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Université de Montréal

The Role of Critical Thinking in the Knowledge Building Process of a Networked Community of Nurses

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Université de Montréal

Faculté des études supérieures

Ce mémoire intitulé:

The Role of Critical Thinking in the Knowledge Building Process of a Networked Community of Nurses

présenté par:

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Résumé

Bien que les notions de critique, de penser de façon critique et l'action de critiquer aient été étudiées depuis des millénaires, ce n'est que récemment que nombre de chercheurs se sont penchés sur l'étude de la pensée critique en tant que sujet de recherche. En dépit des nombreuses définitions attribuées à la notion de pensée critique, l'opérationnalisation du concept s'est avéré nécessaire afin de comprendre le rôle de celle-ci dans le processus de co-construction de connaissances d'une communauté d'infirmières en réseau, objet de notre recherche. Le but de notre recherche est d'analyser et de comprendre comment la pensée critique s'est déployée dans le processus dialogique et récursif de la co-construction de connaissances en réseau.

Nous avons adopté un cadre théorique constructiviste et adopté les notions de *communication progressive* (Campos, 2003) et de *schématization* (Grize, 1991). Nous avons utilisé l'analyse de discours en tant que méthode afin de répondre à nos questions de recherche. Une grille a été développée et appliquée permettant l'identification de la pensée critique dans le discours en réseau. Les données quantitatives et qualitatives ont été utilisées afin de qualifier le niveau de pensée critique (faible ou élevé). Les résultats suggèrent que les infirmières ont utilisé la pensée critique dans leur discours en réseau. Le niveau de pensée critique, dans les séquences étudiées, variait mais, en général, peut être qualifié d'*élevé*. De plus, les données suggèrent que l'utilisation de jugements et l'évaluation des affirmations entre pairs semble avoir été bénéfique.

Mots-clés: communication en réseau, pensée critique, argumentation, collaboration, co-construction de connaissances, analyse de discours, forum de discussion en réseau

Abstract

Although the concepts of criticism, critical thought, and of being critical, etc. have been explored along millennia of human history, it is only recently that critical thinking itself has become a focal point of research. Despite the numerous definitions attributed to critical thinking, operationalizing the concept was key in order to understand its role in the knowledge building process of a networked community of nurses, object of this study. Our research aims to assess, analyze and understand how critical thinking unfolds in the dialogical, reflective and recursive process of networked knowledge building.

The study was based on a constructivist framework and adopted the notions of *progressive communication* (Campos, 2003) and *schematization* (Grize, 1991). The method adopted to verify our research questions is discourse analysis. A grid was developed and applied to identify critical thinking within networked discourse. Quantitative and qualitative data were used in order to assess the level of critical thinking (weak or strong). Results suggest that the nurses engaged in critical thinking. The level of critical thinking, found in the studied sequences, varied but was overall judged as being *strong*. In addition, data suggest that astute use of skepticism (judgment) and assessment of statements by the nurses were beneficial.

Keywords: networked communication, critical thinking, argumentation, collaboration, knowledge building, discourse analysis, online conferencing

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Introduction

What is thinking? How does it develop? Are there different types of thinking? How is thinking applied to doing? There are many types of thinking that can be found in the literature: creative thinking, reflective thinking, imaginative thinking, sensitive thinking, speculative thinking, visual thinking, metaphorical thinking, logical thinking, conceptual thinking, critical thinking, to name a few. Some types of thinking seem to be more creative and expansive while others, such as critical thinking and speculative thinking, more rational and focused.

Thinking is a multifaceted cognitive process. It reflects the self, helps one solve problems and make decisions. Thinking reflects an individual's experience, knowledge and expertise in a variety of areas (social, human, philosophical, scientific spheres). Thinking is, thus, closely related to knowledge.

Knowledge is acquired through learning. It can be formally transmitted in schools but also acquired informally through observation and experience. One learns continuously throughout a lifetime. The level and type of thinking that emerge from learning is variable, dependant upon age and cognitive capabilities such as information processing, comprehension and interpretation. Equally important to consider is the ability of an individual to *reflect* on individual or group motivation, needs and experiences. Cognition refers to complex mental operations. When an individual possesses the level and type of thinking required to reflect metacognitively, i.e., with an awareness of their own mental processes, higher order thinking is achieved. Higher order thinking, generally considered as critical thinking by cognitive scientists, is unique to mankind.

As we step into the 21st century, the quest to define and refine critical thinking is reflected in the philosophies of thinkers like Socrates, Plato, Aristotle, Aquinas, Colet, Erasmus, Bacon, Descartes, More, Machiavelli, Hobbes, etc. who sought to *think about thinking*. Although the necessary training to achieve reasonable ways of thinking date back many

centuries to the days of Socrates in Ancient Greece, such as the logics of Plato's *Dialogues*, more recent attention by philosophers, educators and researchers has focused on critical thinking as a notion and as a process. As the subject of scholarly inquiry for the past forty years, it has fostered debate over its definition. Finding valid tools to understand it, identify it, enhance it, teach it and measure it has also been contentious.

Recently, some scholars have tried to further understand critical thinking. Bereiter (2002) states that thinking cannot be broken down in linear procedures: there is actually a lot of looping back, starting over, jumping ahead and so on. This position is in agreement with that of McPeck (1981). He states that "*thinking is always thinking about something as to think about nothing is a conceptual impossibility*". Critical thinking, according to McPeck, always manifests itself in connection with some identifiable activity or subject area, and only problems, activities or subjects can be thought of critically.

That is why, from a professional perspective in a world increasingly dependant on technology, critical thinking seems to be crucial. Critical thinking enables individual practitioners to deal with complex problems in a rapidly changing technological environment and to form appropriate judgments for the benefit of organizations. They need to maintain and improve their capability to manage knowledge and involve practitioners in problem-solving and decision-making (Wenger, McDermott & Snyder, 2002), which are, based on the capacity to think critically i.e., looping back, starting over and jumping ahead as stated by Bereiter (2002). Organizations would benefit from this process if the following question could be answered: How can critical thinking be sustained over an extended period of time and be incorporated in professional practice in order to advance knowledge?

Because networked communication (interpersonal communication conducted through computers including both asynchronous and synchronous communication) enables the advancement of many work tasks by providing flexible alternatives (i.e., e-mail, instant messaging, teleconferencing, videoconferencing) to traditional face-to-face communication,

it could be used to foster critical thinking. For instance, computer conferencing is bridging large distances, between practitioners who wish, or are requested, to share and interact on the job. In healthcare, as in other professional domains, practitioners supposedly use critical thinking skills to navigate the complexities inherent to new roles and responsibilities brought by technology in order to function competently. Networked communication promotes interaction and active participation by supporting communication between several parties over an extended period of time, connecting practitioners located in multiple sites. Time-delayed dialogue (asynchronous) enables discussion and feedback on topics.

Sustained interaction among practitioners through networked communication, according to Anderson & Garrison (1995), enables them to engage in critical discourse. Workplace communities that use online computer conferencing that have the opportunity to collaborate, build knowledge and solve problems as a community might, hypothetically speaking, have strong critical thinking skills. Tasks requiring reflective thought seem to be agents for community-building in a networked environment. As a result, studies that explore the use of online computer conferencing for sustaining, designing and practicing critical thought are relevant to this examination.

For these reasons, we sought to further investigate how critical thinking unfolds within the specific context of a networked community of nurses engaged in problem-solving, and develop a methodological tool for the identification of critical thinking indicators within their networked discourse.

This Masters thesis is developed in five chapters. ***Chapter 1*** introduces the problem. Background on critical thinking studies in the context of networked environments is provided. The history of the idea of critical thinking and a review of the concept of critical thinking over the past forty years is also explored. The reader will see how the concept of critical thinking has evolved over time through the work of various thinkers

Chapter 2 lays out the theoretical framework used to conduct this study. A constructivist stance was adopted, integrating cognitive science studies to the tradition of informal and natural logic, and communication.

Chapter 3 comprises the context of the research, the methodology used and the tools developed to conduct this study.

Chapter 4 presents the analysis of the data. Quantitative and qualitative analyses as well as a discussion on the limitations of the study are examined. Additional reflections on the study and its implications for practice and future research are discussed in ***Chapter 5***.

Chapter 1: The context of the problem

Critical thinking

Many definitions have been proposed for the concept of critical thinking. They explore the difficulties in finding valid tools to identify, understand, enhance, teach and measure it. In an attempt to reach consensus on defining critical thinking, a cross-disciplinary panel was formed by the American Philosophical Association in 1990 in a landmark publication entitled "Critical Thinking: A Statement of Expert Consensus for Purposes of Educational Assessment and Instruction". This definition was based on a consensus statement, and is discussed thoroughly in Chapter 2 of this thesis. The panel also identified characteristics and traits of the ideal critical thinker, as follows: inquisitive, open-minded, methodical, analytical, self-confident and mature.

Since critical thinking is defined as one of the most important outcomes of education, over the years many tests have been developed to measure the critical thinking skills and dispositions of learners. The California Critical Thinking Skills Test (CCTST)[1], the California Critical Thinking Disposition Inventory (CCTDI)[2], the Holistic Critical Thinking Scoring Rubric (HCTSR)[3], and the Professional Judgment Rating Scale are some examples. They seem to be problematic in terms of this study because they were designed *to measure* critical thinking skills and the dispositions of the individual critical thinker. Our study tries to understand critical thinking as a process leading to various potential outcomes, from a more qualitative perspective.

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[1] Office of Institutional Research and Assessment. University of Tennessee. (2002)
[2] Insight Assessment. California Academic Press. (1997)
[3] Insight Assessment. California Academic Press. (1997)

Critical thinking could be understood as the ability to use one's knowledge and intellectual cognitive skills in situations of ambiguity (APA, 1990). Critical thinking could involve personal experiences that inform the use of cognitive skills such as creativity, inductive reasoning and the ability to analyze arguments. Critical thinking, as a term, was first introduced in Dewey's *How we Think* (1909) as "*reflective thought*", which he defines as an "*active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends*" (pp. 6).

Critical thinking emerged as a new "logic course" in the early 1970's in the United States and Canada as a result of the insatisfaction of some professors with the content of university courses on logics. The movement was inspired by argumentation studies defying formal logic (Toulmin, 1958). Philosophers engaged in this line of inquiry call themselves "informal logicians". At first, "informal logic" was a rhetorical means to differentiate it from "formal logic" through a distinct approach to argument interpretation and evaluation. Informal logicians consider arguments to be social, dialectical and pragmatic in nature. Arguments are considered social because they are "*constituents of a complicated, multifaceted social practice [...] and occur against a background of shared meanings, values, and problems or controversies*" (Van Eemeren & al., 1996) Arguments are also deemed dialectical because they "*are part of an actual or anticipated back-and-forth exchange, and are [thus] interactive*" (pp.164) (Van Eemeren & al., 1996). According to informal logicians, arguments are also pragmatic because their meanings are "*a function of purposive contexts*". (pp. 164) This is in line with Grice's (1975) claims. He states that "*arguments can not be understood apart from their interlocutor's intentions and a rich fabric of contextual rules and understandings*".

Informal logicians study critical thinking because they are concerned with the analysis, evaluation and interpretation of arguments in public discourse. Kahane's *Logic and Contemporary Rhetoric: The Use of Reason in Everyday Life* (1971), Thomas' *Practical Reasoning in Natural Language* (1973) and Scriven's *Reasoning* (1976) are among pioneering books which try to refute the use of formal logic for argument analysis. Later, a second generation of authors emerged with further refinements. Among them were Johnson & Blair (1977), Govier (1985), Damer (1987), Seech (1987) and Freeman (1988). They tackled theoretical questions pertaining to the identification, analysis and logical evaluation of the argument. They turned to Toulmin's *The Uses of Argument* (1958) for orientation and affirmation. Toulmin was a formal logician who ended up criticizing formal logic. The spirit of Toulmin's approach was embraced by informal logicians – "*sensitive to context, be empirical rather than aprioristic, expect differences in standards in different domains*" (pp. 172, 1958). Later still, Fisher (1988) consolidated old formal logic and new informal logic by focusing on actual arguments rather than contrived ones by trying to display the macrostructure of arguments. Freeman (1991) also undertook a revision of the Toulmin model by adding a dialectical dimension to it.

Another current in informal logic is proposed by theorists who adopted Toulmin's model and saw informal logic as *applied epistemology.* McPeck (1981) and Weinstein (1990), among others, suggest that an argument's standards are furnished by the epistemology of its field of knowledge. Following Toulmin's model, McPeck holds that "*any interesting standards for evaluating an argument will be a function of the standards of knowledge, or justified belief, in whatever domain of knowledge the conclusion belongs to*" (pp. 185, 1981)[4]. Despite disagreements between informal logicians on how critical thinking should be defined and understood, most hold that dispositions are intrinsic critical thinking.

[4] The reader will see, in Chapter 2, how we depart from this vision to adopt a constructivist viewpoint (Grize, 1991) that integrates knowledge from cognitive studies.

Dispositions are attitudes of mind – natural or acquired. Theorists of critical thinking "*acknowledge that the ability to analyze and evaluate arguments is of crucial importance to critical thinking* [...]" (pp.187).

Historical overview of the notion of critical thinking

The intellectual roots of critical thinking are as ancient as its etymology, traceable to the teaching practice of Socrates. 2,500 years ago, Socrates developed a method called *Maieutic*. *Maieutic* is a method of teaching by questioning and answering contenders and reflecting upon uncritically held opinions. Confused meanings, inadequate evidence, or self-contradictory beliefs often lurk beneath empty rhetoric. Socrates established that one can not depend upon those in "authority" to have sound knowledge; many people, even those with power in high positions, could be confused and irrational thinkers. He established the importance of asking questions to probe thinking before accepting ideas as worthy of belief. Socrates also emphasized seeking evidence, closely examining assumptions, analyzing basic concepts, and tracing the implications of what is said and done. *Maieutic* is the best-known critical thinking teaching strategy. In his way, Socrates highlighted the need for thinking in a clear, logical, consistent manner.

Socrates set the agenda for the tradition of thinking critically, namely, reflective questioning of common beliefs and explanations, carefully distinguishing reasonable and logical beliefs from those lacking adequate evidence or rational foundation. Socrates' practice was followed by the contributions of Plato (who recorded Socrates' thought), Aristotle, and the Greek skeptics, all of whom emphasized disparity between what seems and what is. Only the trained mind could penetrate the superficial (delusive appearances) to the profound reality beneath the surface. From this ancient Greek tradition emerges a need - for anyone who aspires - to understand the deeper realities of life through systematic thinking, for only thought that is comprehensive, well reasoned, and responsive to

objections can take us beyond the surface. However, "realities" were, for those thinkers, something beyond the realm of the "objective" world, as it is presently understood.

In the middle Ages, Thomas Aquinas embodied the tradition of systematic thinking in his writings and teachings. In order to ensure that his thinking met the test of critical thought, Thomas Aquinas systematically stated, considered and answered all criticisms of his ideas. He considered this process a necessary stage to further developing his ideas. Aquinas stressed the need for systematically cultivated and "cross-examined" reasoning, and the notion that those who do indeed think critically do not always reject reasonable beliefs but only those that lack reasonable foundations.

European scholars of the Renaissance such as Colet and Erasmus followed up on the insights of the ancients and began to discuss religion, art, society, human nature, law and freedom. In line with their predecessors in critical thought, they assumed that most human life domains needed proper methods to analyze and critique thought.

In England, Francis Bacon examined the misuse of our minds in seeking knowledge. He recognized that the mind could not safely be left to its natural tendencies. In *The Advancement of Learning* (1605), he stressed the importance of studying the world empirically. He laid the foundation for modern empiricist science by emphasizing the information-gathering processes. He posited that most people develop bad thinking habits (idols) that lead them to believe in what is false or misleading. His book could be considered one of the earliest texts about thinking critically.

Later in France, Descartes wrote *Rules for the Direction of the Mind* (1628), another text relevant to our present reflections about critical thinking, although far from the empiricist tradition. Descartes argued for the need to systematically discipline the mind for correct thinking. He defended the need for clarity and precision. He developed a procedure based

on the principle of systematic doubt (a method of critical thinking). Descartes emphasized the need to structure thinking on well-founded assumptions. He argued that every part of a given thought could be doubted, questioned and tested.

European Renaissance and post-Renaissance philosophers concerned with politics, democracy, human rights and freedom of thought also contributed to the evolution of the notion of criticism. Machiavelli (*The Prince*, 1515) assessed the politics of his time and laid the foundation for modern critical political thought. Sir Thomas More, for example, developed a model of a new social order, *Utopia*, in which every domain of the present world was subject to critique. He held that established social systems need radical analysis and critique. In England, during the 16th and 17th centuries, Hobbes and Locke (Harrison, 2003) displayed the same confidence in the critical mind of the thinker as Machiavelli. They did not accept the traditional and dominant ideas of their time. What was considered "normal" in their culture was not necessarily rational to them. Hobbes, for example, adopted a naturalistic view of the world in which everything was to be explained by evidence and reasoning whereas Locke defended a common sense analysis of everyday life and thought. Locke laid the theoretical groundwork for critical thinking on basic human rights and the responsibilities of governments to submit to the reasoned criticism of thoughtful citizens.

Political thinkers of the French enlightenment such as Bayle, Montesquieu, Voltaire and Diderot also made their marks. Their premise was that the human mind, when disciplined by reason was able to unveil the nature of the social and political world. They agreed that reason must turn inward, upon itself, in order to determine weaknesses and strengths of thoughts. They valued disciplined intellectual exchanges in which all views were submitted to analysis and critique. They believed that all authorities should be scrutinized by reasonable critical questioning.

Thinkers of the 18th century, unaware of the modern concept of critical thinking, developed during the post-Renaissance period, developed a sense of the power of criticism and of its tools. Smith's *Wealth of Nations* and Kant's *Critique of Pure Reason* are examples of critical endeavors applied to the problem of economics and of reason itself. In the 19th century, further progressions were made by Comte and Spencer, who extended criticism into the domain of human social life. Criticism began to be applied more broadly, to the problems of capitalism (Marx, 1843), the basis of biological life (Darwin, 1859), the unconscious mind (Freud, 1888), the history of human culture (Whitehead, 1920) and many other fields as the capacity to think critically could be understood as being at the core of scientific formulations (Popper, 1978).

In review, the ideas of critics, criticism, and critical thought, are embedded in many philosophical traditions. However, understanding the idea of criticism in reasoning got a new insight with the works of William Graham Summer. In 1906, Summer wrote *Folkways*, documenting the tendency of the human mind to think sociocentrically and the parallel tendency of schools to serve the uncritical function of social indoctrination. Summer pointed to the profound need for critical thinking in life and in education. John Dewey agreed with Summer in that "*education in the critical faculty is the only education of which it can be truly said that it makes good citizens*" (1933). Dewey's work increased awareness of the pragmatic basis of human thought, its instrumental nature and its grounding in actual human purposes, goals and objectives. Piaget (1923) went on to reveal the process through which human beings construct reality departing from a non-reversible and egocentric logical structure to the acquisition of sociocentric and reversible operations, which led to the development of cybernetics and modern cognitive science.

The number of thinkers who developed the notion of critical thinking is extensive. Each major discipline has made a contribution. Some common denominators can be cumulatively

drawn from defined intellectual periods. It is, therefore, safe to suggest that critical thinking, by its very nature, requires systematic monitoring of thought, and that thinking, to be critical, must be analyzed and assessed for its clarity, accuracy, relevance, depth, breadth and logic. That reasoning occurs within the limits of personal points of view and frames of references, and that it proceeds from goals is a hypothesis that many acknowledge today.

Recent notions of critical thinking

For a better understanding of current conceptions, hereunder are some recent definitions for critical thinking proposed in the last forty years. They are presented in chronological order and attributed to the researchers who wrote textbooks and articles on the subject.

Critical thinking has been equated with the creation, use, and testing of meaning (Hullfish & Smith, 1961), the development of logical reasoning abilities (Hallet, 1984; Ruggiero, 1975), and with assumption hunting (Scriven, 1976). Ennis (1962) lists twelve aspects of critical thinking, which include analytical and argumentative capacities such as recognizing ambiguity in reasoning, identifying contradictions in arguments, and ascertaining the empirical soundness of generalized conclusions. D'Angelo (1971) specifies ten attitudes as necessary conditions for being critical, including curiosity, flexibility, skepticism, and honesty. Lindzey, Hall & Thompson (1978) suggest that critical thinking is "*the examination and testing of suggested solutions to see whether they will work*". For Halpern (1984), critical thought is "*a rational and purposeful attempt to use thought in moving toward a future goal.*" O'Neill (1989) proposes that the central component of critical thinking is the ability to distinguish bias from reason and fact from opinion. It has also been equaled with the application of reflective judgments (Kitchener, 1986).

According to Chafee (1988) critical thinking is "*our active, purposeful, and organized efforts to make sense of our world by carefully examining our thinking, and the thinking of others, in order to clarify and improve our understanding*" (p.29). Paul & al (1989) suggest that it is the "*art of thinking about your thinking while you are thinking in order to make your thinking better: clearer, more accurate, or more defensible*". Others, such as Simon & Kaplan (1989), support that critical thinking involves the formation of logical inferences. For Halpern (1984), critical thinking is "*purposeful, reasoned and goal directed. It is the*

kind of thinking involved in solving problems, formulating inferences, calculating likelihoods, and making decisions". Simply put, critical thinking is "*reasonable and reflective thinking that is focused upon deciding what to believe or do*" (Norris & Ennis, 1989). Smith (1990) posits that critical thinking depends on skills such as "*understanding the meaning of a statement, judging ambiguity, judging whether an inductive conclusion is warranted, and judging whether statements made by authorities are acceptable.*" Stall and Stahl (1991) believe that critical thinking is just "*the development of cohesive and logical reasoning patterns*".

More recently, Pascarella and Terenzini compiled several definitions, stating that critical thinking "typically involves the individual's ability to do some or all of the following: identify central issues and assumptions in an argument, recognize important relationships, make correct inferences from data, deduce conclusions from information or data provided, interpret whether conclusions are warranted on the basis of the data given, and evaluate evidence or authority (1991, p. 118)." According to Elder & Paul (1994), "Critical thinking is best understood as the ability of thinkers to take charge of their own thinking. This requires that they develop sound criteria and standards for analyzing and assessing their own thinking and routinely use those criteria and standards to improve its quality." Moore and Parker (1994) state that it is rather "careful and deliberate determination of whether to accept, reject, or suspend judgment."

Another view links critical thinking with problem solving. Critical thinking is differentiated from problem solving (Hedges, 1991) in that problem solving is a linear process of evaluation, while critical thinking is a comprehensive set of abilities allowing the inquirer to properly facilitate each stage of the linear problem-solving process. It could also follow the view of Victor (1992). In her book, "Critical Thinking across the Curriculum: Building the Analytical Classroom", she writes that the "*purpose of critical thinking is [...] to achieve understanding, evaluate view points, and solve problems. Since all three areas*

involve the asking of questions, we can say that critical thinking is the questioning or inquiry we engage in when we seek to understand, evaluate, or resolve." Paul posits that although problem-solving could be seen as intimately linked to critical thinking, some scholars and educators erroneously identify it with higher order thinking or cognitive processing (Paul, 1993).

Undoubtedly, there are already plenty of definitions on the market! Some are refuted, criticized and/or augmented by other researchers. For example, Siegel (1989) criticizes Ennis' conception because it focuses entirely on teaching certain "*skills, abilities, and proficiencies necessary for the correct evaluation of statements*". Siegel suggests that a skill-only conception of critical thinking is flawed because a person could be called a critical thinker but never use the skills outside a test situation. He holds that an adequate conception of critical thinking should include some notion of a person having specific skills and certain "*dispositions, habits of mind, and (even) character traits*" (1989). To be a critical thinker, a person should have proper circumstances to exercise its skills. Siegel defines critical thinking as "*appropriately moved by reasons*". This definition is vague, point out Johnson & Blair (1994), because it could apply to other situations in which critical thinking isn't evident. Johnson & Blair also criticized Lipman's (1988) definition that critical thinking is "*skilful, responsible thinking that facilitates good judgment because it relies on criteria, is self-correcting, and is sensitive to context*". They suggest that "*critical thinking often occurs in a group where the best ideas or criticisms* ***come from others****, not one's self. In fact we are often our own worst enemies when it comes to critiquing our ideas*" (Lipman, 1988).

Networked communication and critical thinking

Networked asynchronous communication, one that is done through the Internet with the help of electronic conferencing, can provide a space in which interlocutors exchange ideas. As through any other means, it could also be used by people express criticism. Since critical thinking in networked communication has mainly been studied in the educational circles, most studies to date are related to pedagogy. Studies on critical thinking (Fahy & al., 2000; Hara, Bonk & Angeli, 2000; Anderson & Garrison, 1995) claim that the distance provides the learners with more flexibility in the management and presentation of their ideas, thus enhancing critical thinking skills. In this case, the idea is that reflection can be relayed into asynchronous communication more easily since conferencing systems allow learners to deliberately plan and review their contributions as well as critique responses of others (Bruer, 1994). Many studies investigate different variables in computer conferencing contexts such as:

(1) **critical thinking** (Bullen, 1998; Fahy & al., 2000; Garrison, Anderson & Archer, 2000a, 2000b, 2001; Hara, Bonk & Angeli, 2000; Newman, Webb & Cochrane, 1995; Weiss & Morrison, 1998)

(2) **participation** (Ahern, Peck & Laycock, 1992; Bullen, 1998; Fahy & al., 2000; Hara, Bonk & Angeli, 2000; Henri, 1992; Howell-Richardson & Mellar, 1996; McDonald, 1998; Zhu, 1996; Blanchette, 1999)

(3) **collaborative knowledge construction** (Campos, 2000, 2002; Anderson & Kanuka, 1997; Kanuka & Anderson, 1998; Zhu, 1996; Jiang & Meskill, 2000)

(4) **interaction** (Ahern, Peck & Laycock, 1992; Blanchette, 1999; Fahy & al., 2000; Hara, Bonk & Angeli, 2000; Henri, 1992; McDonald, 1998; Mowrer, 1996; Rourke & al. 2001; Zhu, 1996; Hillman, 1997; Murphy , Drabier & Epps, 1998) and

(5) **argumentation processes** (Marttunen, 1997, 1998; Campos, 2000, 2002, 2003; Campos & al., 2001; Veerman, Andriessen & Kanselaar, 2002)

Some authors (Anderson & Garrison, 1995; Duffy, Dueber & Hawley, 1998; Garrison, Anderson & Archer, 2000) state that networked communication scaffolds critical thinking and self-assessment. Others defend the notion that computer conferencing serves as an environment enabling problem solving, knowledge building and learning (Harasim & al., 1995; Campos & al., 2001; Scardamalia & Bereiter, 1994). Networked environments allow participants to work in collaboration on solutions to problems by examining each other's contributions as well as assessing the pertinence of their own. In the last decade, research has begun to address problems of interaction in networked environments and how technology can be used to support communication and enable knowledge building and learning. According to Campos (2003), communication is progressively constructed from lower to higher order processes, the latter being related to enhanced critical thinking skills. Bereiter (2002) explains that this new form of collective dialogue happens in a context of progressive discourse.

Bereiter (2002) summarizes our view on how critical thinking unfolds in group processes that make use of networked communication in the following way:

> *"It is perhaps fanciful to say that there is a group thinking process that goes on despite the diversions of individual thought, but it is not fanciful to say that there is a discourse that proceeds thus. The discourse may proceed in a coherent way despite absences and changes in membership. What people's wandering minds keep being drawn back to is that discourse. If a planning committee is working well, the discourse will be seen to progress. Participants or observers will be able to point out substantive ways in which the discourse has progressed from where it was earlier. If a planning committee is working badly, the discourse will not be seen to progress. It will be seen as stalled, going in circles, or moving along in a way that is not judged to constitute progress. All of this applies not just to committees but to any sort of collective endeavor that has a cognitive objective—to solve a problem, produce a design, reach a decision, advance a theory, or whatever. There is a discourse that progresses or fails to progress with respect to its objective.... Individual thinking figures insofar as the individual contributes to and is in turn influenced by the discourse, but it is the discourse itself that constitutes the*

> *collective effort to achieve a cognitive objective. If the discourse succeeds, it does not matter if it is as a result of individual good thinking or a fortunate combination of inputs from people whose individual thinking is unremarkable. If the discourse fails, the effort has failed, and it does not matter how brilliant were the participants and how many bright ideas lay buried in the discourse."* (pp. 11-12; Ch. 10)

This collective process of building knowledge that implies the need of thinking critically is at the core of our interest in trying to understand how a community of practitioners made use of critical thinking skills to advance knowledge through innovation (Scardamalia, 2002).

Research questions

The notion of "critical thinking" has only recently become a focal point of research, apart from its actual practice in the development of critical methods throughout history. Although many studies exist relating critical thinking and networked environments, most focus on educational settings. We lack research on critical thinking in more diversified networked situations, which this study seeks to address. In this study, the role of critical thinking in the knowledge building process of a networked community of nurses is examined.

The questions that we addressed are:

(1) Can we assess critical thinking in networked discourse?

(2) Did the networked community of nurses *engage* in critical thinking?

(3) If so, the knowledge built was of a lower or higher level?

The aim of this research is to explore the dialogical, reflective and recursive process of networked knowledge building in order to assess, to analyze, and to understand how critical thinking unfolds. Critical thinking is understood as a *process* that could be structured and supported within the frame of a networked environment.

Chapter 2: Theoretical framework

That critical thinking is a notion proposed by logicians defying formal logic is now known. Philosophical tradition is also in agreement that critical thinking involves cognitive skills. However, informal logicians do not have the methods to study how cognitive skills develop.

Piaget, one of the most important cognitive scientists in history, conceptualized a constructivist framework in which logical operators are considered natural building blocks for understanding the world. Mental abilities are progressively developed along childhood (Piaget, 1923). Hence education is understood as a process that might improve cognitive skills and brain capacity. Although thinking itself is widely accepted as *"mental operations carried out on stored mental content"* (Bereiter, 2002), the content of this process is comprised of thoughts and ideas enabled by language (Vygotsky, 1979).

Bereiter (2002) introduces a window for integrating these views in networked contexts. He states that thinking cannot be broken down in linear procedures: rather, it is an associative process. There is actually a lot of looping back, starting over, jumping ahead and so on, as we already mentioned. Bereiter is a cognitive psychologist who has been studying how people build knowledge while communicating in writing through networked environments.

Bereiter's position is somehow with the following statement by McPeck (1981): "*thinking is always thinking about something as to think about nothing is a conceptual impossibility.*" Critical thinking, according to McPeck, always manifests itself in connection with some identifiable activity or subject area, as only problems, activities or subjects can be thought of critically. Robert Ennis' landmark paper, "*A concept of critical thinking*" defines critical thinking as the "*correct assessment of statements*" (1993). Ennis's definition is challenged by McPeck who holds that critical thinking does not necessarily entitle the subject to be *correct* in their assessment of statements. According to him, critical thinking also includes the use or rejection of methods, strategies and techniques which are related to cognitive

skills. McPeck argues that critical thinking is the appropriate use of reflective ***skepticism within a problem area under consideration*** (1981). With this in mind, McPeck's skepticism can be understood as related to the idea of construction in the sense that doubt leads to question and re-framing of ideas.

Since critical thinking involves cognitive activities, it requires certain skills that allow mental constructions. The American Philosophical Association (APA), who defines critical thinking as a

> *"purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment is based."* (1990)

lists some cognitive skills that are also considered by McPeck such as:

(1) interpretation: to comprehend and express the meaning or significance of a wide variety of experiences, situations, data, events, judgments, conventions, beliefs, rules, procedures, or criteria.

(2) analysis: to identify the intended and actual inferential relationships among statements, questions, concepts, descriptions, or other forms of representation intended to express belief, judgment, experiences, reasons, information, or opinions.

(3) evaluation: to assess the credibility of statements or other representations which are accounts or descriptions of a person's perception, experience, situation, judgment, belief, or opinion; and to assess the logical strength of the actual or intended inferential relationships among statements, descriptions, questions or other forms of representation.

(4) inference: to identify and secure elements needed to draw reasonable conclusions; to form conjectures and hypotheses; to consider relevant information and to deduce the consequences flowing from data, statements, principles, evidence, judgments, beliefs, opinions, concepts, descriptions, questions, or other forms of representation.

(5) explanation: to state the results of one's reasoning; to justify that reasoning in terms of the evidential, conceptual, methodological, criteriological, and contextual considerations upon which one's results were based; and to present one's reasoning in the form of cogent arguments.

In spite of overlaps and inconsistencies in the analogies that can be drawn between the above mentioned philosophical notions and actual cognitive skills, they enable us to suppose that (1) they could be identified in a written discourse, and that (2) the relationships between them could suggest that critical thinking derived from a networked process of co-construction.

Our idea of construction must be linked to what can be performed in collaboration by diverse people participating in a networked community through online computer conferencing. For that, we adopt the notions of progressive communication (Campos, 2003) and progressive discourse (Scardamalia & Bereiter, 2002). Campos (2003) bases his understanding of the communication process on Piaget's ecological model of permanent, dynamic and constructive interaction, which also informs Grize's communication model. According to Grize's (1991) cognitive model of written or verbal communication (see Figure 1), two individuals discuss a given theme "T". Each person builds an image of this theme. Campos (2003) explains this process, suggesting that during this interactive process, interlocutor A builds an image A of theme T as the result of the interpretation of image B by interlocutor B. B rebuilds the image B of theme T as a result of the interpretation of image A by interlocutor A. Building and rebuilding – or schematization (Grize, 1991) – is a progressive process of reconstruction in which interlocutors help to interpret each other's world, solve problems and build knowledge in collaboration.

COMMUNICATION CONTEXT

"Schematization"

builds
rebuilds
Im (A) Im (T) Im (B)
A → ← B
as a result of
help for the reconstruction
as a result of
finalities
representations
cultural pre-constructs
finalities
representations
cultural pre-constructs

Figure 1. Grize's cognitive model of written/verbal communication

Grize understands communication as argumentation, a discursive phenomenon occurring in co-constructed processes. Argumentation is essentially dialogical: a proposal is made by a speaker to a listener in a specific situation. Grize and McPeck both take into account that argumentation's aim is not necessarily to transfer the *truth* of the premises of the argument to the conclusion, but to gain the listener's *approval or acceptance* of the conclusion. It is thus *plausibility* and not *truth* that is at issue in most networked discourse.

According to Grize's cognitive model of written/verbal communication (presented in Figure 1 above), the interlocutor's *A* representations belong to the domain of the *production process*; they represent a certain knowledge of the necessary conditions for successful communication. It is not simply a simple transmittance of knowledge that occurs but rather a reconstruction process on the part of interlocutor *B* of the schematization of interlocutor *A*. If *B*'s reconstruction is more or less identical to the construction intended by *A*, natural logicians, such as Grize, speak of "*resonance*" between interlocutor's *B* reconstruction and interlocutor's *A* construction.

Grize refers to the notion of *schematization* as the co-construction process (the schema). McPeck views critical thinking as the judicious use of skepticism, tempered by experience, such as the production of a more satisfactory solution to, or insight into, the problem at hand. Like Grize, he does not assume any *a priori* normative concepts of *truth* and *validity* but rather the possibility of achieving *plausible* and *conceivable* constructs. Of course, if formal content is discussed, such as physics or mathematics, then truth and validity would be at stake (Grize, 1991).

The ability to analyze and evaluate arguments that seems to be crucial to critical thinking has a recursive dimension related to the *schematization* process. Interlocutor *B* examines, questions and compares A's ideas, statements or claims and assesses their validity or credibility by making a judgment which can be more or less identical to *A*'s ideas, statements or claims. Interlocutor *A* constructs meaning, which is interpreted and reconstructed by interlocutor *B*. If "resonance" does not occur, one or several loops might take place between the two interlocutors. Such a scenario could extend to include other interlocutors, in a networked community, which members strive to develop common meaning among several participants. In the occurrence of several loops on a "common" meaning schematized by interlocutors, the presence of critical thought in the networked discourse can be discussed, since the know-how of the interlocutors will be visible through the identification of critical thinking (CT) indicators.

The goal of this thesis is to discover whether participants of a networked community of nurses are engaged in critical thinking when communicating, and identifying methods for assessing that activity.

This view of knowledge construction, applied to networked environments, as Campos (2003) has suggested, is aligned with the idea of progressive discourse as stated by Bereiter

(2002). Bereiter (2002) holds that for a project to have a successful outcome (like the community of nurses that we studied), it requires an unrelenting process of productive thinking. The core cognitive skills suggested by the APA and McPeck were chosen as hypothetical instances of discourse through which critical thinking could be identified as a productive process of co-construction. A constructivist view results: thought processes cannot be simply divided in consecutive phases such as those of linear processes but must be understood as inherently *progressive*.

Chapter 3: Methodology

In this chapter, the following elements are presented: the research context of this study; the method and the grid used for analyzing the data and assessing the level of critical thinking. A review of the literature on discourse methods is presented to contextualize our own method.

Research context

The Order of Nurses of Quebec (OIIQ) decided to establish a *networked community of nurses* on heart care in partnership with eight hospitals in three Canadian provinces and the CEFRIO (Francophone Centre for the Informatization of Organizations – Quebec, Canada). The nurses contributed to the community by sharing their expertise on heart care and discussing their practices in order to determine how health services offered to the Canadian francophone population in the field of cardiology could be improved.

The community of nurses was hosted by a server located at the OIIQ headquarters. The software used was Knowledge Forum (KF), a conferencing system conceptualized to sustain and promote knowledge-building processes through progressive discourse (Scardamalia, 2002). In addition to current conferencing system tools, Knowledge Forum has a number of unique features such as quoting, co-authoring, annotations, rise-above (a feature for bundling messages), and scaffolding (a feature that enables networked participants to intentionally structure their thoughts through "labels" or "tags") (see Figure 2, p. 28). Another interesting feature is that of "annotating messages". An annotation is a text-box in which participants intentionally create and insert a note inside a message already published. Note-taking, searching, and organizational features of Knowledge Forum create basic (though insufficient) conditions for community knowledge-building. Concerning the strategy of facilitation, participants of the community were required to "label" or "tag" messages posted using the

above-mentioned scaffolding tools. A coach-facilitator designed the "labels" or "tags" that would help participants structure thoughts as arguments, taking into consideration comments by the facilitator. The labels were:

(1) **Problem** (claim): introduction of a contextual situation that expresses concerns or difficulties concerning a practice or belief held by the writer, stating something.
(2) **Data**: introduction of facts, statistics, scientific data, research results or other works that influence a practice and would support a claim
(3) **Envisaged solutions**: hypothesizing
(4) **Questioning**: formulation of interrogations or conversed hypotheses
(5) **Opinions**: offering judgments concerning claims, data, questioning or envisaged solutions presented to explicitly react to others

The anticipated result was that higher-level reflection and knowledge-building in collaboration would be achieved if the scaffolding tool and adequate facilitation strategies were properly applied.

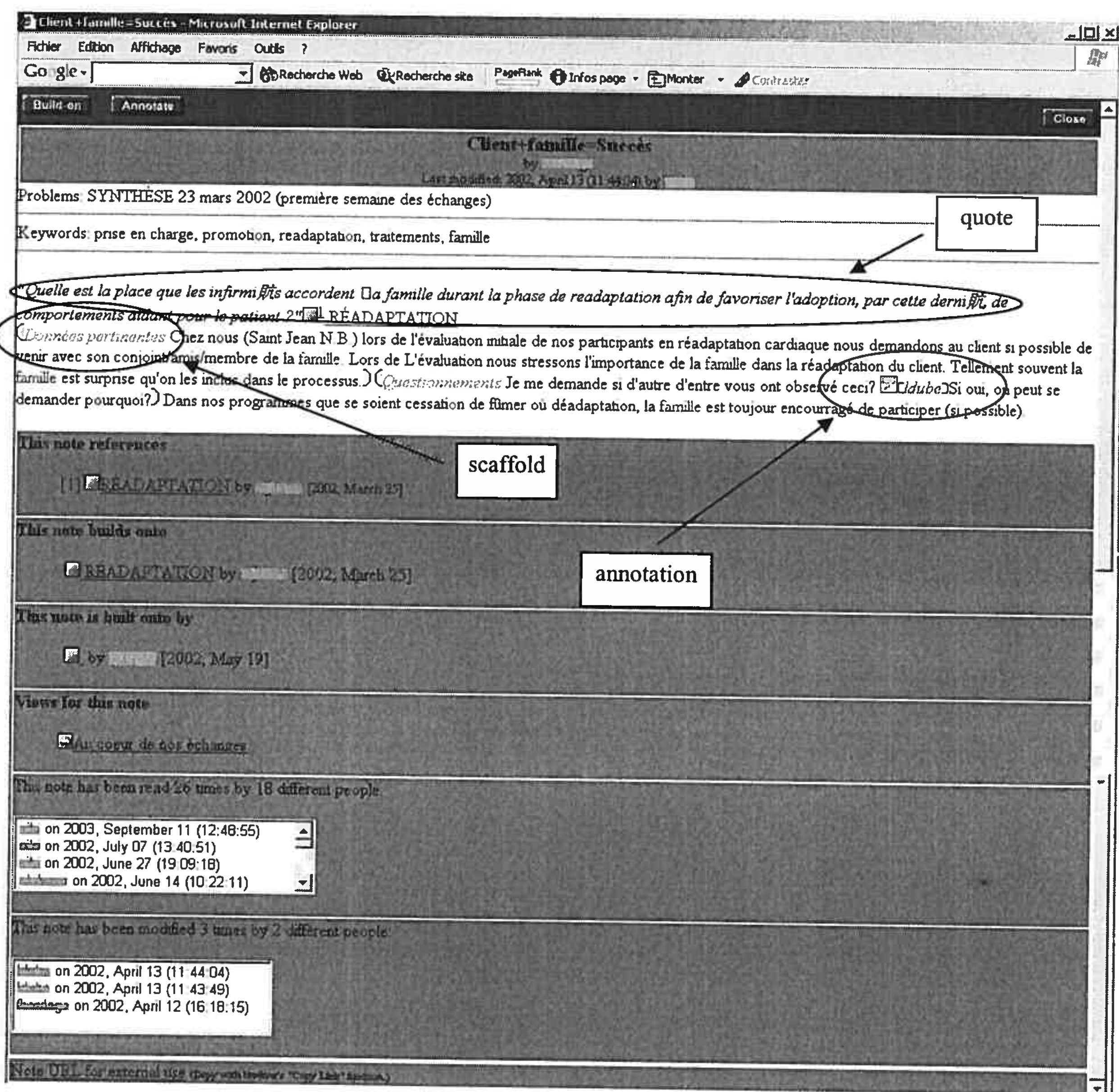

Figure 2. Screen capture of message posted by author *LB*, including an annotation by author *LD*, an in-text quote inserted by author *LB* and two scaffolds (*Data* and *Questioning*). (See p.26-27 for a detailed explanation of what are *annotations* and *scaffolds*)

Method of a networked discourse analysis

We adopted *discourse analysis* as the most suitable method to verify the research questions. The term *discourse analysis* is admittedly very ambiguous. It is normally used to refer to linguistic analysis of *naturally occurring connected speech or written discourse*. Roughly, it refers to attempts to study the organization of language above a sentence or clause, and therefore study *larger linguistic units*, such as conversational exchanges or written texts. It follows that discourse analysis is also concerned with *language use in social contexts*, and in particular with *interaction* or *dialogue* between speakers.

Following a survey of nineteen studies of computer-mediated communication on networked conversation in electronic conferences, we found that most *discourse* methodological approaches for computer conferencing were quantitative descriptions and analyses of participation. *Methods* such as controlled experiments and case studies, and *techniques* such as surveys, user interviews and computer generated statistical measurements are also being used but none to date tell us much about the *quality of the exchanges*. In an early review of methodologies for computer conferencing conducted by Mason (1991), most consisted of descriptive or quantitative accounts of messages exchanged in the conference, and follow different disciplinary perspectives such as sociology (Wagner, 1993; Nurminen, 1988; Urcot, 1993), ethnomethodology (Suchman, 1987; Bowers & Benford, 1991) and human-computer interaction (Macleod, 1993; Urquijo, 1993). According to Mason, much of the research conducted on computer conferencing systems has focused on quantitative results. Little or almost no importance was given to the assessment of the quality of the exchanges.

Based on our survey, it is notable that most research associated with quantitative content analysis conducted in educational settings (Ahern, Peck & Laycock (1992); Bullen (1998);

Craig, Gholson, Ventura & Graesser (2000); Fahy & al (2000); Garrison, Anderson & Archer (2000); Hillman (1997); Howell-Richardson & Mellar (1996); Kanuka & Anderson (1998); Mowrer (1996); Newman, Webb & Cochrane (1995). Most studies are merely descriptive accounts while few have elaborated tools for the qualitative assessment of variables such as: (1) participation, (2) critical thinking, (3) collaborative knowledge construction, (4) interaction and (5) argumentation processes. Various units of analysis were used in different studies: (a) sentence, (b) theme, (c) message, (d) illocutionary act, (e) paragraph and (f) proposition.

Literature review

Table 1 is comprised of a categorization of studies on content analysis of computer conference transcripts, from 1991 to 2004. Nineteen studies are included: ten mentioned by Rourke & al. (2001) and another nine found in our literature review. They are categorized according to each study's topic. Some authors used the same units of analysis to study the same topic. Others used different units of analysis to investigate the same topics.

Topic investigated	Unit of analysis	Study
Interaction	Message	Ahern, Peck & Laycock (1992) Mowrer (1996) Murphy, Drabier & Epps (1998)
	Paragraph	Hara, Bonk & Angeli (2000)
	Thematic	Henri (1991) McDonald (1998)* Zhu (1996)*
	Sentence	Fahy & al. (2000) Hillman (1999)*
Participation	Thematic	Blanchette (1999) Henri (1992) McDonald (1998)* Bullen (1998) Zhu (1996)*
	Sentence	Fahy & al. (2000)
	Illocutionary act	Howell-Richardson & Mellar (1996)
	Paragraph	Hara, Bonk & Angeli (2000)
Critical thinking	Thematic	Bullen (1998) Newman, Webb & Cochrane (1995)
	Message	Weiss & Morrison (1998)* Garrison, Anderson & Archer (2000a, 2000b, 2001)
	Sentence	Fahy & al. (2000)
Knowledge construction	Thematic	Kanuka & Anderson (1998) Anderson & Kanuka (1997) Zhu (1996)*
Argumentation	Message	Martunnen (1997)
		Veerman, Andriessen & Kanselaar (2002)
Metacognitive elements	Paragraph	Hara, Bonk & Angeli (2000) McDonald (1998)*
	Thematic	Henri (1992)
Collaborative learning	Message	Jiang & Meskill (2000)
	Message	Murphy, Drabier & Epps (1998)

*These 3 studies (Zhu, 1996; Weiss & Morrison, 1998; McDonald, 1998) mentioned and discussed by Rourke & al. (2001) were not found and are thus not discussed in our literature review.

Table 1. Some discourse analysis studies on networked communities (education)

The topics investigated were:

1) Interaction

Most discourse analysis methods studied focus on content analysis. In addition, interaction is the main variable. We will first introduce the studies that use the message as the unit of analysis to investigate interaction. Henri (1992) analyzed interaction using "theme" as the unit of analysis. She provides an analytical framework highlighting five dimensions of the learning process: participation, interaction, social, cognitive and metacognitive. According to Henri, CMC messages are polysemic. In her study, she provides a model to discuss the underlying meaning of messages, the problem of analysis and the richness and efficiency of exchange. Her contribution is the provision of a methodological tool for content analysis.

Ahern, Peck & Laycock (1992) use the message as a unit of analysis. They investigate the effects of teacher discourse and identify three different styles of discourse: (1) questions only, (2) statements only and (3) conversational. Participants are randomly assigned to discussion groups (questions only, statements only or conversational). Students are instructed to read and discuss two articles and type their comments. Responses were scored and analyzed quantitatively and qualitatively, and were classified by their level of connection or link to a previous message according to the following rating scale: (1) unlinked, (2) referenced, (3) linked and again (a) unsupported or (b) supported by personal experience. They validate their coding method by using an inter-rater validity test, in which they reach 90% agreement. Results support the hypothesis that a conversational style of discourse produced higher levels of student participation with a more complex interaction pattern.

Mowrer's (1996) study consists of analysis of instructor and student postings in online computer conferences. Categories are identified and interactions coded reaching 85% inter-

judge agreement. The categories for the qualitative content analysis are (1) service learning, (2) group satisfaction, (3) helpful activities, (4) student suggestions, (5) student complaints, (6) good communication, (7) questions to instructor, (8) questions to peers, (9) class structure, (10) helpful hints, (11) encouraging comments, (12) learning advancement, (13) miscellaneous comments and (14) grade assessment. Results were quantitative (such as the frequency of student postings) as well as qualitative (such as the comparison or percentage of topics posted). Mowrer's study discusses the advantages of using electronic conferencing to enhance student learning, improving classroom activities to empower students to become more active in their own learning, and plausible causes for infrequent student postings.

2) Interaction and Participation

Howell-Richardson & Mellar's (1996) study proposes a discourse analysis methodology for the study of online computer conferences based on Speech Act theory, taking the illocutionary act as the unit of analysis. Speech Act Theory provides a means to probe the structure of discourse in terms of surface relations of forms, and underlying relations of communication functions. These meanings are related to their contexts. To identify and compare patterns of interaction, four approaches were used: (1) analysis of message lengths, (2) distribution of messages among group members, (3) analysis of inter-referential links between messages and (4) interaction analysis. This study discusses some methodological issues related to the analysis of computer transcripts, especially that of the unit of analysis. Their research suggests that issues of methodology were clarified by identifying a unit representative of a discourse choice rather than a unit of meaning (the message) for the study of interaction analysis in computer-mediated communication.

Hara, Bonk & Angeli (2000) also conducted a study investigating interaction and participation but used the paragraph as the unit of analysis. Various quantitative measures were recorded to compare instructor and student participation rates. Henri's (1992) model

for content analysis of online computer conferencing was used to qualitatively analyze discourse by looking at: (1) student participation rates, (2) electronic interaction patterns, (3) social cues within student messages, (4) cognitive and metacognitive components of student messages and (5) depth of processing – superficial or deep. An inter-rater reliability test was done with a result of 75% inter-rater agreement. Transcript content analyses showed that while students tended to post a single required comment per week in the conference, their messages were lengthy, cognitively deep, embedded with peer references, and indicative of a student-oriented environment. Moreover, students were using high level cognitive skills such as inference and judgment as well as metacognitive strategies related to reflecting on experience and self-awareness.

A third study by Fahy & al. (2000) investigates interaction, participation and critical thinking. The study integrates the methods of Bullen (1998)[5] and Zhu (1997)[6]. These models are incorporated to explore (1) ease of use, (2) reliability, (3) validity, (4) theoretical support and (5) cross-disciplinary utility through the following categories: (1) vertical questioning, (2) horizontal questioning, (3) statements, (4) reflections and (5) scaffolding with a reported inter-rater reliability of 94% agreement. Results are not reported in this article. The authors claim that they are continuing to investigate and apply their tool, and are looking into increasing its reliability in addition to using it on more lengthy, complex transcripts.

3) Critical thinking

Newman, Webb & Cochrane (1995) not only analyze transcripts to give a descriptive account but elaborate a content analysis method to measure critical thinking, more specifically the quality of group learning. Based on Mason's (1991) and Collis's

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[5] See page 35 for a description of Bullen's method

[6] This study is referred by Fahy & al. (2000) but without further indication on the method used by Zhu (1997)

(1991)[7] literature reviews on the evaluation of CSCL[8] and CSCW[9], the authors of this study take up the challenge to develop research instruments based on the theories of group learning, deep learning and critical thinking. Newman, Webb & Cochrane stipulate that is it in the fourth dimension (cognitive dimension) of Henri's (1992)[10] evaluation of online computer conferencing that critical thinking skills are deployed. They also applied some concepts that Garrison (1992) developed in his model of critical thinking as a 5-stage process and some notions from Anderson's (1993)[11] questionnaires. Ten pairs of indicators were elaborated, forming a grid for analyzing critical thinking in computer conference transcripts. Reliability results are not reported. Results show evidence of critical thinking in both face-to-face and computer conference seminars. The content analysis reveals similar depths of critical thinking on several different indicators, although they find that more new ideas emerge in face-to-face seminars; and that more of the ideas in computer conferences were important, justified or linked together.

Another study analyzing critical thinking and participation patterns is that of Bullen (1998). The study was guided by the following purposes:

(1) Determining whether students are active participants, building on each other's contributions, and whether they think critically about the discussion topics; and

(2) Identifying which factors affect student participation and critical thinking. He used both quantitative and qualitative data. No reliability results are presented. The author suggests that course design, instructor interventions, content and student

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[7] Collis's (1991) literature review is mentioned by the authors without further indication on its utility in the course of their analysis
[8] Computer-supported collaborative learning
[9] Computer-supported collaborative work
[10] See page 32 for a description of Henri's method
[11] Anderson's questionnaires are mentioned by the authors without further indication on their utility in the course of their analysis

characteristics affect the degree of critical thinking in the interactive educational process.

Archer, Garrison, Anderson & Rourke (2000a, 2000b, 2001) undertake a content analysis of a number of computer conference transcripts, identifying indicators of cognitive presence (triggering event, exploration, integration, resolution & other). They achieved a .45, .65 and .84 on Holsti's coefficient of reliability.

4) Knowledge construction

Kanuka & Anderson (1997, 1998) use a constructivist interaction analysis model developed by Gunawardena, Lowe & Anderson (1997) to study learning in online computer conferences. The research focuses on the analysis of data obtained from participants in an online forum. Complementary data were collected through semi-structured telephone interviews and an online survey on the participants' perceptions of the learning environment. Analysis of the transcripts revealed that most of the online interactions are conducted at the lower phases of the reported interaction analysis model. The researchers also studied social-cognitive processes. Results show that there are many types of structures, motivations and applications of online interaction. No reliability rates are reported.

5) Collaborative learning

Murphy, Drabier & Epps (1998) address ways in which online computer conferencing impacts interaction and collaboration. Through a combination of quantitative and qualitative methods, they compare communication and interaction patterns in online computer conferencing and face-to-face environments, identify what encourages online discussion, develop strategies for fostering collaborative learning and analyze the instructors' roles of online computer conferences. Pre and post-course online computer conferencing attitude surveys were also applied. Four categories emerging from grounded theory analysis are identified: auxiliary (outside of the curriculum of the class),

instructional (led by the instructor), and student-moderated and metacognitive (shared student reflections). No indication is given on reliability test results in this study. Findings show that teachers adopt the role of facilitator instead that of content provider.

Jiang & Meskill (2000) undertake the development of a coding system for the evaluation of asynchronous Web-based instruction and learning. They employ qualitative and naturalistic methods in order to gain some understanding on the nature of online learning. They combined existing methodologies to develop a coding system for analyzing online discourse and identified categories of communication (course environment, instructor's questions, instructor's responses and students' responses) and categories of features pertaining to the online course environment (physical organization of the classroom, learning task, teacher's instructional behavior, teacher's communicative behavior, students' academic behavior and students' social behavior). The authors acknowledge that the small sample size and lack of inter-rater reliability require that the findings be considered with caution. Findings suggest that favoured features by learners in online courses, such as content richness, instructor's constructive and probing questions and responses, and the amount and quality of learner participation in discussions, are deemed supportive in students' learning and achievement.

6) Argumentation

Marttunen (1997) conducted a study seeking to clarify the feasibility of e-mail for practicing argumentation. Marttunen performed an argumentation analysis using the e-mail message as the unit of analysis. The messages were classified into three levels of argumentation: good, moderate and poor. The inter-coder reliability coefficient (r) was 0.71 ($p < 0.01$). Results indicate that the messages' level of argumentation improved during the study and that it was higher in those messages that included counter argumentation targeted against others' standpoints. The results suggested that e-mail is a feasible study tool for practicing academic argumentation.

Veerman, Andriessen & Kanselaar (2002) conducted research to discover design principles for educational tasks that provoke collaborative argumentation. They propose a technique for the analysis of argumentative fragments on question asking and argumentation based on earlier research involving the restructuring of the Verbal Observation System developed by Erkens (1997) and the Question Categorization System developed by Graesser, Person & Huber (1993). Researchers report an inter-judge reliability score of .94. Findings show that there is a relationship between question asking and argumentation. Question asking affects argumentation but is dependent on the nature of the task, the instruction, the medium and the roles of the learners (tutor and students).

Campos (2004) presents a discourse analysis method for capturing conceptual change, higher-order learning and knowledge building in networked communication processes taking place in online conferences. His method is grounded in genetic epistemology and integrates constructivist and socio-constructivist theoretical concepts. It consists of capturing different levels of logical operations by verifying frequency of use and the progressive process through which they were developed. His method follows three steps aiming to integrate: (1) logical procedures revealing the nature of the inquiry that structurally guides the following step and (2) instances of arguments to understand how the concepts, notions and ideas forming thoughts are structured. It also establishes relationships between instances of arguments across messages. The sentence was chosen as the unit of analysis in a lower descriptive phase while the message is taken as the unit of analysis in a higher interpretative phase. The author reports that inter-coder reliability rates were higher than 80% and stresses that his method is epistemologically, theoretically and methodologically coherent which in turn enables replication.

We have not found, to date, no discourse analysis studies on professional environments such as that of the networked community of nurses which provided an opportunity to

explore new ground. To do so, a grid, based on the cognitive skills presented in the previous chapter, was developed with the goal of enabling study of the role of critical thinking in the process of progressive communication in networked environments. The grid as well as the methodological steps are presented in the next section. Our review of the literature provides us with models to build our own grid.

Methodological procedures

Data Collection

The data studied consists of a collection of transcriptions of interactions occurring between the thirty-three participants of a networked community of nurses. A total of 595 messages were collected and stored within tables in Word documents. Our work was done throughout three phases.

The **first phase** entailed the collection and organizing of data by *view*[12]. All messages of each of the eleven *views* in the database were copied. Each view was created for specific theme/subject discussions.

[12] A "view" is the name of a conference in *Knowledge Forum*.

These are the titles of each view as well as the number of messages contained in each one:

Title of view	Number of messages
V1 Software Improvement	n.a.
V2 In the heart of our exchanges	139
V3 Tips and techniques	33
V4 Presentation of participants	82
V5 Welcome!	14
V6 Education programs	32
V7 Questions and novelties	28
V8 Clinical consultation	28
V9 Data collection	88
V10 Heart health kit	144
V11 This is not a goodbye!	7
Total	**595**

Table 2. Title of each view and the number of messages contained in each one

To better understand the data, it was organized in two ways: a-) build-on mode and b-) chronological order. Build-on mode indicates organizing messages sorting them by thread[13]. The messages were first organized in build-on mode and then in chronological order. Chronological order implies organizing messages following the date and time of creation. To analyze the progression of discourse, ordering messages chronologically as well as by thread was necessary. The more obvious benefit is a snapshot of progression over time. We selected only three views considered to be representative of the nurses' efforts to solve problems of their practice, as it will be made clear later on (see Chapter 4, p.57).

The nurses initiated their discussion by presenting themselves (*V4*: *Presentation of participants*)[14]. In views 1, 3 & 7 (*V1*: *Software improvement*; *V3*: *Tips and techniques*; *V7*: *Questions and novelties*), the facilitator organized parallel discussions concerning technical matters. Initially, the main view was *V2*: *At the heart of our exchanges* in which the

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[13] By "thread", we refer to the tree-like structure of sequences.

problems the community would address are discussed. Following this, heart care education programs for patients proven successful (*V6*: *Education programs*) were discussed, a clinical consultation on best practices for heart care education of the patient (*V8*: *Clinical consultation*) was conducted, data collected to enable work on the common project was collectively collected (*V9*: *Data collection*), the project was developed (*V10*: *Heart health kit*), and finally the community terminated (*V11*: *This is not a goodbye!*).

The selected views for analysis were: *V2*: At *the heart of our exchanges*, *V9*: *Data collection*, and *V10*: *Heart health kit*. This arbitrary choice followed our judgment about the quality of the exchanges.

The main goal of the networked community of nurses, established by the OIIQ and the nurses, was «*to solve problems related to their practices* ». The act of solving a problem requires individuals to state a problem, form hypotheses and test them, collect data, analyze it and finally draw conclusions (based on the scientific method of problem-solving). It is our understanding that the core of the problem-solving process for the nurses happened throughout the above-mentioned views.

In the first view (*V2*: *At the heart of our exchanges*), the nurses stated the problems, and hypothesized about what would be the best for discussion concerning nursing practices. They discussed successful and less successful programs for heart care patient education. They collectively agreed on the idea of producing an educational tool for the Canadian francophone population suffering from heart-related health problems, the **Heart health kit**. The problem stated - the need to educate the public - is clearly distinguishable in many messages. In this view, the nurses also explored various tools and programs used for patient education. They formulated further hypotheses (patients must take responsibility of their

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[14] We use the letter "V" to identify the "view" or "conference".

health) and explored various techniques already in use by nurses. One of them was that of building a *Heart health kit*.

The idea of the Heart health kit was initiated on April 10th 2002 by author *YJ* in *HHKim* (Heart health kit initiating message) during the quest for a concrete deliverable that could be developed by the joint expertise of participants in the networked community of nurses. The idea of a heart health kit generated much interest, which is confirmed by the number of messages referring to it published between April 10th 2002 and May 10th 2002. In view *V9*: *Data collection*, the nurses collected data for the elaboration of the *Heart health kit*. However, it was only in view *V10*: *Heart health kit* that the nurses elaborated upon the tool for the cardiac population.

The **second phase** consisted of identifying message sequences (tree-like structures or threads) in views *V2*: *At the heart of our exchanges*, *V9*: *Data collection* and *V10*: *Hearth health kit*. The criterion for choosing these views was that they were the most active (see Figure 3).

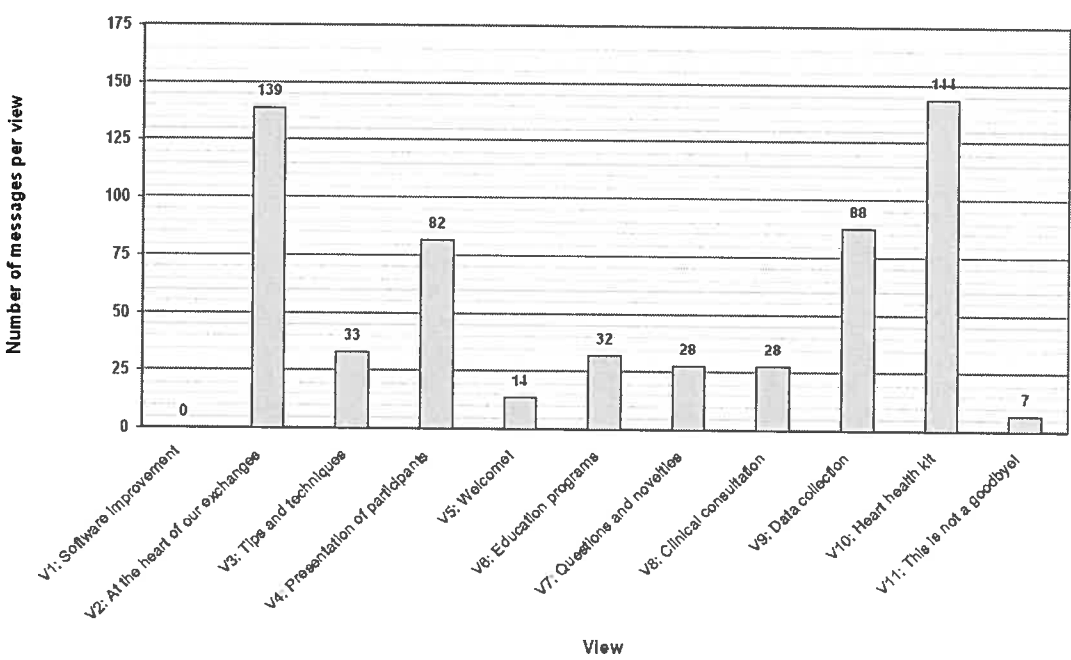

Figure 3. Activity log of all views in *Knowledge Forum*

In addition, the criteria for identifying the sequences were: length, amount of text and presence of scaffolds.[15]

The **third** phase consisted of placing each message of the chosen sequences in separate tables and assigning them appropriate codes to facilitate data organization[16]. Each table also includes other information except the body of the message such as:

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[15] Scaffolds are "tags" that users insert within their text. They allow them to categorize and structure their thoughts. They are presented in *Chapter 3* under *Research context*.
[16] See Appendices 1, 2 and 3

(a) Date of creation,

(b) Last modification of the message,

(c) Subject,

(d) Keywords,

(e) Author,

(f) Code of the message(s) to which a reference was made,

(g) Code of the message(s) which refer(s) to the message,

(h) Code of the original message to which this message is a reply

(i) Code of the message(s) which constitute(s) a reply to the message

(j) Number of times that the message was read,

(k) Number of times that the message was modified

Coding procedures

Hereunder, we introduce the grid using the core cognitive skills and indicators suggested by the consensus reached by the APA (American Philosophical Association, 1990) with a focus on McPeck's (1981) contributions. This grid will be used to identify critical thinking indicators and critical thinking skills within messages of chosen sequences.

Critical thinking indicators in the context of networked discourse	Cognitive skills of the critical thinker	Operational definition in the context of networked discourse
■ categorizing one's or another's ideas and/or data according to one's own understanding ■ decoding meaning (explaining) of one's or another's ideas and/or data according to one's own understanding ■ clarifying meaning of one's or another's ideas and/or data according to one's own understanding	Interpretation	to explain in familiar terms or language AND/OR to express the meaning or significance of one's or another's idea, statement or claim
■ examining one's or another's ideas, statements or claims ■ detecting arguments ■ analyzing arguments ■ counter-argumentation ■ comparing one's or another's ideas, statements or claims with one's or another's ideas, statements or claims with ■ questioning one's or another's ideas, statements or claims	Analysis	the abstract separation of a whole into its constituent parts in order to study the parts and their relations in order to identify the intended and actual inferential relationships among one's or another's idea, statement or claim
■ assessing validity by making a judgment based on perception, experience, situation, belief, or opinion on one's or another's ideas, statements or claims ■ assessing credibility by making a judgment based on perception, experience, situation, belief, or opinion on one's or another's ideas, statements or claims	Evaluation	to assess the credibility of statements or other representations which are accounts or descriptions of a person's perception, experience, situation, judgment, belief, or opinion; and to assess the logical strength of the actual or intended inferential relationships among statements, descriptions, questions or other forms of representation - act of ascertaining or fixing the value or worth of
■ conjecturing alternatives to one's or another's ideas, statements or claims ■ drawing conclusions by hypothesizing one's or another's ideas, statements or claims ■ making hypotheses one's or another's ideas, statements or claims	Inference	to identify and secure elements needed to draw reasonable conclusions; to form conjectures and hypotheses
■ stating results based on one's or another's ideas, statements or claims ■ justifying procedures based on one's or another's ideas, statements or claims ■ presenting arguments based on one's or another's ideas, statements or claims	Explanation	to state the results of one's or another's reasoning; to justify that reasoning in terms of the evidential, conceptual, methodological, criteriological, and contextual considerations upon which one's results were based; and to present one's reasoning in the form of cogent arguments

Table 3. Table developed to identify critical thinking within networked discourse

The grid was used for the purpose of answering our research questions:

(1) Can we assess critical thinking in networked discourse?

(2) Did the networked community of nurses *engage* in critical thinking?

(3) If so, the knowledge built was of a lower or higher level?

In this study, we analyzed discourse qualitatively and quantitatively. The qualitative analysis aimed to assess the process of collective critical thinking.

The quantitative analysis consisted of the measurement of the occurrences of critical thinking indicator in order to assess if there were patterns. Quantitative results provided insights for the qualitative analysis of the transcripts for this networked community.

Patterns mapped in the networked discourse helped us in the qualitative assessment of the level of critical thinking intrinsic to the knowledge building and problem-solving process of the networked community of nurses. The pattern was the inter-message ***looping back, starting over and jumping ahead***. The dialogic dimension of the critical thinking process was assessed by scrutinizing the progressive development of a common meaning between participants following this inter-message pattern. Dialogue comes from the Greek *dialogos – dia,* meaning "through" or "with each other", and *logos*, meaning "the word" or "the meaning". The reflective dimension of the critical thinking process was assessed by examining the progressive establishment of direction for further deliberation and creation of deeper levels of inquiry. The recursive dimension of the critical thinking process was assessed by looking at the extent in which participants *schematized* – constructed and reconstructed meanings, following Grize's model of communication (1991) and contributions brought by Campos (2003).

Since critical thinking is a dialogic, reflective and recursive process people engage in, it can be qualified as *weak* or *strong* depending on the extent of argument analysis and evaluation within the networked progressive discourse (McPeck, 1981). According to Campos (2003), communication can progress from lower to higher cognitive levels. Varying levels are apparent in different types of communities. The level of communication is generally low when intentionality is at a cognitive primary level (broadcasting communities). Similarly, the level of communication is regular when intentions are at the level of cognitive comprehension (collegial communities). The level of communication is high when participants intentionally search for ways to shape and advance ideas together (interpretive or knowledge-building communities).

In the application of the model of progressive construction of communication (Campos, 2003), weak critical thinking is associated with the *compania* level of cognitive networked communication (collegial community) in which a participation is modest, exchanges between participants do not trigger further reflection and learning is mainly assimilatory. Strong critical thinking is associated with the *collaboratio* level of cognitive networked communication (knowledge-building community), in which participation is strong, exchanges demonstrate deeper understanding of subjects and learning is mainly accomodatory (see Campos, 2003). Critical thinking is impossible in a broadcasting community (the lowest level of collaboration reported by Campos) because it demands a minimum of reflection, which is absent in communities where participants only "publish", "broadcast" ideas without further discussion. Critical thinking was thus categorized as either *weak* or *strong* by examining the instances of the looping back, starting over and jumping ahead inter-message pattern in the networked progressive discourse.

We followed two steps to code and analyze the data:

Step A - identification of a common theme linking messages of a given sequence.

Step B - **1)** identification of the parts of an argument within messages and messages with arguments and **2)** identification of critical thinking indicators and cognitive skills within messages pertaining to the theme of the sequence.

Each step embeds a different dimension of the critical thinking analysis in the progressive discourse of the networked community of nurses.

Step A - Identification of a common theme linking messages of a given sequence

A sequence within a networked discourse is a chain of messages created as a result of intentional use of the build-on feature (reply to) by nurses. Messages within a sequence follow a chronological order, meaning that a first message is created and others follow in a tree-like structure. The first step in identifying a common theme linking messages of a given sequence is reading the messages and identifying the main topic(s) and/or theme(s) of each. Most messages contain more than one topic and/or theme. In the case of a message containing more than one topic and/or theme, one of them will be arbitrarily chosen, following Grize's & Le Bonniec (1991) procedure.

Hereunder is an example of the identification of the topic of the message.

E029	
Creation date :	23 Mars 2002
Subject :	**PRISE EN CHARGE**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	
Author :	MJP
This note references:	[1] **E087** by MJP
This note is referenced by :	**E130** by JH **E128** by JH

<table>
<tr><td>This note is built-on to :</td><td colspan="4">E026 by MJP</td></tr>
<tr><td>This note is built-on to by :</td><td colspan="4">E041 by CG
E056 by FB
E107 by JL
E111 by GB
E120 by YJ
E127 by JH
E128 by JH</td></tr>
<tr><td>Information :</td><td colspan="4">This note has been read 79 times by 29 different people
This note has been modified 3 times by the same person</td></tr>
<tr><td>Argument detection</td><td>Topic(s)/Theme(s) of message:
1-) patient responsibility
2-) nursing strategies to adopt
3-)

Theme of sequence:
Patient responsibility concerning his/her health</td><td>Step 1</td><td>Step 2</td><td>Step 3</td></tr>
<tr><td colspan="2">PRISE EN CHARGE :

Problématique La problématique soulevée au sujet de la prise en charge du patient est la non modification par ce dernier des comportements nuisibles à sa santé.

Il semble important, selon vos réflexions, que le patient se responsabilise davantage à l'égard de sa santé.

Pistes de solutions À ce sujet, les pistes de solutions soulevées réfèrent à l'importance de tenir compte des besoins propres de chaque patient et de suivre son niveau d'adaptation à la maladie pour accompagner et guider ce dernier dans le processus de prise en charge.

Questionnements Quelles sont les stratégies infirmières à cibler spécifiquement afin d'accompagner le patient dans la prise en charge de son état et l'amener à modifier les comportements nuisibles à sa santé?

Quels sont les modèles de changement de comportement qui peuvent nous guider dans nos réflexions ?

Suggestions :

Je vous invite à initier votre réflexion à partir de cette note grâce à la fonction élaborer.</td><td></td><td></td><td></td></tr>
</table>

Figure 4. Example of the identification of topic(s)/theme(s) of a message

Once the topic(s) and/or theme(s) of each message of a given sequence is identified, the topic(s) and/or theme(s) of each message is compiled in a chart to discern whether a

common theme links the messages. It is possible that a message in a sequence will not necessarily pertain to the common theme linking all others. In such cases, this message is disregarded and is not included in the sequence. The common themes linking messages of a given sequence are sometimes obvious. In any case, the coder will have to judge which theme constitutes for him/her the main theme of the sequence, and make an arbitrary selection. The unit of analysis in this step is the *message*. Once the theme of a sequence is identified, it is time to proceed to the second step of the analysis of critical thinking within the networked discourse. This consists of identifying the critical thinking indicators emerging from messages related to a theme of a given sequence.

Step B

The method is as follows:

Step1 – Identification of arguments

Step 2 – Identification of CT indicators and cognitive skills

Step 1 - Identification of arguments

The following instrumental definition of an argument is adopted; it is close to that of Hegenberg (1991): "*an argument is a unit of thought that has one or more premises leading to a conclusion*". Imperative sentences and questions are eliminated because they have a rhetorical rather than an argument use (Campos, 2004, Hegenberg, 1991).

Hereunder is an example of the identification of an argument.

E029	
Creation date :	23 Mars 2002
Subject :	**PRISE EN CHARGE**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	
Author :	MJP

This note references:	[1] **E087** by MJP
This note is referenced by :	**E130** by JH **E128** by JH
This note is built-on to :	**E026** by MJP
This note is built-on to by :	***E041*** by CG ***E056*** by FB ***E107*** by JL ***E111*** by GB ***E120*** by YJ ***E127*** by JH ***E128*** by JH
Information :	This note has been read **79** times by **29** different people This note has been modified **3** times by **the same** person

Argument detection ↘ E029 – yes / Pa(1) & Pb(1) → CLa	**Topic(s)/Theme(s) of message:** **1-) patient responsibility** **2-) nursing strategies to adopt** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
PRISE EN CHARGE :		OUT		
Problématique La problématique soulevée au sujet de la prise en charge du patient est la non modification par ce dernier des comportements nuisibles à sa santé.		Pa(1)		
Il semble important, selon vos réflexions, que le patient se responsabilise davantage à l'égard de sa santé.		Pb(1)		
Pistes de solutions À ce sujet, les pistes de solutions soulevées réfèrent à l'importance de tenir compte des besoins propres de chaque patient et de suivre son niveau d'adaptation à la maladie pour accompagner et guider ce dernier dans le processus de prise en charge.		CLa		
Questionnements Quelles sont les stratégies infirmières à cibler spécifiquement afin d'accompagner le patient dans la prise en charge de son état et l'amener à modifier les comportements nuisibles à sa santé?		OUT		
Quels sont les modèles de changement de comportement qui peuvent nous guider dans nos réflexions ?		OUT		
Suggestions : [1]		OUT		
Je vous invite à initier votre réflexion à partir de cette note grâce à la fonction élaborer.		OUT		

Figure 5. Example of the identification of the parts of an argument within a message

Initially, sentences that constitute premises (code tag *P*) and sentences that constitute a conclusion (code tag *CL*) were identified. Interrogations and imperatives are coded with the code tag ***OUT***.

Message E029, above, has an argument with two premises:

Pa(1) : *La problématique soulevée au sujet de la prise en charge du patient est la non modification par ce dernier des comportements nuisibles à sa santé.*
Pb(1) : *Il semble important, selon vos réflexions, que le patient se responsabilise davantage à l'égard de sa santé.*

It also includes one conclusion. It is:

CLa : *À ce sujet, les pistes de solutions soulevées réfèrent à l'importance de tenir compte des besoins propres de chaque patient et de suivre son niveau d'adaptation à la maladie pour accompagner et guider ce dernier dans le processus de prise en charge.*

Once the detection of arguments within each message is completed, the message is tagged YES if it contains one or more arguments and NO if it doesn't contain one or more arguments. Messages will be marked in the following way: E029 – yes / Pa(1) & Pb(1) → CLa

Step 2 - Identification of critical thinking indicators and cognitive skills within the messages related to a theme of a sequence

To identify critical thinking indicators within messages, we applied the already presented Table 3. For that, we assigned a code to each critical thinking indicator (Table 4, first column). CT indicators we identified after cognitive skills (Table 4, second column).

Critical thinking indicators in the context of networked discourse	Cognitive skills of the critical thinker	Operational definition in the context of networked discourse
(int1) categorizing one's or another's ideas and/or data according to one's own understanding **(int2)** decoding significance (explaining) of one's or another's ideas and/or data according to one's own understanding **(int3)** clarifying meaning of one's or another's ideas and/or data according to one's own understanding	Interpretation **(INT)**	to explain in familiar terms or language AND/OR to express the meaning or significance of one's or another's idea, statement or claim
(ana1) examining one's or another's ideas, statements or claims **(ana2)** detecting arguments **(ana3)** analyzing arguments **(ana4)** counter-argumentation **(ana5)** comparing one's or another's ideas, statements or claims with one's or another's ideas, statements or claims with **(ana6)** questioning one's or another's ideas, statements or claims	Analysis **(ANA)**	the abstract separation of a whole into its constituent parts in order to study the parts and their relations in order to identify the intended and actual inferential relationships among one's or another's idea, statement or claim
(eva1) assessing validity by making a judgment based on perception, experience, situation, belief, or opinion on one's or another's ideas, statements or claims **(eva2)** assessing credibility by making a judgment based on perception, experience, situation, belief, or opinion on one's or another's ideas, statements or claims	Evaluation **(EVA)**	to assess the credibility of statements or other representations which are accounts or descriptions of a person's perception, experience, situation, judgment, belief, or opinion; and to assess the logical strength of the actual or intended inferential relationships among statements, descriptions, questions or other forms of representation - act of ascertaining or fixing the value or worth of
(inf1) conjecturing alternatives to one's or another's ideas, statements or claims **(inf2)** drawing conclusions by hypothesizing one's or another's ideas, statements or claims **(inf3)** making hypotheses one's or another's ideas, statements or claims	Inference **(INF)**	to identify and secure elements needed to draw reasonable conclusions; to form conjectures and hypotheses
(exp1) stating results based on one's or another's ideas, statements or claims **(exp2)** justifying procedures based on one's or another's ideas, statements or claims **(exp3)** presenting arguments based on one's or another's ideas, statements or claims	Explanation **(EXP)**	to state the results of one's or another's reasoning; to justify that reasoning in terms of the evidential, conceptual, methodological, criteriological, and contextual considerations upon which one's results were based; and to present one's reasoning in the form of cogent arguments

Table 4. Codes assigned to categories and sub-categories

The unit of analysis for the identification of CT indicators is an *argument related to the common theme of the sequence.*

Hereunder is an example of the identification of the CT indicators and cognitive skills within the corpus of the message. (Table 5)

E029	
Creation date :	23 Mars 2002
Subject :	**PRISE EN CHARGE**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	
Author :	MJP
This note references:	[1] **E087** by MJP
This note is referenced by :	**E130** by JH **E128** by JH
This note is built-on to :	**E026** by MJP
This note is built-on to by :	***E041*** by CG ***E056*** by FB ***E107*** by JL ***E111*** by GB ***E120*** by YJ ***E127*** by JH ***E128*** by JH
Information :	This note has been read **79** times by **29** different people This note has been modified **3** times by **the same** person

Argument detection E029 – yes / Pa(1) & Pb(1) → CLa	**Topic(s)/Theme(s) of message:** **1-) patient responsibility** **2-) nursing strategies to adopt** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
PRISE EN CHARGE :		OUT	(int2)	INT
(Problématique La problématique soulevée au sujet de la prise en charge du patient est la non modification par ce dernier des comportements nuisibles à sa santé.		Pa(1)		
Il semble important, selon vos réflexions, que le patient se responsabilise davantage à l'égard de sa santé.)		Pb(1)		
(Pistes de solutions À ce sujet, les pistes de solutions soulevées réfèrent à l'importance de tenir compte des besoins propres de chaque patient et de		CLa		

suivre son niveau d'adaptation à la maladie pour accompagner et guider ce dernier dans le processus de prise en charge.			
Questionnements **Quelles sont les stratégies infirmières à cibler spécifiquement afin d'accompagner le patient dans la prise en charge de son état et l'amener à modifier les comportements nuisibles à sa santé?**	OUT	**(ana6)**	**ANA**
Quels sont les modèles de changement de comportement qui peuvent nous guider dans nos réflexions ?	OUT		
Suggestions :	OUT		
Je vous invite à initier votre réflexion à partir de cette note grâce à la fonction élaborer.	OUT		

Table 5. Example of the identification of CT indicators within a message

MJP, author of the above message, has synthesized the content of the messages posted by the nurses during the first week of the exchanges into a single message (E029)[17]. The author, who is the facilitator of the networked community of nurses, is trying to summarize the discussion that took place during the prior week. To do so, she is explaining what seems to be the main *problem* that nurses encounter when faced with recurring cardiac patients - patient responsibility. She also brings to the attention of the readers that if patients need to be responsible of their own health, then nursing strategies should be adopted. She asks her colleagues (nurse participants) which nursing strategies should be adopted and which behavioural change models could be used to help them develop nursing strategies.

In the example above, author *MJP* demonstrated ***interpretation*** and ***analytical*** skills, which respectively refer to the ***INT*** and ***ANA*** codes.

[17] « *Synthesizing* » means « *packaging* » many messages in an upper folder by using the *Knowledge Forum rise-above* tool.

The sequence, in which this message is part of, is labeled with the theme "patient responsibility". To identify the CT indicators present in this message, one must always refer to the tool for the analysis of CT within networked discourse and identify the CT indicator that pertains to the theme of the sequence. In this example, the CT indicators identified are: ***int2*** and ***ana6***. The author decodes the significance of the problem associated to patient responsibility: non-modification of habits that are harmful to his/her health. The fact that the author uses the terms "it seems important, according to your reflection on the subject that..." (*il semble important, selon vos réflexions*) indicates that she is trying to interpret, according to her understanding of the messages posted, what other authors deem important and how that problem should be handled. That portion of the message was labeled ***int2*** - *decoding significance (explaining) of one's or another's ideas and/or data according to one's own understanding.*

The second portion of message E029 consists of two questions. The first question is: "which are the nursing strategies that could be adopted to help patients be responsible of their own health?" the second question is: "which behavioural change models can be used for the development of nursing strategies?" refer to the CT indicator ***ana6*** – questioning one's or another's ideas, statements or claims.

Once the coding of the corpus of the message is done, the coder must look at the annotations. If there are any authors might have inserted, the author codes them following the same procedure. In the case of message E029, there are no annotations attached to it.

Chapter 4: Data and analysis

In this section, the reader will find the analysis of our data. In order to facilitate reading of the results, each view will be explored starting by *V2*: *At the heart of our exchanges*, followed by *V9*: *Data collection* and *V10*: *Heart health kit*. Quantitative and qualitative data are presented followed by analyses of the results.

The quantitative data consists of the content of the chosen sequences, categorized as arguments, cognitive skills and CT indicators. In the analysis, we made an effort to demonstrate the schematization process – construction and reconstruction of meanings – that occurred within the chosen sequences and the presence of inter-message loops. In addition, we applied the model of progressive construction of communication (Campos, 2003) in order to assess the level of critical thinking deployed by the nurses in the networked community. Critical thinking is qualified as *weak* or *strong* depending on the extent of argument analysis and evaluation within the progressive networked discourse.

In the next section, we present each view and the sequences chosen for study.

View V2: At the heart of our exchanges

In view *V2*: *At the heart of our exchanges*[18], nurses discussed successful and less successful programs for heart care patient education. This view states the problems at stake and subsequent hypothesizing, which led to a collective agreement on the idea of producing a teaching[19] tool for the Canadian francophone population suffering from heart-related health problems. In this view, the problem (the need to educate the public) and the exploration of various tools and programs used for patient education emerge in many

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[18] See data collection section for an explanation of the reasons we kept the initial labeling of the views.

[19] By « teaching tool », the nurses mean an instrument to teach patients to be responsible towards of their health and the families to help them achieve this goal.

messages. The nurses formulated hypotheses and explored various teaching tools already in use. Five sequences (labeled *A*, *F*, *H*, *J* and *P*)[20] were selected for analysis based on length, amount of text and presence of scaffolds.

The sequences

Sequence A[21]

The first sequence was *A* of *V2: At the heart of our exchanges.*[22] The theme linking all messages of sequence *A* was *patient responsibility concerning his/her health*. The sequence was made up of sixteen messages and sixteen annotations, posted between March 23rd and April 20th, 2002. Message *E029* was the one that initiated the sequence; it consisted of a summary of the discussion of the prior week. The following is a graphic representation of sequence *A*.

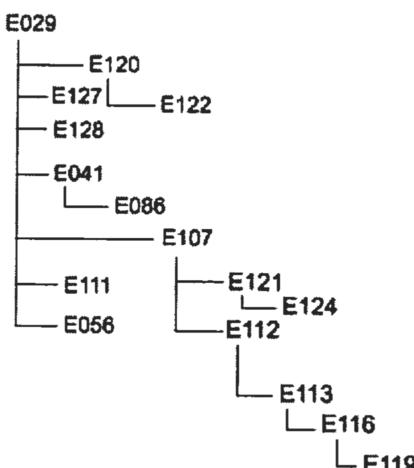

Figure 6. Graphic representation of sequence *A* of *V2*: *At the heart of our exchanges*.

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[20] See Appendix 4
[21] The sequence names (A, F, etc.) do not follow the alphabetical order.
[22] See Appendix 5

Sequence F

The second sequence was *F* of *V2: At the heart of our exchanges.*[23] The theme linking all messages of sequence *F* was *heart care promotion and prevention strategy*. The sequence was made up of ten messages and no annotations, posted between March 15th and March 29th, 2002. Message *E003* was the one that initiated the sequence; it consisted of a concern expressed by author *IG* concerning nursing strategies for the promotion of heart care. The following is a graphic representation of sequence *F*.

Figure 7. Graphic representation of sequence *F* of *V2*: *At the heart of our exchanges*.

Sequence H

The third sequence was *H* of *V2: At the heart of our exchanges*[24]. The theme linking all messages of sequence *H* was *patient education*. The sequence was made up of four messages and no annotations, posted between March 17th and March 20th, 2002. Message *E005* was the one that initiated the sequence; it consisted of a concern expressed by author

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[23] See Appendix 6
[24] See Appendix 7

LL regarding patient education given the short duration of his/her hospitalization. The following is a graphic representation of sequence *H*.

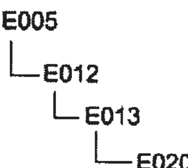

Figure 8. Graphic representation of sequence *H* of *V2*: *At the heart of our exchanges*.

Sequence J

The fourth sequence was *J* of *V2: At the heart of our exchanges*[25]. The theme linking all messages of sequence *J* was also *patient education*. The sequence was made up of five messages and no annotations, posted between March 19th and April 1st, 2002. Message *E014* was the one that initiated the sequence; it consisted of a conclusion on patient education drawn from author *RD*'s professional experience. The following is a graphic representation of sequence *J*.

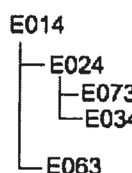

Figure 9. Graphic representation of sequence *J* of *V2*: *At the heart of our exchanges*.

Sequence P

The fifth sequence was *P* of *V2: At the heart of our exchanges*[26]. The theme linking all messages of sequence *P* was also *patient education*. The sequence was made up of two messages and no annotations, posted on March 12th and March 29th, 2002. Message *E019*

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[25] See Appendix 8
[26] See Appendix 9

was the one that initiated the sequence; it consisted of a positive assessment of the importance that should be allocated to the patients' needs. The following is a graphic representation of sequence *P*.

E019
└E062

Figure 10. Graphic representation of sequence *P* of *V2*: *At the heart of our exchanges*.

Quantitative data

Arguments

To identify arguments, we followed the model developed by Campos (2004) based on previous work by Grize (1991) and Hegenberg (1991).

As shown in Figure 11, eight of the sixteen messages (50%) present within sequence *A* of *V2*: *At the heart of our exchanges* contained arguments. In sequence *F*, seven out of the ten messages (70%) contained arguments. In sequence *H*, two out of the four messages (50%) contained arguments. In sequence *J*, three out of the five messages (60%) contained arguments whereas in sequence *P*, both messages (100%) contained arguments.

V2*: *At the heart of our exchanges

Figure 11. Presence of arguments within sequences of *V2*: *At the heart of our exchanges*.

As shown in Figure 12, in sequence *A* of *V2*: *At the heart of our exchanges*, premises were mostly found within the CT skills *EXP* (76%) and *INF* (16%). In sequence *F*, premises were mostly found within the CT skills *EXP* (59%), *INF* (18%) and *ANA* (18%). In sequence *H*, premises were mostly found within the CT skills *EXP* (83%) and *INT* (17%). In sequence *J*, premises were mostly found within the CT skills *EXP* (72%), *INF* (16%) and *EVA* (14%). In sequence *P*, premises were mostly found within the CT skills *EVA* (67%) and *EXP* (33%).

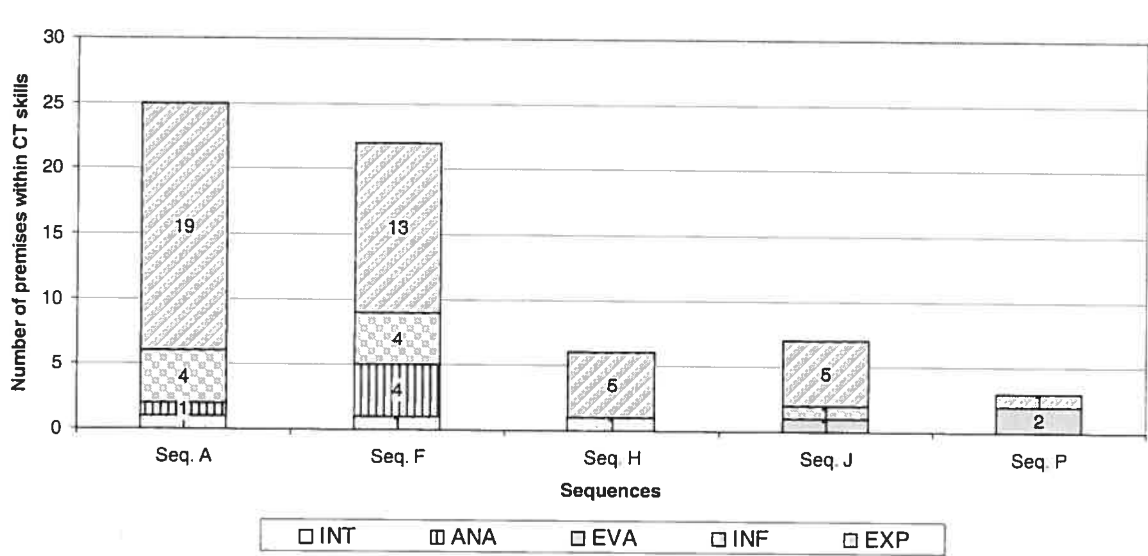

Figure 12. Presence of premises with regards to CT skills within sequences of *V2*: *At the heart of our exchanges*.

As shown in Figure 13, in sequence *A* of *V2*: *At the heart of our exchanges*, conclusions were mostly found within the CT skills *INF* (56%) and *EXP* (44%). In sequence *F*, conclusions were mostly found within the CT skills *EXP* (62%), *ANA* (13%), *INT* (12%) and *INF* (13%). No conclusions were found within the CT skill *evaluation*. Interestingly enough, only conclusions presented the CT skill *interpretation*. In sequence *H*, conclusions were only found within the CT skills *EXP* (50%) and *INT* (50%). In sequence *J*, conclusions were only found within the CT skills *EVA* (34%), *EXP* (33%) and *INF* (33%). In sequence *P*, conclusions were only found within the CT skills *EXP* (50%) and *EVA* (50%).

V2: At the heart of our exchanges

Figure 13. Presence of conclusions with regards to CT skills within sequences of *V2*: *At the heart of our exchanges.*

Critical thinking indicators

Hereunder, Table 6 illustrates the number and type of CT indicators identified within sequences *A*, *F*, *H*, *J* and *P* of *V2*: *At the heart of our exchanges.*

Sequences / CT indicators	Seq. A (16 messages) (14 annotations)	Seq. F (10 messages) (0 annotations)	Seq. H (4 messages) (0 annotations)	Seq. J. (5 messages) (0 annotations)	Seq. P (2 messages) (0 annotations)	**Total** (37 messages) (14 annotations)
int1	0	0	0	0	0	**0**
int2	2	2	1	0	0	**5**
int3	3	1	0	0	0	**4**
ana1	1	0	0	0	0	**1**
ana2	0	0	0	0	0	**0**
ana3	0	3	0	0	0	**3**
ana4	0	1	0	0	0	**1**
ana5	0	0	0	0	0	**0**
ana6	6	4	2	1	0	**13**
eva1	3	3	1	3	2	**12**
eva2	1	0	0	0	0	**1**
inf1	1	0	0	0	0	**1**
inf2	11	2	1	4	0	**18**
inf3	11	1	0	1	0	**13**
exp1	11	9	1	0	0	**21**
exp2	3	7	1	4	1	**16**
exp3	5	8	0	0	0	**13**
Total	**58**	**41**	**7**	**13**	**3**	

Table 6. Frequency of CT indicators within all sequences of *V2*: *At the heart of our exchanges.*

Sequence A

CT indicators were identified within all sixteen messages of this sequence. Of the sixteen annotations, only fourteen were coded and contained CT indicators. The first annotation (*ann.1.E128*) that was excluded was a repeat and the second one (*ann.1.E041*) consisted of technical information posted by the facilitator of the networked community of nurses. In total, fifty-eight CT indicators were identified within the messages and annotations combined. Forty-two CT indicators were identified within the sixteen messages, and sixteen CT indicators were identified within the fourteen annotations. The CT indicators that were most frequently identified within the messages of sequence *A*, in terms of percentage, were respectively: *exp1* (26%), *inf3* (18%), *inf2* (17%), *exp3* (8%) and *ana6* (9%). In terms of cognitive skills, authors manifested the following ones in order of importance: *explanation* (35%), *inference* (34%), *evaluation* (14%), *analysis* (10%) and *interpretation* (7%).

Sequence F

CT indicators were identified within all ten messages of this sequence. In total, forty-one CT indicators were identified within the messages. The CT indicators that were most frequently identified within the messages of sequence *F*, in terms of percentage, were respectively: *exp1* (22%), *exp3* (20%), *exp2* (17%), *ana6* (10%) and *ana3* (7%). In terms of cognitive skills, authors manifested the following ones in order of importance: *explanation* (59%), *analysis* (20%), *interpretation* (7%), *evaluation* (7%) and *inference* (7%).

Sequence H

CT indicators were identified within all four messages of this sequence. In total, seven CT indicators were identified within the messages. The CT indicators that were most frequently identified within the messages of sequence *H*, in terms of percentage, were respectively: *ana6* (29%), *int2* (14%), *eva1* (14%), *inf2* (14%), *exp1* (14%) and *exp2* (14%). In terms of cognitive skills, authors manifested the following ones in order of importance: *analysis* (29%), *interpretation* (14%), *evaluation* (14%), *inference* (14%) and *explanation* (14%).

Sequence J

CT indicators were identified within all five messages of this sequence. In total, thirteen CT indicators were identified within the messages. The CT indicators that were most frequently identified within the messages of sequence *J*, in terms of percentage, were respectively: *exp2* (31%) and *inf2* (31%) followed by *eva1* (23%) and *inf3* (8%). In terms of cognitive skills, authors manifested the following cognitive skills in order of importance: *inference* (38%), *explanation* (31%), *evaluation* (23%) and *analysis* (8%). No indicators of *interpretation* were found in this sequence.

Sequence P

CT indicators were identified in both messages of this sequence. In total, three CT indicators were identified within the messages. The only CT indicators that were identified within the messages of sequence *P* were *eva1* (67%) and *exp2* (33%). In terms of cognitive skills, authors manifested the following ones: *evaluation* (67%) and *experience* (33%).

Qualitative data

The data analyzed in this section consists of the messages in the chosen sequences. The data was analyzed following two steps, as discussed in Chapter 3. First, we identified the common theme linking messages of a given sequence. Once having identified the theme, we identified the premises and conclusions present within messages that presented arguments. We then identified the CT indicators within messages pertaining to the theme of the sequence followed by the interpretation of the CT indicators in terms if cognitive skills.

In addition, the reader will also find conceptual maps (Tolman, 1948) of the schematization nurses engaged in when constructing and reconstructing meaning.

The following icons were used in the conceptual maps:

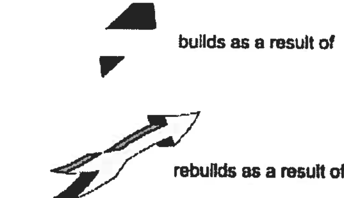

Figure 14. Icons used to illustrate schematization.

Sequence A

The following chart presents the CT indicators, CT skills and the location, when applicable, of the premises and conclusion of the arguments. The theme linking the messages was *patient responsibility concerning his/her health.*

Sequence *A – V2*: *At the heart of our exchanges*

Msg	Presence of argument	Argument parts	CT indicator	Cognitive skill
E029	yes (1)	Pa(1) Pb(1) → CLa	**(int2) explains meaning** of patient responsibility	INT
			(ana6) questions nursing strategies to adopt and behavioral change models for achieving patient responsibility	ANA
E120	no		**(int3) clarifies** what constitutes a reward for certain patients and what doesn't for others	INT
			(inf3) hypothesizes on the need for a patient reward	INF
			(int2) decodes significance of patient reward	INT
ann.1 E120	no		**(eva1) assesses validity** (+) on the need for a patient reward	EVA
ann.2 E120	yes (1)	CLa ← Pa(1)	**(inf3) hypothesizes** (+) on the need for a patient reward	INF
ann.3 E120	yes (1)	Pa(2) → CLa	**(eva1) assesses validity** (-) on the need for a patient reward	EVA
E122	no		**(ana6) questions idea** of a patient reward	ANA
	no		**(eva2) assesses credibility** (+) of patient reward based on situation	EVA
ann.1 E122	no		**(exp2) justifies procedure** of the use of such a patient reward for cardiac patients	EXP
ann.2 E122	no		**(int2) decodes significance** of "reward"	INT
ann.3 E122	no		**(inf3) hypothesizes** (+) on the possibility of conducting a survey on the patients / suggestion made to E122 author	INF
ann.4 E122	no		**(inf3) hypothesizes** (+) on the possibility of conducting a survey on the patients / suggestion made to E122 author	INF
ann.5 E122	yes (1)	Pa(1) → CLa	**(exp2) justifies procedure** by relating to his/her own experience	EXP
E127	yes (3)	Pa(1)	**(ana1) examines the possibility** of grouping theoretical models	ANA
		Pb(1)	**(inf3) hypothesizes** on the need for a study on a plausible model	INF
		→ CLa Pc(1) Pd(1)	**(exp1) states results** based on his/her Master's studies on patient motivation	EXP

		→ CLb		
			↓	
		CLc ←	**(inf2) draws conclusions** by hypothesizing on the need for intervention on patient motivation	INF
			↓	
		Pf(1) Pg(1) Ph(1) Pi(1)	**(exp2) justifies procedures** based on his/her Master's studies	EXP
ann.1 E127	**no**		**(eva1) assesses validity** (+) on the need for a study on a plausible model	
E128	**yes (2)**	Pa(2) → CLa Pb(1) Pc(1) Pd(2) Pe(1) → CLb	**(exp3) presents arguments** for the partial use of established models	EXP
ann.1 E128			**OUT**	
ann.2 E128	**no**		**(inf3) hypothesizes** on the possible use of the McEwen model	INF
ann.3 E128	**no**		**(eva1) assesses validity** (+) of model presented in ann.2 E128	EVA
E041	**no**		**(inf1) conjectures alternatives** by proposing the McEwen model	INF
			(eva1) assesses validity (+) of using the best of each model	EVA
			(eva1) assesses validity (-) of models Lazarus & Folkman and Health Belief	EVA
			↓	
			(exp1) states results on the limitations of the 2 models he/she presents	EXP
ann.1 E041			**OUT**	
E086	**no**		**(eva1) assesses validity (+) of statement** made in E041 i.e. using the best of each model	EVA
			↓	
			(exp1) states results - Pender model has all components of all the other models	EXP
E107	**no**		**(inf3) hypothesizes** on the idea of having the patient sign a contract to obligate him to become responsible of his health	INF
E111	**yes (2)**	Pa(1)	**(int3) clarifies meaning** of lifestyle and behavioral change	INT
			↓	
		Pb(1)	**(exp1) states results** based on data from studies	EXP
		→ CLa	**(inf2) draws conclusion** on the pertinence of the sole use of a	INF

			survivor kit ↓	
			(exp3) presents arguments (use of counseling) against the sole use of a survival kit	EXP
			(ana6) questions quality nurse's vision of patient education	ANA
		Pf(2) → CLb	**(exp3) presents arguments** for the use of a personalized patient education in addition to the use of a survival kit	EXP
E124	**no**		**(exp2) justifies procedure** - relates to patient contract signature - a mandatory procedure at his/her institution	EXP
E121	**yes** **(1)**	Pa(1)	**(exp1) states results** - patient contract signature is a mandatory procedure at his/her institution	EXP
		→ CLa	**(inf2) draws conclusions** (+) on utility of a "cardiac patient contract"	INF
E112	**yes** **(1)**		**(exp1) states results** - a type of "patient contract" is used in his/her institution in cardiac rehabilitation programs	EXP
		CLa ← Pa(2)	**(inf2) draws conclusions** (+) on the heightening of patient responsibility upon signature of a "patient contract"	INF
E113	**yes** **(1)**		**(exp1) states results** - patient responsibility is also a problem in his/her institution hence medical prescription is a must ↓	EXP
		CLa ← Pa(2)	**(inf3) hypothesizes (-)** on the need for a medical prescription to a rehabilitation program for cardiac patients; patients should rather be sensitized to the idea of a healthy lifestyle than have a medically prescribed rehab program to join	INF
ann.1 E113			**(exp2) justifies procedures** – patients are also reticent to joining a rehab program even if medically prescribed - bases himself/herself on situation encountered at his/her institution	EXP
ann.2 E113			**(eva1) assesses validity of medically prescribing a rehab program to a patient (-)** patients are more cooperative and more inclined to following a rehab program when medically prescribed – bases himself/herself on personal observation at his/her institution	EVA
E116	**no**		**(inf2) draws conclusions (-)** patients do not seem to follow rehab program even if medically prescribed	INF
			(ana6) questions idea of the patient contract - patient contract might in fact make the patient feel guilty if he/she doesn't succeed	ANA
E119	**no**		**(exp1) states results** – explains how contract is administered in his/her institution	EXP
			(inf3) hypothesizes on the possibility of patient guilt towards mandatory contract signature	INF
			(exp1) states results - certain patients, at his/her institution, mention that they should have lifestyle changes earlier	EXP
			(inf3) hypothesizes – guilt will not entice patients to successfully complete a 12-week rehab program	INF
E056	**yes**	Pa(1)	**(exp1) states results** - presents the case of a patient who	EXP

	(2)		participated in a rehabilitation program. It was only on his 3rd try that he finally understood the utility of persevering.	
		→ CLa	**(inf3) hypothesizes** – some patients just don't understand the importance of following a rehabilitation program	INF
			(inf2) draws conclusions – perseverance is the key to success in a rehabilitation program	INF
ann.1 E056			**(exp1) states results** – presents a similar case to that of E056 – patients follow rehabilitation programs numerous times before actually completing them successfully	EXP
ann.2 E056			**(ana6) questions** how nurses should deal with patients who do not seem to understand or do not cooperate in the process of getting involved in a rehabilitation program	ANA
ann.3 E056		Pa(2) → CLa	**(exp3) presents arguments** in order to answer question in ann.2. E056 – if a nurse is able to find what motivates the patient, what are his/her beliefs then he/she will be able to make the patient understand	EXP

Table 7. Analysis of sequence *A* of *V2*: *At the heart of our exchanges*.

This sequence was initiated by author *MJP* (facilitator of the networked community of nurses) with message *E029* explaining (*int2*) the meaning of "*patient responsibility*" to his/her fellow nurses while asking (*ana6*) them which nursing strategies and which behavioral change models should be adopted in order to make patients more responsible towards their heart health. His/her contribution (message *E029*) to the networked community consisted, in fact, of a summary of the discussion of the prior week (week of March 23rd, 2002). Six nurses responded directly to his/her questioning by contributing to the networked community with seven messages. Authors *YJ*, *JH*, *CG*, *GB*, *JL* and *FB* contributed by authoring messages *E041*, *E056*, *E107*, *E111*, *E120*, *E127* and *E128*.

By initiating the sequence, author *MJP* (message *E029*) also set the discussion theme within this particular sequence. Since the nurses were exploring the problem of patients' non-responsibility towards their heart health condition in this view, this first sequence was composed of a discussion on various medically prescribed techniques (behavioral change models, rehabilitation programs) and nursing strategies (offering rewards, use of motivation techniques, signature of contracts) that could lead patients to become more responsible concerning their heart health.

At the beginning, the nurses had their own interpretation of patient responsibility. While some argued that patients were responsible for their heart health, others stressed the importance of intervening and becoming active in the patient's process of responsibilization. In discussing *patient responsibility*, models were proposed (see *E041*, *E086*, *E127*, *E128*) and assessed them in terms of their helpfulness (see *E041*, *ann.2.E128*) and limitations (see *E086, E128*), examples were brought up (see *E056*, *E124*, *E127*) stressing the importance of pushing patients to persevere while they were following rehabilitation programs, even if medically prescribed, and suggestions were made (see *E107*) concerning patient responsibility (patient contract).

The idea of a patient signing a contract to obligate him/her to become responsible of his/her health brought up by author *JL* of message *E107* generated six contributions from authors *FB* (message *E112*), *GB* (message *E113*), *LD* (message *E116*), *FB* (message *E119*), *YJ* (message *E121*), *HB* (message *E124*).

Author *FB* (message *E112*) explained (*exp1*) that a type of "*patient contract*" is used in his/her institution in cardiac rehabilitation programs and he/she used an argument to draw a conclusion by making an inference (*inf2*) – "*if a patient signs a "contract", then he/she will feel more responsible*". Author *GB* (message *E113*) explained (*exp1*) that patient responsibility was also a problem in his/her home institution hence medical prescriptions of rehabilitation programs were assigned to patients. He/she used an argument to support his/her explanation. He/she didn't agree with medically prescribing rehabilitation to patients and formulated a hypothesis (*inf3*) – "*if patients are sensitized to the idea of a healthy lifestyle, then there is no need for medical prescription of rehabilitation programs*". Two annotations were inserted within message *E113*. Annotation *1* justified the hypothesis made by author *GB* in message *E113* (*exp2*) by explaining that patients were also reticent in his/her home institution in joining a rehabilitation program even if medically prescribed.

Annotation *2* agreed with hypothesis made by author *GB* in message *E113* but assessed (*eval*) that, based in personal observations in his/her home institution, patients were more cooperative and more inclined to following a rehabilitation program when medically prescribed. Author *LD* (message *E116*) also made an inference (*inf2*) based on the hypothesis made by author *GB* in message *E113*: "*patients do not seem to follow rehabilitation programs even if medically prescribed.*" Author *FB* of message *E119* explained (*exp1*) how contracts were administered to patients in his/her home institution. He/she then formed a hypothesis (*inf3*): "*if a patient signs a contract, he/she will feel guilty if he/she doesn't respect its terms.*" He/she continued explaining (*exp3*) that certain patients, in his/her home institution, have mentioned to him/her that they should have adopted a lifestyle change earlier if they had known. He/she formulated another hypothesis (*inf3*): "*if a patient feels guilty, he/she will not necessarily be able to complete a 12-week rehabilitation program.*" Author *YJ* of message *E121* used an argument to support the utility of a "*cardiac patient contract*". He/she first explained (*exp1*) that the signature of a contract was a mandatory procedure for patients in his/her home institution and drew a conclusion (*inf2*) - patient signing actually entices them to follow the rehabilitation program.

As illustrated in Figure 15, hereunder, the central theme was "patient responsibility".

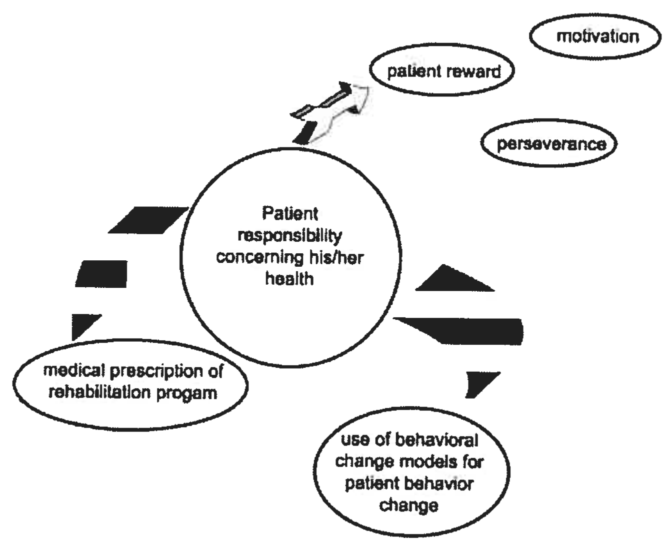

Figure 15. Schematization of sequence *A* of *V2*: *At the heart of our exchanges.*

Authors of messages who discussed the medical prescription of rehabilitation programs for patients (*E113*, *ann.1.E113*, *ann.2.E113*, *E116*, *E119*) and authors that discussed the use of a behavioral change model for patient behavior change (*E128*, *ann.2.E128*, *ann.3.E128*, *E041*, *E086*, *E111*) built an image of the theme *patient responsibility* presented by message *E029*. Authors of messages *E127* and *E056* rebuilt an image of the theme *patient responsibility* by suggesting that it was in fact on the patients' motivation and insistence on perseverance from the patient that was needed and not a medical prescription nor the guilt associated with the signature of a *patient contract* (*E124*, *E121*, *E112*, *E107*). There was a shift in the interpretation of *patient responsibility* in this sequence from being an institutionally enforced behavior (patient contract) to a softer approach towards *responsibility*. The notion of *patient responsibility* was schematized as a result of the interpretation of the authors of messages in this sequence.

Overall, in this sequence, the nurses tried to a-) define *patient responsibility* by exploring various models of behavioral change, and b-) assess the utility of a *patient contract*.

Conclusions brought about in this sequence were a-) the need for the development of a model for behavioral change that is adapted to the cardiac patient and b-) a strategy to persuade patients to become responsible towards their heart health.

Sequence F

In the following chart, the theme linking the messages was *heart care promotion and prevention strategy.*

Sequence *F – V2*: ***At the heart of our exchanges***

Msg	Presence of argument	Argument parts	CT indicator	Cognitive skill
E003	no		**(exp1) states results** – there is a rise in heart related diseases in spite of public evidence of the risk factors (lifestyle habits)	EXP
			(ana6) questions which nursing strategies should be adopted and the attention that should be given to promoting heart care	ANA
E008	yes (1)		**(eva1) assesses validity** (+) on the need for heart health promotion	EVA
		Pa(1) Pb(1) Pc(1)	**(inf3) hypothesizes** – if patients were aware of the risks related to certain habits, then they would take wiser decisions	INF
		Pd → CLa	**(inf2) draws conclusions** – healthcare system should focus on prevention - knowing is power	INF
E009	yes (1)	Pa(1) Pb(1) Pc(1) → CLa	**(exp3) presents arguments** – if we inform the population of the risks associated with certain lifestyle habits then we can help the population make wiser decisions and modify their beliefs	EXP
			(inf2) draws conclusions – author sees himself/herself as a facilitator of self responsibility by giving the patient the means to do so	INF
			(ana6) questions how can patients become more responsible of their health	ANA
E010	yes (1)		**(int3) clarifies meaning** of responsibility (people don't feel concerned by heart-related disease)	INT
			(exp1) states results - relates the case of a patient (smoker) who didn't want to hear anything about stopping smoking (patient's dad died at 80 and smoked all his life)	EXP
		Pa(3)	**(ana4) counter-arguments author of E008** – promotion in *bulk* won't change patients' bad lifestyle habits, especially for heart care	ANA
			↓	
		→ CLa	**(exp2) justifies his/her analysis** on the fact that people who are not concerned by heart disease will not adopt good lifestyle	EXP

			habits	
E064	**yes (1)**		**(eva1) assesses validity (+)** of bulk promotion not being an efficient tool but states that it does reach a significant amount of individuals	EVA
			↓	
		CLa ← Pa(2)	**(exp3) presents arguments to support his/her evaluation** – promotion of heart care in bulk would be efficient if additional tools were developed to individually reach people (by assessing individual needs)	EXP
E016	**yes (1)**		**(exp1) states results** – heart failure is the main cause of death in North America even if there is an increased heart care promotion nowadays	EXP
			(exp2) justifies results - coronary rehabilitation programs enable a better quality of life	EXP
		Pa(1) → CLa	**(ana6) questions** – which are the key elements in reaching the "hard to get" individuals and if primary level prevention should be adopted in our society	ANA
			↓	
			(exp3) presents arguments to answer his/her own questions – informing schoolchildren, identifying food products, cheaper rates at physical conditioning centers, valuing coronary rehabilitation programs	EXP
			(exp2) justifies patient "non-responsibility" – baby-boomers do not pay as much attention to their health as the younger population	EXP
E021	**no**		**(eva1) assesses validity (+)** of idea of focusing on primary level prevention of author of E016	EVA
E025	**yes (1)**		**(ana6) questions** – where to start in order educate patients and make them self-responsible?	ANA
		CLa ←	**(ana3) analyzes arguments presented by author of E009** – the population is already over informed and is incapable of distinguishing	ANA
			↓	
		Pa(3)	**(exp3) presents arguments to support his/her position** – people don't feel concerned by heart-related disease because they breathe normally and think they are immune to them	EXP
E035	**yes (3)**	CLa ← Pa(1)	**(int2) explains** that adults tend to react according to situations they face	INT
			↓	
			(exp3) presents arguments to support his/her interpretation – we all modified our habits with the arrival of the PC, cellular phone and email	EXP
		CLb ← Pa(1)	**(exp3) presents arguments** – if we intervene by doing prevention in the short run, then it will have a positive impact on the long run	EXP
			↓	
			(exp1) states results - patients having gone to see him/her that	EXP

			did not wish to do any physical activity gave in after their beliefs concerning heart care were "shaken"	
			↓	
		CLc ← Pa(1) Pb(1) Pc(1) Pd(1)	**(exp2) justifies his/her results** – he/she gave the patient the choice of choosing between adopting good lifestyle habits and bad ones – giving the choice to the patient helped him/her reach his/her goal of changing his behavior	EXP
			(exp1) states results – presents a brochure on how to stop smoking, published by the Canadian Cancer Society – it was an effective tool for him/her	EXP
E036	**no**		**(ana3) analyzes arguments brought by author of E035** concerning the content of the brochure and relates it to the concepts brought about by the Prochaska model (respecting the stage the patient is at every step)	ANA
			(exp1) states results of his/her own reasoning – he/she is a strong believer of respecting the patient, informing them of his/her choices and letting him/her decide of the next step	EXP
			↓	
			(exp2) justifies the results of his/her reasoning by basing himself/herself on the example of a patient who called him/her to tell him/her that he was ready to stop smoking (it was due to the death of his friend - cause: lung cancer)	EXP

Table 8. Analysis of sequence *F* of *V2*: *At the heart of our exchanges*.

This sequence was initiated by author *IG* of message *E003* explaining (*exp1*) that there was a rise in heart related diseases in spite of public evidence of the risk factors. In his/her message, he/she asked (*ana6*) his/her fellow nurses "*which nursing strategies should be adopted to raise public awareness about risk factors and how much emphasis should be put on promoting heart care?*" Message *E003* generated that of author *FB* of message *E008*, of author *AMR* of message *E009*, of author *IG* of message *E010*, of author *HB* of message *E016* and, much later, that of author *PL* of message *E064*. A response from author *FB* of message *E021* to message *E016* was in turn responded to by author *IG* of message *E025*, who in turn generated a response from author *AMR* of message *E035* and author *FB* of message *E036*.

Sequence *F* is, graphically, the only linear message chain within the networked discourse of the nurses. They built on one another's messages discussing heart care promotion and prevention strategies that could be adopted.

In this sequence, the nurses evaluated and re-evaluated the importance that should be allocated to the patients' role as responsible persons concerning their condition. Authors of this sequence interpreted the theme "*patient education*" from the idea of the responsibility nurses had to assume to that of patients. Authors of messages *E008* and *E009*, *E010* and *E064* saw patient education as a nursing responsibility up until authors of messages *E016* and *E021* deconstructed the theme "*patient education*" into "*primary level prevention*" and "*patient responsibility*". The new meaning of "*patient responsibility*" that authors of messages *E025*, *E035* and *E036* constructed was the following: patients should be responsible of their own health by putting in efforts in eating healthier and adopting better lifestyle habits. In order to make the patient understand these notions, nurses had to focus on assessing their needs and understanding their perception on their condition prior to "*educating*" them on changes they should adopt.

As illustrated in Figure 16, hereunder, authors of messages *E008*, *E016*, *E025* built an image of *heart care promotion* by interpreting it as a societal responsibility and inferring that that prevention should be done at the primary level whereas authors of message *E009*, *E010*, *E064*, *E021* rebuilt an image of patient responsibility by reiterating the importance of patient responsibility for behavioral change and disregarding the idea of promotion "*in bulk*". We noticed that author of message *E035* was conservative in his/her interpretation of *nursing strategies* for heart care promotion; he/she stuck to the idea of prevention done by nurses in the short run while anticipating results in the long run. Author of message *E036* rebuilt an image of *patient responsibility* by re-evaluating his/her own reasoning in terms of respecting the patient and the stage where they were as if he/she wanted to provoke

behavioral change. There was, thus, a reconstruction of the meaning of patient responsibility within this sequence since the interpretation of *patient responsibility* was altered as a result of the contributions of authors on the theme.

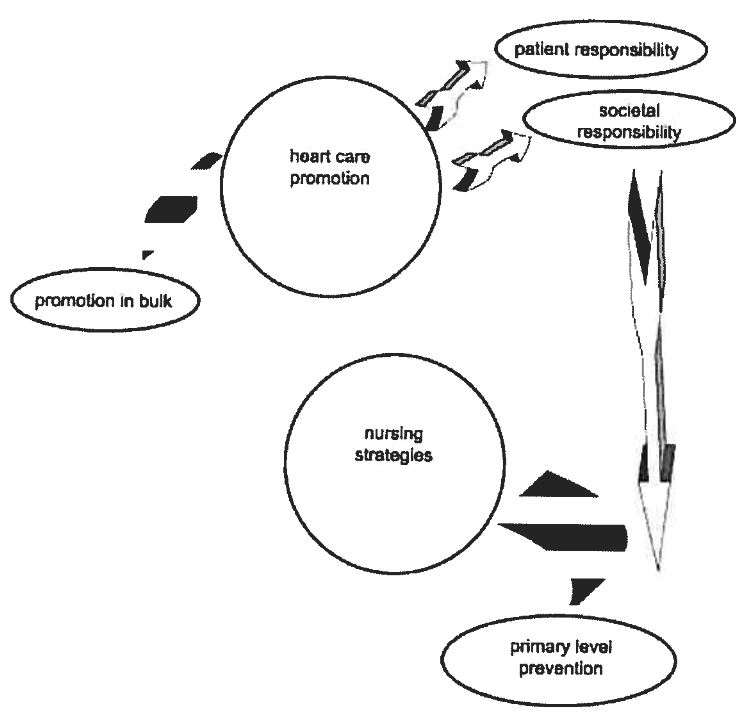

Figure 16. Schematization of sequence *F* of *V2*: *At the heart of our exchanges*.

We noticed that five nurses (*IG*, *FB*, *AMR*, *HB* and *PL*) authored all ten messages of sequence *F*. Arguments were present in seven of the ten messages supporting the various interpretations that nurses had concerning *patient responsibility* and *heart care promotion*. At the beginning of the sequence, there seemed to be an agreement on the necessity of implementing a nursing strategy for the promotion of heart health. The nursing strategy was seen as a-) an individual task for some, b-) a behavioral change model for educating patients and c-) a societal problem that needed to be solved by focusing on primary level prevention. It seems that there was a reinterpretation of the notion of *patient responsibility*, construction of meaning related to *responsibility* and reconstruction of a larger concept of

patient responsibility since they shared different and sometimes conflicting views about *patient responsibility.*

We assessed a pattern within the networked discourse of sequence *F, which consisted of the presentation of arguments supporting statements,* once an assessment was made by another author that had conflicting beliefs and/or views. Despite the variety in the interpretation of the notion of *responsibility,* the nurses tended to be very focused on the subject of conversation without introducing any new elements into the discussion or diverging from the subject.

Sequence H

In the following chart, the theme linking all messages was *patient education.* Sequence *H* consists of a discussion thread made up of four messages, which relates in a more detailed manner of the subject of *patient education* introduced in the previous sequence, sequence *F.*

Sequence H – V2: At the heart of our exchanges

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
E005	no		**(ana6) questions** the type of education to be given to patients since they are hospitalized for a short period of time	ANA
E012	yes (1)	Pa(1) → CLa	**(int2) explains according to his/her own understanding** what should be included in the education given to the patient (knowledge and understanding of diagnosis, risk factors and post-activity activities).	INT
E013	yes (1)		**(ana6) questions** - what type of education should be given to patients suffering from angina and post-thrombosis during a short stay at the hospital?	ANA
			↓	
		Pa(5) Pb(1) → CLa	**(exp1) states results** – description of an approach he/she has developed (draws a heart on the patient's chest, explains its components, explains risk factors, explains symptoms and exams)	EXP
			↓	
			(inf2) draws conclusions on his/her own approach used with cardiac patients – patients that wish to know more will ask for more information – keeping it simple works for the majority of	INF

			patients	
E020	**no**		**(eva1) assesses validity** (+) of approach developed by author of E013	EVA
			↓	
			(exp2) justifies pertinence of inference made by author of E013 – they use the same approach at their hospital	EXP

Table 9. Analysis of sequence *H* of *V2*: *At the heart of our exchanges.*

This short sequence related to the subject of *patient education.* The nurses had discussed about *patient responsibility* and *patient education* being closely tied in sequence *F*. Author *LL* of message *E005* asked (*ana6*): "*what is the type of education to be given to patients since they are hospitalized for a short period of time?"* As mentioned in the description of the above sequence *F*, this sequence was also triggered by a question. Reflection upon the type of patient education to be delivered was visible in the answers provided by authors of messages *E012*, *E013* and *E020*. *Informing the patient on his health state* was a notion that they all shared and assessed in a positive manner.

As illustrated in Figure 17, hereunder, authors *LL* (*E005*), *HB* (*E012*), *YJ* (*E013*) and *HS* (*E020*), shared the same image of the theme *patient education* which was "*patient education should always start by an assessment of his/her needs*". Since the nurses shared the same image of patient education, no schematization occurred within this sequence.

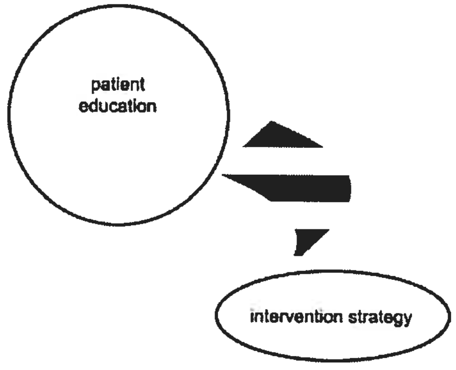

Figure 17. Schematization of sequence *H* of *V2*: *At the heart of our exchanges.*

Further deliberation on the subject of *patient education* was noticed in another short sequence (sequence *J*) which is analyzed next.

Sequence J

In the following chart, the theme linking all messages was *patient education* as in the two previous sequences.

Sequence J – V2: At the heart of our exchanges

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
E014	**yes (1)**	CLa ←	**(inf2) draws conclusions** on patient education – since the stay of the patient is short, education should be general	INF
			↓	
		Pa(1) Pb(1) Pc(1)	**(exp2) justifies his/her conclusion** by relating to his/her own experience based on a research conducted by a Master's student – patients shouldn't ask too many questions, nurses should tell them beforehand which subjects they can educate them about	EXP
			↓	
			(inf2) draws conclusions – asking what a thrombosis MEANS for the patient can help the nurse detect the patient's potential for behavioral change and rehabilitation	INF
			↓	
		Pd(1)	**(exp2) justifies his/her conclusion** – if a thrombosis means death for a patient, it is pointless for the nurse to try convincing him/her to stop smoking	EXP
E024	**yes (1)**		**(eva1) assesses validity (+)** – on the importance of asking patients what the diagnosis means for them	EVA
			↓	
		Pa(1)	**(exp2) justifies his/her assessment** – education of the patient should consider his/her values, needs, life experience, behavior type, environment and family	EXP
		Pb(1)	**(inf3) hypothesizes** - nurses should identify the patient's priorities and not their own priorities for the patient	INF
			↓	
		→ CLa	**(exp2) justifies his/her hypothesis** – a nurse must be able to gain the patient's confidence and respect in order to be able to successfully change his behavior	EXP
E073	**no**		**(inf2) draws conclusions** – based on author of E024, it is pointless to adopt an intervention model	INF
			(ana6) questions – how can we make a patient modify his behavior and make him comply to a rehabilitation program?	ANA
			(inf2) draws conclusions on explanation provided by author in E024 – tools used must be drawn from an existing	INF

			intervention model	
E034	**yes (1)**	Pa(1) → CLa	**(eval) assesses validity (+) of explanation provided by author of E024** – patient education should always start by an assessment of his/her needs	EVA
E063	**no**		**(eval) assesses validity (+) of explanation provided by author of E014** – patient education should always start by an assessment of his/her needs	EVA

Table 10. Analysis of sequence *J* of *V2*: *At the heart of our exchanges*.

This sequence was initiated by author *RD* of message *E014* drawing a conclusion (*inf2*) on *patient education*. He/she stated that since the stay of the patient is short, education should be general. He/she justified his/her inference (*exp2*) by relating to his/her own experience based on a research conducted by a Master's student – patients shouldn't ask too many questions, nurses should tell beforehand which subjects can be educated. He/she then made a second inference (*inf2*) by concluding that asking what a thrombosis *means* for the patient could help nurses detect patient potential for behavioral change and rehabilitation. He/she justified his/her second inference (*exp2*) by explaining that if a thrombosis means death for patients, it is pointless for the nurse to try convincing them to stop smoking. Authors *SH* of message *E024* and *JH* of message *E063* responded to author *RD* of message *E014*.

In this sequence, authors shared the interpretation of the theme *patient education* suggested by author *SH* in message *E024*. As illustrated in Figure 18, hereunder, the nurses assessed, in a positive manner, the understanding author *SH* had of nursing intervention concerning patient education: it will be successful only if identifying a patient's needs, beliefs and perceptions. The patient, in this sequence, was seen as the focus of attention for a successful patient education leading to behavioral change. Authors of messages *E034*, *E063* and *E073* built their image of patient education according to the image author of message *E024* had built. Authors *CV* (*E034*), *JH* (*E063*) and *LD* (*E073*) positively assessed the image built by author *SH* (*E024*) hence interpreting it in the same way but we weren't able to assess if that image was in fact a new image or if it was an interpretation they already shared. We arrived to this conclusion by noticing that authors within this sequence

contributed only once. It was thus a challenge to distinguish if schematization had occurred within this sequence since contributions were very few.

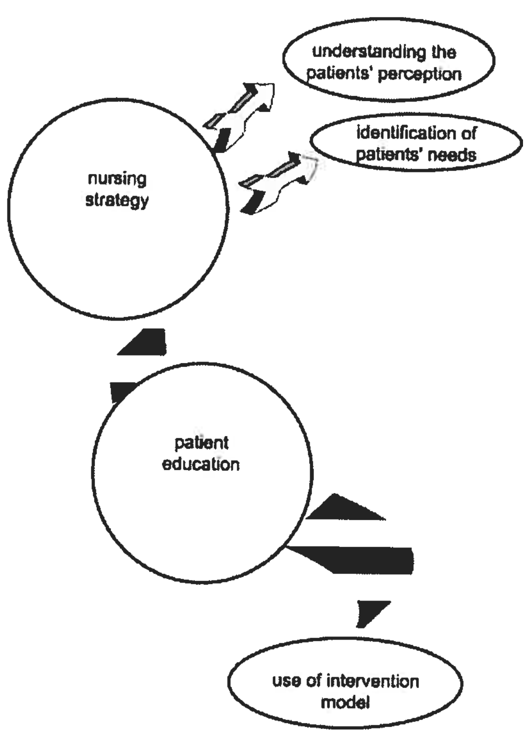

Figure 18. Schematization of sequence *J* of *V2*: *At the heart of our exchanges*.

The following sequence (sequence *P*) contained two contributions, among which, one was authored by *JH* (*E062*) who had also authored message *E063* in sequence *J* but had simply not linked his/her contribution to the chain of replies created in sequence *J*.

The following is the last studied sequence of *V2*: *At the heart of our exchanges*, sequence *P*. It also discussed *patient education*.

Sequence P

In the following chart, the theme discussed was *patient education.*

Sequence P – V2: At the heart of our exchanges				
Msg	**Presence of argument**	**Argument parts**	**CT indicator**	**Cognitive Skill**
E019	**yes (1)**	CLa ← Pa(1) Pb(1)	**(eval) assesses validity (+)** - patient education should always start by an assessment of his/her needs	EVA
E062	**yes (1)**		**(eval) assesses validity (+)** patient education should always start by an assessment of his/her needs	EVA
			↓	
		Pa(1) → CLa	**(exp2) justifies his/her assessment** – relates to his/her own experience, patients express their needs during the first few weeks and they do not always correspond to what the nurse expects	EXP

Table 11. Analysis of sequence *P* of *V2*: *At the heart of our exchanges.*

Author *LL* of message *E019* presented an argument in his/her positive assessment (*eval*) of the explanation that had been provided in message *E014* in sequence *J*: "*if a nurse wishes to educate a patient, then he/she needs to start by an assessment of his/her needs*". Author *JH* of message *E062* presented the same argument as author *LL* of message *E019* in her positive assessment of the explanation (*eval*) that had been provided in message *E014* in sequence *J*: "*if a nurse wishes to educate a patient, then he/she needs to start by an assessment of his/her needs*". Author *JH* of message *E062* justified his/her assessment (*exp2*) by relating to his/her own experience by claiming: "*patients express their needs during the first few weeks and they do not always correspond to what the nurse expects*".

In this sequence, authors *LL* and *JH* assessed in a positive manner the argument that had been presented within the previous sequence (sequence *J*) and also rebuilt the same image as authors that had contributed in sequence *J*: "*if nurses wish to educate patients, then they should start by assessing their needs*".

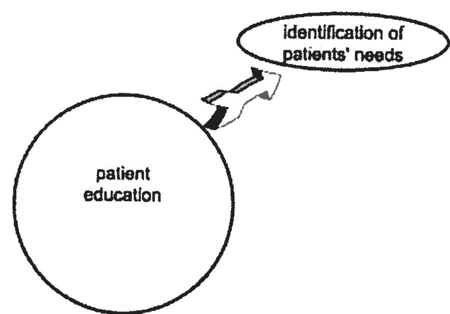

Figure 19. Schematization of sequence *P* of *V2*: *At the heart of our exchanges.*

Level of critical thinking

Sequence A

The most frequent CT indicators found within the sixteen messages contained in sequence *A* were *exp1* (26%), *inf3* (18%) and *inf2* (17%). These CT indicators interpreted in CT skills correspond to a prevalence of the cognitive skills *explanation* and *inference*. While searching for ways to make patients more responsible and nursing strategies as well as behavioral change models, nurses explored various strategies and models and discussed their pros and cons by inferring from previous ideas and searching for new explanations. Arguments were presented by authors of messages *E056*, *E111*, *E112*, *E113*, *E121*, *E127* and *E128* to explain and support their claims. In this sequence, nurses made inferences that led to a new model for behavioral change based on established models. This new model should be developed and that the modalities of the "patient contract" needed to be revised. The nurses agreed that the signature of a contract does not always constitute an engagement for the patient and took a critical stand. Arguments presented, in both messages and annotations were extensively assessed in terms of validity. The level of critical thinking deployed within sequence *A* could be qualified as *strong*.

Sequence F

In sequence *F*, the most frequent CT indicators were *exp1* (22%), *exp3* (20%), *exp2* (17%), *ana6* (10%) and *ana3* (7%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation* and *analysis*. We noticed that the nurses mostly explained to the others their interpretation of the theme *patient responsibility*. In their quest of finding an appropriate nursing strategy to educate patients concerning their heart health, the nurses presented arguments to support their assessments. Arguments were present in seven out of the ten messages (*E008, E009, E010, E016, E025, E035, and E064*) within this sequence. Overall, this sequence suggests that the nurses analyzed their interpretations about patient education. Although there seemed to be a variety of interpretations of the theme at the beginning (since some authors viewed promotion on heart care "*in bulk*" insufficient and others viewed patients as irresponsible towards their heart health), we noticed that the latter authors reinterpreted their vision of patient responsibility as a result of the contributions of the former. In sum, this sequence suggests that heart care promotion "*in bulk*" does not always make patients more aware of risk factors nor does it entice them to be more responsible towards their health. It is rather the individual approach that the nurse adopts in educating the patient, taking into account the stage the patient is at. Arguments presented within this sequence were extensively assessed in terms of validity. The level of critical thinking deployed within sequence *F* could be qualified as *strong*.

Sequence H

The most frequent CT indicators found were *ana6* (29%), *int2* (14%), *eval* (14%), *inf2* (14%), *exp1* (14%), and *exp2* (14%). These CT indicators interpreted in CT skills correspond to the cognitive skills *analysis*, *interpretation*, *evaluation*, *inference* and *explanation*. All cognitive skills of our grid were present in their discussion on *patient education*. Authors that contributed to this sequence already shared the same image of the theme *patient education* which was "*patient education should always start by an assessment of his/her needs*". Since there was no debate, the level of critical thinking could be qualified as *weak*. We could say that all cognitive skills we are working with were

applied do not necessarily lead to a strong process of critical thinking. Conversely, it is reasonable to suppose that those prevalent in the previous sequences might be related to the strong level.

Sequence J

The most frequent CT indicators found were *exp2* (31%) and *inf2* (31%) followed by *eval* (23%) and *inf3* (8%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation*, *evaluation* and *inference*. In this sequence, nurses explained and re-evaluated the importance of the patients' role in taking charge of their health. There was a shift in the interpretation of patient education in this sequence. We noticed that the nurses made inferences and agreed upon the fact that patients needed to be more responsible and that it was not necessarily their responsibility if patients neglected their heart health. However, they recognized that they should focus on the patients' needs. Arguments were presented by authors of messages *E014*, *E024* and *E034* to support their claims. Overall, this sequence suggests that questioning patients on their beliefs and perceptions could facilitate patient education. Contributions in this sequence did include arguments supporting the assessments made by their authors but there was no build-ons demonstrating no further discussion on the theme *patient education*. The level of critical thinking deployed within sequence *J* was thus qualified as *weak*.

Sequence P

The only CT indicators found were *eval* (67%) and *exp2* (33%). These CT indicators interpreted in CT skills correspond to the cognitive skills *evaluation* and *explanation*. In this sequence, author *JH* (*E063*) rebuilt his/her image of *patient education* by basing himself/herself on the contributions made by authors in sequence *J*. Sequence *P* was in fact a chain that should have been attached to the chain of messages in sequence *J*. We were not able to assess if this was an intentional action from author *JH* or if he/she wanted to initiate further discussion on the theme *patient education*. Since contributions

within this sequence were very few and did not lead to reconstructed meanings related to critical thinking, we qualified the level of critical thinking as being *weak*.

View V9: Data collection

Two sequences (labeled *D* and *J*)[27] were selected based on their length, amount of text and presence of scaffolds.

The sequences

Sequence D

The first sequence was *D* of *V9: Data collection*[28]. The theme linking all messages was *repetition in patient data collection*. The sequence was made up of eleven messages and fourteen annotations, posted between April 12th and May 8th, 2002. Message *DC006* was the one that initiated the sequence; it consisted of a concern expressed by author YJ regarding patient data collection. The following is a graphic representation of sequence *D*.

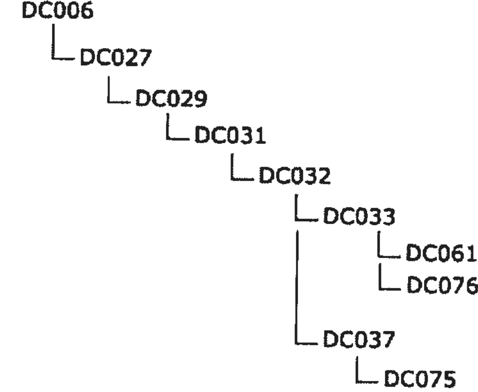

Figure 20. Graphic representation of sequence *D* of *V9*: *Data collection*.

[27] See Appendix 10
[28] See Appendix 11

Sequence J

The second sequence was *J* of *V9: Data collection*[29]. The theme linking all messages was *data collection.* The sequence was made up of seven messages and two annotations, posted between April 22nd and May 20th, 2002. Message *DC045* was the one that initiated the sequence; it consisted of a synthesis[30] of messages pertaining to data collection by the facilitator of the networked community of nurses. The following is a graphic representation of sequence *J.*

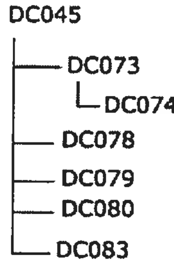

Figure 21. Graphic representation of sequence *J* of *V9*: *Data collection.*

Quantitative data

Arguments

As shown in Figure 22, nine of the eleven messages (82%) of sequence *D* had arguments. In sequence *J*, four out of the seven messages (57%) contained arguments.

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[29] See Appendix 12

[30] « *Synthesizing* » means « *packaging* » many messages in an upper folder by using the *Knowledge Forum rise-above* tool.

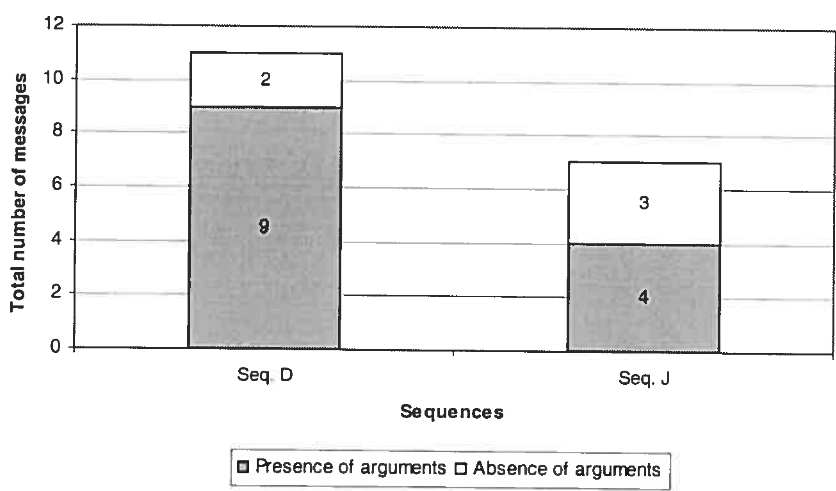

Figure 22. Presence of arguments within sequences of *V9*: *Data collection.*

As shown in Figure 23, in sequence *D*, premises were mostly found within the CT skills *EXP* (81%) and *INT* (14%) while very little were found within the CT skill *INF* (5%). In sequence *J*, premises were only found within the CT skills *EXP* (64%) and *INF* (36%).

V9*: *Data collection

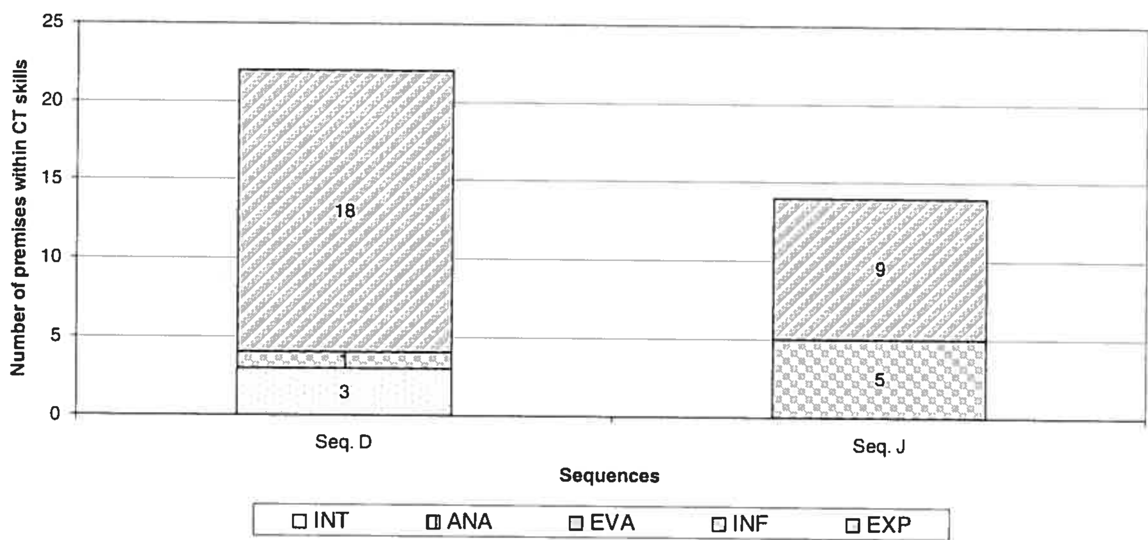

Figure 23. Presence of premises with regards to CT skills within sequences of *V9*: *Data collection.*

As shown in Figure 24, in sequence *D*, conclusions were mostly found within the CT skills *EXP* (45%), *EVA* (33%), *ANA* (11%) and *INT* (11%). In sequence *J*, conclusions were mostly found within the CT skills *INF* (50%), *EXP* (33%) and *EVA* (17%).

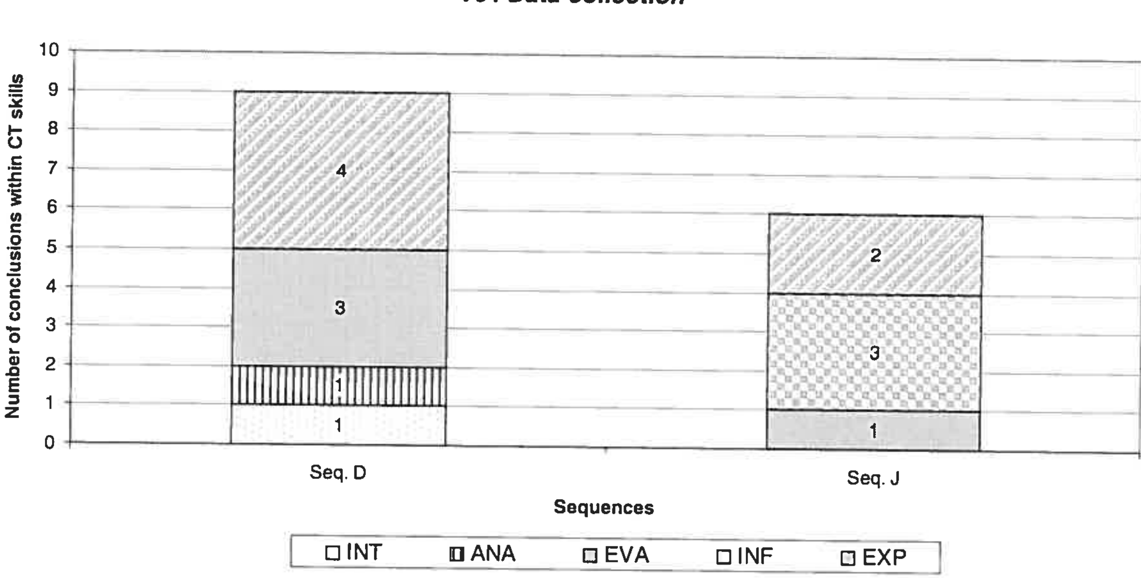

Figure 24. Presence of conclusions with regards to CT skills within sequences of *V9*: *Data collection*.

Critical thinking indicators

Table 12 presents the number and type of CT indicators identified within sequences *D* and *J* of *V9*: *Data collection.*

Sequences / CT indicators	Seq. D (11 messages) (14 annotations)	Seq. J (7 messages) (2 annotations)	Total (18 messages) (16 annotations)
int1	0	0	**0**
int2	0	0	**0**
int3	1	1	**2**
ana1	1	0	**1**
ana2	0	0	**0**
ana3	0	0	**0**
ana4	0	0	**0**
ana5	0	0	**0**
ana6	3	0	**3**
eva1	10	2	**12**
eva2	0	0	**0**
inf1	0	0	**0**
inf2	2	2	**4**
inf3	7	5	**12**
exp1	0	2	**2**
exp2	8	3	**11**
exp3	10	5	**15**
Total	**42**	**20**	

Table 12. Frequency of CT indicators within all sequences of *V9*: *Data collection.*

Sequence D

CT indicators were identified within all eleven messages and fourteen annotations. In total, sixty-one CT indicators were identified within the messages and annotations combined. Forty-two CT indicators were identified within the eleven messages and nineteen CT indicators were identified within the fourteen annotations. The CT indicators that were most frequently identified within the messages of sequence *D*, in terms of percentage, were respectively: *exp3* (24%), *eva1* (24%), *exp2* (19%), *inf3* (17%) followed by *ana6* (7%) and *inf2* (5%). In terms of cognitive skills, authors manifested the following

ones in order of importance: *explanation* (43%), *evaluation* (24%), *inference* (21%), *analysis* (10%) and *interpretation* (2%).

Sequence J

CT indicators were identified within all seven messages and two annotations. In total, twenty-two CT indicators were identified within the messages and annotations combined. Twenty CT indicators were identified within the seven messages and two CT indicators were identified within the two annotations. The CT indicators that were most frequently identified within the messages of sequence *J*, in terms of percentage, were respectively: *exp3* (25%), *inf3* (25%), *exp2* (15%), *exp1* (10%), *inf2* (10%) and *eva1* (10%). In terms of cognitive skills, authors manifested the following ones in order of importance: *explanation* (50%), *inference* (35%), *evaluation* (10%) and *interpretation* (5%). There was no indication of the CT skill *interpretation* in this sequence.

Qualitative data

Sequence D

In the following chart, the theme linking all messages was *repetition in patient data collection*.

Sequence D – V9: Data collection

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
DC006	yes (2)	Pa(1) Pb(1) → CLa← Pc(1)	**(int3) clarifies meaning** of “data collection” by stating that the data collection by the nurse (at triage), the doctor and other medical staff is a repeat data collection done by nurses on the floor – it needs to be improved	INT
			(ana6) questions – will the networked community of nurses solve this “problem” of duplication in data collection?	ANA
		Pd(1)	**(inf3) hypothesizes** on important complementary information that could be used (patient perception of hospital stay, patient expectations, patient knowledge of risk factors)	INF
		→ CLb	**(inf2) draws conclusions** on the data collection procedure – it should be structured and have some sense of direction in order	INF

			to be efficient	
DC027	**yes (1)**	CLa ←	**(eva1) assesses validity** (+) of point brought about (outdated data collection) by author of message DC006	EVA
			↓	
		Pa(1) Pb(2)	**(exp3) presents arguments** - compliance between the various departments is a necessity – it was discussed within his/her own institution	EXP
ann.1 DC027	**yes (1)**	CLa ← Pa(1)	**(int3) clarifies meaning** of the term "compliance" – it is an English term	INT
ann.2 DC027			**(eva1) assesses validity** (+) of argument brought about by author of message DC027	EVA
DC029	**no**		**(ana6) questions** – should the focus be on the fact that heart-related disease are generative diseases ?	ANA
DC031	**yes (1)**		**(eva1) assesses validity** (+) of question brought about by author of message DC029	EVA
			↓	
		CLa ← Pa(2)	**(exp3) presents arguments to support his/her assessment** – nurses need to spend more time at the beginning so their intervention can have a positive impact in the long-term	EXP
DC032	**yes (1)**	CLa ← Pa(1) Pb(1)	**(exp3) presents argument** – a person's beliefs are an indication of their future behavior (bases himself/herself on scientific data)	EXP
			(ana6) questions – should nurses question their approach since they question the type of intervention they use?	ANA
			↓	
			(exp2) justifies his/her questioning – gives an example – it is important to adopt an approach that focuses on the patient's experience and identifying their risk factors	EXP
			↓	
			(exp3) presents arguments – based on his/her experience at his/her institution, nurses need to know a little more about the patient before explaining them the risk factors	EXP
			↓	
			(inf2) draws conclusions – if explaining the risk factors to the patient is important, then questioning the patient on his/her beliefs should equally be important	INF
ann.1 DC032			**(eva1) assesses validity** (+) of conclusion brought about by author of message DC032	EVA
ann.2 DC032			**(eva2) assesses credibility** (+) of conclusion brought about by author of message DC032	EVA
ann.3 DC032			**(eva1) assesses validity** (+) of conclusion brought about by author of message DC032	EVA
			↓	
			(exp3) presents arguments – patient beliefs at home are different than their beliefs when they reach the hospital	EXP
ann.4 DC032			**(eva2) assesses credibility** (+) of argument brought about by author of annotation ann.3 DC032	EVA

			↓	
			(exp2) justifies his/her assessment – if the nurse re-evaluates the patient at different intervals, he/she will be more efficient	EXP
ann.5 DC032	**yes (1)**	CLa ← Pa(1) Pb(1)	**(eva1) assesses validity (+)** of argument brought about by author of message DC032	EVA
			↓	
			(exp2) justifies his/her assessment – if the nurse knows what the patient's beliefs are, then he/she will be able to intervene more efficiently	EXP
ann.6 DC032			**(eva1) assesses validity (+)** of comments brought about by authors of annotations ann.1 DC032, ann.2 DC032, ann.3 DC032 and ann.4 DC032	EVA
ann.7 DC032			**(eva1) assesses validity (+)** of argument brought about by author of message DC032	EVA
			↓	
			(exp2) justifies his/her assessment - if the nurse knows what the patient's beliefs are, then he/she will be able to intervene more efficiently	EXP
DC033	**yes (1)**	CLa ←	**(ana1) examines idea brought by himself/herself in message DC032** – introduces a new element: timing in data collection is important	ANA
			↓	
		Pa(2)	**(exp3) presents arguments** – based on scientific data, some patients, once at home, do not implement what they learned during education program at the hospital	EXP
			(inf3) hypothesizes - if the nurses needs to know how to educate the patient, then he/she should question the patient at different intervals	INF
			↓	
			(exp3) presents argument – not all patients are followed by a case manager at their local CLSC	EXP
ann.1 DC033		CLa ← Pa(2)	**(int2) decodes significance of "timing in data collection"** – could be seen as continuity in patient care	INT
DC061	**yes (1)**	CLa ←	**(eva1) assesses validity (+)** of argument brought about by author of message DC033	EVA
			↓	
		Pa(1)	**(exp3) presents argument** – hospitalized patient education should correspond to his/her immediate needs	EXP
DC076	**yes (1)**	CLa ← Pa(2)	**(exp3) presents argument** – a universal patient data collection is always used and appreciated	EXP
			(inf3) hypothesizes – if everyone needs to do a data collection, then a universal data collection should be conducted and used by all staff (once patient is hospitalized)	INF
			↓	
			(exp2) justifies his/her hypothesis – a more thorough data collection can be conducted by the nurse once basic information has been collected at the emergency room	EXP

DC037	**yes (1)**		**(eval) assesses validity (+)** of argument brought about by author of message DC033	EVA
			↓	
		CLa ← Pa(1) Pb(2)	**(exp2) justifies his/her assessment** - duplication in data collection does not occur in his/her institution because of the continuity of the patient data collection from one department to the other	EXP
			(inf3) hypothesizes – if the patient needs to go through various services, then a universal patient data collection is needed	INF
ann.1 DC037	**no**		**(eval) assesses validity (+)** of justification brought about by author of message DC037	EVA
ann.2 DC037	**yes (1)**	Pa(1) → CLa	**(eval) assesses validity (+)** of hypothesis brought about by author of message DC037 – there is a need to integrate all data within a single data collection	EVA
ann.3 DC037	**no**		**(eval) assesses validity (+)** of hypothesis brought about by author of message DC037 – there is a need to integrate all data within a single data collection, patients should not have to answer the same questions over and over again	EVA
DC075	**no**		**(eval) assesses validity (+)** of hypothesis brought about by author of message DC037 – there is a need to integrate all data within a single data collection	EVA
			↓	
			(exp2) justifies his/her assessment – there is a need for a common tool to be used in patient data collection	EXP

Table 13. Analysis of sequence *D* of *V9*: *Data collection.*

Author *YJ* of message *DC006* was the one that initiated this sequence. His/her message was in fact a synthesis of messages pertaining to the data collection. He/she clarified the meaning (*int3*) of "*data collection*" by stating that the data collected by the nurse (at triage) and the one by the doctor and other medical staff was redundant and needed to be improved. He/she then asked his/her fellow nurses (*ana6*) "*will the networked community of nurses solve this "problem" of duplication in data collection?*" He/she formulated a hypothesis (*inf3*) by stating "*if an efficient data collection is needed, then additional complementary information could be used such as patient perception of hospital stay, patient expectations and patient knowledge of risk factors*". He/she then drew a conclusion (*inf2*) by formulating the following hypothesis: "*if we want an efficient data collection, then it should be structured and have some sense of direction*".

In this sequence, the nurses discussed the theme "*patient data collection*". The sequence consisted, in fact, of the discussion on two themes: 1-) repetition in data collection and 2-) defining "*data collection*". By clarifying the meaning of *data collection*, author *YJ* (*DC006*) introduced the theme "*repetition*" in data collection. This theme was shared by author *FG* (*DC027*) and analyzed by authors *GB* (*DC033*), *FG* (*DC027*) and *SH* (*DC061*). Their interpretation was that *repetition* happened in the various departments visited by patients and there was a need for synchronizing data collection during the various stages the patient goes through. Authors *FB* (*DC031*) and *GB* (*DC032*) answered the question asked by author *CB* in message *DC029* by introducing the following element, to be taken in consideration during data collection: *patients' experience and beliefs*. Authors of the seven annotations (*CB*, *FB*, *HB*, *SH*, *CV*, *JH*) assessed, in a positive manner, the inference that had been made by author *GB* in message *DC032* concerning the importance that should be given to questioning *patients' experience and beliefs*. This reinterpretation of *data collection* led to a reconstruction of the theme *data collection* by authors *CV* (*DC037*) and *HB* (*DC076*) who proposed a *revised* data collection method: a *universal data collection* that would not be a repetition but rather *compliant* and *well-timed* within the various departments and care units the patient visits; a *common tool for all professionals*.

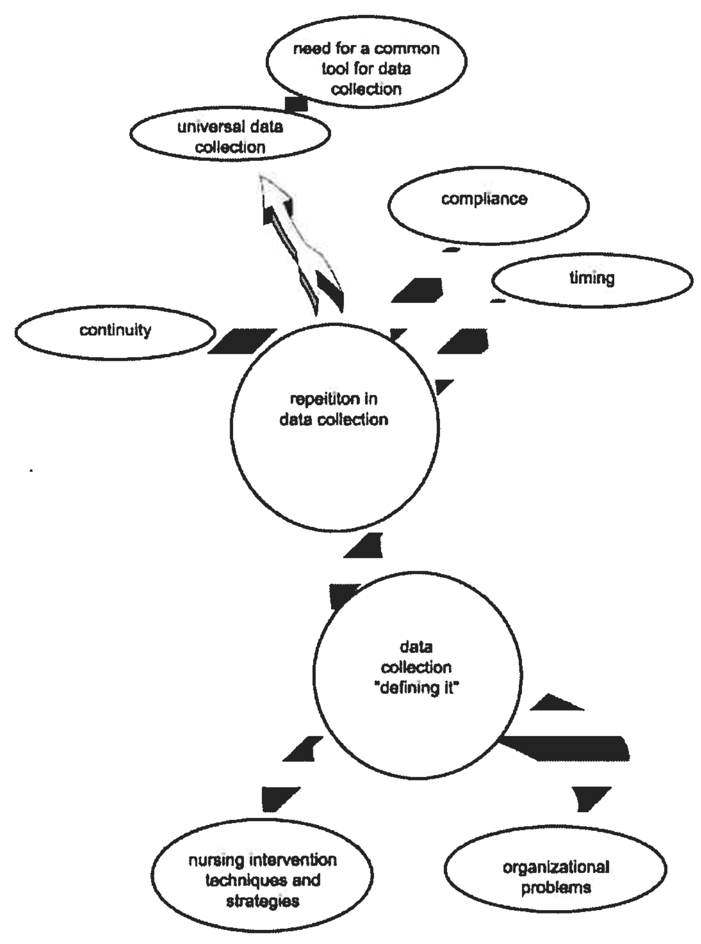

Figure 25. Schematization of sequence *D* of *V9*: *Data collection.*

Sequence J

In the following chart, the theme linking all messages was *data collection*.

Sequence J – V9: Data collection

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
DC045	yes (1)		**(inf3) hypothesizes** – if nurses need a continuous patient data collection, then there should be continuity within data collection between departments	INF
			↓	
		CLa ←	**(exp2) justifies himself/herself** - a follow-up of the patient's	EXP

		Pa(2) Pb(1) Pc(2)	condition would be possible if there was a continuity in data collection between emergency, medical units, CLSC nurse and rehabilitation clinic	
DC073	**yes (3)**	CLa ←	**(eva1) assesses validity (+)** of hypothesis brought about by author of message DC045	EVA
			↓	
		Pa(2)	**(exp3) presents arguments** – data collection from the cardiology institute is very specific (heart failure), there needs to be a more general data collection	EXP
			(exp1) states results – based on his/her observations in the networked community of nurses, there are a lot of specialized nurses in various fields	EXP
			↓	
		CLb ← Pb(1)	**(inf2) draws conclusion** – if a universal data collection is to be conducted, then it should pertain to the cardiac patient	INF
			↓	
		CLc ← Pc(2)	**(inf2) draws conclusion** – if a model of data collection can be developed, all nurses participating in the networked community could build it in collaboration	INF
			↓	
			(exp1) states results – suggests sections to be included in the tool used for data collection – a-) emergency and coronary intensive care unit, b-) cardiology unit, c-) personalized education of the patient	EXP
			↓	
			(inf3) hypothesizes – if nurses wish to conduct a data collection, then it should start when the patient is hospitalized and continued when he/she gets out of the hospital	INF
ann.1 DC073	**no**		**(eva1) assesses validity (+)** of conclusions brought about by author in message DC073	EVA
ann.2 DC073	**yes (1)**	CLa ← Pa(1) Pb(1)	**(exp3) presents argument** – the data collection mode presented by author of message DC073 should be kept in 2 copies – one for the hospital and one for the patient himself in a kit	EXP
DC074	**yes (1)**		**(eva1) assesses validity (+)** of conclusions brought about by author in message DC073 – data collection should be done at the various departments	EVA
			↓	
		Pa(2) → CLa	**(exp2) justifies his/her assessment** – the data collection from the cardiology institute can be used and developed to meet the needs of nurses working in hospitals (in cardiology units)	EXP
			(inf3) hypothesizes – if the members of the networked community of nurses wishes to develop a model for data collection, then they should insert their comments within the 3 following categories: a-) emergency and coronary intensive care unit, b-) cardiology unit, c-) personalized education of the patient	INF
			↓	
			(int3) clarifies meaning of "building together" by suggesting	INT

			that each nurse should contribute to the model of data collection according to their expertise	
DC078	**no**		**(exp3) states results** – presents the questions that generally figure in the data collection sheet	EXP
DC079	**no**		**(exp3) states results** – presents content of education program used at PICC at Sacre-Coeur hospital	EXP
DC080	**no**		**(exp3) states results** – presents content for the sections in the data collection	EXP
DC083	**yes (1)**	CLa ← Pa(1) Pb(1)	**(inf3) hypothesizes** – if there is a data collection, then it should be continually updated and revised prior to the patient's departure from the hospital	INF
			↓	
			(exp3) presents argument – if we wish for continuity on data collection, then the data collected should be included in the startup kit in order to allow adequate follow-up during post-hospitalization	EXP
			↓	
			(exp2) justifies his/her argument – based on his/her experience at his/her institution, the use of Internet-based software (for data collection) allows a facilitated communication between the hospital and the CLSC (post-hospitalization phase)	EXP
			(inf3) hypothesizes – if medical staff needs to consult a patient's file, then they can print data from the Internet-based software	INF

Table 14. Analysis of sequence *J* of *V9*: *Data collection.*

This sequence was initiated by author by *MJP* (facilitator of the community of nurses) with the message *DC045*. His/her message consisted of a synthesis[31] of messages pertaining to the data collection. He/she formulated a hypothesis (*inf3*): "*if nurses need a continuous patient data collection, then there should be continuity within data collection between departments*". He/she justified his/her inference (*exp2*) by stating that a follow-up of the patient's condition would be possible if there was a continuity in data collection between the emergency room, medical units, CLSC nurse and rehabilitation clinics. Author *MJP* used the rise-above tool to include the contributions of himself/herself (*DC074*) and

[31] « *Synthesizing* » means « *packaging* » many messages in an upper folder by using the *Knowledge Forum rise-above* tool.

messages *DC078, DC079* and *DC080* authored by *GB*. Authors *YJ* (DC073) and *CG* (*DC083*) responded to *MJP* of message *DC045*.

The idea of *universal data collection* was constructed within this sequence since authors *YJ* and *IG* rebuilt their image of the tool and even started suggesting content to be included (messages *DC073*, *DC078*, *DC079*, *DC080* and *DC083)*. We saw in sequence *J* that author *YJ*, who had previously suggested that repetition of data was the major problem encountered by professionals in the various units and departments, rebuilt his/her image of data collection by devising a common tool to be used by all professionals of different departments.

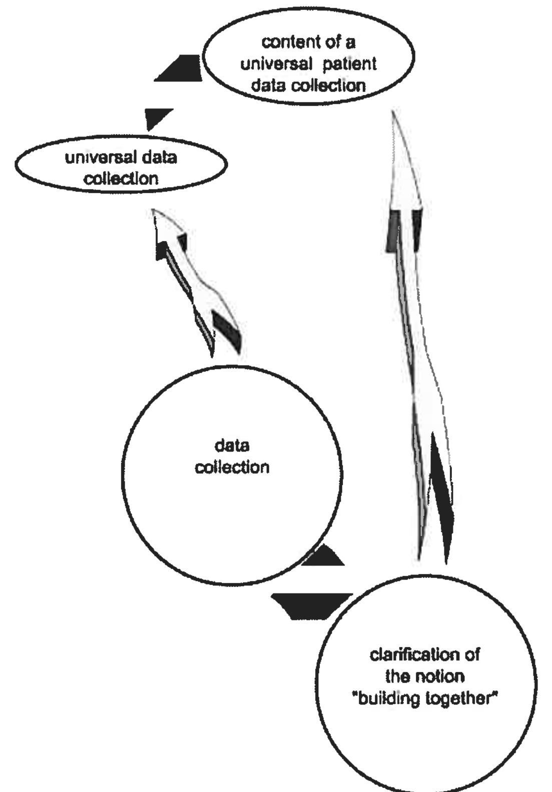

Figure 26. Schematization of sequence *J* of *V9*: *Data collection.*

Level of critical thinking

Sequence D

The most frequent CT indicators found were *exp3* (24%), *eval* (24%), *exp2* (19%), *inf3* (17%) followed by *ana6* (7%) and *inf2* (5%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation* and *evaluation* followed by *inference* and *analysis*. We noticed that the nurses *FG*, *GB*, *HB*, *CV* and *SH* reinterpreted the theme *data collection* introduced by author *YJ* and was reconstructed by authors *CV* and *HB*. In their schematization process, they transformed their interpretation of the theme *patient collection* into a *universal*, *compliant* and *well-timed data collection*. Arguments present in 82% of the messages were assessed in the annotations of message *DC032* by *GB*. Overall, this sequence, balanced in terms of cognitive skills, suggests that the nurses agreed on the development of a common tool (universal data collection) in order to avoid repetition. The tool would encourage compliance in various departments and units and would ensure continuity. A decision concerning tool development was taken in this sequence since contributing authors that had contributed to sequence *D* also contributed to sequence *J*. Arguments presented in sequence *D* were assessed in terms of validity and a decision was taken. The level of critical thinking deployed within sequence *D* could be qualified as *strong*.

Sequence J

The most frequent CT indicators found were *exp3* (25%), *inf3* (25%) and *exp2* (15%) followed by *exp1* (10%), *inf2* (10%) and *eval* (10%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation* and *inference* followed by *evaluation*. Arguments were present in 57% of the messages. The *universal* data collection tool was constructed within this sequence since messages *DC073*, *DC078*, *DC078*, *DC079* and *DC080* consisted of suggestions for content to be included in it. Although the nurses seemed to only be *building* a tool within this sequence, we considered

the actions of *suggesting content for the tool supported by arguments* (*exp3*) and *hypothesizing on the content of the tool* (*inf3*) as a demonstration of a *strong* level of critical thinking.

View V10: Heart health kit

In view *V10*: *Heart health kit*, the nurses developed the *Heart health kit*, explained in the previous view. Two sequences (labeled *A* and *H*)[32] were selected based on their length, amount of text and presence of scaffolds.

The sequences

Sequence A

The first sequence was *A* of *V10: Heart health kit*[33]. The theme linking all messages of sequence *A* was also *heart health kit – a deliverable for the networked community*. The sequence was made up of ten messages and four annotations, posted between April 11th and May 5th, 2002. Message *H002* was the one that initiated the sequence; it consisted of a summary of the discussion of the prior week. The following is a graphic representation of sequence *A*.

[32] See Appendix 13
[33] See Appendix 14

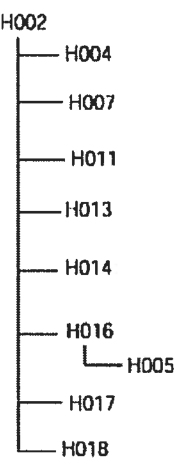

Figure 27. Graphic representation of sequence *A* of *V10*: *Heart health kit.*

Sequence H

The second sequence was *H* of *V10: Heart health kit*[34]. The theme linking all messages of sequence *H* was *defining the Heart health kit*. The sequence was made up of seven messages and four annotations, posted between April 22nd and May 14th, 2002. Message *H029* was the one that initiated the sequence; it consisted of the first message of a series of messages pertaining to the development of the *Heart health kit*. This message was posted by the facilitator of the networked community of nurses. The following is a graphic representation of sequence *H*.

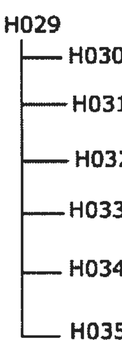

Figure 28. Graphic representation of sequence *H* of *V10*: *Heart health kit.*

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[34] See Appendix 15

Quantitative data

Arguments

As shown in Figure 29, four of the ten messages (40%) of sequence *A* had arguments. In sequence *H*, three out of the seven messages (43%) contained arguments.

Figure 29. Presence of arguments within sequences of *V10*: *Heart health kit.*

As shown in Figure 30, in sequence *A*, premises were only found within the CT skills *EXP* (67%) and *EVA* (33%). In sequence *H*, premises were mostly found within the CT skills *EXP* (86%) followed by some present in CT skills *EVA* (9%) and *INF* (5%).

V10: Heart health kit

Number of premises within CT skills

25
20
15
10
5
0

19
4
1
2
2

Seq. A
Seq. H

Sequences

INT ANA EVA INF EXP

Figure 30. Presence of premises with regards to CT skills within sequences of *V10*: *Heart health kit*.

As shown in Figure 31, in sequence *A*, conclusions were mostly found within the CT skills *EXP* (50%), *INT* (25%) and *ANA* (25%). In sequence *H*, conclusions were mostly found within the CT skills *EXP* (43%) and *EVA* (43%) while some were present in CT skill *INF* (14%).

Figure 31. Presence of conclusions with regards to CT skills within sequences of *V10*: *Heart health kit.*

Critical thinking indicators

Table 15 shows the number and type of CT indicators identified within sequences *A* and *H* of *V10*: *Heart health kit.*

Sequences / CT indicators	Seq. A (10 messages) (4 annotations)	Seq. H (7 messages) (4 annotations)	Total (17 messages) (8 annotations)
int1	0	1	**1**
int2	0	0	**0**
int3	1	1	**2**
ana1	0	0	**0**
ana2	0	0	**0**
ana3	0	0	**0**
ana4	1	0	**1**
ana5	0	0	**0**
ana6	0	1	**1**
eva1	11	7	**18**
eva2	0	0	**0**
inf1	0	0	**0**
inf2	2	5	**7**
inf3	0	0	**0**
exp1	1	4	**5**
exp2	11	7	**18**
exp3	0	0	**0**
Total	**27**	**26**	

Table 15. Frequency of CT indicators within all sequences of *V10*: *Heart health kit*.

Sequence A

CT indicators were identified within all messages and annotations. In total, thirty-three CT indicators were identified within the messages and annotations combined. Twenty-seven CT indicators were identified. The CT indicators that were most frequently identified within the messages of sequence *A*, in terms of percentage, were respectively: *exp2* (41%), *eva1* (41%) followed by *inf2* (7%), *exp1* (4%), *int3* (4%). In terms of cognitive skills, authors manifested the following ones in order of importance: *explanation* (44%), *evaluation* (41%), *inference* (7%), *analysis* (4%) and *interpretation* (4%).

Sequence H

CT indicators were identified within all messages and annotations. In total, thirty-three CT indicators were identified. Twenty-six CT indicators were identified within the seven messages and seven CT indicators were identified within the four annotations. The

CT indicators that were most frequently identified within the messages of sequence *H*, in terms of percentage, were respectively: *exp2* (27%), *eval* (27%), *inf2* (19%) and *exp1* (15%). In terms of cognitive skills, authors manifested the following cognitive skills in order of importance: *explanation* (42%), *evaluation* (27%), *inference* (19%), *interpretation* (8%) and *analysis* (4%).

Qualitative data

Sequence A

In the following chart, the theme linking all messages was *a deliverable for the networked community.*

Sequence A – V10: Heart health kit

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
H002	**no**		**(inf2) draws conclusions** on the discussion that took place in V2: At the heart of our exchanges – a heart health survival kit could be elaborated and suggests that they all work on collecting data on education programs for cardiac patients as well as developing the content of the kit	INF
			(inf2) draws conclusions on the potential positive impact that the deliverables of the networked community has set to deliver on cardiac patients self-responsibility	INF
ann.1 H002	**yes (1)**	CLa ← Pa(3)	**(ana4) counter-arguments** – proposes that the terms "clientele suffering from coronary disease or heart failure" instead of coronary disease and heart failure	ANA
			↓	
			(exp2) justifies his/her analysis – people will feel more concerned if the term is personalized; it is an observation he/she made at the rehabilitation program for cardiac patients	EXP
ann.2 H002	**yes (1)**	CLa ← Pa(1) Pb(2)	**(ana4) counter-arguments** – states that he/she does not like the term "survival kit" proposed by author YJ in message *HHKim* but rather prefers to call it "priority education"	ANA
			↓	
			(exp2) justifies his/her analysis - states that "priority education" refers to what will really be given to patients i.e. education that will permit him/her to safely live at home	EXP
H004	**yes (1)**		**(eval) assesses validity** (+) of the heart health survival kit proposed by author MJP in message 002	EVA
			↓	
		Pa(1)	**(exp2) justifies his/her assessment** by stating that he/she is	EXP

		Pb(1) → CLa	working on a similar "kit" at his/her own institution	
H007	**no**		**(eva1) assesses validity (+)** of the heart health survival kit proposed by author MJP in message 002	EVA
			↓	
			(exp2) justifies his/her assessment – "survival kit" describes the deliverable they have set very well	EXP
H011	**yes (1)**	CLa ←	**(int3) clarifies meaning** of the "survival kit" <u>he/she first introduced</u> - suggests that it be called startup kit or first heart aid kit	INT
			↓	
		Pa(1)	**(exp2) justifies himself/herself** – the kit is necessary for the patient to safely (better-informed) go back home	EXP
H013	**no**		**(eva1) assesses validity (+)** of the heart health survival kit proposed by author MJP in message 002	EVA
H014	**no**		**(exp1) states results** – informs others of the existence of a kit entitled "Vivre de bon Coeur" for patients suffering from heart failure	EXP
H016	**yes (1)**	CLa ←	**(ana4) counter-arguments** – states that he/she does not like the term survival kit proposed by author MJP in message 002 but rather prefers to call it "priority education"	ANA
			↓	
		Pa(1)	**(exp2) justifies himself/herself** – "survival kit" is too pejorative and less significant than "priority education"	EXP
ann.1 H016	**no**		**(eva1) assesses validity (+)** agrees using "priority education" mentioned by author CG in message 016	EVA
H005	**no**		**(eva1) assesses validity (+)** agrees using "priority education" mentioned by author CG in message 016	EVA
			↓	
			(exp2) justifies himself/herself - "survival kit" is "jungle-like" – not appropriate	EXP
H017	**yes (1)**	Pa(2)	**(eva1) assesses validity (+)** of the deliverables proposed by author MJP in message 002	EVA
			↓	
		→ CLa	**(exp2)** the deliverables proposed by MJP in message 002 will help the patient to safely (better-informed) go back home	EXP
H018	**no**		**(eva1) assesses validity (+)** of the heart health survival kit proposed by author MJP in message 002	EVA
			↓	
			(exp2) justifies his/her assessment by stating that he/she is working on a similar "kit" at his/her own institution	EXP
			(eva1) RE-assesses validity (+) of the heart health survival kit proposed by author MJP in message 002	EVA
ann.1 H018	**no**		**(ana4) counter-arguments** – RE-states that he/she prefers to call it "startup kit" or "first heart aid kit"	ANA

Table 16. Analysis of sequence *A* of *V10*: *Heart health kit*.

This sequence was initiated by author *MJP* (facilitator of the community of nurses) who used the rise-above tool to group all messages pertaining to the elaboration of the *Heart health kit* in his/her message *H002*. In his/her message (*H002*)' author *MJP* drew two conclusions (*inf2*) from the discussion that took place in *V2*: *At the heart of our exchanges*: 1-) a heart health survival kit could be elaborated and 2-) a kit could be developed if all nurses worked on collecting data on education programs for cardiac patients as well as developing the content of the kit. He/she then drew a conclusion (*inf2*) on the potential positive impact that the deliverables of the networked community has set to deliver on cardiac patients' self-responsibility. Two annotations were inserted within *H002*. Annotation *1* consisted of a counter-argumentation (*ana4*) on a proposal from author *YJ* stating that the terms "*clientele suffering from coronary disease or heart failure*" should be used instead of coronary disease and heart failure. He/she justified his/her analysis by stating that people would feel more concerned if the term was personalized. Annotation *2* also consisted of a counter-argumentation (*ana4*). The author of *ann.2.H002* claimed that he/she did not like the term "*survival kit*" proposed by author *YJ* in message *HHKim* but rather preferred the term "*priority education*". He/she justified his/her analysis by stating that: ""*priority education*" *refers to what will really be given to patients i.e. education that will permit him/her to safely live at home*".

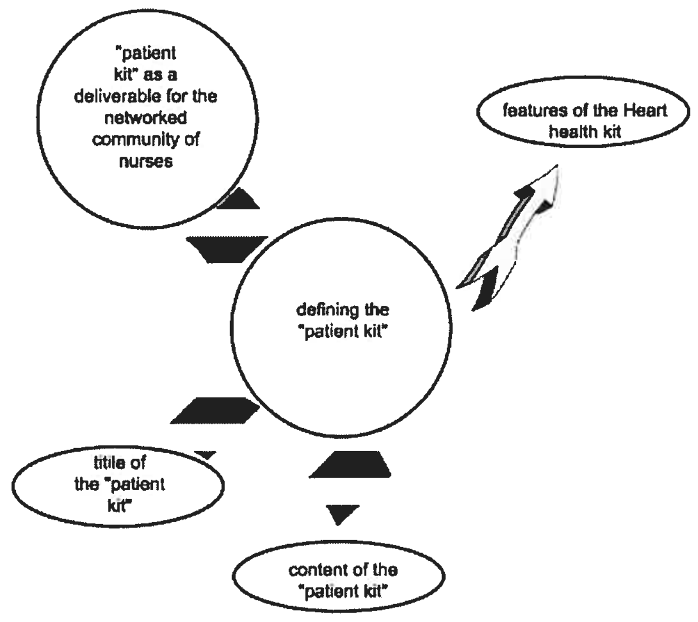

Figure 32. Schematization of sequence *A* of *V10*: *Heart health kit.*

The deliverable discussed within this sequence was firstly referred to as a "*patient kit*" that cardiac patients could take back home to help their rehabilitation process. Author *MJP* of message *H002* had picked up the idea of the "kit" as a deliverable in *V2*: *At the heart of our exchanges*. We assessed that author *YJ* had suggested the idea of a *kit* within *V2*: *At the heart of our exchanges* but that no one had responded to it. One of the reasons this happened was that the facilitator saw the opportunity of a "*concrete deliverable*" and created *V10* for this specific reason. The new view triggered responses from authors *FG* (*DC004*) and *LJ* (*H007*) who assessed, in a positive manner, the idea of elaborating a "*patient kit*" although they were unsure of the format and its utility. By clarifying the meaning of the "*patient kit*" he/she built an image of a "*survival kit*". The image of the "*survival kit*" was counter-argumented by authors *RD* (*H005*), *CG* (*H016*) and *CV* (*ann.1.H016*), while it was assessed, in a positive manner, by authors *CS* (*H013*), *LD* (*H017*) and *CP* (*H018*). There was a reconstruction of the meaning that author *YJ* had initially given to the "*patient kit*" (a kit that was going to be given to all cardiac patients for

self-education) to a renewed one: the patient kit would be a *Heart health kit* that would give priority to information that would allow patients to safely live at home after surgery, for example.

Sequence H

In the following chart, the theme linking all messages was *defining the heart health kit*.

Msg	Presence of argument	Argument parts	CT indicator	Cognitive Skill
Sequence H – V10: Heart health kit				
H029	**no**		**(int3) clarifies meaning** of deliverable intended to help patients be more responsible of their heart health	INT
			(inf2) draws conclusions on the need to ask themselves specific questions concerning the content of the kit	INF
			(ana6) questions – openly asks what the content of the kit should consist of, what the kit should be entitled and what should its mandate be	ANA
			(inf2) draws conclusions on the way answers to his/her questioning should be structured	INF
			(int1) categorizes (synthesizes) all messages posted concerning the kit in a-) mandate, 2-) target population, c-) content, d-) title of the kit	INT
H030	**no**		**(eval) assesses validity (+)** of including information on coronary patient education	EVA
			↓	
			(exp1) states results – answers questions asked by author MJP in message 029	EXP
H031	**no**		**(exp1) answers questions** asked by author MJP in message 029 concerning the a-) mandate, 2-) target population, c-) content, d-) title of the kit	EXP
H032	**yes (1)**		**(eval) assesses validity (+)** of the heart health survival kit proposed by author MJP in message 002	EVA
			↓	
			(exp2) justifies himself/herself – "survival kit" is too pejorative	EXP
		Pa(1) → CLa ←	**(inf2) draws conclusions** – the kit should contain specific elements, necessary for every user	INF
			↓	
		Pb(1)	**(exp2) justifies his/her conclusion** – the kit should be personalized	EXP
ann.1 H032	**yes**	Pa(1) → CLa	**(eval) assesses validity (+)** the kit should be personalized	EVA

			↓	
			(exp2) justifies his/her assessment – basic information should be included and a personalized version could be developed for every user – it would be more efficient	EXP
ann.2 H032	**no**		**(eva1) assesses validity** (+) the possibility of adapting the kit for ach individual is an advantage	EVA
H033	**no**		**(exp1) states results** - answers questions asked by author MJP in message 029 concerning the a-) mandate, 2-) target population, c-) content, d-) title of the kit	EXP
H034	**yes (1)**		**(eva1) assesses validity** (+) of the heart health survival kit proposed by author MJP in message 002	EVA
			(inf2) draws conclusions on the necessity of including available resources for the patient in the kit	INF
			↓	
			(exp1) states results - gives examples of available resources that could be included in the kit	EXP
			(inf2) draws conclusions on the content of the kit – it shouldn't be overwhelming for the patient and should include available resources for him/her	INF
			↓	
		Pa(1) → CLa	**(exp2) justifies his/her conclusion** – if the kit contains too much information, it will have a negative effect on the patient	EXP
H035	**yes (5)**	CLa ←	**(eva1) assesses validity** (+) of the heart health survival kit proposed by author MJP in message 002	EVA
			↓	
		Pa(2) Pb(3)	**(exp2) justifies his/her conclusion** – if the kit contains too much information, it will have a negative effect on the patient	EXP
		Clb ←	**(eva1) assesses validity** (+) the possibility of adapting the kit for each individual is an advantage	EVA
			↓	
		Pc(1) Pd(1) Pe(1)	**(exp2) justifies his/her assessment** – basic information should be included and a personalized version could be developed for every user – it would be more efficient	EXP
		CLc ←	**(eva1) assesses validity** (-) there shouldn't be a number of flyers and papers but the kit should rather be in a booklet format to which sections can be added when needed	EVA
			↓	
		Pf(1) Pg(1) Ph(1) Pi(1) Cld ← Pj(2)	**(exp2) justifies his/her assessment** – too much information will inundate the patient, practical information should be privileged, the kit should be complimentary to the nurse whose role it to evaluate, intervene and educate the patient on his/her illness and risk factors	EXP
		Cle ←	**(eva1) assesses validity** (+) of the heart health survival kit proposed by author MJP in message 002 and proposes ***Heart health kit*** as a title for the kit	EVA
			↓	

		Pk(3)	**(exp2) justifies his/her assessment** – Heart health kit sounds more positive, is more "health-related" than "disease-related" and has an aspect of responsibility and control within its title	EXP
ann.1 H035	**no**		**(eva1) assesses validity (+)** Heart health kit should be simple	EVA
			↓	
			(exp2) justifies his/her assessment – kit should be short and simple and correspond to the immediate needs of the patient	EXP
ann.2 H035	**yes (1)**	Pa(2)	**(eva1) assesses validity (+)** Heart health kit should be simple	EVA
			↓	
		→ CLa	**(exp2) justifies his/her assessment** – kit should be short and simple (2 pages maximum) and should include a lot of schemes so the patient can understand	EXP

Table 17. Analysis of sequence *H* of *V10*: *Heart health kit.*

Author *MJP* of message *H029* started by clarifying the meaning (*int3*) of the deliverable intended to help patients to take charge of their heart health. She drew a conclusion by making an inference (*inf2*): "*if nurses wish to elaborate a kit, then they should themselves what its content should be*". He/she then asked (*ana6*): "*what should the content of the kit consist of, which title should it have and what should it mandate be*". He/she suggested (*int1*) the following categories: *a-) mandate, 2-) target population, c-) content and d-) title of the kit*. Author *HB* of message *H030* assessed, in a positive manner, the validity (*eva1*) of including information on coronary patient education and answered (*exp1*) author *MJP*'s questions. Authors *YJ* (*H031*) and *JV* (*H033*) also answered *MJP*'s questions by sharing their ideas (*exp1*) on the mandate, target population, content and title of the kit.

In this sequence, the nurses continued defining the meaning of the "*Heart health kit*".

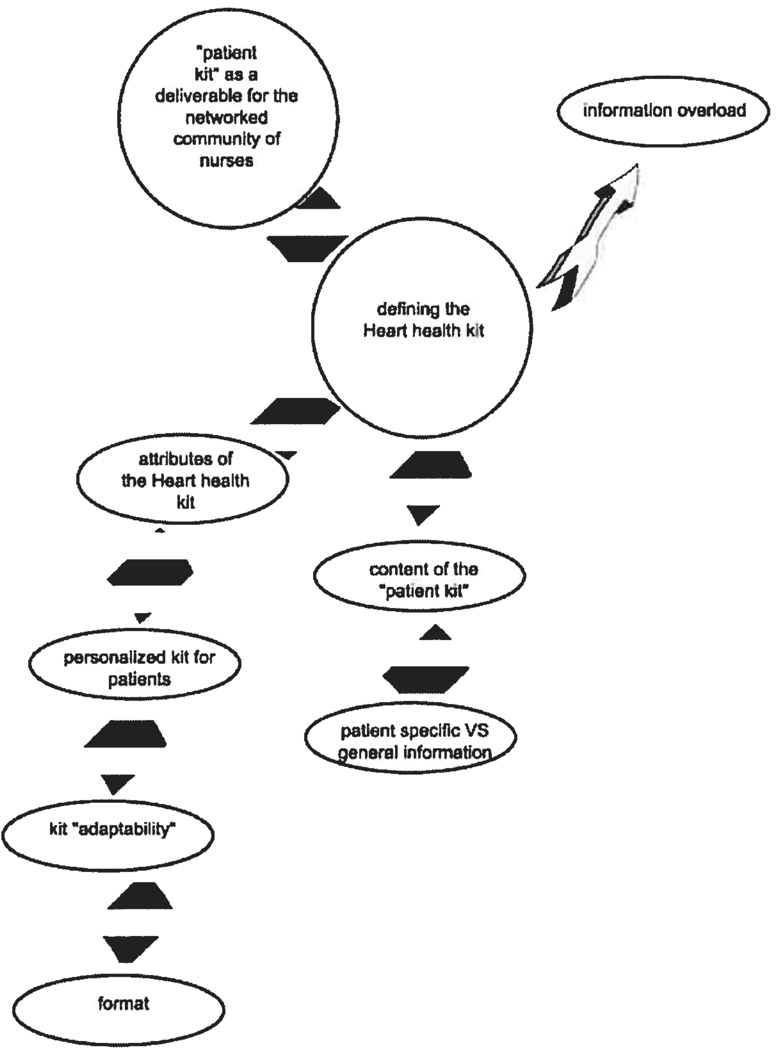

Figure 33. Schematization of sequence *H* of *V10*: *Heart health kit*.

In their reinterpretation of the *Heart health kit*, the nurses discussed a-) the attributes, b-) the content, c-) the adaptability of the kit and d-) the possibility of creating personalized versions of the kit depending on the patient's case and condition. Schematization occurred within sequence *H* since the idea of the *kit* was first seen as a kit containing common information for all cardiac patients to an adaptable kit in which specific information, corresponding to the immediate needs of the patients, would be included and given to them one a one to one basis.

Level of critical thinking

Sequence A

The most frequent CT indicators found were *exp2* (41%) and *eval* (41%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation* and *evaluation*. In this sequence, the nurses mostly debated on the title of the deliverable they would build together and explained their reasons. While the development of a *patient kit* was seen in a favorable manner, the idea of developing a *survival kit* (as suggested by author *YJ* in *HHKim*) got a counter-argument by authors *RD* (*H005*), *CG* (*H016*) and *CV* (*ann.1.H016*) who evaluated the *kit* as a *heart health kit* that would constitute "*priority education for the cardiac patient i.e. education and information that would permit him/her to safely return home after an operation, for example*". Although arguments were present in 60% of the messages in this sequence, the debate was about the title of the deliverable and not its content. Because the contributions within this sequence were mostly concerned the title of the kit, we qualified the level of critical thinking as being *medium-strong* since the title was somewhat indicative of its value as a tool for patient education.

Sequence H

The most frequent CT indicators found were *exp2* (27%) and *eval* (27%) followed by *inf2* (19%) and *exp1* (15%). These CT indicators interpreted in CT skills correspond to the cognitive skills *explanation* and *evaluation* followed by *inference*. It was within this sequence that nurses demonstrated the strongest level of critical thinking. In their reinterpretation of the *Heart health kit* (their deliverable) the nurses discussed a-) the attributes, b-) the content, c-) the adaptability of the kit and d-) the possibility of creating personalized versions of the kit depending on the patient's case and condition. The nurses collectively built a deliverable which would assist them in their patient education in their home institutions. The process of *defining the heart health kit* was from far the most visible effort of *knowledge-building* resulting from the *problem-solving process* that occurred in the networked community of nurses.

Conclusion

Arguments are made of one or more premises that lead to a conclusion. In our analysis, we sought to study the relation between the parts of an argument and critical thinking skills in the most active sequences of three views.

Significant level of argumentation

The total number of messages within all sequences of all three views (*V2*: *At the heart of our exchanges*, *V9*: *Data collection*, and *V10*: *Heart health kit*) equaled seventy-two. Of the seventy-two messages, forty-two messages had arguments, i.e. 58% (Figure 34).

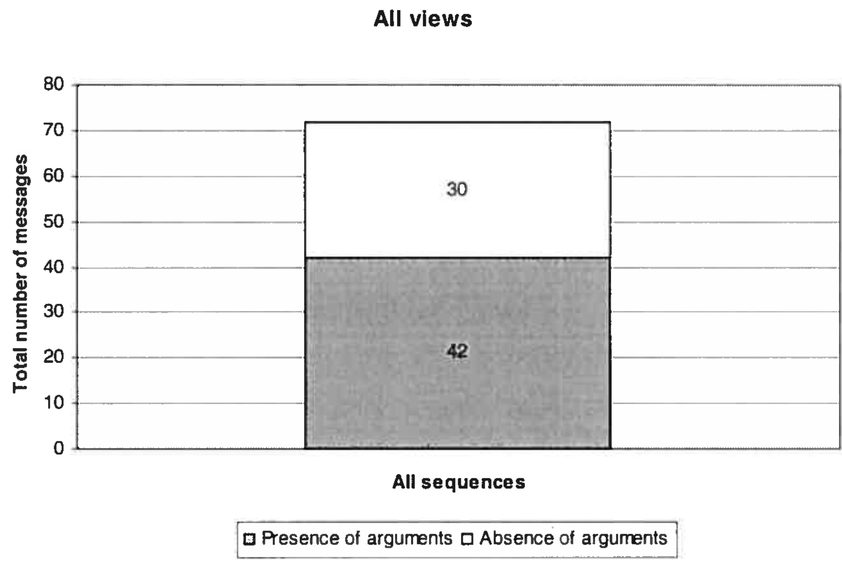

Figure 34. Presence of arguments within all sequences of *V2*: *At the heart of our exchanges*.

Most arguments were found within *V9*: *Data collection* (ratio of .89) in which we assessed the presence of sixteen arguments within the eighteen messages making up sequences *D*

and *J* of the given sequence. Hereunder, Table 18 illustrates the ratio presence of argument/message within each sequence for each view.

	# of arguments	# of messages	Ratio presence of argument/message
Seq. A of V2	13	16	.81
Seq. F of V2	9	10	.90
Seq. H of V2	2	4	.50
Seq. J of V2	3	5	.60
Seq. P of V2	2	2	1.0
All seq. of V2	**27**	**35**	**.77**
Seq. D of V9	10	11	.91
Seq. J of V9	6	7	.86
All. seq. of V9	**16**	**18**	**.89**
Seq. A of V10	5	10	.50
Seq. H of V10	7	7	1.0
All seq. of V10	**12**	**17**	**.71**
All seq. of all V	**55**	**70**	**.79**

Table 18. Ratio presence of argument/message per sequence within each view.

High level of explanation, modest level of inference

In the five sequences making up *V2*: *At the heart of our exchanges*, we noticed that 42 premises out of the total 63 premises presented by the nurses were included within the CT skill *explanation.* In other words, 67% of premises were within code *EXP*. In the two sequences making up *V9*: *Data collection*, 27 premises out of the total 36 premises were also present within the CT skill *explanation - accounting* for 75%. In the two sequences making up *V10*: *Heart health kit*, 23 out of the total 28 premises were also present within the CT skill *explanation* – accounting for 82%. (Table 19)

CT skill / Sequences	*INT*	*ANA*	*EVA*	*INF*	*EXP*	*Total number of CT skills*
Seq. *A* of *V2*	1	1	0	4	19	25
Seq. *F* of *V2*	1	4	0	4	13	22
Seq. *H* of *V2*	1	0	0	0	5	6
Seq. *J* of *V2*	0	0	1	1	5	7
Seq. *P* of *V2*	0	0	2	0	1	3
All seq. of *V2*	**3**	**5**	**3**	**9**	**42**	**63**
Seq. *D* of *V9*	3	0	0	1	18	22
Seq. *J* of *V9*	0	0	0	5	9	14
All. seq. of *V9*	**3**	**0**	**0**	**6**	**27**	**36**
Seq. *A* of *V10*	0	0	2	0	4	6
Seq. *H* of *V10*	0	0	2	1	19	22
All seq. of *V10*	**0**	**0**	**4**	**1**	**23**	**28**
All *VIEWS*	**6**	**5**	**7**	**16**	**92**	

Table 19. Presence of premises within CT skills for all views.

Strong level of critical thinking

In sum, the weakest level of critical thinking was assessed within sequences *H, J* and *P* of *V2*: *At the heart of our exchanges*. The strongest level of critical thinking was assessed within sequences *A* and *F* of *V2*: *At the heart of our exchanges*, *D* and *J* of *V9*: *Data collection* as well as in *H* of *V10*: *Heart health kit*. A medium-strong level of critical thinking was identified within sequence *A* of *V10*: *Heart health kit*. On average, most sequences were qualified as demonstrating a ***strong*** level of critical thinking skills.

Chapter 5: Conclusion

This section discusses the results of the study in relation to the purpose, research questions and the literature. The purpose of this study was to explore the dialogical, reflective and recursive process of networked knowledge building in order to assess, to analyze and to understand how critical thinking unfolds. Critical thinking was understood, in the framework of this study, as a *process* that could be structured and supported within the frame of a networked environment. We sought to address the following questions: (1) Can we assess the presence of critical thinking in networked discourse? (2) Did the networked community of nurses *engage* in critical thinking? and (3) If so, the knowledge built was of a lower of higher level?

The results presented in the previous chapters suggest that there was "*a lot of looping back, starting over, jumping ahead and so on*" (Bereiter, 2002) on "*identifiable subject areas* [and problems]" (McPeck, 1981) which nurses chose to discuss in a critical fashion. Quantitative results (presence of arguments in most messages) along with qualitative results (astute use of skepticism (judgment) and assessment of statements) suggest that there was a "[collaborative] *knowledge building process in which* [nurses] *actively constructed knowledge by formulating ideas into words and built upon the reactions and responses to others*" (Harasim & al., 1995). Although many questions remain about the appropriateness of the critical thinking indicators applied in this study, they generally enabled us to assess critical thinking in the progressive discourse of the networked community of nurses.

Results also show that building knowledge in collaboration within a networked community is not a simple task. While the technology used (*Knowledge Forum*) may have attributes that might have facilitated a dynamic and interactive experience, knowing *how* and *when* to apply reflective skepticism within a problem area under consideration and applying certain

logical skills that allow mental constructions are needed on the part of the participants of any professional networked community.

Based on the «*problems under consideration* » (McPeck, 1981), the nurses deliberately chose the course of their discussion by focusing on problems encountered in their nursing practice. Early on, problems to be resolved such as patient responsibility and patient education gave birth to the idea of creating a «*Heart health kit* ». The «Heart health kit initiator message » (*HHKim*), as we labeled it, was introduced early on in the discussion but was only fully acknowledged and taken in consideration when the facilitator of the networked community of nurses suggested that it could become a concrete deliverable for their community.

Our analysis suggests that the nurses engaged in critical thinking namely in the elaboration of that *Heart health kit*. In order to arrive to the development of the kit, they first introduced the notion of «*patient responsibility* » in their discussions. This theme brought about a discussion on the various behavioral change models which could be used to entice a behavior change of the patient. Models based on literature (Pender, Prochaska, etc.), presented by the nurses in their discussions, and examples drawn from their nursing practice were discussed. Rehabilitation programs were thought to be the most productive to help patients to take charge. The discussion soon shifted on the assessment of whether or not rehabilitation programs should be medically prescribed and on the level of success of such measures. Nursing strategies such as motivating and supporting patients were suggested as a counter-argumentation to medically-prescribed rehabilitation programs because of their softer and more human approach. The idea of a "*patient contract*" soon became a solution to patients' lack of responsibility towards their health. While some nurses were defending the idea that forcing patients to sign contracts will make them more responsible, others saw the problem of patient responsibility at a macro level. The "lack" of responsibility on the patients' part was in part due to the lack of "*patient education*". Patient education was seen as a responsibility

that patients had to assume while others argued that the nurses had the responsibility to properly educate them about the importance of better nutrition and lifestyle habits such as quitting smoking and exercising regularly. The nursing strategy (educating the patient on the importance of their heart health) was seen as an individual task for some while others saw it as a societal problem that needed to be addressed.

Another problem area discussed was "*repetitiveness in patient data collection*". "*Patient data collection*" was seen as conflicting within departments and not well timed. The nurses introduced the idea of elaborating a new, revised version of patient data collection – a universal data collection. The universal data collection would be easily accessible to all departments a patient suffering from heart-related illnesses would visit.

Two problems were solved by the networked community: repetition in patient data collection and creation of a *Heart health kit* to assist them in patient education in order to achieve behavioral change of the patient. In order to solve their problems, the nurses used critical thinking skills such as the use and rejection of methods, strategies and techniques of discussion and the appropriate use of reflective skepticism (McPeck, 1981).

Schematization (Grize, 1991) occurs when interlocutors help to interpret each other's world, solve problems and build knowledge in collaboration. In the case of the networked community of nurses, the themes « *patient education* » and « *data collection* » were built and rebuilt, giving way to new themes « *Heart health kit* » and « *universal data collection* ». This process of productive thinking (Bereiter, 2002) corresponds to Grize's view of « *communication as argumentation* ». In addition, the asynchronous characteristic of text-based communication seems to have enabled deeper reflection that, in turn, enabled engagement in critical discourse (Anderson & Garrison, 1995). In the context of the networked community of nurses, most sequences were qualified as demonstrating a ***strong*** level of critical thinking skills. The asynchronous attribute of the technology is known to

foster in-depth thinking skills (Bruer, 1994) which allowed them to build knowledge. The results are in line with the idea of progressive discourse (Bereiter, 2002) and progressive communication (Campos, 2003). Furthermore, the support features of the technology used can also be said to have helped in the development of hypotheses, problem-solving, idea improvement and knowledge-building (Scardamalia, 2002). In line with McPeck's view (only problems can be thought of critically) and the constructivist view (thought processes cannot be simply divided in consecutive phases such as those of linear processes but must be understood as inherently *progressive*), it can be suggested that the networked community of nurses *engaged* in critical thinking in their problem-solving process achieving moments of strong argumentation typical of knowledge building.

The findings of this study have provided tentative answers to the research questions that guided it. The process of analyzing transcripts of networked communication in the search for evidence of critical thinking, assessment of its level and presence of schematizations is still in its infancy. Nevertheless, the way the critical thinking indicators were operationalized in this study enabled a first trial towards their interpretation in terms of the cognitive skills of the critical thinker.

The results of this study might have implications for practitioners' engaged in networked communities. Whether or not one subscribes to the view that networked communication is an efficient way to enable the advancement of a task, a project or the resolution of a problem at hand, it is unquestionably an opportunity for practitioners to virtually gather, share their knowledge and expertise and interact. And for that, the results of this research suggest that higher order communication ("collaboratio")[35] is related to a strong level of critical thinking.

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[35] See Campos (2003)

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Appendix 1

List of messages in chronological order of the view *V2: At the heart of our exchanges*

# of message	Creation date	Subject of message	Author
E001	11 Jan 2002	Brainstorming	MJP
E002	13 Mars 2002	Thèmes suggérés	RD
E003	15 Mars 2002	Themes	IG
E004	16 Mars 2002	Quetion	CG
E005	17 Mars 2002	(untitled)	LL
E006	17 Mars 2002	Le support à donner aux familles des patients	MJP
E007	17 Mars 2002	questionnements	LD
E008	18 Mars 2002	Education du publique	FB
E009	18 Mars 2002	responsabiliser; état santé	AMR
E010	18 Mars 2002	Maladie de coeur pour les autres seulement	IG
E011	18 Mars 2002	Support a la famille	FB
E012	19 Mars 2002	enseign.durant l,hospitalisation	HB
E013	19 Mars 2002	(untitled)	YJ
E014	19 Mars 2002	Signification de la maladie	RD
E015	19 Mars 2002	(untitled)	YJ
E016	19 Mars 2002	responsabiliser	HB
E017	19 Mars 2002	(untitled)	YJ
E018	20 Mars 2002	Patient/famille/systeme de sante	FB
E019	20 Mars 2002	Personaliser/Respecter	FB
E020	20 Mars 2002	opinion utiliser maquette	HS
E021	20 Mars 2002	Ou commencer?	FB
E022	20 Mars 2002	(untitled)	HS
E023	21 Mars 2002	Prochaska	FB
E024	21 Mars 2002	Enseignement....	SH
E025	21 Mars 2002	(untitled)	IG
E026	23 Mars 2002	SYNTHÈSE / 23 mars 2002	MJP
E027	23 Mars 2002	PROMOTION	MJP
E028	23 Mars 2002	TRAITEMENTS	MJP
E029	23 Mars 2002	PRISE EN CHARGE	MJP
E030	23 Mars 2002	AUTRE : question éthique	MJP
E031	23 Mars 2002	RÉADAPTATION	MJP
E032	25 Mars 2002	Questions sur le modèle de Prochaska	MJP
E033	25 Mars 2002	Di Clemente et Prochaska	NM
E034	25 Mars 2002	enseignement selon les besoins	CV
E035	25 Mars 2002	etape pour fumeur	AMR
E036	25 Mars 2002	Ma santé, ma décision!	FB
E037	25 Mars 2002	support à la famille soins intensifs	CV
E038	25 Mars 2002	Adhésion aux recommandations	NM
E039	25 Mars 2002	Centre Hospitalier Ambulatoire	AMR
E040	25 Mars 2002	Expériences à domicile.	FL
E041	26 Mars 2002	models vs réadaptation	CG
E042	26 Mars 2002	Éléments d'information	MCC
E043	26 Mars 2002	Modèles	LD
E044	26 Mars 2002	comité d'éthique	LD

E045	26 Mars 2002	éthique et douleur	CV
E046	26 Mars 2002	génogramme et écocarte	LD
E047	26 Mars 2002	Patenariat	CG
E048	26 Mars 2002	Adopter une approche	LD
E049	26 Mars 2002	ESTIMATION DE L'OBSERVANCE DE TRAITEMENT	CV
E050	27 Mars 2002	Modèle prochaska	JL
E051	27 Mars 2002	Auto-surveillance I-C	AMR
E052	28 Mars 2002	Être à l'écoute	FB
E053	28 Mars 2002	Positifs	FB
E054	28 Mars 2002	Durée du suivit	FB
E055	28 Mars 2002	Famille Allié où adversaire?	FB
E056	28 Mars 2002	Anecdote	FB
E057	28 Mars 2002	Technologie/solution?	FB
E058	29 Mars 2002	Suivi act. physique	JH
E059	29 Mars 2002	Modele de changement par etapes	JH
E060	29 Mars 2002	Modele de chang. par etapes	JH
E061	29 Mars 2002	En accord	JH
E062	29 Mars 2002	themes d'enseignement	JH
E063	29 Mars 2002	Enseignement	JH
E064	29 Mars 2002	(untitled)	PL
E065	29 Mars 2002	Idee interessante/continuum	JH
E066	29 Mars 2002	Genogramme	JH
E067	29 Mars 2002	Implication famille	JH
E068	29 Mars 2002	Mes questionnements	JH
E069	29 Mars 2002	Motivation	JH
E070	30 Mars 2002	Thèmes de discussion	SH
E071	30 Mars 2002	continuité des soins	LJ
E072	31 Mars 2002	stratégies d'enseignement	JV
E073	1 Avril 2002	outils=modèle	LD
E074	1 Avril 2002	programme d'enseignement angin einfarctus	LL
E075	1 Avril 2002	axer les ressources sur la santé	LD
E076	1 Avril 2002	(untitled)	CG
E077	1 Avril 2002	act. phys.:persévérance	LD
E078	1 Avril 2002	(untitled)	HB
E079	1 Avril 2002	untitled)	CG
E080	1 Avril 2002	Modèle de Calgary	LD
E081	1 Avril 2002	utilisation génogramme	CG
E082	1 Avril 2002	(untitled)	CG
E083	1 Avril 2002	(untitled)	CG
E084	1 Avril 2002	(untitled)	CG
E085	1 Avril 2002	themes	CS
E086	2 Avril 2002	Modèle Pender	RD
E087	2 Avril 2002	Modèles de changements de comportements	MJP
E088	2 Avril 2002	QueQuelqueslues	RD
E089	2 Avril 2002	Enseignement à la clientèle cardiaque	MJP
E090	2 Avril 2002	Questions éthiques	MJP
E091	2 Avril 2002	Promotion de la santé du coeur	MJP
E092	2 Avril 2002	Activités physiques	MJP
E093	2 Avril 2002	Raisons sur le manque d'activités physiques	RD
E094	2 Avril 2002	un peu d'exercices au quotidien	MJP
E095	2 Avril 2002	Escaliers au lieu des ascenseurs	RD
E096	2 Avril 2002	Familles des patients	MJP
E097	2 Avril 2002	Formation aux infirmières incluant le savoir être	RD

E098	2 Avril 2002	Observance aux traitements	MJP
E099	2 Avril 2002	Traitements / dilatation d'un jour	MJP
E100	2 Avril 2002	ESPACE ALLÉGÉ / regroupement des notes	MJP
E101	4 Avril 2002	Autres questionnements	MJP
E102	7 Avril 2002	Élaborer à partir d'une note dite synthétisée	MJP
E103	9 Avril 2002	voici ce que j'aimerais discuter	ML
E104	9 Avril 2002	La visibilité des CLSC	YJ
E105	9 Avril 2002	enseignement avec modèle	YJ
E106	11 Avril 2002	l'enseignement et le client	JL
E107	11 Avril 2002	(untitled)	JL
E108	12 Avril 2002	Bouche-à-bouche	FB
E109	12 Avril 2002	Client+famille=Succès	FB
E110	12 Avril 2002	"Recovery Road"	FB
E111	12 Avril 2002	(untitled)	GB
E112	12 Avril 2002	On sème on récolte	FB
E113	12 Avril 2002	(untitled)	GB
E114	13 Avril 2002	(untitled)	GB
E115	13 Avril 2002	(untitled)	GB
E116	13 Avril 2002	Contrat vs culpabilité	LD
E117	15 Avril 2002	résolutions de problèmes	JV
E118	16 Avril 2002	trousse de survie(enseignement minimum)	YJ
E119	16 Avril 2002	Contrat=Entente	FB
E120	18 Avril 2002	Quel bonbon offrir a votre patient?	YJ
E121	18 Avril 2002	Un contrat.Pourquoi pas?	YJ
E122	19 Avril 2002	(untitled)	PL
E123	20 Avril 2002	enseign et famille=OUI OUI	HB
E124	20 Avril 2002	Consentement/refus	HB
E125	29 Avril 2002	référence pertinente-question#1	JH
E126	29 Avril 2002	référence - question#2	JH
E127	29 Avril 2002	Motivation et facteurs psycho-sociaux - question#1	JH
E128	29 Avril 2002	Modèles théoriques - question#2	JH
E129	29 Avril 2002	problématique de santé et famille	JH
E130	30 Avril 2002	proposition- modèle conceptuel	JH
E131	1 Mai 2002	Élaboration de notes sur les facteurs de risque.	FL
E132	20 Mai 2002	(untitled)	IG
E133	14 Juin 2002	(untitled)	RD
E134	14 Juin 2002	Modèle Wright et leahey (1995)	RD
E135	14 Juin 2002	(untitled)	RD
E136	1 Juillet 2002	(untitled)	LL
E137	6 Août 2002	Selon les ressources en place.	LD

Appendix 2

List of messages in chronological order of the view *V9*: *Data collection*

# of message	Creation date	Subject of message	Author
DC1	04 April	Méthodologie / Livrables	MJP
DC2	09 April	(untitled)	CG
DC3	10 April	Collecte cde données Insuffisance cardiaque	SH
DC4	11 April	collecte de donnees maladie coro.	JH
DC5	12 April	Observations	AR
DC6	12 April	notre collecte de données est désuette	YJ
DC7	13 April	De l'eau au moulin	LD
DC8	13 April	Évaluer l'enseignement... un art à découvrir.	LD
DC10	13 April	Problème de collecte de données?	LD
DC11	13 April	Problème d'alphabétisation	LD
DC12	13 April	Proposition d'un modèle	LD
DC13	13 April	Changer de perspective	MJP
DC14	14 April	Quoi évaluer?	CG
DC15	14 April	Super Logiciel !	CG
DC16	14 April	Collecte de données VS programme d'enseignement	CG
DC17	14 April	Besoins prioritaires	CB
DC18	14 April	Enseignement a clini coeur?	LL
DC19	15 April	(untitled)	JV
DC20	16 April	Outil	FB
DC21	16 April	Matériaux	FB
DC22	16 April	Modèles	FB
DC23	16 April	Opinion sur une collecte de données à domicile.	FL
DC24	16 April	collecte de données en soins aigus versus clinique externe	YJ
DC25	17 April	(untitled)	CB
DC26	17 April	(untitled)	CB
DC27	18 April	Compliance	FG
DC28	18 April	Lectures	FG
DC29	18 April	(untitled)	CB
DC30	19 April	Certains seulement	FB
DC31	19 April	Une bonne fondation	FB
DC32	19 April	(untitled)	GB
DC33	19 April	(untitled)	GB
DC34	19 April	Modèle?	HB
DC35	21 April	collecte: éléments essentiels	LJ
DC36	21 April	collecte de données : éléments essentiels	LJ
DC37	21 April	Données complémentaires au profil	CV
DC38	21 April	Grades pour lecture de textes ?	LD
DC39	21 April	Mesurer le niveau d'anxiété	LD
DC40	21 April	coeur et hormonothérapie	LD
DC41	21 April	type de personnalité	LD
DC42	22 April	Questionnement # 1	MJP

DC43	22 April	Questionnement # 2	MJP
DC44	22 April	Questionnement # 3	MJP
DC45	22 April	Nouveau questionnement : # 4	MJP
DC46	22 April	L'outil multiclientèle	NM
DC47	25 April	Proposition	JH
DC48	25 April	stades d'adaptation du client	SB
DC49	26 April	Quelques pistes	JH
DC50	28 April	personnes âgées, collecte de données, apprentissage	CV
DC51	28 April	Prochaska	NM
DC52	29 April	Bon outil	FB
DC53	29 April	(untitled)	GB
DC54	29 April	(untitled)	GB
DC55	29 April	(untitled)	GB
DC56	29 April	Enseignement à domicile	FL
DC57	29 April	Opinion ré:personnes agées et changement du mode de vie.	FL
DC58	30 April	facteurs psychosociaux	MJP
DC59	30 April	collecte de donnees(untitled)IC	CS
DC60	1 May	(untitled)	SH
DC61	1 May	(untitled)	SH
DC62	1 May	(untitled)	CV
DC63	1 May	Partenaires en réseaux	CV
DC64	2 May	Bonne idée	JH
DC65	2 May	ajout proposé	JH
DC66	2 May	Données socio(untitled)démographique et clinique	MJP
DC67	2 May	Examen clinique et évaluation initiale	MJP
DC68	2 May	Examen Clinique et Suivi	MJP
DC69	2 May	IMPORTANT : Indications de l'animatrice	MJP
DC70	5 May	impact particulier selon l'âge	CG
DC71	5 May	Quelles questions choisir?	CG
DC72	5 May	collecte de données ne rime pas toujours enseignement	CG
DC73	6 May	collecte de données divisée par bloc	YJ
DC74	7 May	Collecte de données en 3 blocs !	MJP
DC75	8 May	Collecte en réseaux intégrés	NM
DC76	8 May	intérêt collecte de données	HB
DC77	9 May	(untitled)	LL
DC78	19 May	(untitled)	GB
DC79	19 May	(untitled)	GB
DC80	19 May	(untitled)	GB
DC81	19 May	données à ajouter	GB
DC82	20 May	(untitled)	GB
DC83	20 May	continuité des soins	CG
DC84	6 June	collecte de données multi, est ce possible et réalisable	HB
DC85	14 June	ajouter marié...	RD
DC86	14 June	ajout fact4eurs de risque	RD
DC87	14 June	Référence Prochaska	RD
DC88	14 June	Coping plutôt que personnalité A et B	RD
DC89	9 July	références coping	RD

Appendix 3

List of messages in chronological order of the view *V10*: *Heart health kit*

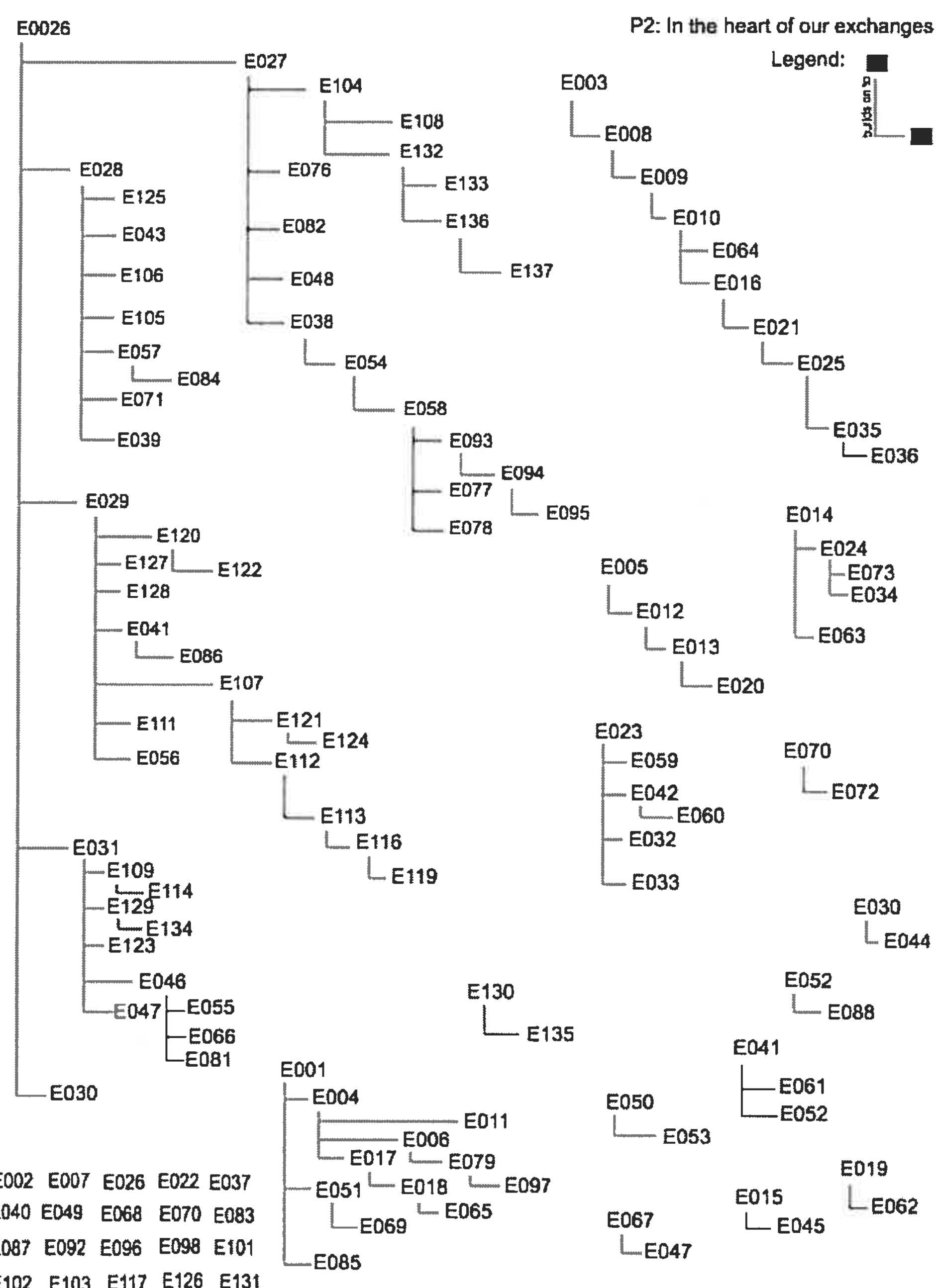
# of message	Creation date	Subject of message	Author
H001	10 Avril 2002	trousse de survie	YJ
H002	11 Avril 2002	Proposition / livrables à se donner	MJP
H003	12 Avril 2002	"Recovery Road"	FB
H004	12 Avril 2002	Trousse de survit	FB
H005	12 Avril 2002	trousse de survie	HS
H006	12 Avril 2002	Trousse de survie	CP
H007	13 Avril 2002	(untitled)	GB
H008	13 Avril 2002	Créer des liens	LD
H009	14 Avril 2002	Trousse de survie	LL
H010	16 Avril 2002	trousse de survie(enseignement minimum)	YJ
H011	19 Avril 2002	la trousse , c,est pour la maison	HB
H012	20 Avril 2002	l'un complète l'autre	HB
H013	21 Avril 2002	(untitled)	CS
H014	22 Avril 2002	Définir notre livrable : Trousse ...	MJP
H015	02 Mai 2002	Kit de survie	FG
H016	05 Mai 2002	D'accord avec enseignement prioritaire	RD
H017	05 Mai 2002	Signification et le modèle de «caring» de Watson	RD
H018	05 Mai 2002	Enseignement prioritaire	CG
H019	05 Mai 2002	(untitled)	CG
H020	07 Mai 2002	Accord et proposition	LJ
H021	07 Mai 2002	Trousse, mode d'emploi.	LD
H022	10 Mai 2002	Contenu de la trousse	PL
H023	10 Mai 2002	trousse de dépannage	JZ
H024	11 Mai 2002	(untitled)	SH
H025	13 Mai 2002	Feuillet : Angine, Plan d'action	MJP
H026	15 Mai 2002	feuillet-commentaire	JH
H027	14 Mai 2002	A eviter	FB
H028	18 Mai 2002	23/05/2002 Résultat du vote	MJP
H029	20 Mai 2002	(untitled)	IG
H030	23 Mai 2002	Symptomes	FB
H031	23 Mai 2002	23/05/2002 Formation des équipes	MJP
H032	23 Mai 2002	(untitled)	CB
H033	29 Mai 2002	(untitled)	SH
H034	29 Mai 2002	Equipes	NSL
H035	29 Mai 2002	Vote	NSL
H036	06 Juin 2002	Information sur la perspective : Trousse ...	MJP
H037	06 Juin 2002	6 juin 2002 / Indications à suivre	MJP
H038	06 Juin 2002	6 juin / Indications à suivre	MJP
H039	06 Juin 2002	6 juin / Indications à suivre	MJP
H040	06 Juin 2002	IC : Auto-surveillance des signes et des symptômes	MJP
H041	06 Juin 2002	IC : Médicaments et mises en garde	MJP
H042	06 Juin 2002	IC : Alimentation	MJP
H043	06 Juin 2002	IC : Activités	MJP

H044	07 Juin 2002	Suggestions	JH
H045	07 Juin 2002	symptômes insuffisance cardiaqu	LL
H046	07 Juin 2002	MC : Auto-surveillance des signes et des symptômes	MJP
H047	07 Juin 2002	MC : Médicaments et mises en garde	MJP
H048	07 Juin 2002	MC : Alimentation	MJP
H049	07 Juin 2002	MC : Activités	MJP
H050	07 juin 2002	Le tabagisme	MJP
H051	07 Juin 2002	L'hypertension artérielle	MJP
H052	07 Juin 2002	Qu'est-ce que la TA	IG
H053	07 Juin 2002	L'obésité	MJP
H054	07 Juin 2002	La dyslipidémie (hypercholestérolémie)	MJP
H055	07 Juin 2002	La sédentarité	MJP
H056	07 Juin 2002	Le diabète	MJP
H057	07 Juin 2002	Aide-mémoire de rendez-vous	MJP
H058	08 Juin 2002	(untitled)	SH
H059	08 Juin 2002	moyens pour favoriser l'observance	CV
H060	08 Juin 2002	Conseils	CV
H061	10 Juin 2002	D'autres facteurs de risque	FB
H062	10 Juin 2002	Resources pour le publique	FB
H063	11 Juin 2002	Le stress	MJP
H064	12 Juin 2002	Symptômes de l'insuffisance cardiaque	YJ
H065	12 Juin 2002	Questions_abandon du tabac	MJP
H066	13 Juin 2002	PQRST	HS
H067	14 Juin 2002	signes et symptomes	JZ
H068	14 Juin 2002	effets du tabac	JH
H069	14 Juin 2002	Moyens	JH
H070	14 Juin 2002	effets de l'HTA	JH
H071	14 Juin 2002	Recommandations	JH
H072	14 Juin 2002	effets	JH
H073	14 Juin 2002	effets	JH
H074	14 Juin 2002	Causes	JH
H075	14 Juin 2002	conseils	JH
H076	16 Juin 2002	indices de détérioration	CG
H077	17 Juin 2002	intensité des signes et symptômes	LJ
H078	17 Juin 2002	Différences	LJ
H079	17 Juin 2002	Conséquences de l'obésité	LD
H080	18 Juin 2002	à partir de vos premières réflexions	MJP
H081	18 Juin 2002	Exercice de la fiche	YJ
H082	18 Juin 2002	Effets du tabagisme	CB
H083	18 Juin 2002	Effets sur l'organisme	FB
H084	19 Juin 2002	plan alimentaire	NM
H085	19 Juin 2002	Temps du sevrage	CB
H086	19 Juin 2002	Conseil-Prochaska	FB
H087	19 Juin 2002	Moyens	FB
H088	21 Juin 2002	Durée du sevrage	MJP
H089	25 Juin 2002	activités physiques	CV
H090	25 Juin 2002	Signes et symptômes	FB
H091	25 Juin 2002	Conseils	FB
H092	26 Juin 2002	sedentarité	HB
H093	27 Juin 2002	suite de la médication	YJ
H094	27 Juin 2002	Bénéfices	HB
H095	27 Juin 2002	AIDE-MÉMOIRE	HB

H096	30 Juin 2002	Avantages à cesser de fumer	CB
H097	04 Juillet 2002	TNT	FG
H098	04 Juillet 2002	Fiche positive	FG
H099	05 Juillet 2002	Diabète	HB
H100	06 Juillet 2002	(untitled)	HB
H101	12 Juillet 2002	Conseils alimentaires	CS
H102	12 Juillet 2002	activité physique	NM
H103	12 Juillet 2002	définition	LD
H104	12 Juillet 2002	opinion	JH
H105	12 Juillet 2002	«Formule gagnante»	JH
H106	12 Juillet 2002	Extrait- mémoire de maîtrise_implications pour la pratique	JH
H107	12 Juillet 2002	connaître ses pilules	LD
H108	12 Juillet 2002	Questionnement sur les réactions face au stress	JH
H109	12 Juillet 2002	Réactions face au stress (détresse psyhologique)	JH
H110	12 Juillet 2002	Qu'Est-ce que le stress ?	JH
H111	15 Juillet 2002	(untitled)	SH
H112	16 Juillet 2002	calculer le taux de sodium dans une journée	JZ
H113	16 Juillet 2002	insuffisance cardiaque et voyages	CV
H114	17 Juillet 2002	(untitled)	SH
H115	24 Juillet 2002	Dossier virtuelle à consulter	MJP
H116	25 Juillet 2002	Un calendrier !	MJP
H117	26 Juillet 2002	contribution pour le calendrier	CV
H118	28 Juillet 2002	pqrst	HB
H119	28 Juillet 2002	Signes	HB
H120	28 Juillet 2002	quoi faire si drs	HB
H121	29 Juillet 2002	(untitled)	SH
H122	29 Juillet 2002	Un calendrier pour les IC	MJP
H123	29 Juillet 2002	Dossier virtuel à consulter	MJP
H124	29 Juillet 2002	(untitled)	SH
H125	29 Juillet 2002	Gestion du stress	SH
H126	29 Juillet 2002	(untitled)	SH
H127	29 Juillet 2002	Douleur des femmes et des hommes	MJP
H128	30 Juillet 2002	(untitled)	HB
H129	30 Juillet 2002	(untitled)	HB
H130	31 Juillet 2002	Lait 1%	RD
H131	02 Août 2002	J'ai une question SVP	MJP
H132	04 Août 2002	(untitled)	SH
H133	05 Août 2002	Une autre question SVP	MJP
H134	05 Août 2002	La pollakiurie, la nuit?	CV
H135	06 Août 2002	Syndrôme du yoyo	RD
H136	06 Août 2002	Diète, régime, etc.	LD
H137	09 Août 2002	(untitled)	CS
H138	09 Août 2002	(untitled)	CS
H139	09 Août 2002	(untitled)	CS
H140	16 Août 2002	J'ai une question SVP	MJP

Appendix 4

Graphic representation of build-on mode of messages of the view V2: *At the heart of our exchanges*



Appendix 5

Coding of sequence A of V2: At the heart of our exchanges

E029	
Creation date :	23 Mars 2002
Subject :	**PRISE EN CHARGE**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	
Author :	MJP
This note references:	[1] Modèles de changement de comportement by MJP
This note is referenced by :	proposition- modèle conceptuel by JL Modèles théoriques - question#2 by JL
This note is built-on to :	SYNTHÈSE / 23 mars 2002 by MJP
This note is built-on to by :	models vs réadaptation by CG Anecdote by FB (untitled) by JL (untitled) by GB Quel bonbon offrir a votre patient? by YJ Motivation et facteurs psycho-sociaux - question#1 by JL Modèles théoriques - question#2 by JL
Informations :	This note has been read **79** times by **29** different people This note has been modified **3** times by **the same** person

Argument detection Yes (1)	**Subject(s) of message:** **1-) patient responsibility** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
PRISE EN CHARGE :		OUT	(int2)	INT
Problématique La problématique soulevée au sujet de la prise en charge du patient est la non modification par ce dernier des comportements nuisibles à sa santé.		Pa(1)		
Il semble important, selon vos réflexions, que le patient se responsabilise davantage à l'égard de sa santé.		Pb(1)		
Pistes de solutions À ce sujet, les pistes de solutions soulevées réfèrent à l'importance de tenir compte des besoins propres de chaque patient et de suivre son niveau d'adaptation à la maladie pour accompagner et guider ce dernier dans le processus de prise en charge.		CLa		
Questionnements **Quelles sont les stratégies infirmières à cibler spécifiquement afin d'accompagner le patient dans la prise en charge de son état et l'amener à modifier les comportements nuisibles à sa santé?**		OUT	(ana6)	ANA

Quels sont les modèles de changement de comportement qui peuvent nous guider dans nos réflexions ?	OUT		
Suggestions : [1])	OUT		
Je vous invite à initier votre réflexion à partir de cette note grâce à la fonction élaborer.	OUT		

E120	
Creation date :	18 Avril 2002
Subject :	**Quel bonbon offrir a votre patient?**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	YJ
This note references:	
This note is referenced by :	
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on to by :	(untitled) by PL
Informations :	

Argument detection no	**Subject(s) of message:** **1-) hypothesis on reward needed to be given to patient in order for him/her to be more responsible concerning his/her health** **2-) need to find a way to make patient more responsible** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
[FB]	Yvette ce que tu dit est tellement plein de vérité. Un but à atteindre quoi....ma jeune adolescente déteste l'exercise mais je d'écouvre qu'elle meurt d'envie de porter un bikini...alors, voilà ici on fait des exercises car le but à atteindre c'est ce beau bikini bleu royal......un petit à côté. J'aime ton expression "Quel est le bonbon pour votre patient?".		(eva1)	EVA
[CL]	Je suis d'accord. C'est un peu comme pour l'enseignement: on peut parler pendant des heures, mais si on ne répond pas aux questions du patient (ce qui le péoccupe), notre enseignement aura bien peu d'impact.	CLa Pa(1)	(inf3)	INF
[JG]	Ouf... pas facile Yvette... il est heureux de même... et ça serait quoi SON bonbon à lui... Disons que ce client est tres engage dans sa maladie, l'idee est d'entreprendre a developper le desir d'un bonbon lorsqu'il est encore possible d'en profiter... on n'arrivera pas a aider tout le monde malheureusement...	Pa(2) ↓ ↓ CLa	(eva1)	EVA
Problématique Voici une histoire de cas réelle : J'ai un patient de 45 ans, avec une obésité morbide de 150 kg., diabétique insulino-dépendant avec toutes les complications du diabète (presqu'aveugle, amputé jusqu'au genou d'un membre ,il se mobilise en chaise roulante électrique , insuffisant rénal, MCAS) qui vient d'être refusé pour des pontages a cause de son poids.			(int3)	INT

Ce patient marié est dépendant de sa femme pour une multitude de petites choses. Il se sent un fardeau pour elle. Je lui ai demandé : Sachant que son obésité est un facteur important dans ses problèmes de santé actuelles, qu'est ce qui pourrait le motiver a se prendre en main? Réponse: il manque le bonbon. La vie devant lui est sans espoir de guérison du diabète qu'il n'a jamais accepté. On lui avait déja fait miroiter que s'il maigrissait, il aurait des chances de passer aux hypoglycémiants oraux. Il était motivé, il avait perdu du poids. Mais quelques temps après ce même médecin lui disait carrément :qu'il serait a l'insuline pour le rester de ses jours. La meilleure chose qui pourrait lui arriver, c'est de mourrir sur la table d'opération. Déprimé ? (c'est-ce que vous pensez) Il avoue avoir fait une dépression après son amputation,il a eu du support de psycholoques. Présentement il ne sent pas le besoin d'être suivi par un psycholoque. Il est heureux avec sa femme.			
Ce qui lui manque c'est le bonbon.		(inf3)	INF
Questionnement Quel est le bonbon que nous proposons de donner a nos patients cardiaques? Une espérance de vie plus longue ? Données pertinentes Aujourd'hui le cardiologue disait a un patient que s'il arrêtait de fumer il multipliait par 5 le temps qu'il lui restait a vivre et que si on lui disait que ses chances de gagner a la loterie serait multiplié par 5, il n'hésiterait pas a en acheter.			
Pistes de solutions **Quel que soit le bonbon, il faut trouver celui que le patient préfère.** *FB* *CL* *IG*		**(int2)**	**INT**

E122	
Creation date :	19 Avril 2002
Subject :	**(untitled)**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	PL
This note references:	
This note is referenced by :	
This note is built-on to :	Quel bonbon offrir a votre patient? by YJ
This note is built-on to by :	
Informations :	This note has been read **46** times by **19** different people This note has been modified **10** times by **5** different people

Argument detection no	**Subject(s) of message:** **1-) type of patient reward prior to intervention** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
HB	c'EST SURTOUT utilisé pour les chirurgies cardiaques et c'est efficace pour avoir personnellement vécu cette situation avec mon conjoint. pour une personne avec un infarctus , dans le programme de réadaptation il es t fréquent qu,il décroche si les autres participants parlent de leurs "bobos"		(exp2)	EXP
JH	Encore faut-il que l'atteinte des résultats présenté par le patient modèle corresponde aux ambitions (le fameux bonbon) de la personne elle-même!		(int2)	INT
YJ	Dans ton département, cardio-gastro, *tu pourrais faire un sondage auprèes de tes patients.*		(inf3)	INF
YJ	Dans ton milieu de travail, cardio-gastro, tu pourrais faire un sondage auprès de tes patients. Donne-nous tes résultats par la suite.		(inf3)	INF
IG	Bonjour, à titre d'exemple, j'ai deja vu un chirurgien de renom (dont les services etaient tres convoites car il operait souvent les clients a risque eleves avec succes), dire a son client qu'il ne l'opererait seulement si il arretait de fumer... disons que c'est plus qu'un bonbon, c'est de la confrontation mais... je crois que parfois pour faire un choix nous devons nous confronter	Pa(1) ↓ ↓ ↓ ↓ CLa	(exp2)	EXP
(Questionnement) Un bonbon mais comment? **Pourrait-on utiliser un autre client pour prouver ce que l'on dit?)**			(ana6) **(eva2)**	ANA **EVA**

HB JH YJ YJ IG			

E127	
Creation date :	29 Avril 2002
Subject :	**Motivation et facteurs psycho-sociaux - question#1**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	readaptation, promotion, prise en charge, traitements, systeme de soutien social, croyances en matiere de sante, influence sociale, motivation, perception d auto efficacite, perception de controle
Author :	JH
This note references:	
This note is referenced by :	facteurs psychosociaux by MJP
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on to by :	
Informations :	This note has been read **49** times by **21** different people This note has been modified **3** times by **3** different people

Argument detection Yes (3)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
IG	Voici une reflexion tres pertinente selon moi. Je me souviens d'une question tres frequente que nous demandions aux clients qui participaient aux seances de counseling familial dans le cadre d'un cours donnŽ par Fabie Duhamel (Universite de Montreal) soit: " Comment votre vie pourrait tre differente si... (ex: vous arretiez de fumer)" Laissez-moi vous dire que les gens Žnoncent facilement des avantages a leur changement de comportement... en fait la strategie etaient de leur faire enoncer et par la suite, de developper sur le comment y arriver.		**(eva1)**	**EVA**
Opinion Comme il a été mentionné par plusieurs ... la mise en commun de plusieurs modèles théoriques (en y retenant ce qu'il y a de meilleur) serait une solution intéressante.... Encore faudrait-il faire une étude afin d'évaluer l'effet d'un tel modèle réinventé à partir de ceux déjà existants ?? Je vous propose des extraits de note de cours (SOI 1046) que j'ai développé suite à mon étude de maitrise.... Ces extraits peuvent contribuer à certaines réflexions. Données pertinentes La motivation est considérée comme étant le facteur qui explique le mieux le degré d'engagement des personnes dans l'adoption		Pa(1) ↓ ↓ ↓ ↓ ↓ Pb(1) ↓ ↓ CLa Pc(1) ↓ ↓	(ana1) (inf3) ↓ (exp1)	ANA INF ↓ EXP

et le maintien de nouvelles habitudes de vie (Cox & Wachs, 1985; Fleury, 1992; Kelly, Zyzanski & Alemagno, 1991; McEwen, 1993).	↓ ↓ Pd(1)		
En effet, plusieurs cliniciens et chercheurs se sont intéressés à la motivation des personnes afin de mieux comprendre le phénomène du manque d'assiduité.	↓ ↓ ↓ CLb		
Il est intéressant de constater qu'un bon nombre d'études de type descriptif et corrélationnel ont démontré une relation significative entre la motivation et l'assiduité aux recommandations thérapeutiques (Dishman, 1982; Dishman & Ickes, 1981; Fleury, 1992; Kelly, Zyzanski & Almagno, 1991; Kristeller, Rossi, Ockene, Goldberg & Prochaska, 1992; Oldridge & Stoedefalke, 1984; Ratdke, 1989).			
Données pertinentes Il semble donc important d'intervenir sur la motivation des personnes afin d'améliorer le degré d'assiduité aux recommandations thérapeutiques.	CLc ↑ ↑ ↑ Pf(1)	(inf2)	INF
Toutefois, plusieurs tentatives d'interventions afin d'améliorer la motivation ont démontré une efficacité limitée.	↑ ↑ Pg(1)	(exp2)	EXP
Selon Godin (1988), avant de mettre sur pied des interventions visant la modification des comportements des individus, il semble particulièrement important d'identifier au préalable les facteurs psychosociaux qui déterminent la motivation à adopter ou non un comportement donné.	↑ ↑ ↑ ↑ Ph(1)		
Nous pouvons constater dans la littérature que certains facteurs psychosociaux semblent influencer la motivation à différentes phases de la réadaptation cardiaque pour l'ensemble des comportements.	↑ ↑ Pi(1)		
Les facteurs psychosociaux les plus souvent identifiés sont: · Le systeme de soutien social ou l'influence sociale; · La perception de controle ou la perception d auto efficacite; · Les croyances en matiere de sante.			
(Derenowski, 1988; 1991; Fleury, 1992; Fushs, 1996; Johnson & Morse, 1990; Kelly, Zyzanski & Alemagno, 1991). IGJ			

E128	
Creation date :	29 Avril 2002
Subject :	**Modèles théoriques - question#2**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	JH
This note references:	[1] PRISE EN CHARGE by MJP
This note is referenced by :	
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on	

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<tr><td>Informations :</td><td colspan="4">This note has been read **30** times by **16** different people
This note has been modified **7** times by **2** different people</td></tr>
<tr><td>**Argument detection**

Yes
(2)</td><td>**Subject(s) of message:**
1-)
2-)
3-)

Theme of sequence:
Patient responsibility concerning his/her health</td><td>**Step 1**</td><td>**Step 2**</td><td>**Step 3**</td></tr>
<tr><td>*JH* ...</td><td>Je rendrai disponible un résumé de ces modèles dans la cyberbibliothèque tel que je le proposais dans le livrable collecte de données.</td><td></td><td></td><td></td></tr>
<tr><td>*HB*</td><td>Bonjour Julie, Le modèle conceptuel de Mc Ewen en réadaptation cardiaque est aussi très intéressant(lu dans la biblio cyber.) peut-être qu'elle recoupe un peu les autres théories?</td><td></td><td>(inf3)</td><td>INF</td></tr>
<tr><td>*JH*</td><td>Tu as raison Hélene, je viens de lire l'article proposé dans la bibliothèque et je le trouve très intéressant.... je ne m'étais jamais vraiment attardé à ce modèle... Je crois effectivement qu'il vaut la peine d'être considéré. Merci!</td><td></td><td>(eva1)</td><td>EVA</td></tr>
<tr><td colspan="2">Pour ce qui est des *"odèles de changement de comportement qui peuvent nous guider dans nos réflexions "*

Pistes de solutions <u>Je propose les modèles suivants... ils ont fait certaines preuves... il suffit de choisir ce que l'on veut conserver parmi ceux-ci</u> *JH* ...

Ces modèles avaient déjà été nommés par d'autres intervenants dans les discussions antérieures.... il y en a peut-être d'autres ...

Données pertinentes Un certain nombre de théories ont été élaborées pour identifier les facteurs psychosociaux qui influencent les comportements des individus et pour expliquer ces mêmes comportements.

Ces théories sont issues du domaine de la psychologie sociale et elles abordent le comportement des individus dans une perspective sociale, c'est-à-dire en considérant l'interaction de l'individu avec son environnement social (Godin, 1988).

Des modèles conceptuels en soins infirmiers sont inspirés de ces différentes théories.

On peut penser, entre autres, au modèle de McGill qui est inspiré, en partie, par la Théorie sociale d'apprentissage de Bandura (1977) . (Extrait des notes de cours SOI 1046 Houle, J (2001) UQTR)

Données pertinentes Théorie sociale d'apprentissage (Bandura, 1977)

Données pertinentes Health needs model (Caplan, 1979)

Données pertinentes Théorie des croyances en matières de santé (Rosenstock, 1974)</td><td>$P_a(2)$
CL_a

$P_b(1)$
↓
↓
↓
$P_c(1)$
↓
↓
$P_d(2)$
↓
↓
↓
↓
↓
$P_e(1)$
↓
↓
CL_b</td><td><u>(exp3)</u></td><td><u>EXP</u></td></tr>
</table>

Données pertinentes Théorie de l'action raisonnée (Fishbein & Ajzen, 1975) Données pertinentes Théorie du comportement planifié (Ajzen, 1985) Données pertinentes Penders ??? HB JH			

E041	
Creation date :	26 Mars 2002
Subject :	**models vs réadaptation**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	CG
This note references:	
This note is referenced by :	
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on to by :	Être à l'écoute by FB En accord by JH Modèle Pender by RD test by MJP test / synthèse by MJP test by MJP test by MJP
Informations :	This note has been read **64** times by **21** different people This note has been modified **5** times by **2** different people

Argument detection	**Subject(s) of message:**	**Step 1**	**Step 2**	**Step 3**
no	**1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**			
MJ	L'article sera disponible sous forme d'un document PDF dans notre cyberbibliothèque			
Données pertinentes <u>Un modèle conceptuel a été développé spécifiquement pour la réadaptation cardiaque.</u> Il s'agit du modèle conceptuel de McEwen. Un article publié dans l'Infirmière Canadienne, avril 1998, par Mmes Anne Desmarais et Sylvie Robichaud-Ekstrand traite de ce modèle. MJ Plusieurs models portent un regard différent et complémentaire à mon avis sur cette problématique.		Pa(1) ↓ ↓ ↓ ↓ ↓ ↓ ↓ Pb(1) ↓	(infl)	INF

Si je fais référence à ceux que j'ai déjà survolés comme: Health belief, Proceed, Self Efficacy, Lazarus et Folkman (Stress, Appraisal and coping), certains models sont plus performants que d'autres dépendant de la personnalité de l'usager, de ses croyances, du stress, du type d'intervention, etc.	↓ CLa		
Mon expérience me dit qu'il esst préférable de se servir du meilleur de chaque model, de s'approprier une pensée personnelle de sa vison des soins et de l'adapter à chaque individu.	Pc(3) ↓ ↓ ↓	(eva1)	EVA
J'ai de la difficulté à me restreindre à un seul model.	CLb		
Le model de Lazarus et Folkman m'a aidé dans la préraration d'une intervention éducative auprés de la personne en attente de pontage coronarien parce que le STRESS et la PERCEPTION DE MENACE étaient des facteurs importants dans l'approche privilégiée..	Pd(2) ↓ ↓ ↓ ↓		
Mais je doute que ce model soit adapté pour la l'observance aux comportements de santé.	CLc	(eva1)	EVA
Le Health Belief semble fonctionné lorsque la personne se sent menacée et voit les bénéfices supérieurs aux inconvénients amenés par le changement de comportement.		↓	↓
Le modèle se limite cependant au concept de la santé/maladie.		(exp1)	EXP

E086	
Creation date :	2 Avril 2002
Subject :	**Modèle Pender**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	RD
This note references:	
This note is referenced by :	
This note is built-on to :	models vs réadaptation by CG
This note is built-on to by :	
Informations :	This note has been read **29** times by **16** different people This note has been modified **once**

Argument detection	**Subject(s) of message:**	**Step 1**	**Step 2**	**Step 3**
no	**1-)** **2-)** **3-)** **Theme of sequence:**			

	Patient responsibility concerning his/her health			
quand tu parles de prendre le meilleur de chaque modèle, je suis d'accord. Le modèle de Pender rassemble toutes les composantes des modèles antérieurs. ü Modèle de Promotion de la Santé de Pender (1982,1987) Pender, N.J. (1996). The Health Promotion Model. Dans Health Promotion (chap 3 p. 51-75) 3e éditon. In Nursing Science : Stamferp, CTé RD)			(eva1) ↓ (exp1)	EVA ↓ EXP

E107	
Creation date :	11 Avril 2002
Subject :	-
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements, contrat, entente, offre
Author :	JL
This note references:	
This note is referenced by :	
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on to by :	On sème on récolte by FB Un contrat.Pourquoi pas? by YJ
Informations :	This note has been read **23** times by **18** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
Au départ ne serait-il pas pertinent de signer un contrat, une entente ne n'importe qu'elle forme que ce soit avec le patient pour que celui-ci sente l'obligation de se prendre en main en échange du temps de la disponibilité qu'on lui offre?			(inf3)	INF

E111	
Creation date :	12 Avril 2002
Subject :	**(untitled)**

Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	PRISE EN CHARGE by MJP
This note is built-on to by :	
Informations :	This note has been read **40** times by **16** different people This note has been modified **5** times by **3** different people

Argument detection Yes (2)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
HB	"la force des gens" ça me rappelle un très bon psychiâtre qui dans n.'importe situation ressortait toujours calmement, on lui a demandé comment il avait désarmorcé une situation de crise avec le patient. Il disait j'utilise toujours ses forces.		(eva1)	EVA
FB	Ceci nous ramene a ceci "Connaitre notre client/patient". Une expression anglaise me vient a l'esprit "What makes him/her tick?"			

Problématique La modification de mode de vie et de comportements de santé et complexe.	Pa(1) ↓ ↓	(int3) ↓	INT ↓
Données pertinantes De plus certaines recherches démontrent que une grande proportion de patients une fois retournés à la maison n'ont pas les comportements escomptés par les intervenants de la santé. Par example, la prise de nitroglycérine lors de douleur thoraciques. Ces mêmes études relate différentes raison des actions inadéquates ou/et inactions des patients. Entre autre, une mauvaise compréhension, la peur de faire quelque de faux, ne pas vouloir subir les effets secondaires de la médication ex: céphalés occasionée par nitro, etc pour n'en nommer que quelques une.	Pb(1) ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	(exp1)	EXP
Opinion **Considérant ces données, bien que je trouve l'idée d'une trousse de survi très novatrice et pertinante, je me demande si on ne pourrait pas bonifier cette été avec d'autre éléments qui suivent.**	CLa	**(inf2)**	**INF**
Questionnements Etant donné ces distortions, ces peurs et incompréhension, l'enseignement au patient ne devrait elle pas prendre une forme davantage orientée vers le counseling ?		↓ (exp3)	EXP
Est ce que notre vision de l'enseignement est suffisament centré sur le vécu de la personne, sur ce qu'elle percevait, comprenait déja et sur ce qu'elle percoit après notre enseignement ?		(ana6)	ANA

Est ce que les structures actuelles favorisent un enseignement de qualité ? (Au niveau hospitalisation). « Pistes de solutions Pour revenir à l'idée initiale de la trousse de survie, je me demande si cet outil offert au patient bonifiée d'un enseignement centré sur son vécu ainsi qu'une personne ressource chevronnée pour répondre à ses besoins une fois à la maison via suivi téléphonique ne serait pas un gage de succès qui permetterai de cibler le plus d'éléments possible. »	Pf(2) ↓ ↓ CLb	(exp3)	EXP

E124				
Creation date :	20 Avril 2002			
Subject :	**Consentement/refus**			
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)			
Keywords :	prise en charge, promotion, readaptation, traitements, contrat, entente, offre			
Author :	HB			
This note references:				
This note is referenced by :				
This note is built-on to :	Un contrat.Pourquoi pas? by YJ			
This note is built-on to by :				
Informations :	This note has been read **20** times by **15** different people This note has been modified **once**			
Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
à l'hôpital Charles Lemoyne, dans la clinique de l'insuff, coro, l'infirmière me disait que le client signe un contrat elle s'assure d'une bonne collaboration avec le client. Elle fait aussi signer un refus de traitement si le client ne collabore plus de façon répété.			(exp2)	EXP

E121	
Creation date :	18 Avril 2002
Subject :	**Un contrat.Pourquoi pas?**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, promotion, readaptation, traitements, contrat, entente, offre

Author :	YJ
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by JL
This note is built-on to by :	Consentement/refus by HB
Informations :	This note has been read **21** times by **15** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
	Problématique Lorsque nous avons des patients de psychiatries, effectivement il y a différents contrats que nous passons avec eux selon leur problème. Il y a un contrat d'appel a l'aide , un autre de non passage a l'acte .... Parce qu'ils sont impliqués dans cette prise de décision, le respect du contrat est assuré pour la plupart.	Pa(1) ↓ ↓ ↓	(exp1)	EXP
	Pistes de solutions Un contrat avec nos patients cardiaques serait une solution probablement a considérer.	CLa	(inf2)	INF

E112	
Creation date :	12 Avril 2002
Subject :	**On sème on récolte**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	traitements, contrat, entente, offre, prise en charge, promotion, readaptation
Author :	FB
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by JL
This note is built-on to by :	(untitled) by GB
Informations :	This note has been read **21** times by **16** different people This note has been modified **once**

Argument detection Yes (1)	Subject(s) of message: 1-) 2-) 3-) Theme of sequence: Patient responsibility concerning his/her health	Step 1	Step 2	Step 3
Johanne, une suggestion intéressante et une dont nous utilisons chez nous en réhabilitation cardiaque. Nos clients/participants à nos programmes signes un genre d'entente quand ils décident de participer à un programme. C'est bien celà mais vous pouvez bien imaginer que certains ne réussissent pas à délivrer ce dont ils ont promis. Cependant, je crois qu'un tel "contrat" si tu veux leur donne la responsabilité de se prendre en charge. Au fond, c'est eux qui doivent faire le gros du travail pas les aidants......je dis toujours à mes participants que j'ai "la job la plus facile" celle de délivrer l'informations. C'est à eux de faire le travail, mais c'est aussi eux autres qui vont récolter le fruit de leur labeur.	CLa ↑ ↑ ↑ ↑ ↑ ↑ Pa(2)	(exp1) (inf2)	EXP INF

E113	
Creation date :	12 Avril 2002
Subject :	**(untitled)**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	traitements, contrat, entente, offre, prise en charge, promotion, readaptation
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	On sème on récolte by FB
This note is built-on to by :	Contrat vs culpabilité by LD
Informations :	This note has been read **33** times by **16** different people This note has been modified **6** times by **4** different people

Argument detection Yes (1)	Subject(s) of message: 1-) 2-) 3-) Theme of sequence: Patient responsibility concerning his/her health	Step 1	Step 2	Step 3

HB	Moi aussi les clients sont parfois réticents à venir au programme, mais si c,est une demande du médecin, là c'est pris au sérieux, présentement deux cardiologues les sollicite pour l'adhésion du programme, les jeunes patients sont les plus réfractaires		(exp2)	EXP
FB	Nous observons le même scénario chez nous de la population médicale. Cependant, quand un patient est référré par son médecin, j'observe (pour la plupart) une plus grande coopération et assiduité au programme.		(eva1)	EVA
Problématique La problématique d'assiduité à la réadaptation est aussi présente dans notre centre. Pistes de solution L'opinion de plusieurs de nos consoeurs est la prescription médicale du programme de réadaptation. Questionnement D'un autre côté, certain médecins refusent d'inclure dans les prescriptions le programme de réadaptation en soutenant que le geste doit venir du patient.			(exp1)	EXP
Personnelement, je suis ambivalante à cet effet puisque d'un côté, oui les changement doivent venir des gens mais d'un autre côté, stimuler une prise de conscience peut aussi être bénéfique. Que pense le groupe de cette problématique ? HB Merci de vos commentaires d'experts ! FB		CLa Pa(2)	**(inf3)**	**INF**

E116	
Creation date :	13 Avril 2002
Subject :	**Contrat vs culpabilité**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	
Author :	LD
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by GB
This note is built-on to by :	Contrat=Entente by FB Signification du contrat by RD
Informations :	This note has been read **26** times by **16** different people This note has been modified **once**

Argument detection	**Subject(s) of message:**	**Step 1**	**Step 2**	**Step 3**
no	**1-)** **2-)** **3-)**			

	Theme of sequence: **Patient responsibility concerning his/her health**			
Pour venir à notre clinique, le patient doit être inscrit par le médecin (forme de prescription médicale). **Il est inscrit soit à partir du bureau du médecin, des soins intensifs, de l'urgence ou d'un autre département.** **Mais je remarque que même le fait d'être formellement inscrit par le médecin ne semble pas augmenter sa volonté à modifier certaines habitudes de vie.** **Ça ne donne pas plus de faciliter à travailler sur des croyances bien ancrées...**			**(inf2)**	**INF**
Je me demande si le contrat dont parle Francine incite davantage les gens à participer au programme et à travailler sur eux-mêmes ou bien n'est-il pas une source de culpabilité pour le patient qui n'a pas réussi à s'y conformer ? J'aimerais bien cependant voir quelle forme a ce contrat, FB.			(ana6)	ANA

E119	
Creation date :	16 Avril 2002
Subject :	**Contrat=Entente**
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	prise en charge, offre, traitements, contrat, entente, promotion, readaptation
Author :	FB
This note references:	
This note is referenced by :	
This note is built-on to :	Contrat vs culpabilité by LD
This note is built-on to by :	
Informations :	This note has been read **22** times by **15** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Patient responsibility concerning his/her health**	**Step 1**	**Step 2**	**Step 3**
Le "contrat" que nous utilisons est un genre de déclaration où acceptance de participer à notre programme.			(exp1)	EXP

À partir de ceci, basés sur notre collecte de données, nous dressons des objectifs plus spécifiques. À la fin du programme (12 semaines) et aussi durant le programme nous revisitons avec le client où il (elle) se situe. S'approche t-il de son objectif à ce qui a trait à son cholesterol, son poids, activité physique, etc.... Le contrat où l'entente est basée sur ce dont le client est préparé à changer. Rien de formel mais quand même très évident durant tout le programme. Il est vrai que parfois la perte de poid n'est pas ce que l'on aurait désiré cependant peut-être que le client a cessé de fûmer! Nous éssayons de mettre l'emphase sur les positifs pour ainsi par la suite attaquer les négatifs.			
(**Culpabilité......peut-être.**		**(inf3)**	**INF**
Certaines personnes me disent se sentir coupable de ne pas avoir fait les changements nécessaires plus tôt (avant leur infarctus par exemple).		(exp1)	EXP
Je crois qu'une personne qui éssait de faire les changements par culpabilité ne tiendra pas le coup pour 12 semaines......je suis peut-être érronée ici...)		**(inf3)**	INF

<table>
<tr><td>E056</td><td colspan="4"></td></tr>
<tr><td>Creation date :</td><td colspan="4">28 Mars 2002</td></tr>
<tr><td>Subject :</td><td colspan="4">Anecdote</td></tr>
<tr><td>Sub-subject :</td><td colspan="4">Problem: SYNTHÈSE 23 mars 2002 (première semaine des échanges)</td></tr>
<tr><td>Keywords :</td><td colspan="4">prise en charge, promotion, readaptation, traitements</td></tr>
<tr><td>Author :</td><td colspan="4">FB</td></tr>
<tr><td>This note references:</td><td colspan="4"></td></tr>
<tr><td>This note is referenced by :</td><td colspan="4"></td></tr>
<tr><td>This note is built-on to :</td><td colspan="4">PRISE EN CHARGE by MJP</td></tr>
<tr><td>This note is built-on to by :</td><td colspan="4"></td></tr>
<tr><td>Informations :</td><td colspan="4">This note has been read 41 times by 20 different people
This note has been modified 9 times by 4 different people</td></tr>
<tr><td>Argument detection

Yes
(2)</td><td>Subject(s) of message:
1-)
2-)
3-)

Theme of sequence:
Patient responsibility concerning his/her health</td><td>Step 1</td><td>Step 2</td><td>Step 3</td></tr>
</table>

<table>
<tr><td>LDJ</td><td>Je connais des patients semblables... Ils écoutent mais n'intègrent pas nécessairement l'information. Ils retournent dans leur milieu, la vie quotidienne reprend avec son lot de croyances pas toujours aidantes et peu à peu, ils oublient à quel point ils ont été malades, à quel point ils étaient inquiets, avaient peur de mourir. Ils reprennent le travail, au même rythme qu'avant, négligent l'activité physique parce qu'il sont fatigués, et mangent comme ils ont appris à le faire depuis l'enfance. Au deuxième événement cardiaque, ils se sentent honteux d'en être encore au même point et retournent aux ateliers d'enseignement. Le cycle peut se poursuivre longtemps si on ne découvre pas l'élément "x" qui ferait basculer l'attitude ou la croyance entravante...</td><td>(exp1)</td><td>EXP</td><td></td></tr>
<tr><td>MJJ</td><td>Comment doit-on réagir avec un patient qui ne semble pas vouloir comprendre et qui ne s'implique pas réellement dans son programme de réhabilitation cardiaque ?</td><td></td><td>(ana6)</td><td>ANA</td></tr>
<tr><td>CVJ</td><td>tenter de trouver sa motivation et trouver ses résistances, connaître ses croyances et ce qu'il sait, on ne peut pas aller plus vite que lui, il faut le faire cheminer...</td><td>Pa(2)
→ CLa</td><td>(exp3)</td><td>EXP</td></tr>
<tr><td colspan="2">Données pertinentes Une petite anecdote...Mr. C. a eu une infarctus et participe à un programme de réhabilitation cardiaque de 12 semaines et ceci TROIS fois!!!

Depuis les derniers 4 ans il va et vient, perd du poid et le reprend etc....

Son médecin ne sachant que faire le réfère à notre programme.

Il vient de terminer # 3 et me dit que finalement il comprend!

Il comprend l'importance de persévérer......et maintenir les changements effectués.

À noter, l'information communiquée à ce client fut la même chaque programme mais il n'était pas convaincu.

Questionnement Ce peut-il que certaines personnes tout simplement ne comprenne tout simplement pas?

Opinion Persévérer, ne laisser jamais tombé, continuer, on ne sait jamais, il y a toujours de l'espoire.

"Je connais des patients semblables...

Ils écoutent mais n'intègrent pas nécessairement l'information.

Ils retournent dans leur milieu, la vie quotidienne reprend avec son lot de croyances pas toujours aidantes et peu à peu, ils oublient à quel point ils ont été malades, à quel point ils étaient inquiets, avaient peur de mourir.

Ils reprennent le travail, au même rythme qu'avant, négligent l'activité physique parce qu'il sont fatigués, et mangent comme ils ont appris à le faire depuis l'enfance.</td><td>Pa(1)
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CLa</td><td>(exp1)

(inf3)

(inf2)</td><td>EXP

INF

INF</td></tr>
</table>

Au deuxième événement cardiaque, ils se sentent honteux d'en être encore au même point et retournent aux ateliers d'enseignement. *Le cycle peut se poursuivre longtemps si on ne découvre pas l'élément "x" qui ferait basculer l'attitude ou la croyance entravante..."*[1] ***LD*** *"Comment doit-on réagir avec un patient qui ne semble pas vouloir comprendre et qui ne s'implique pas réellement dans son programme de réhabilitation cardiaque ? "*[2] (Questionnements) ***MJP*** *"tenter de trouver sa motivation et trouver ses résistances, connaître ses croyances et ce qu'il sait, on ne peut pas aller plus vite que lui, il faut le faire cheminer..."*[3] ***CV***			

Appendix 6

Coding of sequence F of V2: At the heart of our exchanges

E003	
Creation date :	15 Mars 2002
Subject :	**Themes**
Sub-subject :	**Problem:** Themes
Keywords :	
Author :	IG
This note references:	
This note is referenced by :	responsabiliser; état santé by AMR
This note is built-on to :	
This note is built-on to by :	Education du publique by FB
Informations :	This note has been read **59** times by **24** different people This note has been modified **8** times by **3** different people

Argument detection no	**Subject(s) of message:** **1-) nursing strategies to adopt for heart care promotion** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
[CB]	Les gens ne pensent pas que ca peut leurs arriver (pensée magique)Le probleme ne se presente pas toute suite . C'est le plaisir ici et maintenant (un bon chip)le futur on y pense pas trop en se qui concerne sa sante en tout cas . Qu est ce que tu en penses .			
[CG]	Je suis d,accord avec tes propos. Je me demande pourquoi on ne poursuit pas la démarche amorcée avec le lait: le 1% coûte moins cher que le 2% et le 3.25%. Il devrait en être de même avec la margarine non hydrogénée , les charcuterie légères, les produits faibles en gras, etc. On paie toujours plus cher pour les produits meilleurs pour la santé.Ça devrait être le contraire pour inciter le monde à bien s'alimenter... Comme le lait !			
[IG]	Oui je suis d< non décubitus de ulcère un sur pansement faire comme C			
[CB] [CG] [IG] **A noter, impossibilite d utiliser les accents! Finalement je peux, j'ai changé de clavier!!! REALITE:			(exp1)	EXP

La progression de la maladie cardiovasculaire (HTA, angine, infarctus, insuffisance) et ce malgre les evidences rapportees publiquement en ce qui a trait les facteurs de risques (habitudes de vie). *Données pertinentes* **Quelle est la place de la promotion de la sante cardiovasculaire ,** **Quelles sont les strategies a utiliser,** **Pourquoi ca ne colle pas** *Opinion* ~~En fait je me demandais... je ne sais si cette communauté de pratique peut avoir comme mandat de se questionner sur certaines orientations politiques en matière de santé...~~ ~~exemple banal: l'autre jour à l'épicerie je me demandais pourquoi on autorise la mise en marché de margarine à base d'huile hydrogénée alors que l'on sait pertinemment que ces huiles sont nuisibles...~~ ~~ce n'est qu'un exemple alimentaire banal pour lequel il en est existe bien d'autres...~~ ~~Autre opinion... il est possible de déduire des frais de scolarité sur nos impôts (voyons le comme un incitatif pour la populasse à acquérir des connaissances)... pourquoi n'en serait-il pas de même pour l'inscription à des activités ou à des centres de conditionnement (car Dieu sait comme les prix ne sont pas toujours aborbable pour M tout le monde et le centre EPIC en est un bon exemple!!)~~		**(ana6)**	**ANA**

E008	
Creation date :	18 Mars 2002
Subject :	**Education du publique**
Sub-subject :	**Problem:** Themes
Keywords :	
Author :	FB
This note references:	
This note is referenced by :	
This note is built-on to :	Themes by IG
This note is built-on to by :	responsabiliser; état santé by AMR
Informations :	This note has been read **40** times by **24** different people This note has been modified **once**

Argument detection	**Subject(s) of message:**	**Step 1**	**Step 2**	**Step 3**
Yes (1)	**1-) focus on prevention for heart care** **2-)** **3-)** **Theme of sequence:**			

	Heart care promotion and prevention strategy			
Opinion Entierement d'accord avec tes propos Chantal. Je crois que l'EDUCATION du publique est primordial ici. **Si la personne connais les risques d'un certain mode de vie, ses choix sont plus eduque.** **Si un grand nombre de personne decide de ne pas acheter un produit qui est sur le marcher, les grandes compagnies arreteront devront cesser sa production.** **Si la DEMANDE pour un produit est la, on continuera a le produire.** Finalement, tout se relie a $$$$$ n'est-ce pas? Aussi, je crois que notre future systeme de sante doit se pencher sur la "PREVENTION"..... il n'est plus assez de reparer les gens une fois malade, nous devons porter plus d'attention (et de $$$) a eduquer..... finalement "le savoir est le pouvoir"	Pa(1) ↓ ↓ Pb(1) ↓ ↓ ↓ Pc(1) ↓ ↓ ↓ Pd(2) ↓ ↓ ↓ ↓ ↓ CLa	(eval) **(inf3)** (inf2)	EVA **INF** INF

E009	
Creation date :	18 Mars 2002
Subject :	**responsabiliser; état santé**
Sub-subject :	**Problem:** Themes
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	AMR
This note references:	[1] Themes by IG
This note is referenced by :	
This note is built-on to :	Education du publique by FB
This note is built-on to by :	Maladie de coeur pour les autres seulement by IG
Informations :	This note has been read **36** times by **22** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-) prevention starts by informing** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**

Alors qu'en est-il de la cigarette?			
Tous autant que nous sommes connaissons les méfaits du tabac sur nos artères, et des coûts engendrer sur la santé qui en découle.			
Si selon Isabelle le gouvernement devrait interdire la vente de margarine Hydogéne" *l'autre jour à l'épicerie je me demandais pourquoi on autorise la mise en marché de margarine à base d'huile hydrogénée alors que l'on sait pertinemment que ces huiles sont nuisibles...'* Il devrait commencer par la cigarette.			
Comme nous sommes dans un pays libre, nous devons donc unir nos forces pour propager nos connaissances et informer la population de ces méfaits.		(exp3)	EXP
Je trouve les publicités percutantes aiderons la population à faire des choix santé en modifiant des croyances.	Pa(1) ↓ ↓		
Je dis souvent à mes patients investir dans sa sante aujourd'hui c'est comme investir dans nos REER on met l'argent aujourd'hui pour en profiter plus tard.	Pb(1) ↓ ↓ ↓		
C'est notre capital santé à quoi bon avoir de l'argent à la retraite si nos capacités physiques sont altéré et diminué.	Pc(1) ↓ ↓ ↓		
Croire que le gouvernement doit faire des loi pour empècher certaines vente pour améliorer la santé est utopique.	↓ ↓		
C'est de responsabiliser l'état de ce que nous nous devons faire pour nous.	CLa		
Je vois mon rôle d'infirmière comme facilitante à la prise en charge de leur état en leur donnant des moyens concrets afin d'atteindre cette objectif.		(inf2)	INF
Comment pouvons aider les patients à se responsabiliser vis-à-vis leur santé?		(ana6)	ANA

E010	
Creation date :	18 Mars 2002
Subject :	**Maladie de coeur pour les autres seulement**
Sub-subject :	**Problem:** Themes
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	IG
This note references:	
This note is referenced by :	
This note is built-on to :	responsabiliser; état santé by AMR
This note is built-on to by :	responsabiliser by HB (untitled) by PL
Informations :	This note has been read **36** times by **21** different people This note has been modified **once**

Argument detection Yes (1)	Subject(s) of message: 1-) patient "non-responsibility" 2-) 3-) Theme of sequence: Heart care promotion and prevention strategy	Step 1	Step 2	Step 3
PAS D ACCENT version Mac cette fois (Données pertinentes **Diriez-vous que les quebecois manquent d information concernant l alimentation, la cigarette, l exercice...** **moi je dirais que non...** **par ailleurs je dirais qu ils ne se sentent pas concernes par la maladie cardiaque... car maladie tres surnoise, progressive...**)			**(int3)**	**INT**
Anecdote L autre jour ˆ la clinique SRDV lors d'un triage un homme s'est prŽsente ˆ cause d une toux grasse persistante, bref Monsieur etait tanne de tousser et voulait voir un medecin pour qu il lui regle son probleme. Il sentait la cigarette a plein nez... Croyant faire une intervention valable, j ai essaye d aborder le sujet de la cigarette... oups... ce n est pas la madame qui n Žtait pas contente mais le monsieur... j ai recu une tonne de betises... Monsieur m a clairement fait savoir qu il etait ecoeure d en entendre parler, qu il aimait fumer, qu il se foutait de la maladie de coeur car ca avait aucun rapport car son pere avait fume toute sa vie et etait mort a 80 ans...			(exp1)	EXP
(Opinion **Ainsi je ne suis pas certaine que la promotion en vrac des bonnes habitudes de vie est une facon efficace de faire la promotion de la sante du coeur...** car a moins d etre personnellement affecte par la maladie cardiaque ou d avoir un etre cher ayant une maladie coronarienne les gens ne se sentent pas concernes... meme parfois il y a des gens qui subissent un infarctus, sont operes et, apres avoir fait attention 1-2 mois, se sentent mieux et reprennent les mauvaises habitudes... c est classique... mais y doit bien avoir un moyen non??)		Pa(3) ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ CLa	**(ana4)** ↓ (exp2)	**ANA** ↓ EXP

E064	
Creation date :	29 Mars 2002
Subject :	**(untitled)**
Sub-subject :	**Problem:** pROMOTION EN VRAC
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	PL
This note references:	
This note is referenced by :	
This note is built-on to :	Maladie de coeur pour les autres seulement by IG
This note is built-on to by :	
Informations :	

Argument detection	Subject(s) of message:	Step 1	Step 2	Step 3
Yes (1)	**1-) heart care promotion** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**			
Je suis d'accord que la promotion en vrac n'est pas toujours un bon moyen mais cependant elle permet de rejoindre une grande majorité de personnes. **Iil faut cepedant par la suite développer des moyens de rejoindre de façon plus individuels les gens et de répondre ainsi mieux à leurs besoins.** **On aura plus de chance de les rejoindre en tant qu'individu, car nous serons à l'écoute de leurs problèmes à eux et non à un problème général.**		CLa Pa(2)	(eva1) ↓ **(exp3)**	EVA ↓ **EXP**

E016	
Creation date :	19 Mars 2002
Subject :	**responsabiliser**
Sub-subject :	**Problem:** Theme ,responsabiliser
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	HB
This note references:	
This note is referenced by :	Ou commencer? by FB
This note is built-on to :	Maladie de coeur pour les autres seulement by IG

This note is built-on to by :	Ou commencer? by FB
Informations :	This note has been read **56** times by **21** different people This note has been modified **2** times by **the same** person

Argument detection	Subject(s) of message:	Step 1	Step 2	Step 3
Argument detection Yes (1)	**Subject(s) of message:** **1-) need for primary level prevention** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
Problématique la maladie coronarienne est une des principales causes de décès dans notre société nord- américaine, malgré une meilleure diffusion dans la population en général et aux personnes atteintes, il semble que sa régression tarde à venir		(exp1)	EXP
Données pertinentes **Aux Etats-Unis, des études ont démontré que la réadaptation coronarienne permettait une amélioration de qualité de vie auprès de cette clientèle et diminuait le nombre d'hospitalisation**		**(exp2)**	**EXP**
Questionnements Quels élèments -clés nous permettra d'obtenir un meilleur impact sur cette clientèle?		(ana6)	ANA
Pistes de solutions En sachant que la réadaptation coronarienne est bénifique pour le patient et la société, est-ce qu'on pourrait penser que la prévention primaire devrait être une priorité pour notre société?	Pa(1) ↓ CLa		
Un dépistage précoce, une information à l'école auprès des élèves, un sigle sur les produits de consommation avec un coeur, un coût moins élevé dans les centres de conditionnement (crédit-impôt) surtout chez la clientèle cardiaque, une meilleure valorisation des programmes coronariens par les médecins traitants auprès de la clientèle coronarien car il n'est pas rare que ces derniers avares de renforcement à ce sujet.		**(exp3)**	**EXP**
Opinion La population en générale accorde plus de temps pour les activités physiques, un soucis pour l'alimentation faible en gras est également plus répandu aujourd'hui , mais c'est souvent à mon avis la tranche de baby-boomers qui s'y trouve la plus préoccupée par leur santé et font des efforts pour garder la forme.... Mais pour la jeune génération leur style de vie leur prépare un futur bien chargé à risque pour leur santé .		(exp2)	EXP

E021	
Creation date :	20 Mars 2002
Subject :	**Ou commencer?**
Sub-subject :	**Problem:** Theme ,responsabiliser
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	FB
This note references:	[1] responsabiliser by HB
This note is	

L

referenced by :	
This note is built-on to :	responsabiliser by HB
This note is built-on to by :	(untitled) by IG
Informations :	This note has been read **37** times by **21** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-) need for primary level prevention** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
"En sachant que la réadaptation coronarienne est bénifique pour le patient et la société, est-ce qu'on pourrait penser que la prévention primaire devrait être une priorité pour notre société?"[1] (Opinion **A cette question je rpond un gros OUI!** Notre systeme de sant"é"[1] est expert a "r"é"[1] parer" ce qui est bris"é"[1] . Je crois sincerement que le future de la sant"é"[1] de notre populace appartient a la "é"[1] prvention"é"[1] . Il est vrai qu'on a beaucoup de chemin a parcourir avant que tous prenions la responsabilit de notre sant"é"[1] en main ,cependant, il faut bien commencer quelque part. Enseignement au patient/famille, au publique en g"é"[1] n"é"[1] ral, etc.....tout compte pour quelque chose. On ne peut s'attendre de changer les habitudes de vie d'une population du jour au lendemain...je crois qu'il nous faudra beaucoup de persistence pour atteindre ce but."é"[1])			**(eva1)**	**EVA**

E025	
Creation date :	21 Mars 2002
Subject :	**(untitled)**
Sub-subject :	**Problem:** Theme ,responsabiliser
Keywords :	sante, cigarette, croyances, responsabiliser
Author :	IG
This note references:	
This note is referenced by :	
This note is built-on to :	Ou commencer? by FB

This note is built-on to by :	etape pour fumeur by AMR axer les ressources sur la santé by LD
Informations :	This note has been read **30** times by **19** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-) patient responsibility** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
	Justement, par où commencer??		(ana6)	ANA
	éduquer, responsabiliser...		**(ana3)**	**ANA**
	j"ai de la misère à y croire...			
	les gens sont surinformés et leur capacité à discerner est douteuse...	CLa ↑	↓	
	comme je l"ai dit précédemment ils ne se sentent pas concerner, car ils respirent bien sont capables de faire leurs AVQ et qlqs pcroyances en ce qui a trait à leur "immunité" par rapport à la maladie cardiaque...	Pa(3)	(exp3)	EXP
	Regarder l explemple des paquets de cig.			
	Les images dessus ne peuvent pas etre plus clairs...			
	et pourtant plusieurs s"en fichent...			
	Mais pourquoi...			
	nous sommes à un autre niveau je crois...			

E035	
Creation date :	25 Mars 2002
Subject :	**etape pour fumeur**
Sub-subject :	**Problem:** Theme ,responsabiliser
Keywords :	Croyances, responsabiliser, sante, cigarette, cesser de fumer, CHOIX, intervenons, prevention
Author :	AMR
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by IG
This note is built-on to by :	Ma santé, ma decision! By FB
Informations :	This note has been read **26** times by **17** different people

	This note has been modified **once**			
Argument detection Yes (3)	**Subject(s) of message:** **1-) prevention strategy: early prevention for long-term change** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
Je crois que l'adulte réagit en fonction de ce qu'il doit confronter.	CLa ↑	(int2) ↓	INT
Nous avons tout modifié-nous habitudes de travail depuis l'arrivé des Ordinateurs, des cellulaires et du courrier électronique.	**Pa(1)**	**(exp3)**	**EXP**
Nous étions peut-être même un peu résistants aux changements.			
C'est dommage mais en ce qui a attrait à la santé c'est la même chose.			
Nos interventions en terme de prevention, et tout ce dont nous faisons à courte échelle a, à mon avis, un impacte positive à longue échéance sur la qualité de vie de nos clients.	Pa(1) ↓ CLb	(exp3)	EXP
Il faut croire que nos actions ont un impact positif même si cela touche que quelques patients.		↓ **(exp1)**	**EXP**
J'aurais plusieurs anecdotes à vous raconter à ce sujet.			
Nombreux patients qui, en consultation privée qui ne voulaient rien entendre de l'activité physique, a qui j'ai dit "essayez au moins une fois, une seul séance et vous déciderez ensuite".			
Croyez-moi, leurs témoignages m'ont fait vibrer.			
J'ai touché ces gens là pour la vie, et c'etait des patients très têtu qui avait touts les éléments pour m'en faire perdre mon latin et ma patience!!!			
j'ai j'ai ébranlé leur croyance tout en respectant les leurs.		↓	
Je fonction souvent en leur donnant le choix, c'est à dire qu'il peuvent tout arreter si cela ne leur convient pas.	**CLc** ↑ ↑	(exp2)	EXP
Le CHOIX est une valeur fondamentale, les gens on besoin de savoir qu'ils ont le choix.	**Pa(1)** ↑ ↑		
Mon rôle leur faire prendre le bon choix, pas le mien à tout pris mais celui qui leur convient.	↑ ↑ ↑		
Ca ca veut dire faire place à l'erreure mais d'essayer.	↑ ↑		
Rappelez-vous que nous intervenons auprès de personnalité de type "A" ces gens sont des combatifs, des gens persévérant s'il modifie leurs facteurs de risque, il le fait avec toute une détermination.	**Pb(1)** ↑ ↑ ↑		
Mais Il faut y croire et leur imprégner nos croyances.	**Pc(1)** ↑		

Si moi, l'activité physique j'y crois mais je ne me l'impose pas comme hygiène de vie, alors comment vais-je faire pour imposer à mes clients ce qu'ils doivent changer? Pour qu'un discours soit cohérent il doit être authentique. Si moi je remets à plus tard ce que je devrais maintenant faire pour mon capital santé, vais-je être crédible auprès d'eux ??? Je crois beaucoup que mon attitude a un impact direct sur ce que les gens vont faire de mon enseignement. Je cois qu'il faut respecter leur étape avant de s'attendre à un changement, mais il faut y croire si on veut que ses changements s'opèrent sur une plus longue période. Ou alors c'est tout simplement "Chasse le naturel il revient au galop"!	↑ ↑ ↑ ↑ **Pd(1)**		
Pistes de solutions **la Société Canadienne du Cancer a publié une brochure intitulée "Pour les fumeurs qui veulent cesser de fumer"** **Ce dépliant permet aux fumeurs d'identifier l'étape où il se situe avant d'entreprendre ce grand combat qu'est la cessation de fumer.** **Une fois que nous, intervenants avons compris à quelle étape se situe le fumeur ont peut aider notre client à utiliser les moyens qu'il faut pour cesser de fumer.** **Si nous ne respectons pas l'étape où le fumeur se situe, nos interventions peuvent même aller j'usqu'en encourager le fumeur à fumer davantage.** **Ce qui m'a plu dans cette brochure c'est l'aspect positif et le message d'espoir qu'il faut garder vis-à-vis nos clients face à leur tentative** **Pour obtenir cette publication gratuite vous pouvez vous adresser au Service d'information de la Société canadienne du Cancer au: 1-888-939-3333** **ou visitez leur site au http://www.cancer.ca<IMG< A> SRC="/image?ID=scaffold_right.gif">**		**(exp1)**	**EXP**

E036	
Creation date :	25 Mars 2002
Subject :	**Ma santé, ma décision!**
Sub-subject :	**Problem:** Theme ,responsabiliser
Keywords :	responsabiliser, sante, cigarette, cesser de fumer, CHOIX, intervenons, prevention, croyances
Author :	FB
This note references:	
This note is referenced by :	

This note is built-on to :	etape pour fumeur by AMR			
This note is built-on to by :				
Informations :	This note has been read **27** times by **19** different people This note has been modified **once**			
Argument detection no	**Subject(s) of message:** **1-) prevention strategy: respect the patient, informing and providing a choice** **2-)** **3-)** **Theme of sequence:** **Heart care promotion and prevention strategy**	**Step 1**	**Step 2**	**Step 3**
Anne Marie, je suis très familière avec cette brochure dont tu nous parles (de la société canadienne du cancer).				
Ils ont aussi publié une brochure intitulé "Pour le fumeur qui ne veut pas arrèter de fumer".				
Ceci souligne le fait qu'on éssait de rencontrer le client "sur ses termes" en respectant comme tu dit quelle étape il se trouve.			(ana3)	ANA
Ceci est directement relié au modèle de Prochaska (Transtheoretical Model).				
Je suis une grande croyante de respecter le client, lui donner l'information et le laisser décider de la prochaine étape.			**(exp1)**	**EXP**
Après tout, c'est sa santé n'est-ce pas.				
Juste la semaine dernière un client que je connais puis un certain temps, et qui ne voulait rien entendre à propos de cesser de fûmer m'appella pour me dire qu'il est maintenant prêt.			(exp2)	EXP
Il est domage que son "trigger" fut la mort d'un ami de cancer du poumon (il était aussi fumeur).				

Appendix 7

Coding of sequence H of V2: At the heart of our exchanges

E005	
Creation date :	17 Mars 2002
Subject :	**(untitled)**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	
Author :	LL
This note references:	
This note is referenced by :	
This note is built-on to :	
This note is built-on to by:	enseign.durant l,hospitalisation by HB Signification de la maladie by RD
Informations :	This note has been read **55** times by **23** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-) patient education** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
L'enseignement aux patients hospitalisés souffrant d'angine ou d'infarctus. <u>Quel est l'enseigement pertinent à donner par les infirmières durant l'hospitalisation en tenant compte de la courte durée d'hospitalisation?</u>		OUT	<u>(ana6)</u>	<u>ANA</u>

E012	
Creation date :	19 Mars 2002
Subject :	**enseign.durant l,hospitalisation**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	
Author :	HB
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by LL

This note is built-on to by :	(untitled) by YJ			
Informations :	This note has been read **43** times by **22** different people This note has been modified **once**			
Argument detection Yes (1)	**Subject(s) of message:** **1-) content for patient education** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
	Je pense que le continu de l'enseignement coronarien (angine, infarctus,et S.C.A.)à l'hôpital doit être au niveau de la connaissance et la compréhension de son diagnostic,des facteurs le prédisposant, des modifications s'y rapportant s'il y a lieu, de savoir les activités post-évenement coro., de savoir et reconnaître les signes de l'angine , Il devrait être en mesure d'utiliser correctement la nitro et savoir quoi faire si l'angine persiste. L'enseign. pourrait se faire en présence de la famille. Il y a toute la problématique de l'acceptation de cet evènement, qui souvent forme un tampon entre la réception de l'enseignement et sa compréhension et ce surtout chez les jeunes patients sexe confondu. Je trouve que l'enseign.transmis au patient en premier permet à celui-ci de mieux exprimer ses craintes.	Pa(1) ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ CLa	(int2)	INT

E013				
Creation date :	19 Mars 2002			
Subject :	**(untitled)**			
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation			
Keywords :				
Author :	YJ			
This note references:				
This note is referenced by :				
This note is built-on to :	enseign.durant l,hospitalisation by HB			
This note is built-on to by :	Personaliser/Respecter by FB opinion utiliser maquette by HS			
Informations :	This note has been read **41** times by **21** different people This note has been modified **once**			
Argument detection Yes (1)	**Subject(s) of message:** **1-) patient education** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**

Problématique **Quel enseignement donné a un patient souffrant d'angine ou post infarctus durant son court séjour?**		**(ana6)**	**ANA**
Questionnement Aujourd'hui, j'ai justement fait l'enseignement a un patient post infarctus.		↓ (exp1)	EXP
Après quelques années de pratique, je raffine mon enseignement.			
Je suis surprise a chaque fois comment l'enseignement peut être de courte durée et bien comprise lorsque l'on emploi des mots simples et des exemples.			
Au début de l'hospitalisation, nous leur remettons le livre 'Vivre de bon coeur' c'est un livre bien vulgarisé.			
Le patient ou la famille est toujours libre de le lire.			
Lorsque je fais l'enseignement post infarctus ou d'angine, je me réfère toujours au livre pour montrer les illustrations.			
Comment fonctionne le coeur?			
Je résume le chapitre en quelques mots EN DESSINANT SUR SON CORPS d'ou arrive le sang souillé en passant par le coeur droit...			
Le rôle des artères coronaires ex: comme un arbre qui apporte la sève L'athérosclérose ex: processus lent qui obstrue la lumière du conduit comme une tuyauterie dans nos maisons			
Les facteurs de risques? Je les énumère tous, puis le patient me nomme celui ou ceux qui sont les siens			
L'angine vs l'infarctus, en se référant toujours a ces symptômes, en expliquant la maladie coronarienne sous-jacente, que faire si ces symptômes reviennent, l'utilisation de la nitro en leur faisant pratiquer sur eux			
Cet enseignement bien vulgarisé prend environ 15 minutes.			
Pour ce qui est de la convalescence lorsque la personne ne lit pas son livre , il y a toujours un bon vidéo qui peut les renseigner			
De plus a l'intérieur de ce livre, on peut les référer pour l'explication de presque tous les examens qu'ils subissent ainsi que l'explication de la plupart des médicaments qu'ils prennent.			
Souvent notre clientèle est agée, parfois peu motivée a se renseigner sur ce qui leur arrive, peu réceptif a notre enseignement, Il faut bien évalué avant leur besoin et s'adapter a leur niveau de compréhension.	Pa(5) ↓ ↓		
Si un patient refuse notre enseignement, bien sûre qu'on va essayer de comprendre ses raisons mais on va respecter sa décision.	Pb(1) ↓ ↓ ↓		
Opinion **Une approche simple au départ est préférable.**	CLa	↓ **(inf2)**	**INF**

Ceux qui sont avides d'informations vont nous questionner et avec eux on peut pousser l'enseignement plus en détails.			

E020	
Creation date :	20 Mars 2002
Subject :	**opinion utiliser maquette**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	
Author :	HS
This note references:	
This note is referenced by :	
This note is built-on to :	untitled) by YJ
This note is built-on to by :	
Informations :	This note has been read **47** times by **23** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-) patient education** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Opinion **Je trouve très pertinent la façon dont tu abordes l'enseignement.** Nous à notre centre on emploie aussi une maquette d'un coeur sur pied où l'on peut voir à l'intérieur. Les patients apprécient grandement. ils peuvent le manipuler tout en utilisant un vocabulaire qui leur est propre.			**(eva1)** ↓ (exp2)	**EVA** ↓ EXP

Appendix 8

Coding of sequence J of V2: At the heart of our exchanges

E014	
Creation date :	19 Mars 2002
Subject :	**Signification de la maladie**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	signification, Watson
Author :	RD
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by LL
This note is built-on to by :	Enseignement.... by SH Enseignement by JH
Informations :	This note has been read **42** times by **22** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-) patient education starts with assessment of patient needs** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Je crois que la durée étant courte, donner un enseignement global mais à partir des besoins du patient.		CLa ↑	**(inf2)**	**INF**
Actuellement je supervise une infirmière à la maîtrise sur la qualité des soins à UC à partir d'un questionnaire basée sur l'importance de dimensions du caring et la satisfaction des soins face à ces dimensions.		↑ ↑ ↑ ↑ ↑	↓ (exp2)	↓ EXP
L'analyse des résultats prémilinaires disent: le patient ne veut pas avoir à poser plusieurs questions à l'infirmière pour avoir de l''information mais plutôt que l''infirmière dit : Je peux vous parler de sexualité, retour à la maison, alimentation etc mais parlez-moi de ce qui vous préoccupe et je pourraisj répondre à vos questions à ce sujet.		Pa(1) ↑ ↑ ↑ ↑		
Ainsi, en peu de temps, l'infirmière peut répondre sur ce qui est important pour le patient.		Pb(1) ↑ Pc(1)		
De plus, je crois que demander la signification (Théorie du caring, Watson 1985,1988, 1999) pour le patient d'avoir un diagnostic d'infarctus peut permettre à l'infirmière de connaître les préoccupations du patient mais également de déceler le potentiel de réadaptation et de modification de changement de comportement.		↑ ↑ ↑ ↑ ↑ ↑ ↑	↓ **(inf2)**	↓ **INF**
En effet, si un patient affirme que l'infarctus signifie pour lui la mort dans 3		↑ Pd(1)	↓ (exp2)	↓ EXP

mois, il ne sert à rien de lui parler d'arrêter de fumer. RD			

E024	
Creation date :	21 Mars 2002
Subject :	**Enseignement....**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	signification, Watson, confiance, cu, milieu, priorit, respect, valeurs, croyances, besoins, comportement
Author :	SH
This note references:	
This note is referenced by :	
This note is built-on to :	Signification de la maladie by RD
This note is built-on to by :	enseignement selon les besoins by CV outils=modèle by LD
Informations :	This note has been read **59** times by **25** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-) patient education starts with assessment of patient needs** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Opinion Je suis bien d'accord avec toi. **Il est révolu le temps ou l'on croyait que faire un bon enseignement signifiait de couvrir tous les thèmes du sujet, sans regard des besoins, du vécu, des valeurs, des croyances, des types de comportement , du milieu de vie,....du patient et de sa famille.** Je crois aussi qu'il est important, en fait essentiel, d'être à l'écoute du patient et d'identifier ses priorités à lui et non pas les nôtres. **Il faut mettre sa paire de lunette à lui si l'on souhaite entrer en contact, gagner la confiance et le respect mutuel et éventuellement changer certains comportements.**		**Pa(1)** ↓ ↓ ↓ ↓ **Pb(2)** ↓ ↓ **CLa**	(eval) ↓ **(exp2)** (inf3) ↓ **(exp2)**	EVA ↓ **EXP** INF ↓ **EXP**

E073	
Creation date :	1 Avril 2002
Subject :	**outils=modèle**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	
Author :	LD
This note references:	
This note is referenced by :	
This note is built-on to :	Enseignement.... by SH
This note is built-on to by :	
Informations :	This note has been read **31** times by **16** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-) need for an intervention model** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Sonia, est-ce que ça revient à dire qu'il est inutile d'essayer d'appliquer un modèle d'intervention ?			(inf2)	INF
Comment fait-on alors pour augmenter la compliance au traitement, travailler avec le patient pour qu,il change un comportement, une croyance, etc ?			**(ana6)**	**ANA**
Je sais bien que tu utilises des outils pour y parvenir. Mais ils doivent découler d'un modèle, non ?			(inf2)	INF

E034	
Creation date :	25 Mars 2002
Subject :	**enseignement selon les besoins**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	priorit, respect, valeurs, croyances, besoins, comportement, signification, Watson, confiance, cu, milieu
Author :	CV
This note references:	
This note is referenced by :	Enseignement à la clientèle cardiaque by MJP
This note is built-on to :	Enseignement.... by SH
This note is built-on to by :	

Informations :	This note has been read **49** times by **22** different people This note has been modified **once**			
Argument detection Yes (1)	**Subject(s) of message:** **1-) patient education starts with assessment of patient needs** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Opinion Tout à fait d'accord, l'enseignement, selon moi doit toujours commencé par les besoins des patients, c'est de cette façon qu'on arrive à le toucher		Pa(1) CLa	(eval)	EVA

E063				
Creation date :	29 Mars 2002			
Subject :	**Enseignement**			
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation			
Keywords :	signification, Watson			
Author :	JH			
This note references:				
This note is referenced by :				
This note is built-on to :	Signification de la maladie by RD			
This note is built-on to by :				
Informations :	This note has been read **33** times by **20** different people This note has been modified **once**			
Argument detection no	**Subject(s) of message:** **1-) patient education starts with assessment of patient needs** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Opinion J'ai lu cette note apres avoir repondu a Francine... Encore une fois, je vois que les opinions convergent... Je trouve tres interessant ce que tu apportes dans cette note.			(eval)	EVA

Appendix 9

Coding of sequence P of V2: At the heart of our exchanges

E019	
Creation date :	20 Mars 2002
Subject :	**Personaliser/Respecter**
Sub-subject :	**Problem:** Enseigement durant l'hospitalisation
Keywords :	
Author :	FB
This note references:	
This note is referenced by :	
This note is built-on to :	(untitled) by YJ
This note is built-on to by :	themes d'enseignement by JH
Informations :	This note has been read **37** times by **21** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-) respect of the patient** **2-)** **3-)** **Theme of sequence:** **Patient education**	**Step 1**	**Step 2**	**Step 3**
Deux points qui me viennent a l'esprit: 1) Il est primordiale de personaliser l'enseignement (ce qui fonctionne pour un patient ne fonctionne pas pour un autre). Prendre en consideration les facteurs tels que l'age, croyances, niveau d'education, etc. 2) Respecter le patient. Je veux ce qu'il y a de mieux pour mon patient et il m'est tres difficile parfois de respecter ce qu'il (ou elle) veut. Parfois, le patient ne veux tout simplement pas entendre ce que l'on est prepare a lui donne...........peut etre que le temps n'est pas propice, il y a tellement a absorber pour un jeune homme ayant subit un infarctus......		**CLa** ↑ ↑ **Pa(1)** ↑ ↑ **Pb(1)**	(eval)	EVA

<table>
<tr><td>E062</td><td colspan="4"></td></tr>
<tr><td>Creation date :</td><td colspan="4">29 Mars 2002</td></tr>
<tr><td>Subject :</td><td colspan="4">themes d'enseignement</td></tr>
<tr><td>Sub-subject :</td><td colspan="4">Problem: Enseigement durant l'hospitalisation</td></tr>
<tr><td>Keywords :</td><td colspan="4"></td></tr>
<tr><td>Author :</td><td colspan="4">JH</td></tr>
<tr><td>This note references:</td><td colspan="4"></td></tr>
<tr><td>This note is referenced by :</td><td colspan="4"></td></tr>
<tr><td>This note is built-on to :</td><td colspan="4">Personaliser/Respecter by FB</td></tr>
<tr><td>This note is built-on to by :</td><td colspan="4"></td></tr>
<tr><td>Informations :</td><td colspan="4">This note has been read 34 times by 20 different people
This note has been modified once</td></tr>
<tr><td>Argument detection

Yes
(1)</td><td>Subject(s) of message:
1-) patient education starts with assessment of patient needs
2-)
3-)

Theme of sequence:
Patient education</td><td>Step 1</td><td>Step 2</td><td>Step 3</td></tr>
<tr><td colspan="2"><u>Je suis de ton avis...</u>

Il y a des themes qui reviennent plus souvent et qui sont a nos yeux d'intervenants plus importants certe... il faut donc se preparer a les aborder avec diferents outils adaptes a la clientele...

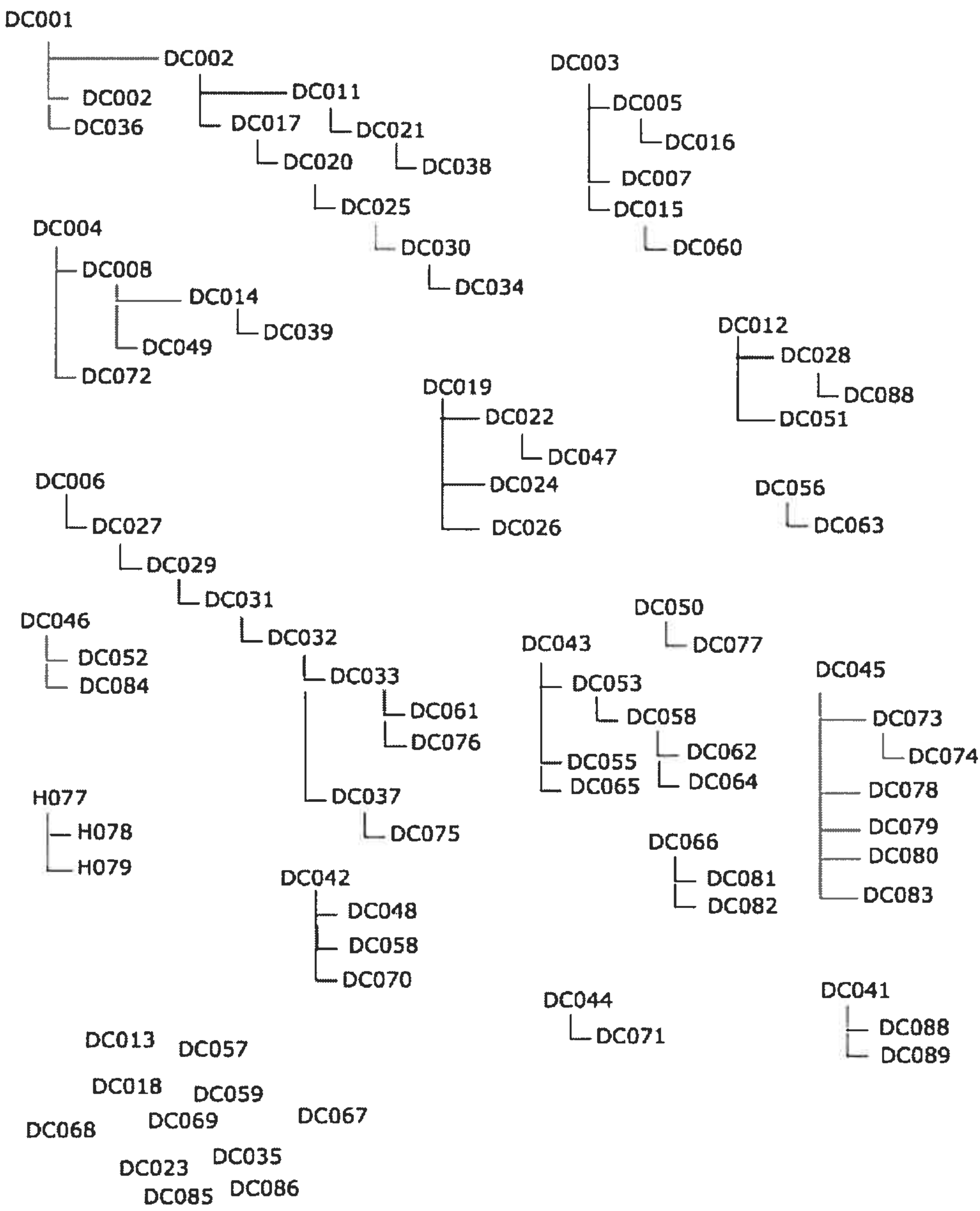
Mais le plus important de tous, va dans le meme sens que toi, c'est de se preoccuper d'abord de ce que le patient trouve de plus important a savoir (on peut parfois etre surpris!!!)...

Ensuite, on doit rendre accessible une ressource ou il pourra prendre l'info necessaire tout au long de son processus de readaptation afin de respecte l'evolution de ses besoins d'info et ses experiences...

NB. les besoins sont souvent plus marques dans les premieres semaines.</td><td>Pa(1)
↓
↓
↓
↓
↓
↓
↓
CLa</td><td><u>(eval)</u>
↓
(exp2)</td><td><u>EVA</u>
↓
EXP</td></tr>
</table>

Appendix 10

Graphic representation of build-on mode of messages of the view V9: *Data collection*



Appendix 11

Coding of sequence D of V9: *Data collection*

DC006	
Creation date :	12 April
Subject :	**notre collecte de données est désuette**
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	YJ
This note references:	
This note is referenced by :	
This note is built-on to :	
This note is built-on to by :	DC027
Informations :	This note has been read 53 times by 23 different people This note has been modified 3 times by 3 different people

Argument detection YES (2)	**Subject(s) of message:** **1-) outdated data collection** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
Ce dossier virtuel contient les contributions à ce message.				
Problématique Notre collecte de données lorsque le patient arrive a l'étage s'inspire des données receuillies a l'urgence par l'infirmière au triage ,l'urgentoloque ,le cardioloque qui ont questionné le patient , la famille si présente qui ont consulté le dossier antérieur et analysé les différents examens de cette hospitalisation actuelle pour en arriver a un diagnostic final.		Pa(1) ↓ ↓ ↓ ↓ ↓ ↓	(int3)	INT
A quelques questions près notre collecte de données infirmieres a l'étage est une répétition.		Pb(1) ↓ CLa		
Il y a de la place a de l'amélioration!!!!!!		↑ Pc(1)		
Nous n'avons aucun modèle conceptuel.!!!!!!				
Questionnements Est- ce que notre communauté de pratique va réaliser ce rêve?			(ana6)	ANA
Des informations importantes complémentaires pourraient être pertinents: Est-ce que le patient ou la famille savait quoi faire ou ont été pris au dépourvu devant le problème cardiaque? Comment le client ou sa famille vit cette hospitalisation? Quest-ce qu'ils attendent du milieu hospitalier? Est-ce qu'ils veulent qu'on discute avec eux des facteurs de risque....?		Pd(1) ↓ ↓ ↓ ↓ ↓ ↓	(inf3)	INF

Est-ce qu'ils connaissent leur médication? Veulent-ils avoir de l'enseignement? Estce qu'ils sont compliants? Sinon pourquoi?De quel façon ils prennent leur médicament: directement du contenant ou via une dosette Sont-ils prêts a avoir de l'information et qu'est ce qui les intéressent?.. A partir de cette collecte un peu mieux structurée, dirigée vers les besoins du patient, on peut planifier un plan d'interventions qui risque de porter fruits.)	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ CLb	(inf2)	INF

DC027	
Creation date :	18 April
Subject :	**Compliance**
Sub-subject :	Problems: Collecte de données
Keywords :	compliance
Author :	FG
This note references:	
This note is referenced by :	
This note is built-on to :	DC006
This note is built-on to by :	DC029
Informations :	This note has been read 35 times by 21 different people This note has been modified 5 times by 3 different people

Argument detection	**Subject(s) of message:**	**Step 1**	**Step 2**	**Step 3**
Yes (1)	**1-) compliance within education of the patient on his/her condition** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**			
[CG]	Compliance est un terme anglais. Nous devrions plutôt utiliser: observance au traitement ou fidélité	CLa Pa(1)	(int3)	INT
[FB]	Entierement d'accord CG		(eva1)	EVA
*[CG]*Ton questionnement est très justifié. La compliance me semble aussi un point sur lequel il faut s'attarder. Je fais parti d'un groupe qui refait le programme d'enseignement de notre milieu. À notre dernière rencontre nous avons abordé la compliance. Certains membres soulignent la confusion face au diagnostic. En effet plusieurs patient se font dire que leur infarctus a avorté grace au traitement qu'ils ont reçu (Activase - Angioplastie...) Alors ils font attention quelque temps, puis reprennent leur rythme de vie et cessent de prendre leur médication. La clareté du message est donc aussi essentielle *[FB]*		CLa ↑ ↑ ↑ Pa(1) Pb(2)	(eva1) ↓ (exp3)	EVA ↓ EXP

DC029				
Creation date :	18 April			
Subject :	-			
Sub-subject :	Problems: Collecte de données			
Keywords :				
Author :	CB			
This note references:				
This note is referenced by :				
This note is built-on to :	DC027			
This note is built-on to by :	DC031			
Informations :	This note has been read 21 times by 19 different people This note has been modified once by one person			
Argument detection no	**Subject(s) of message:** **1-) heart-related disease are generative diseases** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
Opinion Peut-être oublions-nous de mettre l'accent sur le fait que la maladie cardiaque est une maladie évolutive.			(ana6)	ANA

DC031				
Creation date :	19 April			
Subject :	**Une bonne fondation**			
Sub-subject :	Problems: Collecte de données			
Keywords :				
Author :	FB			
This note references:				
This note is referenced by :				
This note is built-on to :	DC029			
This note is built-on to by :	DC032			
Informations :	This note has been read 24 times by 21 different people This note has been modified once by one person			
Argument detection Yes (1)	**Subject(s) of message:** **1-) explaning the situation to the patient** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
Je suis d'accord avec toi CB.			(eva1)	EVA

	Step 1	Step 2	Step 3
Je crois que premièrement nous devons expliquer la situation (infrarctus, etc), et les facteurs qui ont apportés à cette état. Une exemple: certains patients me disent avoir eue une angioplastie coronarienne et me dise que "maintenant tout va bien et je n'aie pas besoin de réadaptation cardiaque". On regarde au dossier et on trouve que ces personnes ont des lésions coronairennes mineures (30, 40, 50%) et ceux ci ne semblent pas faire le connecte entre leur mode de vie (inactivité, fûmer, etc) et la présence d'accumulation de plaque. C'est comme si "Maintenant tout est "fixé" et je n'aie pas a m'inquiter". Nous devons passer beaucoup plus de temps à la base et peut-être nos interventions futures seront - elles mieux reçues. (Peut-être).	CLa ↑ Pa(2)	↓ (exp3)	↓ EXP

DC032	
Creation date :	19 April
Subject :	-
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	DC031
This note is built-on to by :	DC032
Informations :	This note has been read 53 times by 20 different people This note has been modified 16 times by 8 different people

Argument detection Yes (1)	**Subject(s) of message:** **1-) approach based on the patient's needs** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
CB	Je suis entièrement d'accord aussi.		(eva1)	EVA
FB	Je suis d'accord avec ceci. Je crois qu'il est primordial de savoir qu'elle importance le patient met sur son état de santé, facteur de risque etc.		(eva1)	EVA
HB	Bonjour GB Je suis d'accord avec toi sur l'importance des croyances du client, mais à l'hôpital ce qui lui importe est souvent très dfférent de ses attentes à la maison, à mon avis.		(eva1) ↓ (exp3)	EVA ↓ EXP
FB	Je crois que le commentaire d'HB est bien vrai. De ceci l'importance de la re-evaluation de notre patient a differents intervalles....example a l'hopital, lors de son conge,		(eva2) ↓ (exp2)	EVA ↓ EXP

	lors de son introduction dans un programme de readaptation etc. Ceci nous permettra d'avoir notre doigt sur ce qui est important pour le client maintenant (et non 3 mois passe)....			
[SH]	Je suis tout à fait en accord avec ton propos Geneviève. Et je crois aussi qu'avant de faire de l'enseignement sur différents volets de la maladie cardiaque, il est important de partir du patient, même si cela pouvait vouloir dire ne pas aborder du tout certains aspects habituellement enseignés. Je crois comme toi, que losque l'on atteint pas nos objectifs avec un patient, c'est parfois, parce qu'on avait peut-être tout simplement pas fixé les objectifs en fonction du patient...	← CLa Pa(1) Pb(1)	(eva1) ↓ (exp2)	EVA ↓ EXP
[CV]	Je suis d'accord avec tous vos commentaires, l'important c'est de se centrer sur le client et ses besoins		(eva1)	EVA
[JH]	Je suis également en accord avec ce propos... Je considère ces éléments comme étant complémentaire afin de nous aider à mieux planifier nos interventions.		(eva1) ↓ (exp2)	EVA ↓ EXP
[*Problématique* Les croyances d`une personne quand à son état de santé sont un grand indicateurs de futurs comportements.]  [*Données pertinentes* Plusieurs auteurs en soins infirmiers (example Watson) insistent d`ailleurs sur l`importance de l`exploration des croyance de la personne comme une intervention incontournable pour le succès des interventions subséquentes. Effectivement sans exploration des croyances, de ce qui est au coeur du problème, on ne peut moduler nos interventions pour vraiment atteindre le patient dans son expérience de santé.] [*Questionnements* **Je me demande si se questionner sur notre approche au même titre que sur nos inteventions ne serait pas pertinent.** Par example adopter une approche dont la priorité se centre sur ce qui est au coeur du vécu du patient au même titre que d`identifier les facteurs de risque.]  [*Données pertinentes* **En effet, mon expérience m`a fait réalise que souvent ont peut être tenté d`enseigner sur différents facteurs de risque, être frustré par ce que le patient ne réponds pas à notre intervention tout simplement parcque l`on est passé à coté de ce qui importait pour lui.**] [*Pistes de solutions* Pour en revenir à notre collecte de données, je me demande si cette élément (les croyances- en lien avec la maladie, l`expérience de santé actuel et ce qui importe ici et maintenant pour le patient etc.)ne devrait pas prendre une place aussi importantes que celles des facteurs de risque et éléments biophysiques.] [CB][FB][HB][FB][SH][CV][JH]		CLa ↑ ↑ ↑ Pa(1) ↑ ↑ Pb(1)	(exp3) **(ana6)** ↓ (exp2) ↓ **(exp3)** ↓ (inf2)	EXP **ANA** EXP **EXP** INF

DC33	
Creation date :	19 April
Subject :	-
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	DC032
This note is built-on to by :	DC076 DC061
Informations :	This note has been read 32 times by 20 different people This note has been modified 3 times by 2 different people

Argument detection Yes (1)	Subject(s) of message: 1-) importance of timing in data collection 2-) 3-) Theme of sequence: Repetition in patient data collection	Step 1	Step 2	Step 3
JH	En fait, ton propos s'inscrit dans une perspective de continuité de soins... L'outil de collecte de données devrait avoir la qualité de s'adapter à différentes phases de processus de réadaptation et en fonction de l'évolution du patient lui-même à travers les étapes de la maladie	CLa ↑ Pa(2)	(int2)	INT
JH Problématique	Un petit ajout. Le timing assicié à la collecte de données peut s`avérer aussi importante.  Données pertinentes Je pense à une étude entre autre qui démontre que bien que certains patients avaient recu un enseignement avant le retour à la maison avaient quand même des réactions ou comportements inadéquat à la maison. ex: certains patient savaient qu`il devaient prendre de la nitro si drs. Par contre, une fois à la maison, lorsque une drs se présentait, la personne ne croyait pas que sa drs était assez grave et ne prenait pas de nitro. pauvre coeur. ceci n`est qu`une example. Questionnements Ne serait il pas pertinent de colliger des données à différents moments dans l`épisode de soins. A l`hopital bien sur mais aussi d`assurer un certains suivi sèré dans les premiers jours suivant son hospitalisation alors que le patient est comfronté à une mise en application des ses connaissance et que sa situation évolue.  Il y a bien sur les clsc mais tous les patients n`ont pas une référence en clsc (en tout cas chez nous).	CLa ↑ ↑ ↑ Pa(2)	(ana1) ↓ (exp3) (inf3) ↓ (exp3)	ANA ↓ EXP INF ↓ EXP

DC061	
Creation date :	1 May
Subject :	-
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	SH
This note references:	
This note is referenced by :	
This note is built-on to :	DC033
This note is built-on to by :	
Informations :	This note has been read 17 times by 14 different people This note has been modified once by one person

Argument detection Yes (1)	**Subject(s) of message:** **1-) patient education during hospitalization** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
Je suis en accord avec toi. D'ailleurs, il est bien connu que <u>l'enseignement fait lors de l'hospitalisation, en phase aigue, a son importance, mais doit être très simple et adaptée aux besoins immédiats du patient</u>. Notre structure devrait permettre au patient d'avoir des ressources (documents, personnes ressources, suivi téléphonique, suivi en externe ou ambulatoire) à consulter lors du retour à la maison, dans son milieu de vie, ou parfois toute l'information donnée à l'hôpital prend un sens nouveau ou n'a plus du tout de sens!!		← CLa ↑ Pa(1)	(eva1) ↓ (exp3)	EVA ↓ EXP

DC076	
Creation date :	8 May
Subject :	**intérêt collecte de données**
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	HB
This note references:	
This note is referenced by :	
This note is built-on to :	DC033
This note is built-on to by :	DC037
Informations :	This note has been read 24 times by 20 different people: This note has been modified once by one person

Argument detection Yes	**Subject(s) of message:** **1-) universal data collection** **2-)**	**Step 1**	**Step 2**	**Step 3**

(1)	3-) **Theme of sequence:** **Repetition in patient data collection**			
	Problématique À mon centre hospitalier la collecte de données est universelle sauf pour l'urgence, c'est la seule qui se complète et elle sert de référence pour des données essentielles (médication, allergie, l'état physique et psychologique du patient, antécédents......) Bref que je dirais que cette collecte est toujours consultéé et appréciée, tandis que la nôtre est en partie une répétion des données ultérieures et demeure une feuille blanche.	CLa ↑ Pa(2)	(exp3)	EXP
	Questionnements Serait-il plus avantageux de partager la même collecte de données de nos consoeurs (inclus aussi confrère) de l'urgence?		(inf3) ↓	INF
	Opinion Je pense qu'il serait plus harmonieux et encourageant si on pouvait poursuivre la collecte afin de mieux connaître le patient et de répondre à ses besoins et à ses attentes au lieu de revenir sur des données déjà présentes au dossier. Peut-être que cela représentera un intérêt et une motivation pour l'équipe soignante et un plus pour le patient. HB		(exp2)	EXP

DC037	
Creation date :	21 April
Subject :	**Données complémentaires au profil**
Sub-subject :	Problems: Collecte de données
Keywords :	
Author :	CV
This note references:	
This note is referenced by :	
This note is built-on to :	DC032
This note is built-on to by :	DC075
Informations :	This note has been read 42 times by 19 different people This note has been modified 7 times by 4 different people

Argument detection Yes (1)	**Subject(s) of message:** **1-) need for continuity in data collection** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
FB	Même chose chez nous CV		(eval)	EVA
PL	Je suis d'accord avec cela, on passe énoemément de temps à requestionner le patient. Il faut intégrer les données.	**Pa(1)** **CLa**	(eval)	EVA

[LD]	Je suis d'accord avec la collecte de données complémentaire; j'aimerais aussi que l'on cesse de requestionner le client chaque fois qu'il vient dans le réseau...		(eval)	EVA
Opinion Bonjour HB, je suis d'accord avec que la collecte de données devrait être poursuivie à travers les différentes étapes d'évolution du client. Ceci pour que le client ne se tanne pas de répondre aux questions et éviter le duplicata de questions.			(eval) ↓ (exp2)	EVA ↓ EXP
Pistes de solutions La collecte de données devrait être continue tout au long du processus. À notre centre nous utilisons une collecte de données complémentaires lorsque le client est inscrit dans un programme spéciale de façon à obtenir les renseignements qui sont plus pertinents pour ce programme. **Une première collecte est utilisé à l'urgence, par la suite un profil de patient pour tout les patients hospitalisés est complété, et à ceci s'ajoute le profil complémentaire en fonction de la spécialité du programme.Ceci est aidant pour l'infirière qui n'a pas toute les connaissances du programme et cela nous permet de mieux répondre aux besoins de la clientèle** [FB]		CLa ↑ ↑ ↑ Pa(1) Pb(2)		
Problématique Là ou je trouve qu'il y a un problème c'est lorsque qu'on veut intégrer le tout quand le client passe par divers services, l'intégration en réseau demande beaucoup de communication et chacun a ses propres outils de travail et on requestionne le client. [PL] [LD]			(inf3)	INF

DC075	
Creation date :	8 May
Subject :	**Collecte en réseaux intégrés**
Sub-subject :	Problems: Collecte de données
Keywords :	outils communs, resaux integres
Author :	NM
This note references:	
This note is referenced by :	
This note is built-on to :	DC037
This note is built-on to by :	
Informations :	This note has been read 13 times by 12 different people This note has been modified once by one person

Argument detection no	**Subject(s) of message:** **1-) need for common tool for patient data collection** **2-)** **3-)** **Theme of sequence:** **Repetition in patient data collection**	**Step 1**	**Step 2**	**Step 3**
Opinion Bonjour CV, comme je travaille en communautaire je suis tout à fait d'accord avec toi concernant la communication en réseau, nous nous dirigeons vers les «resaux integres de services» et nous infirmières ne			(eval) ↓	EVA ↓

sommes pas les seules intervenantes dans le suivi de la clientèle. Il nous faut donc le plus possible d'outils communs.)		(exp2)	EXP

Appendix 12

Coding of sequence J of V9: *Data collection*

DC045	
Creation date :	22 April
Subject :	**Nouveau questionnement : # 4**
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	stades d'adaptation, suivi infirmier
Author :	MJP
This note references:	
This note is referenced by :	
This note is built-on to :	
This note is built-on to by :	collecte continue by LD - by GB DC073 DC083
Informations :	

Argument detection	Subject(s) of message:	Step 1	Step 2	Step 3
Yes (1)	**1-)** **2-)** **3-)** **Theme of sequence:** **Data collection**			
Questionnements Tout comme vous, j'ai également eu une réflexion en regard d'un processus de continuité dans la collecte de donnees. Par conséquent, est-ce possible de croire qu'une collecte de données peut se compléter de façon continue ? Je m'explique : La collecte de données du patient pourrait être amorcée à l'urgence ou dès son admission, complétée sur les unités de soins et poursuivie à sa sortie de l'hôpital par l'infirmière du CLSC ou de la clinique de réadaptation. Ceci **permettrait d'assurer un suivi infirmier des plus complets et éviterait les problèmes de répétition et de dédoublement dans les tâches infirmières, le temps étant si précieux ! De plus, cela éviterait au patient de répondre aux même questions. La collecte de données serait ainsi complétée par les différents intervenants infirmiers qui recueilleraient l'information pertinente, au moment opportun, tout en respectant l'étape ou le stade auquel se situe le patient.** Ce dossier virtuel contient les contributions à ce message.		CLa ↑ ↑ **Pa(2)** **Pb(1)** **Pc(2)**	(inf3) ↓ (exp2)	INF ↓ EXP

DC073	
Creation date :	6 May
Subject :	**collecte de données divisée par bloc**
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	adaptation, stades d, suivi infirmier collecte de données universelle
Author :	YJ
This note references:	
This note is referenced by :	DC074
This note is built-on to :	DC045
This note is built-on to by :	DC074
Informations :	This note has been read 23 times by 13 different people This note has been modified 6 times by 4 different people

Argument detection Yes (3)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
[LD]	Je suis d'accord avec ce mode de fonctionnement		(eva1)	EVA
[JV]	**Je suggère que ce bloc d'enseignement soit en deux copies, une pour garder au dossier de l'hôpital et l'autre qui appartient au patient dans une trousse**. Car selon que le patient se présente chez son médecin de famille, à une clinique spécialisée, pour l'infirmière du CLSC et d'autre, les différents intervenants auront les données pertinentes de son suivi d'enseignement et le fait que la personne ait en sa possession toutes ses données peut la rendre plus responsable pour sa prise en charge. Idéalement, la collecte de données pour ce bloc serait d'être la même pour tous nos centres.	CLa ↑ Pa(1) ↑ ↑ ↑ ↑ ↑ ↑ ↑ Pb(1)	(exp3)	EXP

Problématique Comme la plupart, je suis d'accord pour une collecte de données universelle. La collecte de données de la clinique d'insuffisance cardiaque de l' ICM est une référence qui sera très utile, mais il reste que c'est une collecte de données en post hospitalisation et de plus pour une clientèle spécifique soit : insuffisante cardiaque. *Questionnements* Dans notre communauté de pratique, nous avons possiblement un large éventail d'infirmières oeuvrant dans des secteurs spécifiques tels que l'urgence, les soins intensifs coronariens, les unités de soins de cardiologie, les clsc, les cliniques de réadaptation. Chaque infirmière a de l'expertise dans un ou des secteurs cités. *Pistes de solutions* Dans l'élaboration d'une collecte de données universelle, il <u>faudrait garder en mémoire que c'est pour une clientèle ayant un problème cardiaque</u> (infarctus, angine, insuffisant cardiaque, péricardite,	<u>CLa</u> ↑ ↑ <u>Pa(2)</u> <u>CLb</u> ↑ ↑	(eva1) ↓ (exp3) (exp1) ↓ (inf2)	EVA ↓ EXP EXP ↓ INF

	Step 1	Step 2	Step 3
trouble de rythme..) Donc les questions ne devraient pas s'adresser a une clientèle très spécifique.	Pb(1)		
Notre collecte de données pourrait être divisée par bloc et selon notre expertise, on pourrait la co-construire	**CLc Pc(2)**	↓ **(inf2)**	↓ **INF**
Voici des blocs que je suggère: Bloc urgence et soins intensifs coronariens Bloc unité de cardiologie on pourrait avoir des sous blocs spécifiques spécifiques a leurs problèmes cardiaques. Ex: infarctus Bloc d'enseignement spécifique a leur problème de santé, avec au préalable une évaluation des besoins du patient, une évaluation du stade du patient selon un modè le......		↓ (exp1)	↓ EXP
Ce bloc pourrait être débuté durant l'hospitalisation et poursuivi en externe. *LD* *JV*		↓ (inf3)	↓ INF

DC074	
Creation date :	7 May
Subject :	**Collecte de données en 3 blocs !**
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	adaptation, stades d, suivi infirmier collecte de données universelle
Author :	MJP
This note references:	DC073
This note is referenced by :	
This note is built-on to :	DC073
This note is built-on to by :	
Informations :	This note has been read 23 times by 14 different people This note has been modified 2 times by one person

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
Opinion Je suis en accord avec toi, YJ, pour construire notre collecte en fonction des différentes étapes du processus de soins hospitaliers et post-hospitaliers pour les patients au prise avec un probème cardiaque.			(eva1)	EVA
Le modèle de l'ICM est, en effet, une collecte de données destinée à une clientèle(IC) et à une étape de soins (enseignement) spécifiques. Cependant, cette dernière peut nous servir dans nos réflexions. Il n'en		**Pa(2) CLa**	↓ **(exp2)**	↓ **EXP**

tient qu'à nous de la bonifier ou de nous en inspirer afin de construire notre collecte.			
Questionnements Seriez-vous d'avis qu'il serait bien d'ouvrir 3 nouvelles notes qui correspondraient aux différentes étapes du processus de soins et dans lesquelles nous pourrions écrire la portion de la collecte de données correspondante soit en insérant des annotations dans ces notes ou en élaborant à partir de celles-ci ? Les trois notes seraient : (en référence à [1] collecte de données divisée par bloc) 1- Bloc d'urgence et Soins intensifs coronariens ; 2- Bloc de l'unité de soins en cardiologie ; 3- Bloc d'enseignement et de suivi.		(inf3)	INF
Opinion Si la réponse est positive, je demande à celles d'entres vous qui le souhaitez, de partir le bal en fonction de vos expertises et de créer, pour chacun des blocs plus haut cités, une note correspondante et ayant pour titre le nom du Bloc et dans laquelle vous inscriverez les éléments pertinents de la collecte de données . Au plaisir de co-construire MJP		↓ (int3)	↓ INT

DC078	
Creation date :	19 May
Subject :	-
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	stades d'adaptation, suivi infirmier
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	DC045
This note is built-on to by :	
Informations :	This note has been read 9 times by 8 different people This note has been modified once by one person

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
L`outil de collecte de données comporte les données suivantes.			(exp3)	EXP

Données pertinentes 1-données démographiques, 2-Personnes ressources (leurs noms, tél fax , personnellement je rajouterais aussi le e-mail., 3- sévérité de l`insufisance cardiaque selon NYHA (classe) et évaluation de la dyspnée, autres problèmes de santé, liste de médication, connaissances des effets secondaires et gestion prise de médication, 5- habitudes de consommation 5.1- tabagisme, alcool,et liquides (restriction et respect de la restriction) 5.2- alimentation (type de régime, compréhension des limitations poids actuel et poids de référence., 5.3- élimination (nombre de mictions dié, intestinal, 5.4 sommeil (satisfesant, difficulté à s`endormir, éveil en raison de difficultés respiratoires, dort assis, cauchemars, éveil tôt le matin, raisons d`éveil la nuit autre. 5.5- connaissances de l`usager face à la maladie (comprend maladie, médication, préveint et traite les exacerbations, respect recommandations et prescriptions, connait et exécute activités physiques, autres. 5.6- état psycholgique(échelle de 1 à 5 pour les items suivants: anxiété, agressivité, difficulté de compréhension, dépression, négation, acceptation de la maladie. 5.7 relations avec les proches: satisfesantes, isolement ou particularité. problèmes cognitifs identification des symptômes observables. suite dans prochaine note.			

DC079	
Creation date :	19 May
Subject :	-
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	stades d'adaptation, suivi infirmier
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	DC045
This note is built-on to by :	
Informations :	This note has been read 6 times by 6 different people This note has been modified once by one person

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
Bonjour MJP *Problématique* Milles excuses pour mon silence des dernières semaines. Les demandes fusent de partout. Merci de ton empathie lors des derniers appels. *Données pertinentes* Concernant le le programme du PICC à Sacré Coeur			(exp3)	EXP

voici les principals données en attendant le logiciel.Ce programme a pour but "d`offrir des soins médicaux, un encadrement et un soutien interdiscipliaire à la clientèle atteinte d;insuffisance cardiaque sur une base ambulatoire avec accessibilité aux soins en médecine de jour." Picc p.1 les outils de collecte de données comporte un outil d`évaluation initiale, un questionnaire téléphonique et un outil d`identification de la clientèle à risque et les documents du logiciel soit une feuille santé qui résume l`état clinique de l`usager et traitements recus.)  J`envoie une autre rubrique tout de suite sur l`outil de collecte de données.			

DC080	
Creation date :	19 May
Subject :	-
Sub-subject :	Problems: Nouveau questionnement / Collecte denées (livrable)
Keywords :	stades d'adaptation, suivi infirmier
Author :	GB
This note references:	
This note is referenced by :	
This note is built-on to :	DC045
This note is built-on to by :	
Informations :	This note has been read 10 times by 8 different people This note has been modified once by one person

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
section avq, avd 1- pas de limitations, limitations légères, limitations modérés, "" sévère. spécifications 2- handicaps: mémoire, mobilité, vision, intellectuelle, audition, language, autre. 3- mode de déplacement: sans aide, marchette etc. soutien social: vit avec x 4-type de résidence 5-local du logis: étage ? ascenseur ? escalier ? 6- intervenants communautaires et autres 7-services communautaires ex: groupe communautaire, transport, etc. 8- services professionels 9- ressources financières: pensions, types de rente, supplément de revenu garantie 10- besoins spécifiques à : enseignement pharmaco, contrôle habitudes de consommation, alimentation, hydratation élimination, réhabilitation, compréhension de la maladie, prévention, reconnaissance et traitement des exacerbations, état psychologique, autonomie, orientation vers les ressources communautaires.			(exp3)	EXP

11- enseignement fait "" vérifiée date sujets: pesée quotidienne, remise calendrier pesée, limite liquidienne, signes et symptômes, remise de "quand chercher de l`aide", limitations physiques, brochures, médications. 12- identification du besoin et objectif à atteindre (date, plan d`action, échéancier, évaluation mesurable et observable.) Ceci termine l`outil de collecte de données.			

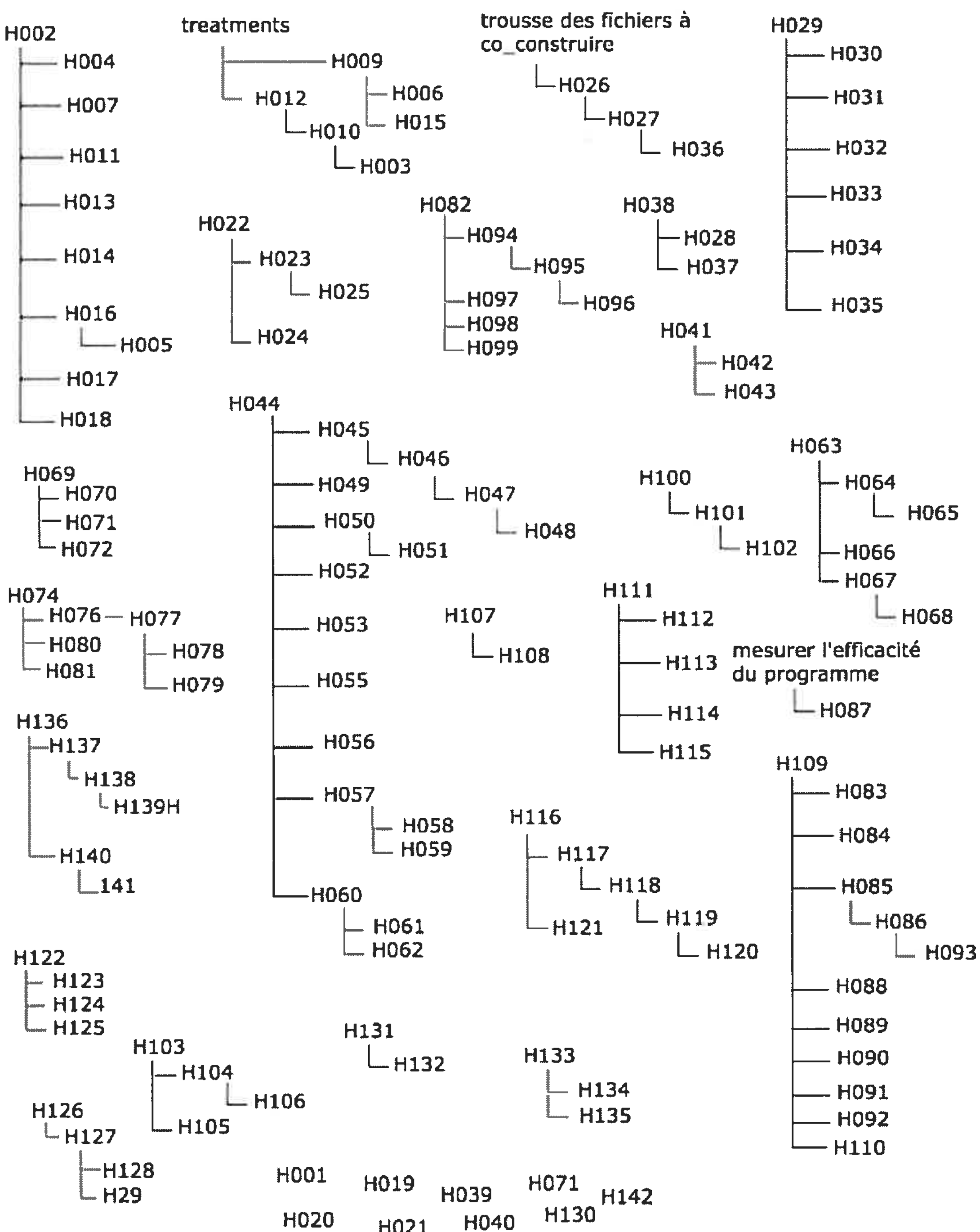
DC083	
Creation date :	20 May
Subject :	**continuité des soins**
Sub-subject :	Problems: Nouveau questionnement / Collecte de données (livrable)
Keywords :	stades d'adaptation, suivi infirmier, Logiciel Lien CH-CLSC
Author :	CG
This note references:	
This note is referenced by :	
This note is built-on to :	DC045
This note is built-on to by :	
Informations :	This note has been read 6 times by 6 different people This note has been modified once by one person

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:**	**Step 1**	**Step 2**	**Step 3**
Pistes de solutions Je crois que la collecte de données devrait être remplis tout au long de l'épisode de soins. Elle devrait également être révisée avant le départ de l'usager pour le domicile. Pour assurer la continuité des soins, la collecte de données devrait être intégrée dans la trousse de départ afin que le personnel qui assure le suivi post hospitalisation (CLSC, Clinique de réadaption) puisse y avoir accès. Dans la région 03, nous utilisons l'Internet pour faire la liaison de l'usager du CH vers le CLSC. Pour ce faire, nous utilisons le Logiciel Lien CH-CLSC du Lotus Notes. Cet outil permet d'acheminer au CLSC les demande de services à domicile ou aux services courants. De cette façon, nous n'avons pas besoin de faxer nos demandes et une personne est attitrée à la réception des messages pour chaque CLSC. Nous recevons un accusé de réception dans l'heure qui suit. Il y aurait lieu de développer un moyen de saisir les données des usagers dans un type de logiciel tel que le Lien CH-CLSC. Ceci nous permettrait de mettre à jour les données tout au long de l'épisode de soins de l'usager et de		CLa Pa(1) ↑ ↑ ↑ Pb(1)	(inf3) ↓ (exp3) ↓ (exp2)	INF ↓ EXP ↓ EXP

les transmettre aux personnes concernées lors du congé de l'usager. Cette collecte pourrait être imprimée pour les personnes qui n'ont pas besoin de référence au CLSC et pourrait être insérée dans la trousse de départ pour fin de consultation par les autres professionnels de la santé (médecin, infirmières, ...)		(inf3)	INF

Appendix 13

Graphic representation of build-on mode of messages of the view V10: *Heart health kit*



Appendix 14

Coding of sequence A of V10: *Heart health kit*

H002	
Creation date :	11 Avril 2002
Subject :	Proposition / livrables à se donner
Sub-subject :	Problem :SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	MJP
This note references:	trousse de survie by YJ
This note is referenced by :	
This note is built-on to :	trousse de survie by YJ
This note is built-on to by :	Trousse de survie by CP Trousse de survit by FB Créer des liens by LD trousse de survie(enseignement minimum) by YJ la trousse , c,est pour la maison by HB (untitled) by CS Kit de survie by FG Enseignement prioritaire by CG Accord et proposition by LJ
Informations :	This note has been read **115** times by **27** different people as follows This note has been modified **11** times by **4** different people as follows

Argument detection	Subject(s) of message:	Step 1	Step 2	Step 3
no	**1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**			
JHJ	En accord avec la proposition des livrables... **Je propose toutefois d'utiliser les termes: clientèle atteinte d'une maladie coronarienne ou d'insuffisance cardiaque...** Je trouve que les termes coronarien et insuffisant cardiaque collent alors moins à la personne mais plutôt à la maladie dont la personne est atteinte... C'est un peu plus long à dire mais pour certaines personnes atteintes de la maladie c'est plus facile à entendre car ca devient un qualificatif de la maladie et non de la personne elle-même. (c'est un opinion personnel ... qui a émergé de certaines expériences auprès de personnes en processus de réadaptation)	CLa ↑ Pa(3)	(ana4) ↓ (exp2)	ANA EXP
CG	**Je n'aime pas le terme "trousse de survie"**. À mon avis, ce terme a une connotation péjorative. Je préfère le terme "Enseignement prioritaire". Il signifie mieux ce que l'on veut donner à l'usager et la famille soit l'enseignement prioritaire afin d'assurer une sortie à domicile sécuritaire	CLa Pa(1) ↑ Pb(2)	(ana4) ↓ (exp2)	ANA EXP

LJ	**Je suis d'accord avec CG**. J'opterais pour un portfolio ou trousse sur les soins priortaires en santé du coeur Lucille		(eval) ↓ (exp2)	EVA EXP

Ce dossier virtuel contient les contributions à ce message. JH Excellente idée ! [1] Opinion Nous pourrions élaborer sur ce sujet à l'intérieur d'une nouvelle perspective si vous êtes d'accord. Le résultat de la réflexion pourraît alors être un livrable concret, soit une Trousse de survie CG LJ pour le patient cardiaque (nous pourrions l'intituler selon l'appellation qui conviendrait le mieux). De plus, cette dernière serait un complément à l'enseignement au patient. Par conséquent, les livrables sur lesquelles nous pourrions conjointement travailler pourraient être : 1- outil commun de Collecte de données (actuellement en cours d'élaboration à l'intérieur de la perspective *Collecte de données*, aussi je vous invite à venir y participer) 2- Programme d'enseignement pour les clientèles coronariennes et insuffisantes cardiaques jeunes et âgées 3- Trousse de survie à remettre aux clientèles coronariennes et insuffisantes cardiaques jeunes et âgées. Questionnement Êtes-vous en accord avec cette proposition de livrables ? **Ces derniers, auraient certainement un impact positif sur la prise en charge par les patients cardiaques de leur situation de santé.**		(inf2) (inf2)	INF INF

H004	
Creation date :	02 Mai 2002
Subject :	Kit de survie
Sub-subject :	Problem :SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie, diagnostic, kit de survie
Author :	FG
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **22** times by **17** different people as follows This note has been modified **once** as follows

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
⟨Opinion **Excellente idée.** Au CHUQ, nous sommes à refaire notre programme et nous nous sommes entendu sur la nécessité d'un "kit de survie", c'est à dire ce que le patient doit absolument savoir avant de quitter le centre hospitalier. ⟨Données pertinentes Il y a des éléments communs dans le kit selon le diagnostic ex.: quand consulter, utilisation (et démystification) de la TNT. Il y a des éléments spécifiques à un diagnostic ex.: moyens pour diminuer la consommation d'oxygène en insuffisance cardiaque. Avec le temps dont nous disposons pour faire l'enseignement le "kit de survie" (ou autre terme) est donc très justifier et très sécuritaire pour nos patients. Après il faudra trouver le moyen de s'assurer que le patient reçoit le reste de la formation.⟩⟩		Pa(1) ↓ ↓ Pb(1) ↓ ↓ CLa	(eva1) ↓ (exp2)	EVA ↓ EXP

H007	
Creation date :	07 Mai 2002
Subject :	Accord et proposition
Sub-subject :	Problem : SYNTHÈSE 23 mars 2002 (première semaine des échanges
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	LJ
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **22** times by **15** different people This note has been modified **once** as follows

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**

Je suis d'accord avec les livrables. **Par ailleurs j'opterais pour une trousse santé du coeur tout simplement**			(eval) ↓ (exp2)	EVA ↓ EXP

H011	
Creation date :	16 Avril 2002
Subject :	**trousse de survie(enseignement minimum)**
Sub-subject :	Problem : SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	YJ
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **39** times by **20** different people This note has been modified **once**

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
(*Problématique*) Cette trousse de survie que je propose (on pourrait l'appeler trousse de première ligne ou trousse de départ sécuritaire) ferait partie intégrante de l'enseignement intra hospitalière. **Étant donné le court séjour,cette trousse doit être un incontournable selon moi pour un retour sécuritaire a la maison.**		CLa ↑ ↑ ↑ Pa(1)	(int3) ↓ **(exp2)**	INT **EXP**

H013	
Creation date :	21 Avril 2002
Subject :	(untitled)
Sub-subject :	Problem :SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, trousse de survie, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen
Author :	CS
This note	

references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **32** times by **21** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
Je suis d' accord. Bonne idee.			(eval)	EVA

H014	
Creation date :	19 Avril 2002
Subject :	la trousse , c,est pour la maison
Sub-subject :	Problem :SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	trousse de survie, enseignement, support a donner aux familles, traitemen, promotion, readaptation, prise en charge
Author :	HB
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read 39 times by 21 different people This note has been modified once

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
(Opinion Il existe chez nous un style de trousse de renseignements sur leur diagnostic. pour l'infarctus, le livre "Vivre de bon coeur" produit par l'hôpital de l'Enfant Jésus de Québec, pour les angineux un chemisier À vous de jouer"			(expl)	EXP

	Step 1	Step 2	Step 3
leur est suggéré. Une feuille explicative sur les délais des activités permises post-im, ainsi qu'un mémo pour la prise de R.V. avec le md et la cardiologue ainsi que la conduite à faire si récidive de malaise cardiaque sont inscrites. En premier lieu, l'enseign. verbal est toujours privilégié, une fois semaine ,je suis libérée pour l'enseign.coro. sur les étages et je valide leurs connaisances et compléte s,'l y a lieu selon leurs demandes et attentes, les documentations reçues sont souvent rendues à la maison avec eux.			

H016	
Creation date :	05 Mai 2002
Subject :	Enseignement prioritaire
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	CG
This note references:	
This note is referenced by :	Définir notre livrable : Trousse ... by MJP
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	D'accord avec enseignement prioritaire by RD
Informations :	This note has been read **30** times by **18** different people This note has been modified **3** times by **2** different people

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
[CV]	je trouve également le terme plus approprié		(eva1)	EVA
[CV] Je crois que nous devrions utiliser le terme"Enseignement prioritaire" pour signifier l'enseignement que l'on désire priorisé pour assurer un retour à domicile sécuritaire. **Je trouve que ce terme est plus significatif et moins péjoratif que "trousse de survie"**		CLa ↑ ↑ ↑ Pa(1)	(ana4) ↓ (exp2)	ANA ↓ **EXP**

H005	
Creation date :	05 Mai 2002
Subject :	D'accord avec enseignement prioritaire
Sub-subject :	Problem : SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	RD
This note references:	
This note is referenced by :	
This note is built-on to :	Enseignement prioritaire by CG
This note is built-on to by :	
Informations :	This note has been read **23** times by **16** different people This note has been modified **once**

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
Je suis tout à fait d'accord avec toi CG, l'enseignement prioritaire est plus juste et fait moins «jungle» que trousse de survie			(eval) ↓ (exp2)	EVA ↓ EXP

H017	
Creation date :	13 Avril 2002
Subject :	Créer des liens
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	LD
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **37** times by **21** different people This note has been modified **2** times by **the same** person

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)**	**Step 1**	**Step 2**	**Step 3**

	Theme of sequence: **Heart health kit - a deliverable for the networked community**			
Opinion Je suis bien d'accord avec ces livrables car ils vont nous permettre de dresser un plan d'action réaliste et de créer des liens avec les différents intervenants (Soins intensifs, clinique de suivi, CLSC, communauté). Tout ça pour une meilleure prise en charge ou orientation du client et sa famille. LD		Pa(2) ↓ ↓ ↓ CLa	(eva1) ↓ (exp2)	EVA ↓ EXP

H018	
Creation date :	12 Avril 2002
Subject :	Trousse de survie
Sub-subject :	**Problem:** SYNTHÈSE 23 mars 2002 (première semaine des échanges)
Keywords :	promotion, readaptation, prise en charge, enseignement, support a donner aux familles, traitemen, trousse de survie
Author :	CP
This note references:	
This note is referenced by :	
This note is built-on to :	Proposition / livrables à se donner by MJP
This note is built-on to by :	
Informations :	This note has been read **43** times by **22** different people This note has been modified **3** times by **2** different people

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Heart health kit - a deliverable for the networked community**	**Step 1**	**Step 2**	**Step 3**
[YJ]	Pourquoi pas une trousse de première ligne? une trousse de départ sécuritaire? Y.		(ana4)	ANA
Opinion Je trouve l'idée de "trousse de survie" des plus intéressantes. Au CHUQ, nous avons formé un Comité multidisciplinaire pour élaborer un programme d'enseignement à la clientèle de cardiologie. Les différents professionnels se questionnent présentement sur les éléments de cette "trousse de survie" (Il faudrait cependant trouver une autre apellation à mon avis). [YJ] Je suis en accord pour que ce thème devienne notre 3e bien livrable!			(eva1) ↓ (exp2) (eva1)	EVA ↓ EXP EVA

Appendix 15

Coding of sequence H of V10: *Heart health kit*

H029	
Creation date :	22 Avril 2002
Subject :	Définir notre livrable : Trousse ...
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	
Author :	MJP
This note references:	Enseignement prioritaire by CG
This note is referenced by :	
This note is built-on to :	
This note is built-on to by :	(untitled) by CG trousse de dépannage by JV (untitled) by SH Coeur en main by HB Réponse à notre 3ième livrable by YJ A eviter by FB (untitled) by GB
Informations :	This note has been read **117** times by **26** different people This note has been modified **8** times by **the same** person

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Defining the heart health kit**	**Step 1**	**Step 2**	**Step 3**
Ce dossier virtuel contient les contributions à ce message. Problématique <u>Plusieurs d'entre vous ont manifesté l'intérêt de travailler sur un troisième livrable, soit une trousse destinée à soutenir le patient dans la prise en charge de son état de santé / maladie</u>.			<u>(int3)</u>	<u>INT</u>
Il importe, à ce stade-ci, de se poser des questions bien précises en regard de cette Trousse.			(inf2)	INF
Questionnements <u>1- Quel est l'intérêt de cette TROUSSE ? C'est-à-dire ; définir le mandat que l'on veut lui accorder.</u> <u>2- Quelle est la ou les clientèles que nous désirons cibler dans le cadre de nos travaux actuels ?</u> <u>3- Quel est le contenu que nous voulons insérer à l'intérieur ?</u> <u>4- Quel est le nom que nous souhaitons lui donner ?</u>			<u>(ana6)</u>	<u>ANA</u>

Afin de faciliter notre travail, je vous suggère de structurer vos notes de réponses de la manière que voici : **1- Mandat : …** **2- Clientèle : …** **3- Contenu : …** **4- Nom :**		(inf2)	INF
Afin de redémarrer vos réflexions, je vous présente la synthèse de vos premières réflexions. Vous remarquerez que avez déjà identifié des pistes de solutions aux questions : 1- Mandat : Cette trousse serait remise au patient cardiaque durant son hospitalisation et l'accompagnerait à sa sortie. Elle serait utilisée comme un complément à l'enseignement et favoriserait la prise en charge, par le patient, de sa situation et par le fait même, un retour sécuritaire à la maison. 2- Clientèle : - Le contenu de la trousse pourrait différer en fonction du diagnostic : angine, infarctus, insuffisance cardiaque, etc. 3- Contenu : - Un cahier avec illustrations qui couvre tous les aspects importants de la maladie du patient, - Le livre "Vivre de bon cœur" produit par l'hôpital de l'Enfant Jésus ; - Le chemisier "À vous de jouer" ; - Une feuille explicative sur les délais et les activités permises post-infarctus du myocarde ; - Un mémo pour la prise de R.V. avec le cardiologue ; - L'information au sujet de la conduite à faire si récidive d'un malaise cardiaque : savoir reconnaître ces signes d'angine, comment prendre de la TNT et quand consulter ; - Des questionnaires destinés à identifier les besoins du patient en matière d'enseignement. 4- Nom : Certaines d'entre vous la surnomment la Trousse de survie, d'autres l'appellent Trousse de première ligne, Trousse de départ sécuritaire, Trousse de dépannage, Trousse en santé du coeur, Enseignement prioritaire. J'aimerais, moi aussi, vous faire connaître ma suggestion : la Trousse cœur en mains qui représentent le rôle actif du patient en regard de sa situation. De plus, il serait pertinent que cette trousse devienne un livrable virtuel à diffuser sur le site de L'infirmière virtuelle en téléconsultation et à laquelle pourrait se référer les personnes au prise avec un problème cardiaque. Celle-ci serait conçue par les infirmières expertes dans le domaine.		(int1)	INT

Avis aux intéressées de contribuer à la réalisation de ce livrable qui dépassera largement les murs des centres hospitaliers. Le site de Santé Canada a déjà initié le pas et a mis en ligne la trousse Coeur en santé qui donne de l'information sur les facteurs de risque. L'adresse pour y accéder est la suivante : http://www.hc-sc.gc.ca/hppb/sai/healthyheartkit/healthyheartkit_fr.htm MJP			

H030	
Creation date :	12 Mai 2002
Subject :	Coeur en main
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	
Author :	HB
This note references:	
This note is referenced by :	
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **22** times by **13** different people This note has been modified **2** times by **2** different people

Argument detection	Subject(s) of message:	Step 1	Step 2	Step 3
no	1-) 2-) 3-) **Theme of sequence:** **Defining the heart health kit**			
je suis d'accord avec la perspective de « S » pour l,enseign.coro. **le mandat: que chaque patient et une personne significative pour lui quittent l'hôpital avec une bonne compréhension de son état de santé et des directives claires pour un retour à la maison sécuritaire et confiant.** **Clientèle: angine, infarctus, insuff, coronarienne, conseils post-dilatation,stent,post-chirurgie ou en attente de chirurgie.(PAC) (Rempl, valve), pace permanent ect.** **Contenu: Indivualisé selon le dx de chacun.** **L'enseign. verbal demeure toujours priorisé.** **Chemisier angine: explication de l'angine, souligné ses facteurs de risque correspondant, commment les contrôler s'il y a lieu ,utilisation de la nitro, quoi faire si l'angine persiste, conseils sur les activités, les médications et l'alimentation.**			(eva1) ↓ (exp1)	EVA ↓ EXP

Chemisier infarctus: idem à l'angine mais avec des informations plus pointu pour les activités en autres., doit savoir qu'il doit prendre rendez-vous avec md et cardio. qu'il aura un tapis d'effort à la fin de la convalescence. **chaque catégorie de patient doit retrouver les renseignements pertinents à son état et sa condition.** **on devrait aussi s'assurer que le patient aura des ressources nécessaires s'il y a lieu à la maison et enclencher la demande le plus rapidement..** **Coeur en main me convient comme nom.**			

H031	
Creation date :	13 Mai 2002
Subject :	Réponse à notre 3ième livrable
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	enseignement, insuffisance cardiaque, trousse, Exemple, anticoagulee
Author :	YJ
This note references:	
This note is referenced by :	
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **19** times by **9** different people This note has been modified **2** times by **2** different people

Argument detection no	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Defining the heart health kit**	**Step 1**	**Step 2**	**Step 3**
Pistes de solutions 1. Mandat: Cette trousse, comme je l'avais proposée au tout début, n' était pour moi que quelques notions de base minimum qu' un patient doit recevoir pour un départ sécuritaire a la maison. Une feuille suffit a cocher si l'enseignement est faite et comprise. Ces notions de bases peuvent être mentionnées (comme enseignées et comprises) par l'infirmière de liaison lorsqu' elle fait une référence au CLSC pour un suivi. 2. Clientèle: une trousse pour l'insuffisant cardiaque une trousse post infarctus une trousse pour les angineux			(exp1)	EXP

on pourrait dans un deuxième temps élaborer :une trousse pour les personnes anticoagulées une trousse post- coronarographie ou post dilatation une trousse post installation de stimulateur cardiaque etc... Lors d'un départ, un patient pourrait recevoir l'enseignement de deux trousses (selon la situation du patient): insuffisance cardiaque et anticoagulee post- installation de stimulateur cardiaque et anticoagulée angine et insuffisance cardiaque 3. Contenu: Comme je l'expliquais ci-haut une simple feuille mentionnant l'enseignement minimum Exemple: TROUSSE DE DÉPART SÉCURITAIRE POUR L' INSUFFISANT CARDIAQUE Enseignement coché si fait note sur la compréhension -- ---------------------- sur la consommation de sel -- ------------------------------ sur la prise de liquide -- ------------------------------- sur la surveillance du poids -- --------------------------------- quand consulter? (symptômes) -- --------------------------------- qui consulter et où et no tel:? -- ---------------------------------- à noter que je n'ai pas l'expertise dans ce domaine, ce n'est qu' une suggestion TROUSSE DE DÉPART SÉCURITAIRE POUR LES PERSONNES ANGINEUSES Enseignement coché si fait note sur la compréhension -- -- la prise de TNT -- -- quand consulter?(symptômes) --			

--- qui consulter? où? no tél --- -- TROUSSE DE DÉPART SÉCURITAIRE POST-INFARCTUS Enseignement coché si fait note sur la compréhension --- --- activités post infarctus --- -- prise de TNT --- -- quand consulter --- --------------------------------------- qui consulter, où,tél --- -------------------------------------- 4. Nom: TROUSSE DE DÉPART SÉCURITAIRE			

H032	
Creation date :	05 Mai 2002
Subject :	(untitled)
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	
Author :	CG
This note references:	
This note is referenced by :	
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **37** times by **17** different people This note has been modified **6** times by **3** different people

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)** **Theme of sequence:** **Defining the heart health kit**	**Step 1**	**Step 2**	**Step 3**
JH	**J'aime bien l'idée de personnaliser la trousse**... toutefois, on pourrait retrouver des éléments de base pour l'ensemble des trousses... qui servirait de point de départ... on s'assure ainsi d'un minimum d'information.	Pa(1) CLa	(eva1) ↓ (exp2)	EVA ↓ EXP

[PL]	**L'idée de pouvoir adapter la trousse à chaque personne m'apparait fort intéressante**		(eval)	EVA
Opinion [JH] [PL] Je suis d'accord avec l'idée d'une trousse de départ **que l'on pourrait nommer par des éléments plus significatifs que "trousse de survie " qui me semble plutôt péroratif.** **Un titre comme "Votre santé nous tient À COEUR" me semble plus révélateur que "Kit de survie".** Pistes de solutions Appelez-le comme vousle voulez, ce Kit ou cette trousse devrait contenir les élements nécessaires spécifiques à l'usager. Il devrait donc être personnalisé. **Le format devrait permettre d'insérer dans une pochette des dépliants ou des livrets relatifs à diffférents thèmes comme :** **L'infarctus,** **l'angine,** **L'insuffisance cardiaque** **etles différents élements de traitements ou d'informations comme:** **les traitements** **les facteurs de risques ,** **la médication,** **les examens,** **le support à la famille,** **etc.** (Opinion)	Pa(1) ↓ CLa ↑ Pb(1)	(eval) ↓ (exp2) (inf2) ↓ (exp2)	EVA ↓ EXP INF ↓ EXP

H033	
Creation date :	10 Mai 2002
Subject :	trousse de dépannage
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	trousse, CLIENT, MANDAT, NOM, CONTENU
Author :	JV
This note references:	
This note is referenced by :	
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **20** times by **12** different people This note has been modified **once**

Argument detection	**Subject(s) of message:** **1-)** **2-)**	**Step 1**	**Step 2**	**Step 3**

C

no	3-) **Theme of sequence:** **Defining the heart health kit**			
Opinion Je vous présente ma façon de voir cette trousse de dépannage 1) MANDAT: Répondre aux besoins immédiats et à long terme du patient. 2) CLIENTÈLE: Toutes les personnes atteintes de maladies cardiovasculaires (angine, infarctus, insuffisance cardiaque, pathologies valvulaires) 3) CONTENU: Il y aurait une plus grande trousse qu'on pourrait nommer " trousse en santé coeur" qui contiendrait toutes les informations utiles pour sa maladie (anatomie du coeur, sa physiologie et la pathophysiologie de l'infarctus, de l'angine, de l'insuffisance cadiaque etc..., et des renseignements sur les traitements, la médication, la diète, les facteurs de risques, la gestion du stress etc...). Une deuxième petite trousse qu'on pourrait nommer "trousse de dépannage" que la personne pourrait traîner partout (peut-être même avec une petite ganse pour attacher à une ceinture) et qui contiendrait pour celle qui a fait un infarctus et/ou de l'angine: de la T.N.T, une ASA, des directives sur quoi faire en cas de DRS et un ou deux numéros de téléphone d'urgence; tandis que pour la personne qui de l'insuffisance cardiaque cette trousse contiendrait: de la T.N.T., du Lasix, des directives sur quoi faire en cas de détresse respiratoire et un ou deux numéros de téléphone d'urgence. 4) NOM: trousse en santé du coeur dans laquelle se retrouverait une petite trousse de dépannage.			(exp1)	EXP

H034	
Creation date :	14 Mai 2002
Subject :	A eviter
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	trousse, ressources
Author :	FB
This note references:	
This note is referenced by :	
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **17** times by **9** different people This note has been modified **2** times by **2** different people

Argument detection Yes (1)	**Subject(s) of message:** **1-)** **2-)** **3-)**	**Step 1**	**Step 2**	**Step 3**

	Theme of sequence: Defining the heart health kit			
Opinion Je suis d'accord avec l'information suggere. Opinion **Un item bien important a inclure dans la trousse est les ressources disponibles au patient une fois chez lui (elle).** Par exemple: CLSC, fondation des maladies du coeur, programme de rehabilitation cardiaque, etc. Numero de telephone, couriel, etc. Problématique **La trousse ne devrais pas etre trop charger mais etre tenu simple avec resources au client.** Si on le surcharge je m'inquiete de l'effet que ceci pourrait avoir sur le patient.		Pa(1) CLa	(eval) (inf2) ↓ (exp1) (inf2) ↓ (exp2)	EVA INF ↓ EXP INF ↓ EXP

H035	
Creation date :	11 Mai 2002
Subject :	(untitled)
Sub-subject :	**Problem:** Troisième livrable : Trousse…
Keywords :	
Author :	SH
This note references:	
This note is referenced by :	Programmes d'enseignement prioritaite et Fiches d'info. by MJP
This note is built-on to :	Définir notre livrable : Trousse ... by MJP
This note is built-on to by :	
Informations :	This note has been read **36** times by **12** different people This note has been modified **4** times by **3** different people

Argument detection Yes (5)	Subject(s) of message: 1-) 2-) 3-) Theme of sequence: Defining the heart health kit	Step 1	Step 2	Step 3
FB	« S », je suis entierement d'accord avec tes propos ici. **"Keep it simple"....court et simple, info qui repond au besoins immediats du patietn. Si bien choisi, le contenu provoquera des questions chez celui-ci. Ces questions peuvent etre repondu par des personnes resources (faire certain que le patient peut contacter quelqu'un soit par telephone, couriel, etc.**		(eval) ↓ (exp2)	EVA ↓ EXP
IG	Bonjour, Je suis tout a fait d'accord avec vous! **Car Dieu sait comment il en existe de la documentation et 1/4 des personnes la lisent, pas plus !!! Il faut simplifier et schematiser le plus possible pour que le tout soit**	Pa(2) ↓ ↓ ↓	(eval) ↓ (exp2)	EVA ↓ EXP

<table>
<tr><td></td><td>accessible dans un pamplet de 2 pages sans plus.</td><td>CL_a</td><td></td><td></td></tr>
<tr><td colspan="2">Pistes de solutions
Mandat: <u>Je crois que l'idée d'une trousse est bonne.</u>

Par contre, si l'on n'est pas prudent et trop ambitieux, on risque, je crois, de manquer l'objectif.

Je m'explique.... Il est prouvé que de noyer les patients d'informations et de papiers (comme les infirmières d'ailleurs... penser aux babillards qu'on ne consulte plus parce qu'ils sont surchargés) est très peu efficace.

En ce qui concerne une trousse virtuelle, alors c'est à mon avis un peu différent, puisque le patient peut sélectionner l'information qui le concerne spécifiquement.

Par contre, au départ de l'hôpital ou en clinique ambulatoire, une trousse contenant une multitude de brochures et de papiers risquent peut-être d'apparaître très lourde au patient.

Peut-être que je pense trop à ma clientèle insuffisante cardiaque, qui est définitivement fatiguée et très limitée et auquelle je dois répondre aux besoins prioritaires si je veux atteindre les objectifs. FB IG</td><td>CL_a
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$P_a(2)$
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$P_b(3)$</td><td>(eva1)
↓
(exp2)</td><td>EVA
↓
EXP</td></tr>
<tr><td colspan="2">Clientèle: <u>Je crois que ce qui se retrouve dans la trousse du patient doit lui correspondre uniquement.</u>

Ex: s'il est insuffisant cardiaque, c'est l'information en lien avec ce problème qui devrait être retrouver dans la trousse.

Si le patient n'a jamais fait d'infarctus, je ne crois pas que tout l'enseignement sur l'infarctus le concerne.

Par contre les facteurs de risque concernent tous les cardiaques (en fait toute la population!)

Contenu: En fait , je vais peut-être me prononcer d'abord sur le contenant, avant le contenu.</td><td>CL_b
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$P_c(1)$
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$P_d(1)$
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↑
$P_e(1)$</td><td>(eva1)
↓
(exp2)</td><td>EVA
↓
EXP</td></tr>
<tr><td colspan="2"><u>Je crois qu'un tas de papier individuel risque d'être perdu, confondant et encore une fois lourd pour le patient.</u>

Il s'agit d'une suggestion, mais il pourrait peut-être s'agir d'un petit cahier complet, relié d'une façon quelconque, auquel des parties peuvent être ajoutées ou retirées dépendant du besoin du patient.

Encore une fois, je crois que ce n'est pas grave de ne pas tout donner ce qui existe sur la santé du coeur au patient.

Ce qui est plus grave c'est de ne pas avoir identifier ce que lui a besoin ou ce à quoi il est intéressé...

Je crois que notre rôle d'infirmière en évaluation, intervention et</td><td>CL_c
↑
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$P_f(1)$
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↑
$P_g(1)$
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↑
$P_h(1)$
↑
↑
$P_i(1)$</td><td>(eva1)
↓
(exp2)</td><td>EVA
↓
EXP</td></tr>
</table>

enseignement ne pourra jamais être remplacé par des papiers.			
Cette trousse devrait être, je crois, complémentaire.	CLd		
Bien que ce puisse être intéressant pour certains patients, je crois que je mettrais l'accent davantage sur les renseignements pratiques, qui permettent au patient d'avoir un certain contrôle sur sa maladie et sa vie, de savoir quoi faire au bon moment, de faire un lien entre symptômes et habitudes de vie, plutôt que sur l'explication plus théorique de la maladie, du fonctionnement du coeur ou de l'anatomie.	Pj(2)		
Ex: - Liste de médicaments à garder sur soit : mise en garde particulières quant à la médication du patient **- Activités permises, à risque ou à éviter pour le patient et indices ou signes à reconnaître qu'une activité est trop exigeante ou doit être modérée** **- Informations sur l'alimentation (sel, sucre, gras, excès/modération,....) puisque tous les cardiaques sont touchés et que manger est un plaisir de la vie!!** **- Auto surveillance de ses signes et symptômes: savoir reconnaître précocément les indices d'une détérioration et quoi faire.** **Quand référer immédiatement à l'urgence ou quand appeler son médecin ou son infirmière... encore une fois spécifique à la problématique de santé du patient** **- Annotation des personnes ressources principales et des numéros de téléphone et moments ou on peut les rejoindre** **- Espace pour annoter les R.V.** **Je n'ai pas d'autres idées pour l'instant .....**			
Nom: J'irais pour Trousse Santé du coeur ou Trousse Coeur en mains, **qui, comme le disait Christian je crois, m'apparaît plus positif, parle de Santé plutôt que de maladie (aspect positif, optimiste) et comme le disait Marie-Josée, je suis d'accord qu'il y a dans ces 2 titres (plus particulièrement celui de Coeur en mains) un aspect de prise en charge et de contrôle que j'aime bien.**	CLe Pk(3)	(eval) ↓ (exp2)	EVA ↓ EXP
S.)			

Appendix 16 Certificate of ethics

Université de Montréal

COMITÉ D'ÉTHIQUE DE LA RECHERCHE DE LA FACULTÉ DES ARTS ET DES SCIENCES DE L'UNIVERSITÉ DE MONTRÉAL

CERTIFICAT D'ÉTHIQUE

Le Comité d'éthique de la recherche de la Faculté des arts et des sciences de l'Université de Montréal, selon les procédures en vigueur, a examiné le projet de recherche intitulé :

The Role of Argumentation in Solving Problems of Practice Through Asynchronous Communication

et soumis par : ***Milton Nunes Campos, professeur adjoint, département de communication***

Le Comité a conclu que la recherche proposée respecte les règles d'éthique énoncées à la « Politique relative à l'utilisation des êtres humains en recherche » de l'Université de Montréal.

Gilles Houle,
Président du comité d'évaluation

Joseph Hubert, Président
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