

# THE ROLES AND FUNCTIONS OF NURSING

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THE speakers yesterday tried to provide a conceptual frame-work within which we could look at problems arising out of the preparation of nurses and out of the system of health care delivery. Clearly the first step is to identify what the problems are and how they relate to one another. So often we refer to our problems in an isolated fashion as though they existed as separate and independent entities. In our frame-work we tried to see how our structural, learning, and practise problems were interrelated and how they generated interactant effects. Such a framework is important in preventing us from looking at problems and issues as dead ends and thus not capable of solution. In other words, if we respond to a problem in ways such as the following: "the system is problematic and I as an individual can't deal with systems" or "the situation doesn't allow me to operate as I would like" or "other groups are too difficult to change" or "the others don't really want to change and I do," then it seems to me we abdicate our responsibility to improve the situation. We work ourselves into a corner from which there is no exit. The statements may be true and rational but because of inadequate breadth of conceptualization there are no possible solutions.

We must feel that there are solutions to these problems if we are to raise new issues and ideas and evolve new positions and experimental programs aimed at solution. People who have developed new things and have been creative have only done so because they have believed in and were committed to the idea that things can be changed and problems can be solved by individuals. We have found it relatively easy over the years to identify some of the apparent problems but have usually assumed the validity of these with insufficient evidence. We often fail to identify clearly the interrelationship among areas of difficulty, to label these appropriately and to become really committed to finding solutions. If we consider ourselves among the group of

well-prepared nurses who are attempting to move forward, then we surely must begin to look at the whole framework in which nursing is practiced as well as the nature of that nursing so that roles and functions may be adapted to a more modern system of delivering health care. The credibility and viability of nursing within the health professions and within the social order will be seriously challenged by governments, by other professions, and by consumers if we are unable to create broader functions and increase our accountability to the consumer.

I will first recapitulate briefly the points which I made in my presentation yesterday since these are directly related to the variety of structural changes which I will suggest today and which will subsequently be related to the functions and roles of nursing.

1. Programs are exclusively focused on the curing aspect of care to the exclusion of health care and other needs which consumers have.
2. Programs are almost exclusively developed according to the health professionals' opinions of what is good for the client.
3. Present facilities are often used inefficiently.
4. Professionals of all sorts are prepared to be conformists rather than creators and innovators.
5. Nursing is based on the application of *a priori* knowledge rather than upon an assessment and refinement of the action in terms of its outcomes. That is, research has not become an integral part of the action program and an investigative approach has not been used in carrying out nursing.
6. Decision-making still rests in the authority of the physician and/or an organizational superior not the needs of the situation.
7. Health professionals still operate as independent autonomous beings in their own clearly defined and legitimated roles.

Our question today is simply, what are the avenues through which we can bring about reform? Clearly we cannot identify all the particular situations and the possible changes appropriate to each. This is what all of you will be doing this afternoon as you deal with some individual issues. Our job this morning is to identify areas of concern. Structural reform is already occurring in many parts of the country through the development of new entities for the provision of health care. But existing institutions will also be required to change.

The acute care general hospital will have a somewhat adapted role to play with altered internal structural relationships. It will remain

a crucial element of the health care delivery system. Moreover, connected to it will be facilities oriented to other facets of the curing role. For example, there will be a variety of programs carried on in extended care facilities. These will need to be structured to permit continuity of care to become a reality during the diagnostic process and the follow-up care emanating from illness situations. Rationalization of existing facilities is necessary to this outcome. In terms of change, however, the important focus of the new health systems across Canada will be toward achieving goals of continuity, comprehensiveness, and accessibility of care which are expected to emanate largely from the establishment of local community health centres, family practice units, and other care facilities outside the hospital in-patient areas but intimately linked to them.

Turning to the functioning of care workers through the system we find the health team being emphasized largely because "the doctor cannot be available constantly". Not only is this rationale faulty, but bringing together a number of persons does not alone constitute a team. It is important that its members must complement each other mutually through training and functions so that the team efficiently satisfies the needs of the people for complete and continual services. The team concept as an organization of relationships would eliminate the necessity for the doctor to represent the sole point of entry into the health care system and permit other health care workers, who might through interest and preparation be more appropriate persons to deal with particular client needs, to assume a primary care role.

Examinations of the functions of team members and the roles appropriate to each has become a major issue and has focused primarily on the physician and the nurse. Clearly, there are not enough physicians to carry the burden of health care, nor is any one professional group capable of doing so. How then can the functions of the physician and the nurse be realized in accordance with the health needs of the people?

It is apparent that many of the activities related to the diagnostic and treatment function of the physician can be carried out by the nurse in a supervised situation in close contact with the physician and where problems and decisions are relatively well structured. This is the role we view as being the function of the well-prepared diploma nurse from the college program. Viewing more broadly the health needs of the population, health supervision, counseling, and early detection of illness, fall within the functions of the nurse with more than this basic preparation. Some nurses will be required to assess the state of health of individuals and to take some responsibility in deciding upon a

course of action. An extension of the nurse's assessment skills allows an expansion of the role of the nurse to perform these functions. This is the nurse practitioner role for the person prepared in the university.

We are much concerned with the suggestion in the Boudreau Report that the two points of view of the nurse practitioner, one as a technical expert and the other as a primary care worker, could or should become reconciled. These two roles actually reflect the two modes of preparation. A bringing together of these two is neither possible nor desirable. The diploma nurse can and will increasingly become highly skilled technically, and will operate well in many settings within a set of guidelines. The baccalaureate nurse on the other hand will perform a broad primary care role requiring a strong base of preparation from the biological and social sciences which is obtained most efficiently in the university setting. These two views regarding the utilization of the nurse are not in opposition as suggested in the Boudreau Report but are rather complementary. What remains for us now is to demonstrate these roles and to more clearly define the educational preparation required.

According to most plans health services will vary in emphasis depending upon the needs, and therefore the role of the nurse will have variations. We should not attempt a singular definition of the role of the nurse in any particular facility. However, the functions of the nurse measured in terms of patient needs fall into a pattern which facilitates instruction and placement of the nurse. Evidence already exists in support of the two types of nurses required to expand the role of nursing in the health system. Concomitantly, there must be two clearly defined career lines for nurses. The nurse prepared in the CEGEPs or the community colleges, or the colleges of applied arts and technology, with additional instruction in designated skills built into the curriculum, can function as one type of nurse practitioner within a prescribed sphere of action under medical supervision. This will allow for a much more satisfying nursing role for many than presently exists. "In some instances nurses have felt frustration when they are aware of necessary action and they are unable to proceed. Some nurses are in a strategic position to act had they acquired the necessary skills. There are many areas throughout the health system where the placement of the nurse with the required skills would facilitate patient care and relieve the physician of time-consuming activities." (1)

The expert clinical role which I have just described can largely be developed by building within and upon the diploma program, and has already been demonstrated in some specialty areas in hospitals

and elsewhere. College programs now generally prepare diploma graduates to become skilled practitioners in many hospital as well as non-hospital settings. In addition, some formal means of assisting the diploma nurse to add the skills necessary to assume an extended practitioner role in any of the areas to which she contributes are being developed. Often on-the-job training has been utilized in the past to produce this expertise, but this is perhaps not the most efficient method.

This form of nurse practice which we have, perhaps erroneously, labelled the nurse practitioner role, will provide an alternative to the usual career line. In the past some clinical courses have been provided in hospitals but nurses have usually found it necessary to go to university and become administrators and teachers if they wished to continue their education. In other words, this was the most viable method of advancement. This educational structure took many of the best clinical practitioners out of the field of practice and only those who ceased to practice and became teachers and administrators were rewarded with additional salary and prestige.

To identify the functions and placements of the other type of nurse, the primary care worker, a view of health needs in a broad perspective is required. "Important aspects of health supervision and counseling are left undone because the physician lacks sufficient time and preparation and to some degree the preparation of the nurse falls short of the need. This preparation depends on a sound base of biological and social sciences and the development of assessment skills such as medical history-taking and physical examinations. Thus prepared, the nurse is able to distinguish those who need medical diagnosis and treatment and to function in the health team as a primary care worker. The nurse designated in the Quebec Commission Report as the clinical nurse and in other reports as a nurse specialist or a nurse clinician can also find a place in other health services where assessment skills are the key to the nurse's function"(2). The relative proportion of the two types of nurses, doctors and other health professionals on the team will depend upon the patient needs in a particular area.

The preparation of the nurse as a primary care worker or nurse clinician is within the university at the baccalaureate level. Such a plan is being developed in many of our programs through the incorporation of history-taking and physical examination skills into the armamentarium of the nurse in the baccalaureate degree programs. These educational programs provide a base for clinical judgement and the recognition of the boundaries that the nurse may realistically assume.

The crucial distinction which must be made here concerns the basis



of discriminating between the preparation and function appropriate to the two nursing roles. These cannot be discriminated logically on the basis of the knowledge and application of technological skills. All nurses must have a sound understanding of, and ability to apply, more diagnostic and treatment skills and to know how to practice good nursing. The differentiation can be made however, on the basis of the context in which the nurse functions and the requisite knowledge to that context. Where there is a high degree of organizational structure, relatively close supervision of activities and the prime requirement is in dealing with obvious physical and other needs directly, the diploma nurse can be prepared to make a useful and extremely necessary contribution. Where there is need for independence in decision-making and health assessment in complex situations requiring a sound knowledge base to determine a course of action, the university prepared nurse can be most usefully employed.

For either of these nurse practitioner roles to work effectively the method of nursing must be altered from that frequently seen today. A mode of approaching a nursing situation with pre-determined and fixed expectations concerning the nursing and client behavior is no longer appropriate. Rather nurses must commit themselves to a process of nursing with constant inquiry and assessment of nurse behavior and patient outcomes a predominant feature.

In summary I feel sure that we are in agreement with the principle that we must either adapt our roles and our functions so that our services will become more closely related to the health needs of the community, or other groups will evolve to fill the gaps. These would probably evolve in a way which could only protect and promote the present singular orientation to disease and cure. It is this focus which we have said must be enlarged in scope to encompass the study of health. This opportunity is now at hand because the governments, other professional groups, nurses themselves, and our potential clients are all wondering which way to go. We should not be content to follow along the directions determined by others but should negotiate our position from a base which includes research, learning, administrative, and above all, nursing practice knowledge. Perhaps above all we need to become more willing to take the risks which change entails.

#### *References*

1. Elizabeth Logan. Unpublished manuscript, School of Nursing, McGill University, 1972.
2. *Ibid.*