Letters to the editor

Letters received from readers in response to articles and ideas published in ANS are regularly featured, providing an opportunity for constructive critique, discussion, disagreements, and comment intended to stimulate the development of nursing science. Unless otherwise stated, we assume that letters addressed to the editor are intended for publication with your name and affiliation. When space is limited and we cannot publish all letters received, we select letters reflecting the range of opinions and ideas received. If a letter merits a response from an ANS author, we will obtain a reply and publish both letters.

RELAPSE AMONG EX-SMOKERS: THEORY DERIVATION

To the editor:

Mary Ellen Wewers and Elizabeth Lenz have provided an important needed piece to the literature on theory-development strategies in their article, "Relapse among Ex-smokers: An Example of Theory Derivation" (*ANS* 9:2, January 1987). Quite correctly they identify that the illustrations of theory derivation in *Strategies for Theory Construction in Nursing* were to some extent limited by being hypothetical, partially developed, or not empirically tested. Especially useful in their article was the careful elaboration of each step in the theory-derivation process.

In step 1 (becoming familiar with the literature concerning the phenomenon of interest and evaluating its suitability for explaining the phenomenon) they provide an informative and critical review of literature on smoking relapse, noting that most extant studies have focused on single factor explanations. In step 2 (reviewing literature from other fields) they present an important element in selecting fields of literature for review by demonstrating commonalities that exist between the phenomenon of interest (smoking relapse) and a related phenomenon (alcohol abuse). The delineation of commonalities between the parent field and the field of interest is an interesting criterion that may well enhance the success of theory derivation and may narrow the overwhelming number of possibilities open to a theorist. In step 3 (selecting a parent theory) they provide a well-reasoned basis for selecting the parent theory from two potential candidates. In steps 4 and 5 (identifying and modifying analogous content or structure from the parent theory and restating as a theory of smoking relapse) they provide a careful integration of structural and general content features from the theory of alcohol relapse and recovery with substantive knowledge about smoking relapse. Their precision at these final steps shows that the development of suitable derived theory is not an arbitrary process, but one built on an intimate knowledge of the phenomenon of interest. In their illustration, that knowledge is based on a firm grasp of extant research literature on smoking relapse, but it might also be of a more clinical nature in other cases.

Most encouraging about Wewers and Lenz's work is the test to which they put their newly derived theory. The connection between theory development and theory testing is vital to sound nursing science. In this regard their work is a model for other theorists.

We wholeheartedly endorse the middle-range theory posture adopted by Wewers and Lenz. Development of theory at this level is essential to a full and rich understanding of nursing phenomena. Theory developed at the middle-range level has the level of specificity that makes theory testing more focused and potentially informative.

Finally, we acknowledge the importance of Wewers and Lenz's work in elaborating on the process of theory derivation. Their work will

aid others who attempt the challenging and arduous task of theory derivation.

Lorraine Walker, RN, EdD
Luci B. Johnson Centennial Professor of Nursing

Kay Avant, RN, PhD
Associate Professor
School of Nursing
University of Texas at Austin
Austin, Texas

PRENATAL DIAGNOSTIC TECHNOLOGY

To the editor:

In her article, in *ANS*, 9:3 (April 1987), "The Ethical Dimensions of Policy for Prenatal Diagnostic Technologies: The Case of Maternal Serum α-Fetoprotein Screening, Sara T. Fry states that a policy of routine, mandatory prenatal screening for neural tube defects (NTDs) via serum α-fetoprotein testing can be ethically justified since a "reasonable person would agree to slight infringement of liberty now so that his or her later choices could be fully informed and voluntary." She also states that neither further diagnostic work nor abortion could be mandated ethically. If we do not make abortion of fetuses with NTDs mandatory, then I see no justification for mandatory screening. If the ultimate choice lies with the mother, should not the choice to be tested be hers as well?

There is no precedent for this type of interference in the choices of women regarding their pregnancies. We have handled the genetic testing of amniotic fluid α-fetoprotein on a voluntary basis and have stressed the importance of advising pregnant clients of their relative risk of problems and of the risks and benefits of the test. It seems more important to stress the education of health care providers regarding the availability of serum testing and its appropriate use.

The policy issue that I would like to see addressed is not whether this testing should be made mandatory, but whether it should be made accessible. At the least expensive local laboratory, the price of a serum test is about $50. The follow-up ultrasonography and other examinations add hundreds of dollars to the cost of a woman's prenatal care. The result is that only women with financial resources have access to these tests and thus to the choice of whether to bear a child with an NTD. This issue is far more ethically compelling.

Lisa Chickadonz, RN, MN, CNM
Doctoral Student
University of California
San Francisco, California

Author's response:

I appreciate Ms. Chickadonz's response to my article. She apparently disagrees with mandatory maternal serum α-fetoprotein (MSAFP) screening at the initial level because it is not justified. Her reasons for this judgment seem to be that since abortion of fetuses with neural tube defects (NTDs) is not mandatory, MSAFP screening should not be mandatory, and since ultimate choice about whether to bear an NTD-affected fetus always resides with the pregnant woman, then she should be allowed to choose whether to have the test. Neither reason supports the judgment that mandatory MSAFP screening is not justified.

First, the degree of bodily invasion in an abortion is much greater than the degree of bodily invasion in obtaining a sample of maternal blood serum. The degree of bodily invasion is directly correlative to infringement of individual freedom and privacy. I demonstrated that the initial MSAFP test could be justifiably mandatory for all pregnant women through an interpretation of the moral principle of weak paternalism and through the argument that a minor limitation of freedom for the MSAFP screening would be acceptable to