NURSING PAPERS

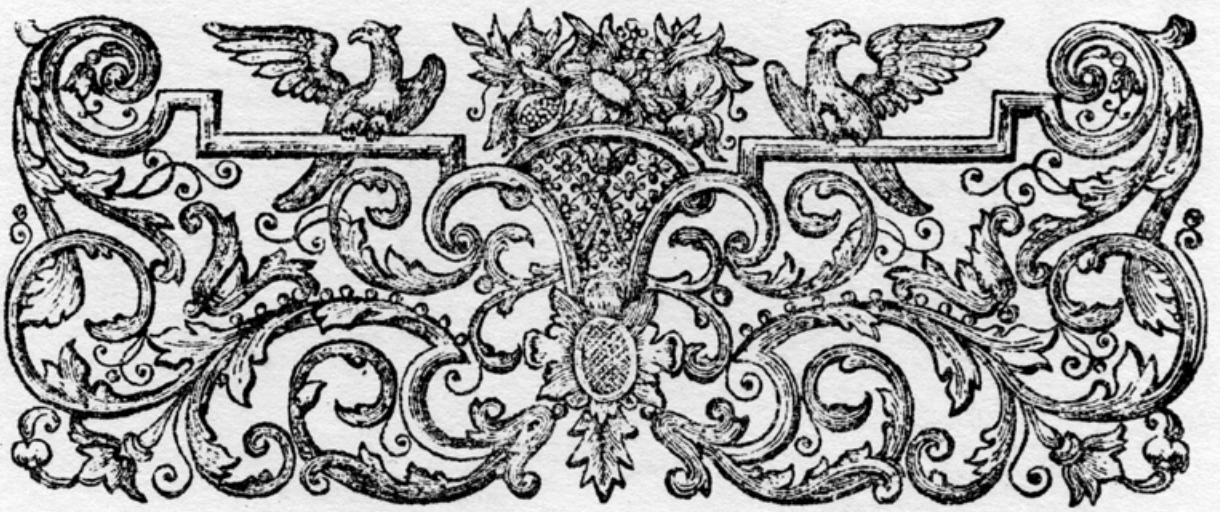
NOVEMBER 1970

RESPONSE TO THE TASK FORCE REPORTS

POSTPARTAL INTERACTION

LOOKING AT BACCALAUREATE NURSING EDUCATION AND PRACTICE

Volume 2, No. 2



YEAR II

Since we initiated a subscription plan to Nursing Papers in the June 1970 issue, 136 persons or institutions have subscribed: 58 for one year and 78 for two years. A financial statement for our first two years follows:

	Expenses	Income
Expenses for the April 1969 issue	$ 600.00	
Income from contributions to November 1969		$ 207.85
Expenses for the November 1969 issue	$ 550.00	
Income from contributions to June 1970		$ 475.70
Expenses for the June 1970 issue	$ 510.00	
Income from subscriptions and contributions to October 30, 1970		$ 556.47
Total	$1660.00	$1240.02
Balance	$ 419.98	

Despite your contributions and repeated comment on the need for a forum for discussion among university schools and their graduates, only one letter in response to the content has been received. A major issue, "The Future of Public Health Nursing in Canada", printed in the June 1970 issue in reply to a request from the Canadian Public Health Association, elicited not a twitter! Views differ on the notion of public health nursing; what are yours? We invite your contribution to this journal either in the form of original papers or of responses to articles.

Nursing Papers for November 1970 contains the "Response of the Canadian Conference of University Schools of Nursing to the Task Force Reports". In addition to the statement included here, CCUSN responded to the specific recommendations of the Reports. This statement and commentary on the recommendations are being forwarded to the Honourable John Munro, Minister of National Health and Welfare, by the new President, Miss Beth McCann of the University of British Columbia. We hope you will consider the position of CCUSN carefully and make your reply available to us.

In a second article Miss Peggy Saunders and Miss Claire Tissington have described their approach to the study of nursing while looking at the nursing of new mothers in hospital. In the third paper Miss Margaret MacLachlan has been kind enough to share with us her visits to a number of university schools of nursing in the United States.

M.A.

THE TASK FORCE REPORTS OF THE COST OF HEALTH SERVICES IN CANADA . . . A RESPONSE

From the Canadian Conference of University Schools of Nursing

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THE CANADIAN CONFERENCE of University Schools of Nursing, an association of 22 university schools from nine Canadian provinces and a member of the Association of Universities and Colleges of Canada, is concerned with the nation's health and with the university preparation of nurses well qualified to contribute with other health workers to the development of health services.

We in this organization endorse the aims of the Committee to Study the Cost of Health Services in Canada and find in the Report of the Task Forces recommendations which point to better delivery of health care and more effective use of the health dollar.

Focusing as the Report does on the costliest areas of health care, hospital facilities and medical care, some of the recommendations tend to look inward and to be remedial. The broad picture, however, is one of regional planning, with the assessment of health needs, the establishment of priorities, the development of health services in relation to population, and the utilization of health workers as a team. We believe that only in this context can the functions of personnel be assessed and appropriate educational programs developed.

Health centres with a balance of ambulatory and hospital facilities can provide a flexibility of care located in the community where it is needed. The health centre along with the specialized hospital, which can no longer remain isolated, and other health facilities can provide a chain of services geared to the patient and not to any professional group. In the health care system of the future, workers must find new ways to function and to work together.

The Reports recommend that internal management of health facilities be studied and proven management principles be applied. This applies especially to the hospital which is aptly described as "a series of related systems with multiple goals in which a delicate balance must be maintained." The essential purpose of the hospital is the provision of medical care for the sick and a considerable portion of expenditure is originated by physicians with little accountablity.

Nursing service closely associated with medical care accounts for approximately 50% of the hospital personnel budget and suggests a fruitful area for cost reduction through better utilization of the nurse.

Health services outside of the hospital are directed towards the prevention or early detection of illness, an objective which, if achieved, would reduce hospital usage and therefore costs, and would in the long run result in a higher level of health. In this area the number and kind of health personnel appear to be the key to effectiveness. The development of interdisciplinary experimental projects providing health care and the examination of professional functions is of prime importance.

NURSING

The Reports make recommendations with respect to nursing: (1) measurement, assessment and improved management of nursing services in hospital and (2) extension of the role of the nurse, particularly in relation to that of the physician.

Some 70% of nurses are employed in hospitals and similar institutions across the country. Nearly all of them have been prepared in hospital schools of nursing; i.e., in situations similar to the one in which they work and less than 5% have had any additional preparation. It seems unlikely that without considerable help, this large group will markedly change a system, through which they themselves have been conditioned. Nurses with a high degree of skill in nursing and an understanding of human behaviour are needed to alter a rigid outmoded system. Nursing alone cannot effect this change.

Most of the suggestions for the improvement of nursing service require systematic investigation. The relationship between turnover rates of general duty nurses and their opportunity to use knowledge and judgment can only be assumed. Studies of timing and staffing patterns have had little overall effect. Research of nursing and quality criteria has scarcely begun. Lack of funds and of nurses adequately qualified has retarded research in nursing.

The extension of the role of the nurse is a part of progress and professional development. There is question as to the direction this development should take. Some physicians, committed to a particular pattern of medical care and overworked, are seeking an assistant and they see the nurse with a basic preparation in health science a suitable person to take on "trivial fatiguing activities" or locating in remote areas "trained to diagnose and offer some therapy." A physician's assistant suggests a new cadre of health worker for an already complex system of health care delivery. On the other hand

it is apparent that nurses at the baccalaureate level now have many skills which they do not have an opportunity to use and these include health assessment, health counselling, and technical skills. We believe that this question regarding the extended role of the nurse must be answered in terms of total health services, not just medical care. Study of the utilization of health professionals should include a well designed project to demonstrate the most effective role for the graduate of the university nursing program.

The Responsibility of the University School of Nursing

Far reaching changes are taking place in nursing education across this country and a pattern is emerging which is more nearly related to present demands in the health field.

Basic schools of nursing are moving from service oriented hospitals into educational institutions and nurses in a setting geared to learning are being prepared to give a high quality of intensive nursing care to the acutely ill in home or institution. Career development is along the line of patient care, through special clinical courses, and not by way of administration. This graduate with attention focused on patient care should be able to relinquish non-nursing activities.

The university, at the baccalaureate and graduate level, prepares nursing experts in various fields, teachers for all types of nursing programmes and, increasingly, nurses able to carry out research. These graduates function in a variety of settings in association with the physician and others in the health team.

The baccalaureate programme in nursing consisting of courses in nursing with a foundation in the biological and social sciences, prepares a nurse able to assess the health status of individuals, to supervise a treatment plan, to do health counselling. This nurse is able in hospital to plan nursing care on an "individual rather than routine" basis; carry a large portion of patients who come to the clinic and to increased ambulatory facilities; care for patients in the home; see patients in the doctor's office. This nurse is the physician's associate.

Time is a vital factor in this nurse's function. The nature of nursing requires that a nurse spend time, over a period, with a patient which provides an opportunity to assess the patient's health needs and to influence health plans.

The number of these graduates from the university is still small, but all Schools of Nursing are prepared to increase enrolments. Programmes for the post-basic preparation of graduate nurses are proving less effectual and are being phased out. Even the small number of graduates from basic nursing programmes in University,

give ample evidence of their ability to extend the role of nursing within the health care system.

Graduate programmes in the University prepare the Nurse Specialist for consultation, research, teaching in the University and directing nursing services.

It has been estimated that one quarter of the nurse population should be graduates of university programmes. To meet this requirement, university schools must increase student enrolment. This is difficult until more well qualified nurses can be added to faculty. The situation can only be improved when more money than is now available for bursaries, is forthcoming.

Improvement in the quality of nursing care and utilization of nurse practitioners depends upon soundly developed research projects. Research grants must be made available to university schools for the development of such projects.

POSTPARTAL INTERACTION

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THERE WERE approximately four hundred thousand babies born in Canada during 1969, the majority of whom were born in hospital.[1] In a society such as ours, parents frequently seek information outside the family about child-bearing and early child-rearing. This trend has come about partly as geographic mobility of individuals and families has increased, and partly in relation to the changing role and functions of the family. The period of hospitalization for childbirth affords contact by parents with others sharing similar, yet unique, experiences. It also makes available to them nurses and other members of the health team.

If nursing is concerned with helping the individual determine and meet his or her own needs then postpartal nursing offers boundless opportunities. Anyone who has shared these early days will perhaps remember the eagerness with which parents examine every detail of their baby's appearance and activities. They might remember, too, the shifting moods from excitement and elation to concern and doubt, as the responsibilities of child-rearing develop and the many adjustments to a new family member begin.

Some aspects of meeting the needs for individuals, who are at present unable to meet these themselves, are relatively well provided by postpartal nursing in North America today. Uterine involution, fluid, electrolyte and nutritional needs are usually met, as are needs for elimination and exercise. However, when one evaluates the degree to which nurses help parents meet their needs related to family living with a new baby, many failures are revealed. Some of these failures have been described by nurses in studies carried out in children's clinics. Others may be observed in the behaviour of parents during the early puerperium both in the hospital and in the home.[2]

Perhaps a close look at the behaviour of parents recently involved with pregnancy would be helpful to nurses. An opportunity to observe behaviour critically in order to identify and explore nursing problems was provided for the writers to this paper during a Master's Degree Programme.

THE GENERAL PROBLEM

The general area of interest was the assistance provided parents in Canadian society regarding adjustment to life with a new baby. Concern for this problem developed from our experiences with families in hospitals, in clinics and in their own homes, as well as from available literature. There are many questions for which nursing might seek answers:

How do nurses help parents adjust to their new roles?

How do parents respond to nurses during the days following childbirth?

How do nurses include parents in the planning of postpartal programmes?

What is happening every day in the hospital as parents begin the acquaintanceship process with a new family member?

How do mothers respond to each other during early puerperium?

Do mothers view each other as resource persons?

Do nurses facilitate interaction among mothers? Among parents?

The following two studies carried out in the same maternity setting illustrate how observation during the early puerperium can be used to identify and explore nursing problems. One is the study of interaction among mothers, while the other study is of interaction between mothers and nurses. We have included some of the observations and thoughts that led us in different directions while studying the same general problem, that is, helping parents adjust to family living with a new baby.

THE STUDY OF INTERACTION AMONG MOTHERS DURING THE EARLY PUERPERIUM

Interest in adjustment to parenthood began from observations made by the writer while working in a doctor's office. Later, while working with parents in hospital and visiting them at home following childbirth, this interest increased. It was noted that conversation among parents focused upon family life. Content of verbal interaction, facial expression and voice inflection suggested concern, often fatigue and frequently general lack of preparedness to cope with life and a new baby during the first weeks.

Perhaps studies from the field of social psychology can help provide clues to the complexities of human relationships. For example, a 'like me' feeling was found to correlate with positive responses of children to other persons.[3] Perhaps mothers respond positively to other mothers they view as being like themselves. Studies of person perception indicate the individual responds positively toward persons believed to be of higher status than themselves.[4] Perhaps the mother of two or more children has a higher status than the mother of a first child, in the eyes of mothers in the early puerperium. The cost and reward of a relationship has been studied in relationship to the acquaintanceship process.[5] Does a mother continue a relationship with another mother if it satisfies her need for information? Do mothers seek other more rewarding relationships than those offered with her room-mate in hospital?

Women in hospital postpartum units have long been noted for their chattiness, but are nurses aware of what is happening? Greater mutual benefit might be derived from the interaction among mothers, if nurses were cognizant of the mothers' behaviour, the ways in which they respond to each other, and the factors that seem to influence this behaviour. If a sample of mothers was studied and the responses of mothers to each other recorded, could we discover clues to maternal and infant care? If so, we might be lead towards postpartal programmes based upon the unique problems of individual families, rather than upon nurses' generalizations about parents. The problem isolated for study was: How do mothers respond to each other during the early puerperium in matters of family living with a new baby?

In order to observe a number of women during the early puerperium, mothers in the postpartum unit of an active, metropolitan hospital were selected for study. During preliminary observations repeated patterns of behaviour were noted. Three categories of behaviour predominated. These were contact seeking, contact developing and information-accepting behaviours. To facilitate recording, a check-list was constructed in terms of the above categories and related to the behaviours of smiling, watching and conversing. Data related to conversing included topics of conversation. Two hundred observations, each of a ten minute duration, were made as ninety-six mothers interacted together in rooms of two, three and four mothers.

Variables considered in this study were:

1. Responses of mothers to each other in matters of family living with a new baby.
2. Parity, age, days postpartum, country of birth, religion

and socio-economic status (based upon the Blishen scale of husband's occupation).

Verbal responses included eighteen topics related to family living with a new baby. Multiparas tended to discuss infant care and ways of obtaining rest more frequently than did primiparous mothers. The latter group spoke more often of the baby's appearance than of their husbands. It was also noted that although they conversed about family matters together, they tended to speak of specific tasks in conversations in which nurses were mentioned.

Further analysis of the data revealed the following information:

A. *Responses in relation to Parity:*

1. All mothers included in the sample sought contact with other mothers. The most frequent behaviour demonstrated in seeking contact was conversing, although smiling and watching were also practised. Multiparous mothers tended to initiate conversation more often than did primiparas; however, the difference was not significant.

2. Contact or interaction among mothers was continued through acts of smiling, watching and conversing. Significantly more multiparas than primiparas continued conversation with other mothers.

3. Interest in accepting information from another mother was suggested in forty-three percent of the mothers who continued to watch another mother with her baby, and in twenty-one percent of mothers who asked questions of each other after the initial contact had been established. There was no significant difference between primiparas and multiparas in these behaviours.

B. *Variables other than Parity:*

1. Significantly more mothers of Canadian birth initiated contact and continued conversing than did mothers born in other countries.

2. Socio-economic status was not significant in behaviours of seeking, continuing interaction or accepting information.

3. Mothers tended to interact together more during the first three days of hospitalization following childbirth than they did during the next three days.

4. Mothers under thirty years of age continued to interact together significantly more than mothers over thirty.

5. Religion was not significant to the responses of mothers.

In summary the study revealed that mothers tend to respond positively to each other during the early puerperium in matters of family living with a new baby. Such responses include smiling, watching and conversing. The variables of parity, age, days postpartum and country of birth were significant in frequency and type

of response among mothers. This type of information could prove useful to nurses in attacking the problem of helping parents adjust to life with a new baby.

THE STUDY OF INTERACTION BETWEEN MOTHERS AND NURSES

"In nursing, the interaction between nurse and patient usually is seen as an essential ingredient in practice."[6] Most of the research in nursing related to interaction has been in the psychiatric setting. However, before this process can be applied more fully, it is required that the factors affecting interaction in a variety of nurse-patient situations be explored.

For example, in the field of maternal and child health, the preparation of parents depends largely upon the process of interaction. In our society new mothers may be more isolated from other kinship members and their experience and preparation for child-rearing may vary greatly from one to another. Through interaction the nurse may gain some knowledge of the individual mother's concerns, capabilities, problems and needs which will provide a basis for planning and giving nursing care. Therefore, interaction between nurse and patient becomes an integral aspect of early postpartum care.

The approach used in studying interaction in this study arose from views expressed by new mothers during visits with them in their homes. Many mothers implied that some nurses were more helpful and understanding than others. The use of close physical contact and interest shown in the mother and baby seemed to contribute to these views. With this in mind the research study was designed to explore nurse-patient verbal interaction and its relationship to physical and social-psychological distance.

Tools were designed to study this problem based on the following assumptions:

1. The use of touch in nursing may be used as an index of interpersonal relationships.[7]
2. When similarity is assumed between persons, this can be interpreted as indicating psychological warmth, acceptance and permissiveness.[8]

By concurrently observing verbal interaction of nursery nurses with mothers and measuring their perception of a use of touch gestures with these mothers, it was hoped to discover some factors affecting interaction. Originally, it was planned to record interaction by means of a tape recorder but it was found unsatisfactory due to technical difficulties arising when nurses were moving in and out of patient rooms. To facilitate data collection, check-lists for verbal

interaction and for physical distance were constructed. Social psychological distance was measured by means of the Assumed Similarity Scale developed and tested by F. E. Fiedler.[9]

Nine nurses, students and graduates, working in the nursery on the maternity ward of a 265-bed general hospital were selected. They were observed in their contact with new mothers which was generally limited to the one-hour infant feeding period occurring twice on each shift. Eighty-one different patients of varying age, parity, socio-economic group, marital status, birth place and day postpartum were contacted by the nurses in the one hundred observations made.

Analysis of the data showed that the verbal interaction of the nurses was mainly task-centered and in the form of giving information, i.e. "Give the baby two ounces," "He will not eat if he is sleeping, you'll just have to wake him up." Nurses gave many instructions regarding hospital routines and infant feeding, particularly during the first postpartum days. The instructions were often repeated by other nurses in subsequent feeding periods. Rarely did nurses ask specific questions to ascertain the mother's degree of preparation regarding other aspects of infant care or problems she might encounter once at home. Little individual variation was noted between nurses in relation to the range of conversation topics. Baby-, patient-, family-centered conversation concerned such things as the baby's name, his appearance or the number of other children in the family. However, these subjects were not usually pursued to gain further information upon which to base nursing care.

The amount of interaction nurses had with patients during one feeding period was relatively small. Factors which seemed to influence the length of contact and the type of interaction with individual mothers appear to be dependent upon:

1. other events occurring in the nursery during the infant feeding period, e.g. circumcisions, doctors' visits.
2. other tasks to be performed, e.g. washing cribs.
3. location of the mother's rooms in relation to the nursing, i.e. when rooms were a great distance from the nursery, nurses tended to have contact with mothers only when taking out and bringing back the babies.
4. coffee breaks occurring during the infant feeding period.
5. short term assignments, i.e. a nurse was not assigned to the same babies each day or even for two periods during one shift.

It was found that nurses interacted significantly more with mother of Para II, in the 25 to 29 year age range, of lower socio-economic status and in the first one or two days postpartum. Interaction

occurred between the nurse and one patient at her bedside, rather than involving several patients in the room simultaneously. The nurse seldom talked to a patient when she was not within the individual patient's bedside area. Most conversation was directed only to one patient. Seldom did the nurse converse with the patients as a group. No significant difference was seen between physical distance maintained by the nurse and the type or topic of interaction with the patient.

During interaction with a patient the nurse most frequently assumed a "fairly close" distance, i.e. could touch the patient without moving but at the same time standing away and not leaning toward the patient. Touch gestures were infrequent. It would appear that nurses maintain the distance necessary to perform a task but do not invade the personal distance zone of the patient. Edward Hall identified distance zones used by people in Western culture ranging from very close or intimate to personal and social distance, to extreme public distance.[10] On this basis the distance maintained by nurses may be due to the relationship between physical and social territoriality determined by our culture.

Each nurse varied considerably in how she perceived individual patients. Some nurses consistently saw the patients as being similar to themselves, while others saw them as more distant. It was found that there was less social-psychological distance expressed by nurses in relation to patients with whom they shared conversation which was predominately patient- or baby-centered. Students generally perceived themselves as more similar to patients than did the graduates. Being in a learning situation students may be in a somewhat similar position to that of the new mother.

In summary, it would appear that verbal interaction between patient and nurse was most frequently task-centered in the form of the nurse giving information. The amount of interaction was small and generally the nurse related to the individual patient rather than to patients as a group. There appeared to be a relationship between social-psychological distance and the topic of conversation.

SUMMARY AND CONCLUSIONS

The two observers set out to study the behaviour of mothers as they interacted with nurses and with each other. Results indicate that information is available to nurses in short term periods of observation. That all nurses are cognizant of the information available in day-to-day interaction is questionable. It may be noted in both studies that there is a difference in topics discussed by mothers with mothers as compared with topics discussed by mothers with

nurses. The family-centeredness of conversation among mothers and the task-centeredness of conversation between nurses and mothers suggests that the mothers' behaviour is not the basis for nursing action in the situations observed. Nor was the responsiveness of mothers to each other during the puerperium made use of as a means to help parents prepare for family living with a new baby.

The changing values of a modern, urbanized, industrial society, as well as family planning, changes in abortion, adoption and divorce laws, are all influencing the structure and function of the family in our society. Parents themselves are different from those of the last decade. Nurses can no longer show a mother how to bathe her baby and make formula in the belief that she has achieved all that is required in helping parents to adjust to family life with a new baby.

It, therefore, seems not only reasonable but essential that we find ways to provide family-centered maternal and infant nursing in an environment conducive to the sharing of thoughts, ideas and plans. Parents could then participate in self and infant care and begin to adjust to their new roles while members of the health team are on hand to guide them to identify and meet their own needs.

Suggestions for incorporation of these ideas into nursing practice are as follows:

1. The responsiveness of mothers to each other should be made a working tool by nurses to help mothers identify needs peculiar to their own family situation.

2. Age, parity and days postpartum should be reviewed when planning nursing care and attempting to identify parent needs.

3. Room placement of mothers should be considered in view of her age, parity, days postpartum, cultural background and opportunities to interact with other mothers.

4. Ways in which the postpartum environment could be made conducive to sharing of thoughts and plans among parents might be considered by nurses and other members of the health team.

The significance of helping parents meet their needs in relation to family living with a new baby cannot be ignored. Erikson states:

> . . . that each further stage of growth in a given individual is not only dependent upon the relatively successful completion of his own previous stages but also on the completion of the subsequent stages in those other individuals with whom he interacts and whom he accepts as models.[11]

Footnotes

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LOOKING AT BACCALAUREATE NURSING EDUCATION AND PRACTICES

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A SABBATICAL LEAVE can mean many things: time to look more closely at engrossing problems, to carry out needed research, time to travel to broaden one's outlook, time to reflect. A sabbatical promises all of these things and yields some of them. The focus of this sabbatical leave was a study* which centred on the question of possible reasons for the relatively limited impact of baccalaureate nursing education on the whole pattern of patient care. Graduates of generic nursing education programmes have been on the scene in Canada for some years yet the percentage of these nurses in active practice is still well below the 25 per cent goal; and the number in direct patient care much lower. Generic nursing education has been built around the concept of patient-centred care, yet much of the nursing practiced in our hospitals is still task-oriented, or functional nursing.

Prodding and pushing for answers to the preceding questions is the spectre of the cost of university education. Nursing is one of the more expensive programmes in the university and the time is swiftly coming when the product must give greater evidence of value to justify the expenditure. If the baccalaureate nurse is to be prepared to function in a leadership role, and this appears to be the current thinking, then her basic educational preparation must include the development of the necessary skills in a broader sense than is currently the case. Since her reason for being is then different from that of the non-baccalaureate nurse her preparation must be different; and her practice upon graduation must offer the opportunity to reflect that difference.

With the above in mind, this observer visited and observed a few of those university nursing education programmes which gave evi-

*This study tour was financed through a World Health Organization Fellowship and a Research Grant from the University of New Brunswick, Fredericton, New Brunswick, Canada.

dence of an ability to imbue the students so thoroughly with the leadership role that these graduates could be expected to demonstrate, in practice, the value of university education in nursing. Visits were also made to those hospitals which, as employing agencies, were engaged in conscious and serious efforts to use graduates of baccalaureate programmes effectively. It was hypothesized that if nursing educationists were sufficiently explicit in clarifying this leadership role in patient care, and if employers of nurses were able to create an attitudinal climate wherein baccalaureate graduates could practice patient-centred care, more would remain in nursing and fewer of those who did remain would revert to the *status quo* of task-oriented patient care.

The problem of baccalaureate nursing education and practice is no longer one for the educational institutions alone to solve; the employing agencies must make it possible for baccalaureate graduates to remain in nursing and practice the kind of nursing which gives satisfaction to patient and practitioner. And, as well, this whole question of high quality patient care requires a closer integration of effort between the agency and the university: between the educational institution and the employer of nurses.

This tour involved visits, from three days to two weeks in length, to three major university nursing programmes and to four selected hospitals in the United States which were reported to be "doing things" in nursing education and practice. At the university centres opportunity was afforded for discussions and observations with students, graduates and faculty personnel in the university and also in the various areas used for clinical practice. It was regrettable that a scheduled visit to a fourth university programme had to be cancelled because of the degree of student unrest prevailing at the time.

It is not intended in this article to review in detail the nursing education programmes found in these universities nor the methods of achieving a high level of patient care in the selected hospitals, rather the focus will be on some of the factors which would appear to have particular meaning for university nursing personnel. The bibliography will include material in which the reader will find excellent explanations of the programmes and the concepts through which the quality of nursing practice has been improved.

Many strong impressions were left with this observer after visiting the university centres. One of the strongest was the realization that while each programme was strong, yet each was different in basic

approach and in execution of detail. One emphasized the intellectual component of nursing as practiced by the baccalaureate nurse. These nurses are visualized as leaders who are responsible for the assessment, implementation, largely through others, and evaluation of the patient's nursing care needs. Their practice is based on an ongoing development of the patient's nursing history which is a major clinical tool for these nurses. High level communication skills enable the nurse to elicit the necessary information on which the nursing care is based and through which a high level of patient care is assured.

Another university programme visualizes nursing as an applied science and is emphasizing the application of psychology, physiology, biology and sociology to nursing. This curriculum is in the process of being redesigned along these lines and, at this point in time, further information is not available. However, progress will be watched with a good deal of interest.

The third university has a strong and systematized framework within which the emphasis is on the nurse as a 'change agent'. From the nursing point of view an assessment is made of the health needs of the patient, family, group or community and through the problem-solving process appropriate action is taken to deal with the particular problem; at the same time alternative suggestions are considered. In all instances the consequences of the suggested proposals are weighed. Throughout the programme every course: discussion, seminar, lecture and clinical experience, is approached by student and faculty member in this manner. It is the conscious, repetitive and integrated use of this approach which gives strength to this programme.

In all of these programmes much emphasis is given to the development of communication skills, skill in interpersonal relationships and skill in, and understanding of, the dynamics of the group process. This emphasis would appear to activate the concepts inherent in the philosophies of these programmes, namely that:

(1) it is the function of the nurse to enable the patient, family, group or community to better cope with their health problems,

(2) nursing functions within a social system in which the nurse is one influence. For nursing to be effective the nurse must understand, and be able to relate to, any impinging components of the system.

Increasingly these skills are seen as essential if the baccalaureate nurse is to demonstrate leadership in, and for, nursing.

In some of the programmes there was a deliberate deemphasis on psychomotor skills. The rationale appeared to be that this was necessary to counteract the heavy emphasis on manual skills in traditional nursing education programmes, and on the prevalent equation of quality nursing with efficiency in techniques. 'Doing things' to patients is gradually giving way to 'helping people better cope' with those health problems which fall within the jurisdiction of the nurse. At the same time this deemphasis is not Intended to negate the very real value psychomotor skills play in the comfort of the patient and as an expression of care for the person.

This observer was particularly impressed with the progress made in the motivation of personnel for high quality patient care in the selected hospitals visited. Certainly progress has been made in nursing practice in these institutions and is reflected not only in patient care and comfort, but also in the stability of nurse personnel and in their interest in nursing practice. The general atmosphere among the nursing personnel was one of genuine and intense concern for the patient, enthusiasm for learning ways to improve the quality of their own practice, and satisfaction with the working situation. Especially noticed was a personal satisfaction which seemed to stem from the fact that the nurse, at whatever level, was regarded as a professional practitioner whose work was respected by peers and colleagues, and whose personal identity and welfare was a matter of real concern to those in administrative positions. This positive, enthusiastic and constructive atmosphere was felt by this observer. The primary focus of the entire nursing department was on the quality of patient care and on how best to achieve and maintain it.

The basic factors influencing these situations appeared to include the philosophy of the senior nursing executive which permeated the entire nursing staff. One nurse executive expressed this in words as she explained her beliefs in relation to the delegation of responsibility. This delegation, she felt, must also include the delegation of the necessary authority to accomplish the task, and the holding of a sense of trust in the nurse that the job would be accomplished.

A long and close working relationship between the senior hospital administrator and the senior nursing executive: between the one who can provide the nursing practice and the one who can make good practice more possible through management of the environment, was common in each of these hospitals in which baccalaureate graduates found scope and challenge for their skills. These senior personnel held a common philosophy about the primacy of patient-centred care and the value of quality nursing to provide that care.

These hospitals were decentralized and the nurses, at all levels, were involved in decision-making related to the care of patients and to nursing practice. There were as few levels as possible between the staff nurse and the senior nursing executive. Along with this much progress had been made in removing from nursing responsibility the multitude of non-nursing practice activities which for so long have bedevilled the nursing supervisor, head nurse and staff nurse. The extension of hours of operation of many of the departments, other than nursing, enabled the nurses to concentrate their activities on nursing practice to a greater extent than formerly. This management of the environment in the interest of better patient care has affected the quality of nursing practice.

In each of these situations the approaches used in arriving at a high level of patient care were different for each institution and appeared to depend on the purpose of that institution: rehabilitative care, care for people with catastrophic diseases, or general care and treatment; the fundamental concepts regarding nursing practice; and the particular interests of the nursing staff. One institution was focussing efforts on providing additional knowledge and opportunity for refining skills so that every nurse at each level could do a better job in her area of responsibility. Another institution achieved a higher quality of care through a process of motivation through evaluation not only by the nurse of herself, but also by a committee of nurses. The findings from the evaluation led on to an individual programme of staff development. A third had achieved results through the involvement of the nurse in decision-making as related to all aspects of nursing policies and practice, and to a large extent, to as many aspects of hospital functioning as possible. The fourth institution achieved a very high level of patient care through the implementation of the concept that the patient should, to the greatest extent possible, be an active participant in the decision-making regarding his own care; that to engage the patient to this degree required that the nursing care be given only by registered nurses; that each nurse be totally responsible for the nursing care of the patients in her district; that the nurse-patient relationship be as undisturbed by rotation of staff as was possible; and that the same number of nursing personnel be available on the evening as on the day tour of duty. All these approaches required constructive and sustained programmes of staff development both of an individual and group nature.

The need for a greater number of baccalaureate programmes in nursing which would operate within a strong and systemized framework is seen as a necessity. Here the objectives of the curriculum

and the goals to be achieved would be clearly defined and understood by students and faculty so that each learning experience would represent a visualized step toward the goal. It is the belief of this writer that the breadth and dept of knowledge offered in the strong baccalaureate programme is the best means through which the nurse learns to become that practitioner who can, as described by Harmer & Henderson, ". . . [enable] the individual (sick or well) [to perform] those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge . . ." The substitution in Henderson's definition of 'enable' for 'assist', along with the necessary grammatical changes, would seem to put increased emphasis on the nurse's responsibility. It would appear to highlight the importance of communication skills in their deepest and broadest sense. The nurse, if she is to be effective, must not only understand the intricacies of the one-to-one nurse-patient relationship but also must be able to work productively with a group whether it be a family, nursing team, interdisciplinary team, or whatever, whose primary concern is patient care. She must be able to use these relationships to convey her responsibility for, and skill in, all aspects of nursing.

This enabling ability of the nurse is strengthened according to her skill in interpersonal relations, constructive use of the group process and the proficient use of the problem-solving process in direct patient care. There is still a great deal to be learned in each of these area by nurses and it would appear that these might be some of the most effective and productive aspects of the leadership role for the baccalaureate nurse as we see it at this point in time.

It became a matter of real concern that patient care in some of the university hospitals was rated by the nursing personnel as "poor". One reason might be that the nurses in these situations held a clearer perception of standards for care and thus were more acutely aware of deviations from those standards. Another reason could be that these hospitals, similar to most university hospitals, provide clinical experience for a multiplicity of students: medical students, pharmacy students, dental students, nursing students, to mention a few. This concentration of educational programmes, with its accompanying emphasis on research, could result in a situation in which the patient receives less than quality care. When the nursing care practiced by the student and staff fails to meet the expressed goal of patient-centred care not only does the patient suffer but also the education of the student suffers.

Evaluation and the redesigning of the curriculum seem to be a constant process in university nursing programmes. This is as it

should be and this observer was impressed that, in the situations visited, outside assistance was seen as a strength in that the selected assistant represented educational expertise which was brought to bear on nursing education and, as well, interjected a more objective point of view. The time taken to redesign the curriculum is also a matter for comment. When each concept is thoroughly thought through, researched and discussed by faculty members then, and only then, has there been time to explore new ideas and discard outworn ones, change attitudes and learn new ways of coping with proposed suggestions to the end that they are incorporated into the curriculum in a meaningful way. Evaluations in depth and carried out by those with the necessary background and experience should be considered as essential budgetary items if the kind of progress needed in nursing is to be forthcoming. The United States is to be commended for a government attitude which permits financial grants for such undertakings.

The widening gap between some educational institutions and patient care agencies continues to be an obstacle to patient care, staff satisfaction and student education in nursing. This study tour strengthened this observer's viewpoint that ways must be found to increase in these institutions the sense of trust each has for the other. A deeper commitment to direct patient care could do much to increase in each this sense of trust in, and respect by increased involvement of university personnel with the problems of nursing service, by increased evidence of an ability to listen with understanding. Situations have often verified the truth of the saying that nurses are their own worst enemies. Struggles for identification and power in nursing ensue while, at the same time, recognition is given in all quarters that education and service must better integrate their efforts if quality in patient care is to become a reality.

Many of the hospitals and centres visited were examples of what can be achieved when there is vision, creative activity and the ability to take constructive action. Experiencd nurses have much to gain from exposure to such situations. Residencies should be established through which nurses with strong backgrounds might have the opportunity of being participant observers in these outstanding institutions. This would mean a residency of sufficient length that the resident could observe, read, listen, have time to drop her own biases, time to develop the necessary enthusiasm and commitment so that changes could take place upon return to the home institution.

Team nursing would appear to be a concept which is very difficult to carry out in practice unless the philosophy underlying this form of nursing has become an integral part of all involved in the actual

patient care situation; otherwise the nursing practice becomes a functional type of nursing. It could be that nursing needs to take another look at this concept to find ways through which it could be practiced in a more meaningful way.

In Canada we have been concentrating for the past few years on increasing the number of baccalaureate programmes in nursing so that students with the necessary potential could receive the kind of education which would prepare them to fill leadership positions in nursing: administrative, teaching and in patient care. We have been attempting to offer programmes of high quality but perhaps we need to synchronize more closely our offerings with the social structure in which these graduates will function. Will they know how to motivate others so that the very best in patient care will result; will they, consciously and within an intellectual framework, be able to work with nurses, doctors, pharmacists, family members and others to bring about the best care for the patient; will they be able to help bridge the gap between the work situation and the educational institution; will they be able to demonstrate convincingly and permanently that university education is a necessary basis for nursing leadership in direct patient care?

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