The Artinian Intersystem Model
Barbara M. Artinian, PhD, RN, is professor emeritus in the School of Nursing, Azusa Pacific University. She has taught courses in community health nursing, family theory, nursing theory, and qualitative research methodology. She developed the Artinian Intersystem Model based on the work of Alfred Kuhn and Aaron Antonovsky. She published several articles about the model in the 1990s that culminated in the publication of the book entitled *The Intersystem Model: Integrating Theory and Practice* by Sage Publications (1997). The model has been used in a variety of practice settings and was used by David Taylor as a framework for his doctoral dissertation work done at the University of Wollongong, Wollongong, Australia. This book presents work done by students who were introduced to the model during their studies or from reading the publications about the model.

Dr. Artinian has served as advisor for grounded theory research for five doctoral and 24 master level students. The work of these students was reported in the book *Glaserian Grounded in Nursing Research: Trusting Emergence* by Springer Publishing Company (2009). This book has received excellent reviews.

Dr. Artinian grew up in Wisconsin and graduated from Wheaton College in Wheaton, Illinois. She attended Case Western Reserve University where she received a degree in nursing. She completed her graduate work at the University of Southern California, Los Angeles, earning an MSN degree. At the University of California, Los Angeles, she earned a PhD in sociology with a major emphasis in family theory. She completed a postdoctoral research fellowship at the University of California, San Francisco, in the area of chronic illness and was introduced to the methodology of grounded theory at that time. Her knowledge of grounded theory research has enhanced her understanding of the process of the Artinian Intersystem Model.

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West is a contributing author to books on qualitative research and rural nursing and has created online content for textbooks on maternal-newborn nursing and served as a reviewer for the leading nursing informatics text. Since 1992, she has taught nursing at all levels from vocational to graduate with an emphasis on Public Health nursing. Her extensive experience coupled with her scholarship and abilities to communicate make her an outstanding educator of computer technologies applied to health care. Her podium and paper presentations on using computer technologies in nursing are enthusiastically received at local, regional, national, and international conferences.

West has been recognized with several awards, including a Sigma Theta Tau research grant, Dale Carnegie Leadership awards, and service awards from employers. West's varied and dynamic experience is distinctive among nurses, as she discerns health care trends, translates them into pragmatic learning opportunities, and articulates the implications for clinical care.
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She is the coauthor of the book *The Intersystem Model* (1997) and author of *Managed Care: Practice Strategies for Nursing* (1999). She has published numerous journal articles in the areas of nursing education, case management, and international nursing. She has been a presenter at many conferences in the United States and keynote speaker at conferences in the Netherlands, Sweden, Lithuania, and the Czech Republic.

As an educator, Dr. Conger was instrumental in developing a rural clinical specialist program at Northern Arizona University. She has also taught extensively in the area of nursing case management and nursing leadership. She served as Associate Director of the School of Nursing at Northern Arizona University. She developed and coordinated an intercultural institute to bring nurses from the United States and Europe and Africa together to explore nursing care delivery to underserved populations. Her current interests lie in the area of working with nursing programs in Eastern Europe and Africa to assist them in developing professional nursing education.
We dedicate this book to

Avo Artinian, Barbara's husband, who has participated in discourse about the model since its inception,

Our mothers, who modeled scholarship and creativity, and

All of our students who have used the model to develop mutual plans of care with their patients and clients.
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Foreword

Work on the Artinian Intersystem Model (AIM) began in the 1980s by Dr. Barbara Artinian. The model was refined over the next years with a focus on the interaction between the nurse and the client who could be a patient, a family, an institution, or a community. After a series of journal publications, the model was published as a much-awaited book in 1997. The model explains, as does no other, the process that takes place between the nurse and client in resolving a concern of either nurse or client.

Adopting the concept of sense of coherence (SOC) from Antonovsky’s work, she refined and adapted the concept into the real world-nursing construct that she called situational sense of coherence (SSOC). SSOC corresponds more closely to the reality of professional nursing practice. Antonovsky saw SOC as a stable trait, resistant to change in adults whereas Artinian views its logical offspring, SSOC, as a process through which a patient or client in a state of disorganization can be helped to recover or increase the level of SOC during recovery.

Artinian’s work is modern, logical, and it flows from a lifelong practice of observing how with appropriate nursing interventions, clients during health and illness can move from disorganization to reorganization leading to improved health. This is a model that is imminently useful to nurses in any area of nursing practice. It can be used as much by the bedside nurse as the community health nurse, the critical care nurse, the school nurse, the nurse providing elder care, or the nurse working with large institutions.

The research process inherent in this model is as important to the academic nurse as the nursing process she has provided is for the practice of nursing. In the grounded theory research process, the research is directed to understanding how a group of clients resolve their main concern. In the AIM, the effort is directed to assisting the client to resolve the individual main concern through use of the steps of the model. It provides a basis for the professional nurse to evaluate a client’s state of health and plan cooperatively with
the client for nursing interventions. The results of these interventions can be analyzed by measuring change in the client’s SSOC.

This model is the result of Dr. Artinian’s life work grounded in practical experience with clients and application of literature and research findings. It reflects her careful thought about what it means to be a nurse, an individual patient, or an aggregate in a state of needing nursing attention.

I am most pleased to be able to recommend this work to all nurses who want to have an organized, well researched, and thoroughly thought out structure for their nursing in any theater of nursing.

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This book came about because a graduate student asked “How do you develop a model?” This book answers that question and also the next logical question, “How do you use a model in daily professional nursing?” The Artinian Intersystem Model (AIM) is unique among nursing models because in addition to being used in daily professional nursing, it helps the nurse address both qualitative and quantitative aspects of patient care. It requires the nurse to ask the patient, “What is your Main Concern?” and then negotiate what the patient can do and is willing to do in the formation of a mutual plan of care. The model also provides for quantification of nursing care by establishing a baseline score on the patient’s SSOC followed by a summation score that simply and easily identifies change that occurred in response to nursing care.

To answer the second question, this book gives recommendations for developing programs to promote health and provides examples of such programs. One of these is a program that encourages heart failure patients to participate in decision making to promote self care practices. Another is a resident-centered program in a nursing home that is designed to preserve the identity of the resident. Whereas most nursing theorists state that their models can be used at the individual level as well as the family level, the AIM provides examples of how the model is actually being used at individual, family, institutional, and community or national levels. The book also provides examples of how research can be used to inform nursing practice. Six of the studies presented in the companion book, *Glaserian Grounded Theory in Nursing Research: Trusting Emergence* (Artinian, Giske, & Cone, 2009), are given to show how nursing practice can be enhanced with the use of a grounded theory.

In essence, the AIM is a model of the nursing process that guides the nurse or provider to make it possible for the patient to participate in the planning of care on a more equal basis (shared decision making). This is done by reducing...
the inequality of power distribution by assessing the patient’s own knowledge, by being attentive to values, and by assessing behaviors about the main concern before engaging in interaction to resolve the concern. The AIM is also based on the concept that each person or client is an intrasystem in his or her own right, made up of a biological self, a psychosocial self, and a spiritual self. Foundational to the model is the mutuality of the interaction between the patient/client and nurse/provider intrasystems that fosters mutual problem solving. Gone are the days of patronistic interactions where the “Doctor or Nurse knows best” and soliciting information from the patient was deemed inconsequential. The AIM fits well with today’s healthcare paradigm where patients desire a central role in decisionmaking and in all aspects of their care.

An earlier iteration of the model had been presented in the 1990s in a series of journal articles and then presented in depth in the book The Intersystem Model: Integrating Theory and Practice (Artinian & Conger, 1997). Because few institutions used the model for planning care at that time, the focus of that book was on presenting theories associated with each aspect of the model accompanied by a care plan related to that aspect. This second edition contains many refinements of the model based on actual use in professional nursing. The most important of these is the refinement of Artinian’s Situational Sense of Coherence Theory of Recovery that is incorporated into the model. This theory is based on the definition of SSOC as the meaning that patients bring to the events of their lives during times of stress or disorganization. Antonovsky described SOC as a relatively stable aspect of a person that changes only slightly after early adulthood. Many social scientists want to use the concept of SOC in their practice, where the goal is behavioral change, but are unable to because Antonovsky did not indicate how change can be brought about. The SSOC Theory of Recovery answers this dilemma and, by using the process of the AIM, a method has been developed that enables a health care professional to guide the client to actually improve the level of SSOC using the situation itself as the catalyst for change. This increased SSOC is reflected in the new level of SOC the person achieves following the period of disorganization.

The main benefits of using the AIM are summarized in the following. The Model:

- Makes it possible for the patient to participate in the planning of care on a more equal basis (shared decision making)
- Demonstrates a systematic way to assess the patient and provide care
- Places the spiritual subsystem at the core of the person
- Respects the dignity of patients by collaborating with them in the decision-making process
■ Explores what the patient knows about the Main Concern, what the patient wants to do about it, and the resources the patient has to resolve the Main Concern
■ Allows negotiation of values to develop a mutual plan of care
■ Scores patient on SSOC using a simple descriptive scoring measurement of high, medium, or low on each aspect of SSOC
■ Evaluates the effectiveness of the intervention by re-scoring on SSOC

This book is divided into four sections. Part I provides the theoretical background of the model and, with the core concept throughout of promoting the equalization of power, introduces the main concepts of the model: the developmental environment, the situational environment, the SSOC, and resolution of the main concern. Part II illustrates the way the model is used with aggregate populations to increase their SOC. Part III describes the use of the model in educational settings, and Part IV gives examples of actual use of the model in practice settings. The relationship between theory and practice is illustrated in care plans informed by qualitative research. An online adjunct manual contains many of the forms used in the practice settings and all of the care plans referred to in many of the chapters. It is available at www.springerpub.com/artinian.

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Acknowledgments

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The Artinian Intersystem Model describes the interactional process that takes place between the nurse/provider and patient/client when nursing assistance is needed. The assistance can be in the form of health promotion or resolution of a health concern. In the model, the client can be an individual, a family, an institution, a community, a state, or a nation each with its own network of significant others. Likewise, the nurse can be an individual or a health provider system in an institutional context each with its own network. In the interactional process, the two systems come together to form an intersystem characterized by the specific set of relations that connect them to each other. Intersystem interaction is mutually influencing and focuses on how information is communicated, how values are negotiated, and how behaviors are organized to implement a mutual plan of care that will increase the client’s situational sense of coherence (SSOC).

DEVELOPMENT OF THE MODEL: EARLY PHASES

The first patient-centered model I used was the Clinical Analysis Record developed by Matheney (1960). I began teaching in a diploma school of nursing at the midpoint of a semester. At the end of the semester, much to my dismay, the care plans turned in by the students were very specific about the type of surgery a patient had had even to describing the size of the suture, but nothing was said about the patient’s response to the surgery. During the Christmas recess, I found the book *Patient-centered Approaches to Nursing* by Abdellah, Beland, Martin, and Matheney (1960). In Matheney’s chapter “Application of a Patient-centered Curriculum in an Associate Degree Program,” I found a model for analyzing patient care. I modified the Clinical Analysis Record (Matheney, p. 82) to allow students to state a nursing problem in their own terms rather than using the “21 Problems” as described earlier in Matheney’s chapter. The modified Clinical Analysis Record simply asked students to
identify the following four areas: nursing care problem of the patient, scientific basis for problem, nursing care given, and scientific basis for care. This helped students focus on the patient response to a problem and the reason for the problem as well as describe what the nurse did to alleviate the problem and why she had chosen that approach. I used the definition that Matheney used to describe the problem-solving process related to health, “A nursing problem is defined as a condition and/or situation faced by a patient, or his family, which the nurse can assist him to meet through the performance of her professional function” (1960, p. 80). By using this approach to analyze patient care, the curriculum at the diploma school was transformed and the students became adept at focusing on the problems presented by the patient.

While I was a graduate student at the University of California, Los Angeles (UCLA), I was introduced to the concepts developed by Peplau (1952) and Orlando (1961). Although these concepts provided a rationale for practice, they did not provide a structure for practice. It was when I found the work of Robert Chin (1969) that I realized that the essence of interpersonal relationships is an intersystem model. Chin writes that an intersystem model has the following characteristics (pp. 304–305):

- An intersystem model involves two open systems connected to each other. A visualization of this type of an intersystem model would be two systems side by side, with separately identified links (see Figure 1.1).
- Connectives represent the lines of relationships of the two systems. Connectives tie together parts.
- The intersystem model exaggerates the virtues of autonomy and the limited nature of interdependence of the interactions between the two connected systems.
- The external change-agent... does not completely become a part of the client-system. He must remain separate to some extent; he must create and maintain some distance between himself and the client, thus standing apart “in another system” from which he re-relates.
- Intersystem analysis of the change-agent’s role leads to fruitful analysis of the connectives—their nature in the beginning, how they shift, and how they are cutoff.
- Intersystem analysis also poses squarely an unexplored issue, namely the internal system of the change-agent, whether a single person, consultant group, or a nation. Helpers of change are prone at times not to see that their own systems as change-agents have boundaries, tensions, stresses and strains, equilibria, and feedback mechanisms which may be just as much parts of the problem as are similar aspects of the client-systems.
1. Development of the Artinian Intersystem Model

FIGURE 1.1 Representation of Chin’s Intersystem Model (1969).
Source: Artinian (2011).

TABLE 1.1 A Therapist-Family Intersystem Model

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Goal of action</td>
<td>Changing the processes of coping for each individual, thus altering the system to produce new ways of communication and increased productivity so that each system can identify and use its own resources.</td>
</tr>
<tr>
<td>2. Patiency [sic]</td>
<td>A family system that is dysfunctional because family rules for interacting do not fit needs for survival, growth, getting close to others, and productivity on the part of each member of the system.</td>
</tr>
<tr>
<td>3. Actor</td>
<td>Place: Outside target system bound to system by connectives such as social contract of mutual role expectation Role: Actively assists family system to accomplish change necessitated by inadequate interactional patterns</td>
</tr>
<tr>
<td>4. Source of difficulty</td>
<td>Family relationships that hamper growth and development</td>
</tr>
<tr>
<td>5. Intervention</td>
<td>Focus: Dysfunctional communication patterns which produce directly observable behavior Mode: A collaborative process to change communication patterns</td>
</tr>
<tr>
<td>6. Consequences</td>
<td>Reorganization in family members’ ways of extending and maintaining self-esteem, use of feedback, and the use of words making it possible for members to give, receive, and check out communication meanings</td>
</tr>
<tr>
<td>7. Unintended consequences</td>
<td>If interaction has not been collaborative and therapist has not accurately assessed system needs, action may:</td>
</tr>
<tr>
<td></td>
<td>■ not benefit subsystems or family system</td>
</tr>
<tr>
<td></td>
<td>■ cause condition of system to become less organized</td>
</tr>
<tr>
<td></td>
<td>■ be wasteful of material or of personnel time and effort</td>
</tr>
</tbody>
</table>

Theoretical Background of the Artinian Intersystem Model

An understanding of these characteristics has been the foundation for my work with intersystem models. Using these concepts from Chin (1969), I developed a Therapist-Family Intersystem Model (Artinian, 1971). Many of the units of this model have been carried over into the present Artinian Intersystem Model (see Table 1.1).

**DEVELOPMENT OF THE INTERSYSTEM MODEL**

When I was introduced to the book *The Logic of Social Systems* (Kuhn, 1974), I immediately recognized the value of this model in fostering interpersonal interaction and its use in nursing practice. The Kuhn model had many of the same principles developed by Chin, but it provided a more specific framework.

![Early Intersystem Model diagram](source: Artinian (1975)).

**FIGURE 1.2 Early Intersystem Model diagram.**

Source: Artinian (1975).
for using them. The Kuhn model is explicitly system-based and “system concepts form an integral part of the analytic structure in his model” (1974, p. xiii). Although Kuhn was an economist, he envisioned his model to be the central core of social science. When I began teaching pediatric nursing at UCLA, I introduced elements of the nursing process into the structure of the Kuhn model and used it in my teaching (see Figure 1.2). The use of this model assisted the students in including the patients in the planning of care. I discussed my adaptation of this intersystem model with Kuhn at a sociological conference in 1975, and he was pleased with the way I had adapted it for the nursing profession.

The first use of the model outside of the educational setting was in 1982 in a large public hospital when a nursing care plan study was carried out (Artinian, 1982). The same diagram of the model that I had used at UCLA was given to participants in the study and they used it in analyzing care plans. At that time, the nurses listed information they had about all of the patient problems and the plan for meeting each problem was placed next to each item. They did the same analysis for the values and the behaviors related to the identified problems (see Table 1.2). By identifying more than one problem, this approach was similar to the Clinical Analysis Record developed by Matheney (1960).

**TABLE 1.2 Sample of Nursing Process Study Care Plan (1982)**

<table>
<thead>
<tr>
<th>Knowledge about patient</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is not eating because of nausea and vomiting</td>
<td>NG tube</td>
</tr>
<tr>
<td>Patient becomes nauseated during radiation therapy</td>
<td>Give medication before going</td>
</tr>
<tr>
<td>Patient has experienced side effects in previous chemotherapy</td>
<td>Watch for side effects</td>
</tr>
<tr>
<td>Patient has poor veins</td>
<td>Give hot packs before inserting needles</td>
</tr>
<tr>
<td>Family does not accept terminal diagnosis</td>
<td>Talk with family</td>
</tr>
</tbody>
</table>

**Values or preferences of patient**

| Patient has poor appetite but likes milk | Offer milk with meal |
| Patient wants to know schedule of procedures | Keep patient informed |
| Patient dislikes _____ type of dressing | Use type of dressing |

**Behavior of patient**

| Patient is experiencing pain | Establish optimum drug schedule |
| Patient is confused | Give instructions clearly; observe |
| Patient is fatalistic about dying process | Understand and encourage patient |
| Patient is worried about dying | Initiate talk when he desires; provide respite |

Source: Artinian (1982).
The next step in clarifying the model was to limit the focus of interaction to one specific problem and introduce a concept of person. The same diagram that had been used at UCLA and for the nursing care study was published in separate articles in 1983 and in 1984 (see Figure 1.2). These discussions of the model described the model in detail showing how the identified problem was the main focus of concern and how collaborative planning was carried out to meet that concern. These articles presented a clearer picture of the collaborative nature of intersystem interaction and how the nurse focused on only one problem until it was resolved. At that time, I depicted person as a person with social, psychosocial, and biological subsystems.

When I began teaching at Azusa Pacific University (APU), the faculty was using a model they called “The Nursing Process Systems Model based on the Developmental-Stress Model” developed by Chrisman at UCLA (1974). The model incorporated the concept of person as having three subsystems: spiritual, psychosocial, and biological as described by Stallwood and Stoll (1975; see Figure 1.3).

Stallwood and Stoll’s concept of person was viewed to be the framework in which to perform the various components of the nursing process. In using the Nursing Process Systems Model, the nurse “looks at the patient’s systems in terms of the stressor encountered and the degree of success of the stress...
response. This helps in identifying problem areas and in determining appropriate methods of intervention to assist in the attempt toward adaptation and equilibrium” (Brown, 1981, p. 39). The description of person developed by Stallwood and Stoll (1975) formed the structure of the Nursing Process Systems Model (see Figure 1.4).

Since the Nursing Process Systems Model did not provide an explicit framework for guiding practice and many of its concepts were in the already published Intersystem Model, the APU dean, Dr. Marilyn Wood, encouraged me to integrate the concepts from the Nursing Process Systems Model into the Intersystem Model framework. To gain acceptance of the Intersystem Model by the APU faculty, a document was used for several years, which placed all aspects of the Nursing Process Systems Model into the structure of the Intersystem Model. In
In this working document, I had initially identified all of the four nursing meta-paradigm concepts except for the concept of health. I wanted a definition of health that would allow a person to be classified as healthy while dying. A new construct, SSOC, adapted from Antonovsky’s (1987) *sense of coherence* concept (SOC), was incorporated into the model to equate the client's integrative potential in his or her response to an illness situation with health. This completed the model, and the Intersystem Model was adopted by the faculty at APU as the model for curriculum development. The name “Intersystem Model” reflects the interactional process that takes place between client and nurse in using the nursing process to develop a collaborative plan of care. The new diagram added the SSOC construct to the figure and replaced the action of “transactions in terms of values” with the action of “negotiating values” (see Figure 1.5).

In order to clarify the steps to follow in using the model, a flow chart was developed (see Figure 1.6). This flow chart and the revised version of the

![Diagram](image.png)

**FIGURE 1.5 Early Intersystem Model.**

*Source: Artinian (1991, 1997).*
The reconceptualization of the model that prompted the change of the name from the Intersystem Model to the Artinian Intersystem Model (AIM) introduced changes into the diagram of the model. An intermediate version of the model was prepared in 2009 using the flowchart format (see Figure 1.7). Because the process depicted in the 2009 diagram was not clear to persons unfamiliar with the model, a new diagram of the model was developed. This latest revision of the Artinian Intersystem Model diagram made few changes in the concepts of the model, but the diagram depicting the concepts was changed to include all aspects of the model in one diagram (see Figure 1.8).
ARTINIAN INTERSYSTEM MODEL

DEVELOPMENTAL ENVIRONMENT
- Organizational Memory
  - Describe Focus of Situational Interaction
  - Assess Patient/Client Subsystems
    - Biological
    - Psychosocial
    - Spiritual
  - Identify Main Concern of Patient/Client or Nurse/Provider

SITUATIONAL ENVIRONMENT
- Analysis of Intrasytem Information
  - Identify Stressors
  - Identify Coping Resources of Patient
  - Score on Situational Sense of Coherence
  - Identify goals to increase SSOC
  - Assess ability of patient and nurse to resolve MAIN CONCERN together

INTERSYSTEM ASSESSMENT
- Intrasytem Mindset of Patient/Client
- Client Knowledge
- Client Values
- Client Behaviors
- Nurse/Provider Knowledge
- Nurse/Provider Values
- Nurse/Provider Behaviors

INTERSYSTEM INTERACTION TO RESOLVE MAIN CONCERN
- Communicating Information
- Negotiating Values
- Develop Goals & Strategies for the Mutual Plan of Care
- Implementing Strategies
- Description of Implementation Strategies

OUTCOMES
- Evaluate Resolution of MAIN CONCERN
  - Comprehensibility
  - Meaningfulness
  - Manageability

IDENTIFICATION OF NEW CONCERN
- MAIN CONCERN RESOLVED?
  - Yes
  - No
  - Further Intervention

EVALUATION

FIGURE 1.7 The Artinian Intersystem Model (2009).
By integrating the theories of Chin (1969), Kuhn (1974), Antonovsky (1987), Blumer (1969), Stallwood and Stoll (1975), and Knickrehm (1994), the AIM provides a way of looking at person as a whole dynamic entity in a hierarchical relation of subsystems and suprasystems in mutual interaction. The model focuses on the main concern of the patient or of the nurse and how they work together to resolve the concern using the steps of the Artinian Intersystem Model. This model has been published in a series of articles and a book (1983, 1984, 1991, and 1997). The major concepts of the model are summarized within the metaparadigm concepts of nursing, which are person, environment, health, and nursing action.

**Person**

In the Artinian Intersystem Model, a person is viewed as a coherent being or aggregate that continually strives to make sense of the world. Person is seen as a system made up of various subsystems that can be viewed in terms of change over time. The subsystems that make up the whole person are the biological, psychosocial, and spiritual subsystems depicted as a series of concentric circles (Stallwood & Stoll, 1975) (see Figure 1.3). The biological subsystem is on the outside since it is through the body that the psychosocial and spiritual subsystems are manifested in the environment. The spiritual subsystem is in the center since the spirit is the core of the individual person or aggregate. Although person is viewed as having three subsystems, the “system must be understood as a whole and cannot be comprehended by examining its individual parts in isolation from each other” (Whitchurch & Constantine, 1993, p. 328).

When person is an individual, either the term “client” or “patient” can be used in the AIM. When person is an aggregate, the term “client” is used. The term client is derived from the Latin word meaning “to lean on” and implies that the person as client needs the professional advice or services of the nurse. The term patient is derived from the Latin word meaning “to suffer” and implies that the person as patient needs the caring the nurse can provide in a time of distress. Therefore, the choice of term will depend on the need of the patient/client in a particular interactional situation.

**Environment**

**Developmental Environment**

Merriam-Webster’s School Dictionary (1999) defines *environment* as “the social and cultural conditions that influence the life of a person or human
community” (p. 296). Therefore, the developmental environment can be defined as all the events, factors, and influences that affect the system experienced through its biological, psychosocial, and spiritual subsystems as it passes through its developmental stages. In systems theory, whatever is not the system is its environment. In this way, each suprasystem or subsystem is the environment for a particular system.

The developmental environment is the arena in which the system is developed and provides the context for the interaction at the time of a specific encounter in which nursing service is offered to assist with an illness or management problem that the system is unable to resolve independently. Symbolic interaction theory helps in understanding the interaction that takes place in the developmental environment. Symbolic interaction theory focuses on the nature of human social interaction by examining the connection between symbols (shared meanings) and interactions (verbal and nonverbal) with which individuals in relation to each other create symbolic worlds. Blumer (1969) says that people “act toward things on the basis of the meanings that the things have for them” and that “these meanings are socially derived” (p. 2). This provides the “integrative and interpretative framework” for judging life events and “the standard by which reality is managed and pursued” (Olthuis, 1989, p. 29). As such, it has a major impact on the health beliefs and practices held by individuals and aggregates. It also strongly influences the orientation the person has to life as being comprehensible, meaningful, and manageable—that is, the SOC as defined by Antonovsky (1987). A worldview is socially acquired within a cultural community and is shared by that community.

The set of environmental factors that bring the patient and nurse together form the focus of the interaction. During the interaction of the nurse/provider with the patient/client, the nurse is able to assess the effect of both the external and internal environments on the biological, psychosocial, and spiritual subsystems of the individual or aggregate. In addition, data are collected about the intrasystem functions of the person, which are the knowledge, values, and behaviors of the person (Kuhn, 1974). By analyzing all the factors in the developmental environment, the nurse can identify the main concern of the patient or nurse. When the nurse has previously interacted with the patient, knowledge of previous interactions with health professionals and the community at large facilitates the analysis since each interaction in a situational environment becomes part of the person’s developmental environment when it is finished. This knowledge is stored as the organizational memory about the patient.
1. Development of the Artinian Intersystem Model

**Situational Environment**

It is in the situational environment that the nurse and client organize a plan of care and implement it. All the unique characteristics of the nurse and of the client as well as the characteristics of the setting interact to make the experience what it is. Different nurses with differing life experiences would make the encounter a different type of experience for a particular client, as would different characteristics of the setting. The situational environment includes all the details of the encounter such as the place, time, circumstance, motivational state, and receptivity of the care provider and recipient.

Following the identification of the main concern of the client or nurse in the developmental environment, intrasystem analysis and intersystem interaction take place in the situational environment to resolve the main concern of the client or nurse using the framework adapted from Kuhn (1974) and the SSOC scoring evaluation of the outcome adapted from Antonovsky (1987).

Nurses bear initial and ongoing responsibility for establishing relatedness with clients. The client approaches the interaction because of a need for assistance in matters of health and well-being. It is important for the nurse to assess how the client is interpreting the illness and what treatments are believed to be appropriate. Effective nursing requires that nurses become skilled in recognizing and responding to the client's need for help and become sufficiently involved to explore the client's interests.

**Health**

Health and disease are viewed on a multidimensional health/disease continuum. It would be difficult to find a person in perfect health, totally sound in body, mind, and spirit with full vigor and freedom from all signs of disease. On the other hand, as long as individuals live, they have some measure of health. Antonovsky (1987) suggests that people can manage stress and stay well by developing a strong SOC.

When individuals have a strong SOC, they can use a variety of coping strategies, which Antonovsky defines as generalized resistance resources in seeking a solution to a problem. If a person has a low SOC or the stressor generates more tension than can be managed, the person experiences a generalized resistance deficit and is in need of assistance to develop strategies to cope with the problem.
Antonovsky (1987) views the SOC as a “deeply rooted, stable dispositional orientation of a person” (p. 124) but states that there can be fluctuations around a mean, as in a time of crisis. Because the global SOC construct is conceived to be stable over the life span, a new construct, the SSOC has been developed (Artinian, 1991). This narrower construct describes the response that occurs in the period of disorganization in which a client is attempting to deal with a serious life event. When nursing assistance is provided, the SSOC theory of recovery describes how nursing action is given to assist the person to increase in SSOC when confronted with stressors that cannot be managed independently. These components are scored on a scale from 1 to 3 (high, medium, or low) with 3 being the highest. The SSOC contains the same three dimensions identified in the SOC, but they are defined by Artinian (1991) to reflect a present, specific orientation rather than a global orientation. When a successful stress response occurs, the response is adaptive and is reflected in a higher SSOC and a higher SOC.

By using the SSOC theory of recovery as implemented in the AIM, the nurse helps ensure that the client will be able to achieve the best possible state of health or outcome given the circumstances. Through strengthening a person’s SSOC, health is achieved by successful adaptation to the stressors in the internal and external environments. Therefore, in the AIM, health is defined as a strong SOC. This means that the person has confidence that events are comprehensible, are worth investing in, and are manageable.

To assist the client to increase in SSOC, the goals of both the nurse/provider and patient/client must be met. The nurse as a professional person has knowledge, values, and behavioral skills that help to identify tentative goals for the person. This is done by assessing the client’s knowledge about the main concern (comprehensibility), the resources available to make it manageable (manageability), and the client’s motivation to accept the challenges created by the problems (meaningfulness).

Nursing Action

A systematic way has been developed to explore the definitions of the situation held by patient and nurse so that a plan of care that is acceptable to both can be made. This is done using the framework of the AIM adapted from Alfred Kuhn (1974). The Kuhn model consists of two interrelated models: the intrasystem model and the intersystem model. Kuhn states that any controlled adaptive system must use knowledge, preferences or values, and behavioral responses. Intrasystem analysis assesses the knowledge, values, and behaviors of both the
nurse and the client in relation to the main concern. Based on these data, the nurse can assess the SSOC of the patient and develop a nursing diagnosis and tentative goals. If the nurse determines that he/she has the necessary knowledge and resources available to help, and that the nurse and client can work together to resolve the main concern, then intersystem interaction begins.

An intersystem model consists of two intrasystem models that are connected to each other through a specific set of relations. Intersystem interaction differs from the interaction of two open systems with each other because in the intersystem model the autonomy of each system is retained but the connectives which “represent the lines of relationships of the two systems” can be described (Chin, 1969, p. 304). In the Kuhn model, when two intrasystems interact, the focus is on how information is communicated between the two intrasystems, how values are negotiated to develop a joint plan of care, and how behaviors are organized to implement the plan that will resolve the main concern. For the nursing process to be effective, the priorities of both intrasystems must be taken into account. Through feedback loops, the intrasystems’ knowledge, values, and behaviors are progressively clarified and modified to develop a joint plan of care.

The relationships between the developmental environment and the situational environment where the interaction occurs to resolve the main concern are diagrammed in Figure 1.8. This diagram traces the thought process of the nurse from understanding the situation that brings the nurse and patient together in interaction to collect intrasystem data in the Developmental Environment about the patient’s biological, psychosocial, and spiritual subsystems. This leads to a tentative identification of the main concern of the patient or the nurse. The Main Concern is validated through assessment of the intrasystem functions of the patient and of the nurse in terms of their knowledge, values, and behaviors or resources in relation to the main concern.

The diagram specifies the link between the Developmental Environment and the Situational Environment through the Analysis of Intrasystem Data done by the nurse/provider. This includes identifying patient stressors and coping resources and scoring the patient on SSOC in order to make nursing diagnoses. The nurse then develops goals to increase the SSOC of the patient and assesses the ability of the nurse to resolve the main concern in interaction with the patient. If the nurse determines that patient and nurse can work together, Intersystem Interaction begins to resolve the main concern. This is done by communicating information, negotiating values, developing joint goals, and strategizing a mutual plan of care. The plan is implemented and evaluated by the nurse by re-scoring on SSOC. If the main concern is not resolved, the nurse must return to collecting and reanalyzing data from the intrasystems and begin
Intrasystem Data Collection to Identify Main Concern
- Describe focus of interaction
- Access Organizational Memory
- Assess Patient/Client Subsystems

Analysis of Intrasystem Information by Nurse
- Identify stressors
- Identify coping resources of patient
- Score Situational Sense of Coherence (SSOC)
- State nursing diagnosis/es
- Identify goals to increase SSOC
- Assess ability of patient & nurse to resolve Main Concern together

Intersystem Interaction to Resolve Main Concern
- Communicate Information
- Negotiate Values
- Implement Strategies
- Develop Mutual Plan of Care

Validation of Main Concern

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interaction again to resolve the main concern. If the interaction resolved the main concern, information about the interaction is stored in the organizational memory to be used if a new concern arises.

Because the Artinian Intersystem Model allows assessment of both the individual systems and the interaction between them, it provides a systematic way to assess the initial SSOC of the client about the main concern, provides a framework for increasing SSOC, and provides a means of evaluating the resolution of the main concern. If the concern is not resolved, a reassessment that focuses on the main concern is done. As client and nurse work together to develop successful coping strategies, both increase in their ability to resolve the main concern and to face new problems in the future. The same process occurs when the client is an aggregate. Just as input into the individual system is a life event that creates change, input into the aggregate is also a change event that is processed through the biological, psychosocial, and spiritual subsystems of the aggregate.

The most recent diagram of the AIM (2011) was developed to clarify the process of first completing intrasystem assessment followed by analysis of intrasystem information. This analysis is done prior to intersystem interaction.

If the client and the nurse are not able to agree on a plan of care, the nurse will need to begin another round of communication and negotiations in an effort to develop a plan of care that is mutually acceptable. When either the emotional or physical safety of the client is in question, the nurse must exercise professional power to protect the client while recognizing that this action constitutes a failure of the interactional process. This was illustrated in the research of Vuckovich (2003) who reported that when nurses were compelled...
to take legal action to force patients to take medications that they believed would be effective in helping the patients; they then justified their coercion so that they could see themselves as good nurses. Vuckovich (2009) published her study in *Glaserian Grounded Theory: Trusting Emergence* (Artinian, Giske, & Cone, 2009).

**INTRODUCTION TO CARE PLANS**

Although the AIM provides a specific framework to assist the nurse to make a collaborative plan of care with patient, the underlying principles of the model can be used by any health care provider who truly wants to include the patient in the planning of care. Two examples are given of mutual plans of care that were developed by professionals who were unfamiliar with the AIM. The first of these is a report of an interaction by an anesthesiologist who used the principles of the model to resolve the main concern of a patient having eyelid surgery and illustrates how the main concern of the patient was resolved (see Care Plan 1.1). The second example was developed from a first person account of pain management for a patient following surgery that was published in the American Journal of Nursing (Gordon & Ward, 1995). The patient feared becoming addicted to pain medication and the nurses knew that pain management was necessary for her recovery (see Care Plan 1.2). It illustrates how the main concern of the nurses was resolved. Both of the examples are concerned with pain management. In each case, the patient was reluctant to take the prescribed medication. In the first example, through negotiation, an alternative plan was strategized. In the second example, the patient was persuaded that she needed pain medication and a plan was set up to put her in control. The first care plan presents a truncated form of analysis that can be used by providers who can quickly assess the intrasystems of patient and self and make a diagnosis and determine their ability to resolve the main concern of the patient. The second example is one that can be used to teach students to critically analyze each aspect of the model.

The management of postoperative pain is just one aspect of providing care for the cancer patient. With the focus on helping the patient accept the need for setting a goal for pain management, many other issues are not addressed. The trust and confidence in the nurse and the institutional setting that were developed during this interactional sequence, however, will become part of the developmental environment of the patient and will influence future interactions. Issues such as further treatment for the cancer and the ambiguity of whether the cancer will become worse will need attention as they are
introduced by the patient. This analysis of the interaction around the need for goal setting for pain relief illustrates that in using the AIM format it is permissible, based on the intrasystem assessment of the patient and self, for the nurse to introduce her concerns for the patient that the patient did not even know should be a concern.

CONCLUSION

The AIM can be used in brief nurse–client encounters or in long-term interactions. Each time the feedback loop is completed, the nurse and client will know more about each other, and the plan they organize can be more appropriate to resolve the main concern of either the client or the nurse. The information about the interaction is stored in the organizational memory. The AIM can be used by the novice practitioner as well as by the expert because the complexity of the model derives from the knowledge base of the user, not from the structure of the model.

In conclusion, the AIM has been developed from the work of many theorists. I am indebted to these theorists who understood the need for mutual interaction from a patient-centered perspective. This chapter illustrates how nursing knowledge advances based on the work of preceding theorists.

REFERENCES

Theoretical Background of the Artinian Intersystem Model


CARE PLAN 1.1 Illustrating the Resolution of the Main Concern of Patient
(Short Form to be used by an expert practitioner)

<table>
<thead>
<tr>
<th>DEVELOPMENTAL ENVIRONMENT</th>
<th>COLLECTION OF INTRASYSTEM DATA TO IDENTIFY MAIN CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe Focus of Interaction</td>
<td>When the patient first considered surgery for eyelid repair, she was told that she would be awake during the procedure. Later she was told that she would be given “twilight sleep.” She almost cancelled the surgery because of reports of situations in which people had died during cosmetic surgery and the previous experiences she had had with anesthesia. This information was relayed to the surgeon and he called back to let her know that he could do the procedure with local anesthesia. He also said that he would discuss the preference of the patient with the anesthesiologist.</td>
</tr>
</tbody>
</table>

| Access Organizational Memory | Clinic chart provided to anesthesiologist. |

<table>
<thead>
<tr>
<th>Assess Patient/Client Subsystems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Subsystem</td>
</tr>
<tr>
<td>Psychosocial Subsystem</td>
</tr>
<tr>
<td>Spiritual Subsystem</td>
</tr>
<tr>
<td>Validation of Main Concern of Patient/Client or Nurse/Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SITUATIONAL ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess Ability of Patient and Nurse to Work Together to Resolve Main Concern</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERSYSTEM INTERACTION TO RESOLVE MAIN CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate Information</td>
</tr>
</tbody>
</table>

---

1 See Figure 1.8
**CARE PLAN 1.1 (Continued)**

<table>
<thead>
<tr>
<th>Negotiate Values</th>
<th>The anesthesiologist assured the patient that he wants to follow the patient’s wishes unless they could lead to harm.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop Mutual Plan of Care</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Develop Joint Goals** | 1. Make patient comfortable about procedure.  
2. Decrease anxiety about the use of anesthesia. |
| **Develop Joint Objectives** | To keep patient pain-free during procedure |
| **Develop Implementation Strategies** | Congruency of values made possible the development of joint plan of care.  
1. A small amount of relaxant would be given initially to reduce anxiety.  
2. The surgeon would inject local anesthesia.  
3. At any time during the procedure if she experienced pain, the surgeon would signal the anesthesiologist to provide medication.  
4. She was to use breathing techniques to promote relaxation.  
At this point the patient told the surgeon and anesthesiologist that they had practiced all the principles of the Intersystem Model. The anesthesiologist asked: “Doesn’t everyone do this?” |
| **Implement Strategies** | Local anesthesia was injected into both eyelids. During the procedure while the second eye was being repaired, the local anesthesia had lost some effect and the patient signaled that she felt the procedure. The eyelid was again injected with anesthesia. The second time the patient indicated that she was having pain, the surgeon said that he was at a point where he couldn’t stop and he instructed the anesthesiologist to provide medication. During the procedure her vital signs remained stable and she was relaxed. She was confident that the surgeon was able to complete the procedure successfully because during the time of the surgery, the anesthesiologist asked the surgeon how he had become so skillful. The surgeon replied that after his residency he had visited the major eye centers in the country and had observed the best surgeons performing the operation and had picked up some hints from them. |
1. Development of the Artinian Intersystem Model

CARE PLAN 1.1 (Continued)

**EVALUATION OF RESOLUTION OF MAIN CONCERN**

<table>
<thead>
<tr>
<th>Score Patient on Situational Sense of Coherence (SSOC)</th>
<th>Comprehensibility</th>
<th>3</th>
<th>The patient learned it is possible to have surgery while awake.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Meaningfulness</td>
<td>3</td>
<td>The patient acknowledged it was worthwhile to have had the procedure because the experience had not been stressful and she anticipated having better vision.</td>
</tr>
<tr>
<td></td>
<td>Manageability</td>
<td>3</td>
<td>The patient tolerated the procedure as planned according to the desired goal.</td>
</tr>
</tbody>
</table>

**Reassess Need for Further Interaction**

Main Concern Is Resolved
No Further Intervention.
Storage of Information in Organizational Memory.

Procedure successful. Patient was satisfied with anesthesiologist’s adaptation to patient’s needs.

CARE PLAN 1.2 Illustrating the Resolution of the Main Concern of the Nurse

**DEVELOPMENTAL ENVIRONMENT**

| DESCRIPTION OF INTRASYSTEM DATA TO IDENTIFY MAIN CONCERN |
|---|---|
| **Describe Focus of Interaction** | The nurse asks the patient a question that she has not thought about: “On the 0–10 scale, what’s your goal? What level of pain relief do you want to achieve?” The interaction that takes place focuses on helping the patient understand what she could expect in terms of pain control and what goals are possible for her and on helping the nurse understand the patient’s perspective on pain control. The purpose is to provide a target and sense of direction for the pain management plan. |
| **Access Organizational Memory** | First admission. |

(Continued)

1 See Figure 1.8
CARE PLAN 1.2 (Continued)

Assess Patient/Client Subsystems

<table>
<thead>
<tr>
<th>Subsystem</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Subsystem</td>
<td>J. S., age 42, had had a hysterectomy for uterine cancer 48 hours prior to this interaction. She is a patient on a surgical gynecology unit and has been asked frequently to describe the intensity and type of pain she is feeling. She reports a pain level of 4 to 7 depending on her activity.</td>
</tr>
<tr>
<td>Psychosocial Subsystem</td>
<td>She prides herself on her ability to “tough things out” and has rarely taken analgesics. She has teenage children and has worked hard to keep them off drugs. She believes that the misuse of drugs will cause her to get hooked on them and may lead to their ineffectiveness at a later time.</td>
</tr>
<tr>
<td>Spiritual Subsystem</td>
<td>Nothing is known about her spiritual orientation at this time. With further interaction, particularly if her cancer is not cured, she may discuss this with the nurse.</td>
</tr>
</tbody>
</table>

Tentative Identification of Main Concern of Patient or Provider

The patient did not have a goal for pain management.

ASSESSMENT OF INTRASYSTEM FUNCTIONS RELATED TO MAIN CONCERN

Intrasystem Information About Nurse/Provider Related to Main Concern

| Knowledge | The patient believes that some pain is associated with cancer and surgery and is not aware of the negative consequences of pain on her recovery. She is not aware of breathing and splinting techniques to relieve pain. She has misconceptions about addiction and pain relief. She believes that the nurses are doing everything they can to control her pain. |
| Values    | The patient would like to be free of pain but does not expect to be. She does not see herself as a complainer. She is more concerned about her future need for effective analgesics than for the pain she is currently experiencing. |
| Behaviors | The patient is using a patient-controlled analgesia (PCA) pump to give her own morphine but is reporting a pain level of 4 to 7 depending on her activity. Although she is experiencing pain, she is able to do some coughing and deep breathing exercises. |

(Continued)
### CARE PLAN 1.2 (Continued)

#### Intrasystem Information About Nurse/Provider Related to Main Concern

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>The nurse understands the principles of pain control management and their benefit for comfort and recovery and the adverse effects of analgesic drugs. She understands that although the patient expresses satisfaction with the pain relief provided, it may be a result of not providing the patient with enough information to make a proper evaluation. She knows that she could be doing a better job. She understands the need for patients to define a goal for pain relief.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>The nurse values knowing patient expectations and preferences for pain control. She values patient teaching so that the patient can be a participant in planning care by knowing how to develop a goal that would assist her to make informed decisions about her care.</td>
</tr>
<tr>
<td>Behaviors</td>
<td>The nurse assessed patient’s physiologic and behavioral responses to pain by monitoring pain level every 2 to 4 hours and noting drug usage and possible adverse effects of drugs. The behavior of the nurses displayed accurate perception, confidence, and the ability to provide anticipatory guidance.</td>
</tr>
</tbody>
</table>

**Validation of Main Concern of Patient/Client or Nurse/Provider**

The Main Concern of the Nurse is that the patient will benefit from active pain management, but patient does not believe it is possible.

### SITUATIONAL ENVIRONMENT

#### ANALYSIS OF INTRASYSTEM INFORMATION BY NURSE

| Identify Stressors of Patient | Diagnosis of cancer  
Pain from recent surgery |
| Identify Coping Resources of Patient | Previous experience with “toughing things out”  
Teenagers who are important to her  
Available analgesics  
Supportive nursing staff |

**Score Patient/Client on Situational Sense of Coherence (SSOC)**

(high = 3, medium = 2, or low = 1)

| Comprehensibility | 1  Patient does not know the benefits of pain relief and the negative consequences of pain. She is concerned about getting hooked and fears she will develop tolerance to medications so that |

*(Continued)*
CARE PLAN 1.2 (Continued)

<table>
<thead>
<tr>
<th>Meaningfulness</th>
<th>The nurse believes that a goal for pain management is important, but the patient does not see the importance of having a goal.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manageability</td>
<td>Since surgery, pain has not been kept within acceptable limits because of inadequate goals. The patient, however, is well educated and able to process the information effectively and can learn to develop adequate goals if she sees the importance of pain relief. The institution has the needed resources for pain management in terms of effective nursing staff, adequate equipment, and analgesics.</td>
</tr>
<tr>
<td>State Nursing Diagnosis/es</td>
<td>Inadequate management of pain related to knowledge deficit about adequate pain relief.</td>
</tr>
</tbody>
</table>
| Identify Goals to Increase SSOC | 1. Instruct patient about the benefit of pain management.  
2. Negotiate a plan for pain management patient sees as beneficial for her. |
| Assess Ability of Patient and Nurse to Work Together to Resolve Main Concern | The nurse had the necessary knowledge and patient was willing to work with her. |

**INTERSYSTEM INTERACTION TO RESOLVE MAIN CONCERN**

| Communicate Information | In response to the patient’s misconceptions about the use of analgesics, information was given in a way that would not make her feel foolish. Authoritative literature was provided that would dispel her fears about addiction, tolerance, and side effects. Pillow splinting and breathing techniques to lessen pain while coughing and deep breathing were demonstrated. This information was accepted because the patient recognized its validity and perceived that the nurse was accurate in her assessment of her need for pain relief. The patient recognized that although this was a new and uncertain situation for her, the nurse had experienced it before and was competent to provide guidance for her. |
| Negotiate Values | Although the nurse and patient were far apart in their perception of the value of pain management at

(Continued)
1. Development of the Artinian Intersystem Model

CARE PLAN 1.2 (Continued)

the beginning of the interaction, through the caring behaviors of the nurse, her value of needing to set a goal for pain relief was recognized by the patient as being appropriate for her and was accepted as her own. When she realized that the valued behavior of “toughing it out” was actually detrimental to her recovery process, she reinterpreted the situation so that both patient and nurse shared the same interpretation of the value of goal setting for pain management. At the beginning of the interaction, the patient was in a position of low power because of inadequate knowledge. Through appropriate teaching, the patient was brought to the place where she could make an informed decision about her care. She was no longer satisfied with a pain rating of 4 or more. This made it possible for a goal to be determined that would be both reasonable and realistic and acceptable to both patient and nurse.

<table>
<thead>
<tr>
<th>Develop Mutual Plan of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Joint Goals</td>
</tr>
<tr>
<td>1. Patient will study information provided by nurse and test the effectiveness of new pain control techniques.</td>
</tr>
<tr>
<td>2. Patient will monitor her pain during times of rest and activity to identify a reasonable pain goal linked to activities necessary for her recovery.</td>
</tr>
<tr>
<td>3. Patient will evaluate the new program.</td>
</tr>
<tr>
<td>Develop Joint Objectives</td>
</tr>
<tr>
<td>Manage pain to stay within patient’s stated acceptable pain range of 2–3.</td>
</tr>
<tr>
<td>Develop Implementation Strategies</td>
</tr>
<tr>
<td>Because the patient did not like to focus on pain, with the consent of the surgeon a continuous hourly basal infusion of analgesic was added to her PCA regimen while still allowing her to have personal control over additional medication during activity. The nurse continued to monitor her use of analgesics and asked, “Do you feel we need to adjust your dose?”</td>
</tr>
<tr>
<td>Implement Strategies</td>
</tr>
<tr>
<td>With reassessments of pain control during the next 12 hours, the patient's self report of pain was brought down to her desired goal of 2 or 3. She was able to switch to an oral analgesic. She continued to direct her pain management program and recommended that her dosing schedule be</td>
</tr>
</tbody>
</table>

(Continued)
CARE PLAN 1.2  (Continued)

<table>
<thead>
<tr>
<th>EVALUATION OF THE RESOLUTION OF MAIN CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-score Patient on SSOC</td>
</tr>
<tr>
<td>Comprehensibility: 3  The patient has full understanding of the pain management program and was able to set a realistic goal for herself and meet it.</td>
</tr>
<tr>
<td>Meaningfulness: 3  The patient recognized the value of setting a goal for pain relief in terms of her overall recovery and actively developed her own program.</td>
</tr>
<tr>
<td>Manageability: 3  The patient had the resources to manage her pain and the needed assistance to use them. Her pain was maintained at the desired goal.</td>
</tr>
</tbody>
</table>

Assess Effectiveness of Implementation Strategies

Identify Strengths and Weaknesses of Implementation by Nurse

The negotiations that took place within the structural context of the surgical gynecology unit led to a mutual definition of the situation and a negotiated order that was exemplified in the plan for meeting the patient’s goal for pain relief.

Reassess Need for Further Interaction

<table>
<thead>
<tr>
<th>(select one of the following three options)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Concern Is Not Resolved Return to Intrasystem Data Collection and Care Plan Process.</td>
</tr>
<tr>
<td>Main Concern Is Resolved Identification of New Main Concern, Start Over.</td>
</tr>
<tr>
<td>Main Concern Is Resolved No Further Intervention. Storage of Information in Organizational Memory.</td>
</tr>
</tbody>
</table>

She was able to be more active and independent, and by the next day, she was able to switch to an oral analgesic.