STRATEGIES FOR REDUCING CONFLICTS BETWEEN NURSING SERVICE AND NURSING EDUCATION

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THERE are those who maintain that there is no such thing as service-education conflicts "because we all share the same aims." I regard this as "head in the sand" thinking. The practitioners and educators who maintain that they do not have conflicts more than likely are making unsafe assumptions about their counterparts and/or have never asked their counterparts what are some of the major areas of tension.

In trying to think of strategies for reducing service-education conflicts and increasing compatibilities, I've tried to think of practical approaches rather than fundamental principles as such, but there is one principle underlying this address: that we are and will be operating in a changing environment for the rest of all time, and that we will, even if we "progress," progress from one set of problems to another. I think that often we are disheartened and disillusioned by the feeling that we are not getting any place, and some of us function under the illusion that if we work hard enough and fast enough that, ultimately, everything will be running smoothly. That is unrealistic; our approaches to problem solving would be much more functional if we would accept the basic notion of change.

One of the most practical strategies I can think of is if, say, a nursing instructor and head nurse are having repeated conflicts over their work situation, that each should sit down and list three of their biggest problems, and then list what they think are the three biggest problems of the *other* person. The next step would be to compare problems, and see if they are related in any way. For example, the

instructor might say that one of her greatest sources of dissatisfaction is in the type of nursing care given on the ward. She may feel that the students can't learn good nursing, given the examples they see around them. On the other hand, the head nurse may feel that there is a lot of job dissatisfaction in her general duty nurses and that much of this is related to the nurses' not being able to give the kind of nursing care that they want to. More than likely the problems would not be quite that congruent, but it is very unlikely that the service and educational problems identified would be totally unrelated.

The head nurse might feel one of the worst problem areas is that of patient assignment. She may find that the instructor continually objects to the types of patients which the head nurse suggests for the student nurse learners. I think that open communication about this is very, very important.

Another source of conflict often centers around team leaders' authority in connection with students, and/or student-instructor communication channels and procedures. Again, it is a matter of clarifying what the problems are and really communicating feelings and suggestions for improvement. Some sources of conflict can be reduced through the modification of hospital policy. For example, if the head nurse has up to six or seven different types of learners on her ward at any one time, I can see no strategies that will reduce related conflicts over time in any substantial way. So I think that in these regards, the hospital has to set limits as to the types and numbers of learners in any one unit. I have heard of some hospitals' setting a limit at three types per nursing unit, on the assumption that it is unrealistic to expect both a high quality of nursing care and sound coordination of educational programs if the ward staff and the instructors have to deal with a wide range and number of clinical learning needs. Along these lines I would cite the examples of one city health department which has 90 public health nurses who deal with 203 student learners a year from nine different educational programs, and a hospital,with its own school of nursing, which had until recently over 1000 affiliates from over twenty programs. Tensions? Conflicts? Yes!

Another strategy that might be very useful is to give serious attention to who makes decisions regarding arrangements for clinical experience. Too often they are made in the offices of directors of nursing and/or those of university clinical coordinators; rather than being heavily decentralized. I think that if we could have as many arrangements as possible made at the nursing unit level, we would avoid a lot of problems. Another thing that might be helpful is if we

got a little less hysterical about involving agency staff in the actual clinical instruction of students, and when I say "staff," I don't just mean head nurses and general duty nurses, but I am including auxiliary staff. I can remember that at Sick Children's Hospital in Toronto, there was a CNA named Jenny Kapeski, who knew far more about the Stryker frame than probably any professional around, and she routinely taught students and professionals about the care of patients on these frames.

I think that if examined very closely the degree to which students constitute an interruption in ward staff's activities, we would find that very often there is indeed *too little* "interruption." Students relating primarily to an instructor are unlikely to learn very much about health team functioning.

A suggestion revolves around Helen Glass' work in connection with instructors as "guests" in hospitals. I think it really is ridiculous to expect an instructor to feel part of a ward of a social unit, if she literally has no place to hang her hat and/or has to conduct student conferences in hopper rooms. Space, I know, is very difficult to come by in hospitals, but we do find space for those services we consider crucial. I think it takes concerned effort on the parts of head nurses and supervisors and directors of nursing to see that such problems are attacked.

Too often, nursing education curricula are "announced" to service personnel rather than being evolved on the basis of suggestions from them. Involvement does take time, and I am sure that the average general duty nurse, head nurse, public health nurse, staff nurse, does not have the amount of time to devote to curriculum development which university programs and hospital programs might consider ideal — but that doesn't mean they cannot be involved in the planning. Educators cannot expect commitment on the basis of "announcements."

I asked one nursing educator recently if they involved service people in the classroom teaching of their students, and she said, "Oh yes, we certainly do." Then I asked what was the last instance of this type and she said, "well. . . ." and thought very carefully, "about a year and a half ago we had had a head nurse from a neuro-surgical ward, a person who was a very,very good clinical teacher, come as a guest into the formal classroom situation."

Another idea which may meet with a lot of opposition but which may have tremendous pay-off in the long run, is the notion of exchanging personnel. This might involve an instructor's going into a hospital as relief head nurse for a month or it might involve a head

nurse and instructor changing positions for a six-month period. I don't think we can generalize very much as to what will work out in what specific situations, but this idea of exchanging of personnel is bound to help us see the other side of the picture. Another strategy is that of dual appointments, such as the appointment of a clinical nurse specialist or public health nurse to a university staff — or vice versa.

A strategy that we might keep in mind is that of head nurses and instructors or general duty nurses and instructors co-authoring articles. This is done rather rarely. I think that here we have a good example of *functional interdependence,* that it might be that neither one would write the article by herself, and in co-authoring there *is* a team-work approach — and there's nothing phony about it. Along this same vein is the business of cooperative research. I think Joan Gilchrist's work on a time and activity study in the Montreal hospitals is an excellent example of this: a university person involving herself directly with a concrete research problem in several hospitals at one time, with data being collected by hospital personnel themselves.

Sometimes research may not be very "formal" yet can constitute an approach which can really help the head nurse. I can remember one head nurse being absolutely exasperated by the comings and goings of people on her ward. The instructor helped her to set up a kind of tabulation system which the ward clerk and some volunteers could carry out to ascertain the number of people who came and went in that unit in a twenty-four hour period. In this particular instance, the tabulation for the day happened to be 823! That was a bit irregular, we thought, because of one group of visiting physicians who came in one large group, but it was enough to give that head nurse some of the "ammunition" she needed to change the situation (and policies), for when the head nurse got this kind of hard data, she started to get somewhere in connection with the control of traffic on that ward.

Other areas in which the service and educational people can work closely together pertains to introduction of new drugs. Very often the instructor has at her finger tips a lot of resource material on new drugs, but the difficulty comes in her not knowing her role: possibly in the service staff becoming offended if she presumes to present them with new information. There is the other side of the coin, too, where we have instructors who are ignorant of new drugs and are really in no position to be the "educators" of service personnel.

I know of another situation in which an instructor is giving a series of lectures on child development because the head nurse and

the staff feel that their preparation in this area was grossly insufficient. Again, communication has to be very good for this type of thing to evolve without raising further conflicts.

I wonder, too, about flexibility of time in relation to obtaining clinical learning experience. This one of the chief concerns, I think, of service people. I can remember in Toronto not being able to work out a mutually agreeable time with a two-year school. They seemed to want to come at times only suitable to them, and we in the hospital could not justify bringing them in for the short periods of "interrupted" time that they suggested. The result was that we did not have them come in as learners and that they had to get less appropriate experience elsewhere. I think we both "lost."

What about clarifying the policy of students' coming on the ward *without* their instructors? This practice can raise problems unless the road is paved ahead of time. But it might be an answer to some of the problems created from the very minimal amounts of time a student spends in an area and also the minimal amount of time that any one instructor can give to any one student.

Underlying all these suggestions are the implicit assumptions that educators *do* know what they want students to learn, and that the nursing profession *does know* what are safe, desirable, standards of nursing care. I am not at all sure that we know very much about either. Very often, our objectives for student learning are vague, and too little onus is put on the student to learn and a lot of onus is put on staff and instructors to "make" the student learn. The more we can work towards operationalizing standards of nursing care and student learning objectives, the better we will be able to reduce conflicts surrounding these situations.

A point which I would leave you with is that historically in all professions, there has been tension amongst teachers, practioners, and researchers. I would argue that to a large extent, intraprofessional tensions can be functional in that they can act to balance emphases and priorities within and amongst various modes of professional and personal endeavor. It is our task to ensure that conflicts are productive — not paralytic. And to do this, we must understand the value systems of those with whom we work. This applies both *within* special groups such as educators, or practitioners, and also, *between* special groups. I wonder how many of us really know what others consider as "rewards."

I was reminded recently of a story told by a psychologist. She was working with the teachers of emotionally disturbed children, and there was this one youngster who was quite autistic. She was a little three-

year-old oriental child who had been born slightly disfigured. And whereas in the home country, the oriental mother would have quite "rightly" killed the child because she was imperfect, in the United States she didn't have this alternative choice open to her, so she had kept the little girl in a cardboard box in the basement. That was the main place the little girl stayed until she was discovered at some three years of age. She had been coming to a school for emotionally disturbed youngsters for some time and was making quite a bit of progress. This school was being operated on the basis of a reward system of behavior modification and the teachers in this school were fairly new to this mode of handling children. But they were learning to identify children's rewards, and making quite a bit of progress. So when this little youngster did something in the way of relating to another child that the teacher thought constitued very desirable behavior, she tried to think of a reward for the three-year-old's behavior. She thought, "Well now, let's see . . . three-year-olds love boxes and they love being pulled around in boxes," so she put the youngster in a cardboard box and started to pull her around the room. All hell broke loose, and the child went into a regression which lasted for some time. Sometimes I think that we inadvertently "reward" behaviors of people in other groups or people whose value systems are somewhat different from our own by "pulling them in boxes" instead of basing the rewards on *their* value systems.

This brings us to the final but perhaps most important factor in understanding and approaching service-education conflicts: I wonder how many instructors really know what it is that the head nurses and general duty nurses with whom they work value — and vice-versa? I think that the more we know and appreciate the value systems of the people we work with, the more likely it is that conflicts which exist will be productive ones, and that our compatibilities will carry us through to achieving our mutual objective: improved nursing care to people.