

Tailoring Nursing Education Programs to Meet the Nature of Community Needs

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La conception d'un programme qui permet aux infirmières de répondre aux besoins de la collectivité oblige les professeurs d'université à résoudre une foule de questions difficiles sur la composition de telle ou telle collectivité, la nature de ses besoins en matière de santé et sur le rôle que devront être capables d'assumer les futures infirmières. Les responsables de ces programmes se heurtent à beaucoup d'obstacles : Les restrictions budgétaires qui affectent aujourd'hui les universités, le nombre relativement restreint de candidates qualifiées pour les postes d'enseignement, les possibilités limitées en matière d'études supérieures en sciences infirmières au Canada et la confusion qui règne quant aux responsabilités que les infirmières professionnelles sont à même d'assumer et le cadre dans lequel elles doivent recevoir leur formation. Le problème crucial est de savoir si le grade de bachelier constituera le point d'entrée pour exercer la profession d'infirmière dans l'avenir. Par conséquent, il faut établir une distinction nette entre le rôle et les fonctions d'une infirmière bachelière et ceux d'une infirmière dont la formation a duré moins longtemps. Pour résoudre ce problème, il faudra consulter les autorités qui émettent le permis d'exercice, déterminer les ressources financières et autres et obtenir l'appui des associations professionnelles, des syndicats, des employeurs, d'autres travailleurs de la santé et de la population en général.

The invitation to be your theme speaker is an honour and a responsibility which I accepted willingly but with many misgivings. The theme as stated incorporates a philosophy that is basic to planning any educational program which prepares candidates for entrance to professional practice, since professions accept an obligation to be of service to society. Yet within the theme lies a broad range of questions pertinent to our concerns as members of the nursing profession and members of the academic community. Selection from that range proved even more difficult than I had anticipated. There are also connotations to the term "tailoring" which have troubled my thoughts. This word usually refers to a process which involves consultation with the purchaser, selection by him of a design and fabric suited to his wishes, measurement and meticulous attention to construct with exact fit. If the tailoring is successful the result is a garment that is functional and appropriate to the

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needs of the purchaser. Are the nursing education programs which we tailor proving to be functional and appropriate in meeting the needs of our purchasers — ultimately the community — and can we hope to achieve an exact fit?

I propose to develop a focus within the theme by reviewing briefly the nature of community needs which our programs are attempting to meet and the areas of unmet need which we could or should meet. Against this background I intend to examine the degree of freedom we have and the types of constraints placed on us in tailoring our programs, and then to identify what seem to be crucial issues to be faced.

The education programs which are CAUSN's primary concern are, by definition, programs of nursing education within a university system. A majority of these are programs at the baccalaureate level which prepare candidates for entry into practice as registered nurses. Each university school was established in response to environmental conditions unique to its location at the time but with shared values about the aims of university education for nursing. Although the pace and form of development has varied among schools, all in recent years have been active in curriculum evaluation and revision reflecting recognition of the rapid changes taking place in Canada's health care system and the increasing demands being placed on nursing. Whatever the approach used, the process of curriculum revision has included the assessment of changing community health needs, the acceptance of an obligation for nursing to contribute to meeting those needs, and a redefinition of the specific role of the nurse who is prepared in a university program.

It should be noted that the nursing profession supports both a diploma and a degree route for entry into practice as a registered nurse. Faculty responsible for diploma programs would also carry out an assessment of community nursing needs and make decisions as to the range and level of needs the diploma program should prepare its graduates to meet. Because of the lack of differentiation of legal status at the point of entry to practice, it is not too surprising for an assumption to be made by the community in general that there is little difference between the beginning practitioner who has a degree and one who has a diploma. When both are employed on the staff of a hospital the expectation is that either can cope with a broad range of nursing needs and decisions as assigned by the employing agency.

Because of the method of university financing and the provincial responsibility for education there is some expectation that the community of immediate concern to university nursing programs will be the

region or province in which the university is situated, with specific attention to the health needs of various population groups within that community. Yet there is also a valid point of view which argues that universities are, at the least, a national resource rather than a regional or provincial resource. The mobility of Canadians within Canada and in travel to other parts of the world, the reception of immigrants to this country, and the mobility of health professionals as they pursue career opportunities are all influences towards using a broad definition of community. So a decision has to be made about the extent of community we intend to serve, the sources of data we will use to identify the nature of present health needs, and the trends to be anticipated for the future. For an audience such as this, it is hardly necessary to mention the many sources of data about the needs for health care both in terms of demands for and utilization of services and in the statistical evidence of unmet needs. Much of these data, for example morbidity and mortality rates, have substantiated the need for curative services during illness but provide only indications of need for care to promote health maintenance and health-enhancing behaviour. Documents such as Lalonde's (1974) *A New Perspective on the Health of Canadians* have encouraged health professionals and the general public to accept a more comprehensive definition of the nature of health needs and this has been reflected in the design of nursing education programs by university faculty.

I have suggested that a realistic assessment of community health needs can be made with existing data. The clarification of nursing needs within the complex of total health needs is more difficult, possibly because the definition of nursing is diffuse, expands and contracts in relation to the presence or absence of other health professionals, and varies with the education and career aspirations of its practitioners.

For many years, and more forcefully within the past decade, attention has been given to re-defining the role of nursing and clarifying the contribution that nurses can make to health care as independent professionals in a collaborative rather than a dependent role. Frequently innovative nurse researchers and writers have formulated proposals for improvements in health care based on a more independent role for the nurse which incorporates caring and decision-making functions which many nurses recognize as already within their competence. One such proposal, "An open health care system model" by Madeleine Leininger (1973), provides for attention to the social, cultural, and environmental aspects of the client community and emphasizes health promotion, health maintenance, and health restoration. It is interesting to compare this with the model proposed in *The Community Health Centre in Canada*

(Hasting, 1972) in which there is more constraint placed on the role of the nurse. Another example of creative redefinition of the nurse's role is being carried out in the demonstration of "The Workshop" under the direction of Dr. Moyra Allen at McGill. These models, among others, have highlighted methods of practice and a level of competence which many nurses believe are appropriate for nursing and would be effective ways of meeting needs for health care, some of which are now neglected. Yet others, along with physicians and administrators, view these models as too independent of medical authority to be safe or organizationally acceptable.

Many examples could be cited of expansion and contraction of the nurse's role in relation to the supply and availability of other health workers, especially physicians. The degree of responsibility for diagnosis and treatment expected of nurses posted in northern areas is well known and such nurses suffer a special form of culture shock when they return to large hospitals in southern Canada and find their role sharply constricted. In this province when the Nurse Practitioner Pilot Project was under way there was a definite change in acceptance of this role by physicians as the likelihood of an increasing supply of physicians in rural communities developed.

There is considerable evidence that a broader perception of nursing responsibility and of capacity for a more independent role is held by nurses prepared in a baccalaureate program and is demonstrated early in their practice. This is partially a result of the scope and length of their educational experience and may also reflect a different approach to career selection from that held by those who choose a shorter program of preparation. Evidence is accumulating that the changing health care system could use a larger proportion of nurses with preparation at the baccalaureate level and will require sharper delineation at entry to practice between the roles and responsibilities of baccalaureate nurses and those with shorter preparation. There have been many attempts to grapple with the implications of the quality of our present system of education for meeting emerging needs for nursing. The *Report of the Alberta Task Force on Nursing Education* (Alberta, 1975) presents an analysis of community needs for nursing on which are based recommendations for changes in education. This report is of interest not only because of the expansion of university nursing education which it proposes but also because it is a report of the Department of Advanced Education and Manpower.

In general, university nursing programs at the baccalaureate level have accepted a generic model as functional and have designed pro-

grams to enable the graduate to enter nursing practice in a variety of settings, to use a self-directing, problem-solving approach, and to be accountable for her continued learning and competence in practice. Response to changing community needs has been shown by recent curriculum changes such as increased emphasis on concepts of health promotion and health maintenance, on mastery of more comprehensive skills of health assessment, and on greater attention to health needs and health care of the aging client.

Specialization in a clinical area of practice or in functional areas of teaching and administration is not now regarded as appropriate in the undergraduate program, although the student may have various options during the baccalaureate program that will allow some introduction to these areas. Specialization with mastery of a selected area of practice is included in programs of graduate study.

From evidence collected in surveys of graduates we — as university teachers — believe we have programs that supply our communities with practitioners who are prepared to deal with major health needs and to demonstrate competence in a broad spectrum of nursing activities. If this is so, can we be satisfied to have areas where these nurses are needed but not employed? A major area of unmet need for effective health care is among Native groups both in rural areas and as migrants into cities. Although needs for illness care persist and graduates have preparation to care for patients with acute illness, are we making adequate provision to deal more effectively with the need to help clients change behaviour and lifestyles likely to be injurious to health? Some writers have suggested that universities have not served society well as innovators and promoters of needed change in the health care system. Dr. Marguerite Schaefer (1974) deals with this role of the university as a “fighter for change” and contrasts it with the ideal of the university as the preserver of knowledge which works “to promote *gradual* social program.” This criticism of universities as somewhat inflexible and slow in responding to a need for change is specifically directed at nursing programs in universities by Jeanne Marie Hurd (1979). She is critical not only of curricula but also of the educational methods and their effects on students.

Other questions that could be raised by each of us about the “fit” of nursing education programs to the needs of the community might include:

- What community need is our program *primarily* designed to meet?

- Are we measuring the output of the program in ways that are reliable and have validity for the public that provides the resources for our use?
- To whom and how do we communicate information about the aims and accomplishments of our program?
- To what extent have we accepted the judgement of consumers about nursing needs in identifying and selecting those that our program should aim to meet?
- Can the program focus on the needs of the outside community and simultaneously meet the academic standards of the university community?
- What of the needs of the student community that gains entrance to our program, personal needs for development through education and vocational need for a credential that is portable in the wider community where they seek employment?
- What consideration do we give to the needs expressed by our professional community, our colleagues in associations and in service agencies?
- Are we prepared to state priorities among community needs that our program could meet and, in a time of restricted funding for university education, select those that we will meet?

My hypothesis is that although we have been conscientious and persistent in our attempts to tailor university nursing education programs to meet community needs for nursing, our perception of the nature of those needs is congruent only in part with the perception of other members of the community. Our perception differs from that of many consumers of health care, from members of other health professions, from funding agencies, and from many colleagues in other fields of nursing. A recent example of this gap in perception occurred during a conversation I had at the Convocation Tea. I was speaking to a friend of one of the graduates of the post-R.N. program. After a complimentary remark about the graduate's achievement her friend said, "What does she plan to do? Now that she has her degree she won't go back to nursing." Let me hasten to add that I do not imply that our perceptions are in error, but until we find ways to close that gap we will lack credibility and support. Perhaps we should state that our programs are designed to meet only certain selected needs within the range of the community's total nursing needs. If this be so, then, as members of a profession that supports both a diploma route and a degree route to

registration for nursing practice, we must work with colleagues in nursing to clarify public understanding of the dual system.

What evidence do I have to support this hypothesis? One consistent indicator is that employment practices and personnel policies in a substantial number of health care institutions give only token emphasis to the desirability of a baccalaureate degree in nursing as a qualification for nursing practice. Advertisements for positions as head nurse, supervisor, or director convey a clear message when they state, following a requirement about experience, "baccalaureate degree desirable," with some adding "but not required." These same institutions do not appear to believe there is any relationship between initial recruitment of B.S.N. graduates and their later availability within the agency for promotion. On the other hand these employers may have found that new graduates from university programs do not practise in a way that meets the nursing needs of patients in their care. The difficulties new graduates face in coping with "reality shock" have been described vividly by Marlene Kramer (1974). Others have referred to different kinds of difficulty and suggested that these result from inadequacies in the educational program. This is the point of view of Jeanne Marie Hurd, to whom reference was made earlier.

Another kind of evidence is supplied by requests from employers who identify a need for post-diploma courses of specialization. The Canadian Nurses Association in 1973 issued a position statement on Specialization in Nursing based on work done by Hall, Baumgart, and Stinson (1972) which recommended such courses. The response to requests for short courses of specialization has been uneven at best. If we perceive these needs but believe that such educational programs cannot be appropriately provided by the university, do we take action to encourage development elsewhere? We may deplore the "quick fix" approach of a multitude of short courses, particularly if there is an expectation that these will add up to meet requirements for a degree. But in terms of the urgency of the need, and the time and freedom of nurses to enroll in more comprehensive educational programs, short courses may be a realistic answer.

Another type of gap in perception sometimes exists in regard to the educational opportunities needed for registered nurses to achieve the B.S.N. On one hand it is difficult to accurately assess the demand for such opportunities and the motivation for continuing in an academic program. On the other hand it is difficult, particularly for women who have family responsibilities, to perceive the objectives of a university program as tailored to meet their needs. Add to this a certain difficulty

in achieving flexibility within a university system, compounded by the need of the system to deploy resources in the most economical way possible, and the perception of unmet need in the professional community may be reinforced.

Many of you could bring forth evidence to disprove my hypothesis and argue convincingly that differences in perception of need would not be a problem if we could produce a critical mass of nurses with university education. Better prepared nurses would demonstrate that nursing and health care needs could be effectively met. It seems logical then to advocate the baccalaureate degree as the basic preparation for entry into the practice of professional nursing. Other personnel prepared in different programs identified as non-professional patient-care assistants would function in association with and under the direction of the nurse. This is the proposal outlined in the American Nurses Association (1975) position paper and is the basis of the Resolution on Entry into Professional Practice approved by the New York State Nurses Association in 1974 for implementation by 1985. A similar proposal was presented by the Alberta Task Force (Alberta, 1975) with a specific timetable for achievement through a combination of university-based baccalaureate programs and articulated baccalaureate programs.

A recommendation regarding the baccalaureate degree as mandatory for entry into practice has been discussed by CAUSN on more than one occasion with reactions ranging from enthusiastic acceptance to extreme caution. Three intermediate points on that scale could be classified as reluctant approval in principle, delay until further evidence is presented, and a clear willingness only to back into the future.

Although a mandatory degree program seems inevitable to many, it is still primarily at the stage of examination and review among those involved in university nursing programs and some groups within nursing associations. There is a paucity of evidence that the wider community — the consumers of nursing care and the government departments responsible for funding nursing service — share these perceptions of the nature of the needs for nursing that should be met and that could be met most effectively by nurses prepared for practice in a university program of nursing education. We may believe that their view of need for nursing is simplistic and tied to a model which perceives nursing as needed most to assist with cure of illness of an acute and/or life-threatening nature. Recognition is given to the need for sufficient quantity of nurses, where and when the need is apparent, but the prevailing view of the wider community is that the cost of the nursing component within health care should be restrained, and that the addi-

tional time and cost of university preparation should be required for only a small proportion of the work force. It is now 15 years since the Hall Commission (Canada, 1964) included a recommendation that 25% of the supply of registered nurses should be prepared at the baccalaureate level. Progress towards that goal has been slow.

Some administrators of nursing service have contributed to and supported a perception of the nature of community nursing needs similar to the above and as a consequence have required that staff have university preparation for practice. This is the situation in many public health nursing agencies where vigorous recruitment has secured a high proportion of staff with a baccalaureate degree.

Dr. Margaret McClure of New York spoke to the WRCAUSN meeting in Winnipeg in February 1979 (McClure, 1979) and emphasized the requirement for improved education of nurses as the basis for competence. She made particular reference to the perception of this need by Nursing Service Administrators in New York and their conviction that baccalaureate education was a prerequisite for the assurance of quality nursing service in hospitals. The sequel to their conviction was their action in bringing to the New York State Nurses Association the resolution to which I referred earlier. Their personnel policies in hiring staff nurses reflect this conviction.

But I reiterate — there is a gap between our perception of the nature of nursing needs and the perception of the community which we aim to serve. I suggest that gap will exist until we find ways of demonstrating conclusively that there are serious unmet needs which could be ameliorated by nursing practitioners prepared in education programs which we tailor to meet those needs. The community — and governments which set policy and determine the allocation of funds for the range of health services — will then have a more comprehensive understanding of the cost-benefit ratio of university nursing education programs and will make informed judgements whether or not to supply the resources we believe are necessary.

I have attempted to show that as nurse educators we are concerned that the educational programs we design should competently prepare practitioners of nursing to meet the present and future needs of the community, or communities, we serve. I have suggested that we are aware of changed needs and increasing demands placed on nurses and that we acknowledge the fact that, although in Canada access to health care is regarded as a right, there are significant areas of unmet need here in this country. Against this background let us consider what

freedom we have and what constraints are placed on us in tailoring university programs in nursing education.

We have one important freedom that we have perhaps failed to recognize as a freedom. I refer to the dual system of educational preparation for nurse registration/licensure. This permits us freedom from the direct pressures of responsibility for a quantitative supply of nurses in response to the fluctuating market. There are adequate numbers of diploma programs, and, since the larger proportion of the nurse manpower reaches the market from those programs, we are free to consider emerging needs and to select our areas for concentration.

Another freedom that we have is the availability to us of the resources of the university. This provides support in curriculum implementation because there are general basic classes shared with students in different colleges. The university setting also allows faculty to evaluate their endeavours in teaching, research, and scholarly and professional work. Associated with this is the concept of academic freedom to pursue excellence in a climate of responsibility and mutual respect.

As you will see, these examples of freedom also carry with them concomitant restraints. The dual system of preparation for entry into the practice of nursing contributes to widespread misunderstanding of the role and responsibility of nursing. And, in the agencies where services are provided to meet the nursing needs of clients and the community, there are not only registered nurses with two levels of preparation. There is, in addition, a large group of other persons with varying kinds of preparation classified as nursing personnel. Confusion about who is a professional nurse, what responsibilities she can handle, and in what educational setting she should be prepared presents a major constraint for future planning.

In the present context of university budget restrictions, it is hardly necessary to comment that the access to university resources does not imply unlimited freedom. Nonetheless, I do not believe that there is evidence that the financial resources that flow through other channels to support nursing education programs are much more liberal.

A serious constraint in terms of resources is the relatively small supply of well-qualified candidates for faculty positions and the limited opportunities for graduate study in nursing available in Canada for members of the nursing profession who wish to embark on an academic career. This constraint has been highlighted by the conference on doctoral education in nursing held in November 1978 (Canadian Nurses Association, 1979). The magnitude of the need for well-pre-

pared teachers in nursing is greater when we include in the estimate the numbers of qualified teachers required by the diploma programs.

One aspect of this constraint is that of the desirable balance between expertise as a clinical practitioner of nursing and expertise in other areas such as teaching, curriculum, nursing administration, and research. As a practice profession we must address ourselves to the problems of practice including the need to ensure that nurses maintain and improve competence as nursing practitioners and that this element, to me the core of the profession, is retained under the control of nursing. As we observe the influences on the practice of nursing and situations in which non-nurses are acquiring greater control over the administration of patient care including nursing care, we can forecast further shifts in decision-making authority away from nurses so that others will decide the parameters of nursing practice and the priorities to be set. It is crucial that students in their educational program be taught by nurses whose commitment to and accountability for clinical practice is unequivocal whatever their major area of teaching or their specialization as practitioners.

Reference has been made to the lack of understanding by the public of the present responsibilities of nurses and their potential for changed contributions to health care. Everyone knows what a nurse is, or at least they are familiar with such symbols as the cap, and they have an ideal of a person who gives compassionate care during illness with a continuing devotion to duty. I would suggest that this traditional image of the nurse and the consequent favourable impression the public retains was the result of much contact, planned and unplanned, between nurses and the community they served which was reflected in a perception of nursing that is part of folklore. This limited outdated image must be replaced. This can only be achieved if we give more attention to co-operative work with consumers in assessing the health care needs of their community. We must encourage them to explore with us the ways in which the potential of nurses for improved services is now untapped or restricted, and how this potential can be released.

One other constraint that I wish to mention before leaving this topic is the constraint imposed by our difficulties as members of a profession in which the majority are women. Strong social values about the role of women influence the priorities that women may give to the needs and requirements of their career and to their professional affiliations. One area in which ambivalence affects our functioning may be seen in variations in quality and persistence of nurses' involvement in broad issues of importance to the progress and power of the nursing profession.

There is evidence that nurses, as a group, do not show consistent support for their association and for their colleagues in nursing. Disagreement is healthy and essential for productive change but we must find ways of eliminating divisiveness once the issues have been discussed and a decision reached. It is a serious constraint when nurses as a group do not support the endeavours of their colleagues and instead allow themselves to be aligned with the aims of other professions and/or authorities who in their own interests — not the interests of improvement of health care — do not wish nursing to become independent, competitive, and powerful. This question, which was categorized as an issue of unity among nurses, was presented in an interesting and convincing fashion as an article in *American Journal of Nursing* (1975) recording a discussion among a group of well-known American nurses.

In conclusion, then, what are the issues to be faced if university nursing education programs are to achieve a more exact "fit" to the nature of community needs for nursing? First, there is an issue of credibility in our definition of the *nature* of community needs which our graduates are prepared to meet. This occurs among a large number of the average nurse members of the profession; it occurs among other health care workers; and it occurs among the members of the community who are consumers of health care.

There is also an issue of our credibility with non-nurse members of the university community. How are we like other nursing education programs and how different? In what ways are we similar to other faculties and how dissimilar? Can we achieve greater clarity about what our mission and place should be vis-à-vis other university programs?

Second, there is the issue of achieving acceptance of the baccalaureate degree as the requirement for entry to the practice of nursing or supporting a clear division of the role and functions for each of two levels of registered nurses. Resolution of this issue will involve consultation with the registration bodies, determination of financing and other resources, achievement of support from professional associations, unions, employers, other health care workers, and the general public, our community.

Third, if decisions are taken that the baccalaureate degree will be required as the entry to practice, subsequent issues will have to be resolved. Would there be adequate numbers of candidates to meet the needs, and would they accept this obligation of greater preparation time? Would there be sufficient nurses remaining in practice over time to justify the social cost of the longer program with the concomitant

need for greater educational costs for preparation of faculty, and for administrators and specialists in service agencies?

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