deeply concerned about the remoteness from clinical skills or problems of the investigations of their colleagues in biophysics or biochemistry. There is a growing schism between some areas of interest of the medical scientist, and the areas of interest to clinical medicine. Seldin illustrates this as follows:

Successful and important investigations from a biochemical vantage point may lure the clinical investigator in a direction progressively more remote from clinical medicine. The problems posed by patients no longer elicit curiosity. Deranged physiology becomes too complicated for the powerful but restricted tools of basic biochemistry. The net effect may be research not pertinent to any activity in a clinical department(4).

It is to be hoped that nursing can avoid this pitfall if nurse scientists are primarily oriented to the values of clinical nursing though they need not themselves be engaged in practice.

Some of the vicissitudes of becoming a nurse scientist have been mentioned or can be inferred from the above discussion of values and orientation. Some of these vicissitudes remain in the career of a nurse scientist, and additional ones develop.

There is always the question of "To whom does the nurse scientist relate for communion?" From whom does she seek exchange, stimulation, and a sense of companionship, in the work world? As a member of a very small minority group, the nurse scientist has a rare-zero distribution in the nursing departments of health or illness agencies, and, with few exceptions, in schools of nursing. Nurses caught up in the exigencies of providing nursing care, or of facilitating the learning of beginners in nursing, are not likely to find appreciable amounts of time to give to the nurse scientist, even if they have the inclination or interest. The pace, the locale, and the modus operandi, of the doer and the thinker usually do not coincide. Yet even those who think well alone, or who enjoy the autonomy in research, must, at some point, require the stimulation of response to, validation of, or refutation of, their ideas. For the scientist nurse to achieve this requires that the scientist nurse be willing to become involved to some extent, in the interests, issues, discouragements, and excitements, of the nurse who is not a scientist. Where the values of nursing are evident in the scientist nurse, the gaps between the nonscientist nurse and the scientist nurse are narrowed, to their mutual benefit. The scientist nurse, however, must pick her career arena carefully to ensure that it has the potential for a sense of community in the work world.

The choice of where to work, and what to work at, confronts the newly-prepared nurse scientist. Re-entry problems, if one chooses to work in a nursing institution, may plague some nurse scientists. One must become oriented to the institution, to affiliated care agencies, and in some measure, be willing to take on the institution's philosophy and problems. These will be different than those seen as paramount from the graduate student view. There is apt to be a testing by new colleagues of one's identity as a nurse at a time when the new science graduate feels vulnerable or uncertain because of the time-or-distance-from-nursing costs involved in completing a typical doctoral program. Identity challenges recur with any major life transition, and for the nurse scientist, the challenges may come subtly from other nurses.

Then there is the question of "Which language do you speak?" It is amazing to realize how markedly one's language is altered in the process of

becoming and being a scientist. Quite unconsciously one begins to use the jargon and special terminology of the world in which one lives. If this is the world of the professional and student in a select discipline, one gradually acquires the language which facilitates communication within the discipline, but does so at the price of impairing communication with those outside the discipline. Even the terms used with some common meaning across sciences, for example the word "variable," if used in communication with the nonscientist, may produce lack of understanding and, possibly, some alienation. Even when one is aware of this hazard, and consciously tries to avoid it, terminology once learned and used creeps into all speech. If one seeks effective communication with nurses, their patients, and their world, one had better use the language of that world, and avoid the terminology of one's scientist training. This requires a continuing conscious attempt to distinguish, and to use appropriately, the languages of two different worlds.

The aforementioned vicissitudes originate from the role of the scientist nurse. What of those in the actual work of the scientist nurse? What of the problems in theoretical study or research relevant to nursing? There are some that arise from the nature of science, and some that arise from the nature of nursing.

First a look at the practice of science. Science is a process for the generation of knowledge. To be useful, the knowledge must be put to some purpose. At times, the scientist's frame of reference may be too narrow for the general good. The development, testing, and introduction of DDT is but one example of some scientist's inadequate frame of reference, a frame of reference inadequate to foresee the important consequences of the use of DDT which are vastly more costly than its benefit. A narrow focus essential to high command of knowledge, techniques, and materials in one sphere, is not the best base from which to consider the universe to which the sphere relates. Analogies to the DDT problem probably could be found in behavioral science practices as well.

Science boundaries are useful for the learner in a scientific community. They limit what he can be expected to master, and give a base for identity of problems. Science boundaries are barriers, rather than benefits, in the application of science because of the way they influence the generation and structure of knowledge. Recall the dilemma of medicine. As biochemistry becomes increasingly basic, in the sense of moving to finer and finer particularization, it becomes far less a base for clinical medicine.

A mythical view of science engenders the notion that research finds answers, solves problems, or is an avenue to specific theory. In practice, it is a phase in the vicissitude of theory and research; it is a phase in the alternation of a continuous cycle of theory-research-theory. Far more questions than answers are generated by research. One simply gets another leg up on learning what is yet unknown. In practice, research is more productive for identifying new problems, than it is for giving solutions for empirical problems.

Another view of the practice of science that is open to some question is that significant achievement comes *only* from careful, small, rigorous, sequential studies. Serendipity is recognized as occurring, but no statistics are kept to give insight to the frequency with which chance is an important element in the successful practice of science. What is overlooked in serendipity is the priming of the scientist for a sensitivity for relating heretofore unrelated observations or ideas. Such priming can occur in a variety of ways of which rigorously designed methodical study is only one. Watson's story of *The Double Helix* is a spectacular example of the triumph of the model builder over the "good guy" methodical scientist(5).

Objective scientists run the risk of being blinded by theory. Several years before oceanographers paid serious attention to it, a young woman doing routine tasks in the data analysis laboratory of an oceanographer noted a persistent notch in the tracings of soundings of ridges of the ocean floor. She mentioned it to the oceanographer who dismissed it. It did not fit with his theory. Several years later another bit of information caused the oceanographer to recall the notch. With a new frame of reference, the scientist reviewed the tracings of the notch, and a significant breakthrough in the understanding of ocean floor ridges, and a new theory of continent formation and drift, evolved. Now scientists are saying that the continents of South America and Africa were once joined, something the schoolchild of recent generations intuitively guessed from looking at a map, only to be refuted by the scientist of his time. Theory, inadequate facts and limited focus can be hazards for the unwary scientist.

Now for some problems that arise from the nature of nursing. It is said that one knows nothing about something unless one can quantify it. The present capacity of scientist nurses to quantify important variables for the study of nursing is almost nil. The situation is little better even if one elects to study phenomena or variables which are not those of nursing but of something thought to be relevant for nursing. In this era, if scientist nurses limit their research to that which permits of measurement, they run the risk of limiting themselves to studying trivia or tangents of nursing. One is forced to premature precision by too stringent a requirement of measurability in the present day in nursing.

Nursing is in an acute state of groping. At best, it has some imprecise labels for many thought-to-be important variables, rather than sound and useful tools for measurement. For some time to come, the scientist nurse must balance the requirements of science with the state of nursing. Too rigorous adherence to the ideals of tight design, careful control, and extensively tested methodologies or tools, can be limiting in this day. Very rarely does clinical research permit such adherence. The hazards in less rigid adherence are to be run, if the scientist nurse seeks to explore clinical problems. Koch in a recent article on psychology, decries scientism because it produces "ameaningful" thinking(6).

(Ameaningful, as defined by Koch, is the word *meaningful* with the prefix *a* where *a* has the same force as it does in words like *amoral*.) Ameaningful thought or inquiry "assumes that inquiring action is so rigidly and fully regulated by *rule* that in its conception of inquiry it often allows the rules totally to displace their human users," according to Koch. The object of inquiry, in such circumstances, appears to become an "ungainly and annoying irrelevance." Scientism and ameaningful inquiry are as possible in nursing as in psychology.

Some of the problems in inquiry of clinical phenomena can be illustrated from the following examples. Some patients give names to their pathology, or to a body part altered by pathology. A patient with a diagnosis of duodenal ulcer disease spoke of "Mr. Peptic," when he spoke of his ulcer site or ulcer disease. A patient with a crippled hand which was being treated by splinting and physiotherapy called the hand "Monkey." A woman with a colostomy called it "Suzie." A patient with ear noise associated with advancing hearing loss called the ear noise "Cricket."

On the assumption that the naming serves some purpose, it would be useful for the nurse to have some understanding of the phenomena. The case of "Monkey" suggested that the use of the name "Monkey" by the patient and her husband served to achieve some distance and objectivity for the crippled hand. It became a special object upon which special attention, tenderness, and love could be lavished. Each evening the husband would carefully rewrap "Monkey" in its splint. The choice of the name "Monkey" suggests some derision, but it also suggests a pet. It could be seen as an effective coping mechanism for a transitional state.

"Mr. Peptic" was used in another way. As the patient discussed his disease, and his regimens for dealing with it, he indicated that "Mr. Peptic" would remind him if he deviated from his regimens very much. "Mr. Peptic" also would not let him do some things. It appeared as though "Mr. Peptic" was a way of avoiding activities the patient wanted to avoid. "Mr. Peptic" would not let him go to a party if the patient did not wish to attend it.

The naming phenomenon suggests ego alienation. It also provides a short nickname for ease of communication about a diseased body part or process.

From these fragments one can make a case for further study of the phenomenon of patient or patient relative naming of diseased body parts. But how does one study it? One cannot create the phenomenon; one must wait until it comes along. One cannot think of sampling, but what is the population to be studied? How does one study the phenomenon without altering it by the asking of questions? If one simply observes, what does one observe? Piaget's study of his three children on which he bases his theory on the development of reality thinking in the young child offers one method(7). Even this approach offers no easy solution for the inquiry of the naming phenomenon.

Another example can be drawn from interest in patients' use of humor. This is not something which has been studied, yet it may be another coping

mechanism. Some patients seem to use humor as means of transcending a painful experience. This use of humor for transcendence has not been systematically explored. How would one proceed?

Another problem which arises in clinical research in nursing is that of retaining data as the patient moves through time. It is not possible in the present state of knowledge of nursing to anticipate all the possibly important variables. What makes a critical difference is not known. One cannot fully anticipate what should be observed and recorded, therefore one has no entry through a re-run of the data for a variable one has not anticipated. The experiment cannot be repeated with identical subjects. In this time of groping in nursing research, the identification, measurement, collection, and retention of important data, as a patient and nurse move through time, remain problems of great magnitude. Exact repetition of clinical experiments is difficult because of many patient factors beyond the nurses' control, and it is time-consuming.

Further problems in clinical research can be illustrated from an experience with a widely used personality inventory with a patient sample. In the course of studies of eye surgery, stapedectomy, and general surgery patients, in which the writer has been engaged, the Eysenck Personality Inventory was used to measure capacity for introversion(8). This variable was thought possibly to be related to having unusual sensory or cognitive experiences under conditions of relative sensory deprivation. One unexpected finding was that the mean scores for various patient groups for the Lie Scale of the Eysenck Personality Inventory exceeded that of the American norms for the instrument. These norms were, however, based on testing of a college population. The difference might be explainable on the mean age differences between the college sample and the patient samples. It might be due to the fact that because patients with poor vision or eye patching comprised one of our samples, the test had been administered verbally rather than in the written form. The test manual states that the test may be given verbally or in written form, but the norms are presumably based on written administration. Perhaps a higher Lie Scale score results if one is required to respond verbally to questions like "Would you always declare everything at customs even if you knew you could get away with it?" One might be less willing to say out loud, than with a checkmark, that one has a touch of dishonesty. Could the difference be due to the status of patient? All these elements seemed possible. The point of all this is to illustrate that the very limited use of even common psychological tests with a general hospital population does not provide much base for anticipating the outcomes from such testing. There is little base for interpreting test scores from non-patient norms. Reliable measurement tools developed and used with nonpatient populations may need re-evaluation for use with patient populations.

A final comment on nursing. Nursing is essentially a special type of human caring. Some perceive human caring and science to be antithetical. Science, for some, conjures up images of test tubes,

laboratories and increasing remoteness from the real world. This is not the whole story. Science is also the careful measurement of strain in the pinned hip joint, as a patient goes through various movements attendant to selected nursing activities. Measurement of the strain on a hip union during the movement of the patient by means of a draw sheet, or other nursing maneuvers, is for the ultimate purpose of selection or development of nursing maneuvers that produce the least strain on the healing, reconstructed bone. It is a means of achieving a kind of caring that is not simple sentiment, but a kind of caring that includes deliberate, scientifically selected action. Science can be an effective tool of the humanist. It is not his enemy.

Whitehead identified three stages in a process of education: the stage of Romance, the stage of Precision, and the stage of Generalization(9). The stage of Romance is characterized by the freshness of inexperience. Romance gives way to precision as one learns that there are right ways, accepted rules, and ideologies. Over time, one moves to a stage of generalization. This last stage is characterized by the production of active wisdom. Knowledge is barren until tested and used. Knowledge alone is insufficient, one also needs wisdom. Whitehead states that wisdom comes from freedom in the presence of knowledge. Science and knowledge are the tools of the scientist nurse. Wisdom is an ultimate goal.

The sequential stages of romance, precision, and generalization, characterize the development of the scientist nurse. They also describe a successful nursing career. A young June graduate recently shared the experiences of her first eight months as a staff nurse. She was plunged into responsibilities for which she felt inadequate. Because of the pace and volume of her work, she failed to obtain the satisfactions she had anticipated from nursing. In searching her feelings about nursing, she had come to feel that "nobility is not the thing". Romance had come to an end, as she realized that her romantic view of a Florence Nightingale was not the real world.

Though it is readily understandable why this young nurse feels as she does, one cannot agree with her. From the perspective of more years in nursing, one can see a cycle of romance, to realism, to a return to a sense of nobility that is based on realism. Nobility is the thing in nursing, when "noble" is correctly understood as meaning admirable in dignity of conception, and in manner of expression or execution. There are many ways of expressing or executing nursing. A scientific contribution to the improvement of practice can be a satisfying one for the scientist nurse. It combines the nursing ethos of service to others with great opportunity for self-realization.

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