# THE NATURE OF NURSING IN THE HEALTH CARE STRUCTURE

BY JOAN M. GILCHRIST
Director, School of Nursing
McGill University

THE purpose of my remarks in initiating this first symposium of the conference is to look at some of the structural factors which are important in affecting the nature of nursing care and the implications these have for the delivery of health services. By structural factors, I mean the kinds of system characteristics within which we work in nursing and through which we try to provide health care. I will be making some suggestions for system change from our present pattern. Many of these are not going to be new ideas but perhaps we can place these ideas within a logical framework to permit the elaboration of a nursing role or roles in our discussions tomorrow, based upon the implications of structure.

In order to gain a perspective upon our present structural characteristics with respect to health services and to project future change, we have to begin with the historical developments of the profession of nursing and of other health professions, for the delivery system evolved to create the type of facilities which these professions felt they required. I would like to emphasize the important distinction which I am making and to which I will refer later, when I suggest that the system of health care delivery has been built around the need for facilities as expressed by the professionals rather than the need for facilities as expressed in accordance with requirements of the citizens, for clearly these are not synonymous. Historically we can trace the kind of health care delivery system we have at the moment back to attempts of society to deal with the kinds of health problems with which it was faced. In other words the system was a response oriented around the curing of disease or of illness. The story of health care is not really that but the story of illness care. This becomes an-

other important distinction in my conceptual model. The social order as it has evolved and as we know it today, has been built around the value system of society and a major value has been curing and finding solutions to health problems which were in effect illness problems.*

Obviously there has always been a great need to solve the problems of illness and concomitantly to develop people especially prepared to cure people who are ill. The health care delivery system has been the vehicle through which our knowledge of cure has been effected. Out of this has come quite a distinct and obvious interest in, and social recognition for, those who have been able to cure. In other words, the rewards and the recognition of society were not available to those who prevented people from being ill, or to put it another way, who helped people to be healthy, but to those who were able to cure illnesses. This impeded the development of expertise in health and health care. A good example of this is apparent in the development of medicine. It has frequently been suggested by medical persons themselves that those doctors in the public health field were often the least academically successful students, the people who were less able for any number of reasons to establish a specialized and/or high caliber medical practice. Moreover, the social value of cure has been facilitated, I think, by tremendous advances in medical and related sciences which have made it possible for more and more cures to be effected.

This kind of development is very natural and understandable. To some extent the same thing has happened in all sectors of society, not only in the health field. The structures or institutions of a society evolve in direct relationship to the social order and are part of that order, which in turn is reflective of the values of the society. This being the case, it is only natural that the acute general hospital where valued cures are attempted and sometimes successful, would become the hub and the focus of so-called health care activity. Over the years it has developed into a complex, highly specialized and departmentalized social organism which has to date largely defied our best attempts at accurate description, prediction, and explanation.

Around this very important focus of health care delivery, satellite facilities and services, also oriented to the cure phenomenon, evolved.

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* In discussion among workshop participants, many rejected the dichotomy of health and illness used here, accepting instead the traditional notion of a health-illness continuum. The thrust of this paper is rather that we know virtually nothing about health — what it is, how it is created or maintained, — and therefore that a health-illness continuum is a theoretical construct which lacks validation.

The preventive care measures, for example, were oriented to the prevention of particular diseases by and large, rather than the promotion of health. Public health as we know it is really illness prevention. The extended care facilities, such as convalescent and old age homes, and services such as home care have as their major focus an extention of this hospital oriented goal — to cure. They try to either keep people out of the acute care facilities or help them once they have left them hopefully allowing them to live a more or less normal life. Ambulatory care clinics have likewise been oriented to caring for those who are, or those who have been, ill and almost all of these are highly disease oriented. Virtually all of our health care institutions and all of our health care programs are "illness curing" programs or are related directly to these. Now, it seems clear that we have begun to do rather well in some aspects of cure. Over the last number of years we have solved many illness problems. When we compare this to what we have done in the area of health, we have made great strides. We know far less however, in fact one could even suggest we know virtually nothing, of what health is in comparison to our knowledge of illness.

Another aspect of the situation of which we must be cognizant is that the structure as it develops was not based upon the needs of the people who are using health facilities. This has created very critical problems for today. As we know more and more about what people are like and what careers and career motivations are like, it seems that most of the health institutions of society have evolved as a response to the needs of professionals for a forum wherein they could ply their trades as they defined them. In other words they developed increasingly around the self-interest and knowledge base of the groups involved in these institutions. Many people still reject this position but it is an issue which is becoming clearer and clearer the more we look at institutional life within some kind of research framework. It is becoming increasingly evident that business, professions, and governments, are through their own devices and for many of their own purposes, developing and have developed health care facilities around what they would like to do and what they would like to accomplish. Of course, the conscious and unconscious motives of people are very difficult to ascertain, but it does seem that professions have developed in the form of social movements and social movements are usually oriented towards the attainment of their own particular goals. The medical and nursing professions definitely have proceeded in this direction, so that the development of the struc-

ture has really been the development of a social monument if you like, to the health care professionals.

The outcome of this set of motivating factors has not only been to influence the nature of the health care facilities but has also been to influence the utilization of these facilities. There is every indication that our health care facilities of the moment are tremendously over-utilized. Moreover we have all seen the development of highly competetive situations, for example, among hospitals all of which want to have the same complex treatment facilities without reference to community needs. This has become even more evident where huge financial resources must be devoted to the development of a particular facility in each of a number of different places all of them only partially and inefficently used. This is only one aspect of the over-utilization phenomenon which provides us with strong evidence of the need for regionalization. It is also a sympton of the role of the professionals in the structural development of our institutions. Mengus, in an article called "The Age of Over-Utilization" says, "The whole country has gone ape over our electronic plastic, fantastically complicated armamentarium. With these machines we have accomplished miracles of cure and survival. Never has so much effort and money been extended for so few." Consider, for example, the clinics available "for a good check-up". Included in the good checks are many very fancy tests and most often the results and the outcomes of these annual check-ups, costing the taxpayer millions of dollars, are exactly the same as the findings which could have been generated by a very minimal set of tests with much less expenditure.

In this vein, some of our very simple and straight forward acts have been put into such a complex framework that it simply boggles the mind. I would like to show you someone's attempt to put into cartoon form the trend toward making very simple procedures very complex. As with the old cartoons in the comic strips one must follow through the series of acts and events in the proper order to understand the significance of the picture. The story starts with a tablet and glass of water. The tablet is dropped into the water, and this releases carbon dioxide which inflates a balloon. The inflated balloon pushes against a lever causing a stainless steel ball to fall down a chute and onto Button D lighting lamp E which shines on a morning glory plant. The morning glory blooms, because of the light, and as it blooms the humming bird who is sitting above it gets very excited and flaps its wings. As the bird flaps its wings it sets into motion a child's wheel. Keep in mind we now have a wheel turning around. The child sitting in a high chair gets very excited over his wheel being turned

around by the humming bird's wings, and he leans forward spilling his milk which falls into a saucer on the floor. The cat standing beside the saucer leans forward to drink the milk and pulls the string which is attached to lever M. Lever M moves and activates lever N which strikes and pricks patient's finger O taking blood for a blood test. Ergo, the simple act of taking blood for a blood test has been placed within a more adequate structure in terms of the esoteric nature of today's medical care.

It seems that utilization and complexity are necessarily linked together. Much of the literature suggests quite clearly that tremendously involved screening programs, for example, which have become routinized and which are believed by lay people and medical people alike to be necessary, are a complete waste of money. Our money should be devoted to another cause. In fact, studies have shown that the identification of illness through these procedures is extremely rare where the individual believes himself to be well.

The pathology of disease rapidly became the knowledge base and the skill base of both medicine and nursing, and therefore these professional groups are primarily oriented to the cure syndrome. The delivery system is a reflection of this orientation. Moreover, psychological and sociological theories also bear the imprint of this focus of concern. A good example of this are theories of personality. These have evolved out of the study of sick people and, therefore, they are illness theories as opposed to theories which might be usefully applied to an understanding of health and to assist healthy people to remain so. In addition, in both of these social science disciplines, which are considered to be close to and important in nursing, the medical model of care has been assumed as a given and as appropriate. I mean by the medical model one in which the basic care relationship is one to one, doctor to patient. The doctor makes the decisions for his patient and the latter complies. Around these two are people appropriately labelled para-medical. Only recently has this set of premises been challenged succinctly.

In summary, my thesis is that we have a tremendously complex set of institutions harbouring a tremendously complex set of roles and relationships, with tremendously complex skills, abilities, and functions attached to these roles utilizing a fantastic proportion of the national budget to cure or identify illness. We have allocated very few institutional, financial, or human resources toward the identification or maintenance of health and prevention of illness.

If this is what we have, then what do we want? Quite clearly a restructuring of the health care delivery system is important and, in

fact, we can settle for nothing less. This does not mean changing bits and pieces of the present structural arrangement but rather changing the essence of each institution in terms of its major focus and concomitantly changing the nature of the relationships among institutions. In determining what needs to be changed we must reflect upon what the client needs, what the institution needs to maintain its integrity, and what the professions need to become increasingly competent in a highly complex network of skills and relationships. Rapid and sweeping changes are necessary now. A reorganization of facilities in terms of broader purposes and the establishment of articulating mechanisms needs to occur quickly.

It is one thing however, to recognize what needs to happen and another thing to bring it about. In this conference we must discuss these very issues, that is, possible methods of bringing about changed role relationships, changed roles, and changed institutional systems, especially as these relate to nursing. As a professional group, we fit into the same kind of mold as most other professions. We are very much oriented to the status quo in spite of repeated suggestions to the contrary, and therefore very conservative. We are finding it increasingly difficult to get our own profession to feel that change needs to be made in spite of, or perhaps because of, rapid change in other parts of the society.

Let us look first at the acute care facility and contemplate possible avenues of change in very general terms. These generalities should be discussed and assessed in this conference. Firstly, we need a strict monitoring of the use of all equipment and of all personnel, so that we can eliminate non-essential tasks, non-essential tests, and non-essential activities that go on within acute care facilities. Some of the data we have gathered in acute facilities, shows that a very high proportion of the nurse's time is spent doing non-essential tasks, if the concept of essential is based on what the patient really needs and not what a set routine or ritual prescribes.

We need secondly, a strict monitoring of the clientele using these facilities so that they can be used only for those people whose needs require it. Some of the ways of bringing this about are obvious and frequently discussed but very little seems to have happened in adjusting to the utilization factors. The best facility for individual needs must be selected and a system evolved which is dependent upon the availability of a broader spectrum of institutions favouring a client oriented approach. The hospital must cease to be an all-purpose institution and the end all and be all of the health care delivery system.

Thirdly, we need a careful and considered look at the plethora of roles within this structure. These are multiplying faster than we can keep track of them. Indeed they are multiplying like rabbits for just about as useful a purpose. Rather than broadening responsibility and expertise for task-limited individuals, we narrow them within increasingly well defined limits. While this may work well on the production line of General Motors, it is not a useful endeavor in the health care delivery system. We should consider ward units with perhaps thirty patients operating as truly decentralized in administrative structure in which the needs of the clients in that unit would be the important factor in generating the structural relationships. This provides a very different milieu for nursing from similar ward units where individuals must make sure the unit fits in with general institutional policies and procedures.

Much more individual authority and responsibility would be generated in this fashion and above all an increased accountability to the client rather than to the system. Moreover such changes would imply role definitions which are broad and functional as opposed to narrow and disfunctional. Fourthly then, we must reverse aur trend toward centralization of administrative function and work instead to highly decentralized units.

In considering these sorts of structural changes in either verbal or written form, one can anticipate the nature of the responses from nurses, administrators, doctors and others. Most feel it is a dream which is too idealized to be realized. This sort of response arises when a change in only one part of the system is conceptualized assuming the remainder retains the status quo. What is being suggested here is a broad enough change so that characteristics as described above can be viewed in relation to one another and not individually related to the present system. For example, the type of job definitions mentioned above may not be possible within our present structure of labour management relations. What needs to be changed perhaps are the labour management relations and not let that factor impede our progress toward the development of a better system. If changes do not fit in with union contracts or other aspects of structure then we have to do many things in the political and managerial arenas to rid ourselves of the present legislation and structural arrangements.

If these are the changes which must come about in the acute care facility then a variety of extended care facilities will obviously be required. We will surely need more and different types of such facilities. These must obviously fulfil a function in preventing over-use of

the acute care areas and certainly many of them in their present form require a good deal of structural adjustment in order to fit the philosophical and other commitments of the new health care delivery system.

The third area, the so-called preventive programs which we find in ambulatory clinics as well as visiting nurse programs of all types, need to be virtually phased out in their present form. The contention is not that they need to be eliminated but rather they should be replaced by a comprehensive and accessable system of family practice. The orientation toward comprehensive family practice will include all those functions which are now very fragmented among a variety of different groups producing gaps and over-laps in service and focusing upon illness and illness prevention as opposed to health care. the focus in the new facility will be to learn about health and to help people develop ways of healthy living as well as to assist in restoring health following illness. In other words we must complement our orientation toward cure and at the same time not eliminate effort and resources required to improve our knowledge of how to help people deal with illness situations.

These things will come about only so far as people, lay and professional, demand it and there is some evidence that they are doing so. Laymen demand it through pressure upon governments and professionals. Small groups of professionals within the larger structure are now asking the question what will be "a change for the better" and "how is it better" and "for whom is it better"? We have very seldom asked these questions and if we have we have not spent very much time in thinking about an appropriate answer. We cannot be permitted to make changes either the ones suggested here or others, without a clearly identifiable focus resting upon client needs as they determine them.

I would like to conclude by looking at the nature of nursing within the present and future health care delivery systems since these are related to, and directed by, structural arrangements. These, and perhaps other structural changes, imply a great deal for nursing. They imply a radical change in the definition of nursing as practiced in many of the health care institutions. We need to recognize more than one nursing role. The restructuring of facilities and the redefining of roles will take place in a revolutionary kind of social movement. Our attempts in the past have been to effect change in an evolutionary manner and this has not been very successful.

We need what could be called an educational revolution in nursing. We must learn how to generate creative behaviours as opposed to

conforming ones. We have done rather well in helping people to conform. We have probably done a better job of socializing people into nursing than any other professional group and socializing them into it has required that they become conformists. Our educational programs have been primarily devoted to that which was known, that is, beliefs and attitudes, knowledge and values, and so on which were known and relayed by the teacher to the student. Really this should be only a small part of the educational process. The fact that it is virtually all of our education is what leads to the conforming behaviors. True education is much more liberating and differentiating than this and in order to accomplish it we must place the learner in situations in which she or he must become innovative and for which she or he must generate new and suitable means of response. Taking knowledge and applying it is not good enough. In real learning the applied knowledge must be subjected to assessment and further refinement. This is, in a sense, the process we have labelled "problem-solving" which is also the essential core of the research process although not in itself research.

The second type of revolution which we need is that which I have called elsewhere an administrative revolution. The first thing we need to understand is that administrative structure determines behavior only in part. In other words, in an institution where there are regulations, rules, norms, and so on, they can only partly account for persons' behaviors in the organization. We would often like to think that institutional limitations were the things preventing us from doing everything we "really wanted" to do, but indeed they are not. It has been found, for example, that lifting the authority structure does not in itself bring about creativity. Now it would be foolish to suggest that structural implications of working in any kind of an agency don't affect people. They do. However, if people are prepared to be creative, then they can be creative in any sort of setting no matter what kind of external pressures there are. Professionalization, specialization, and innovation, will hopefully bring about a new structural model which will reward and permit creativity, but it will not create it.

The new structural model will replace the old crumbling hierarchical pyramid. Management in other words will change its focus. It will become coordinating and supportive with the authority emanating from the situation and not the position. I am sure all of us will need to give considerable thought as to how acceptance of that principle will effect our individual functioning in educational and service agencies.

I recently read an article which touches on this problem. "Managers and Administrators are taught the principles of behavioral science, not with the idea of sensitizing them to the needs of the people served but to condition them to respond to the needs of the organization. The much publicized human relations approach is merely a manipulative device whereby the concern of the individual's motivation, attitudes and involvement in his work are used by management as a means to solve organization problems of adaptation, authority and power." The author is saying here that the human relations approach in management is not a way of individualizing the worker's contribution but in making him satisfied to do what he is told. The popular notion that this so-called individualistic approach to the worker, "understanding his problems" is usually the way it is phrased, leads to high morale which in turn results in high productivity is a myth which must be exploded once and for all. In fact the outcome of this tends to be just what management is seeking which is conformity. People treated in this fashion are not necessarily productive people nor is productivity simply meeting the organization's goals. Moreover the resulting conformity is the antithesis of the creativity which we so desperately need.

In the education of doctors and nurses these two groups are taught the principles of behavioral science with a similar goal in mind which is to help the individual client to adapt to the society and live as best he can within it. Behavioral science is not taught with a view to sensitizing us to the clients' needs. In both cases the focus is upon evolving ways and means of creating a situation in which symptoms of discontent or symptoms of illness or whatever else, are avoided and productivity increased. In neither case are the needs of the client a central factor except as these are determined by the organization and/or by the practitioner whose goals we suggested before may be at great variance with the system and with the client.

How will these changes come about? The answer to that question we ourselves must at least partly determine. Certainly professions must become much less autonomous. In other words they must become more interdependent upon one another and must become much more responsible and accountable to the society which they serve. Those professions which now have a great deal of power to control what they do and what their clients do and what the service itself renders must cease to have such indivdual power.

Secondly, the clients will demand that the system meet the needs of the community as a vital, functioning entity, and not focus solely on the needs of individual persons who come for help. What is good for

General Motors is not necessarily good for the United States and what is good for an individual person is not necessarily good for a community.

Thirdly, it seems that the educational and administrative revolutions about which I have spoken must be fostered and developed at a rate which far exceeds that which we have seen to the present time.