ISSUES IDENTIFIED AND DISCUSSED BY PARTICIPANTS

IN THE C.A.U.S.N. (WESTERN REGION) CONFERENCE, FEBRUARY 24 - 26, 1973.

An attempt has been made in the following summaries to convey some of the flavour of the groups' presentations. It is appreciated that in the condensation, some ideas may be presented in different contexts, but it is hoped that participants will recognize the thrust and intent.

I. THE NURSE'S ROLE AND FUNCTION

How do we help ourselves, other nurses, and the nursing profession in general to assume our potentially powerful role in the development of new health care structures and new roles for nursing within these structures?

Our assumption was that we do have power to influence, and that we do have a potentially greater power to influence given a conceptualization of the kind of question being asked. Each of us has to have a conscious awareness of issues, has to have a commitment to the values of change for the common good. We must trust our own and the group's ability to influence. This could be achieved by:

— Developing an individual who accepts without value judgments, each person that functions within his/her role.

— Having a commitment to personal growth, continuing education, and the sharing of ideas.

— Collecting data, preparing and presenting evidence in a significant way, and finding media in which it is heard. Nursing associations have done this through the dissemination of information about major issues.

—Nursing's having a sense of direction, a message, and knowing how to communicate it through, for example, training and education in pressure techniques.

— Nurses having a willingness to take risks, to make decisions, and accept the consequences of those decisions. This requires establishing feedback mechanisms for involvement.

What problems are faced by the person who tries to effect a major system and/or role change? What can be done about these?

As we started listing all the problems that would have to be considered, we kept going back to a major theme we heard throughout the Conference — that hospitals do not see a place for the baccalaureate graduate. So we propose that a research project be developed in an acute general hospital, and that three units be established: one staffed by two-year graduates; one by four-year graduates, and one by a mix. The purposes would be to react to patients' needs in those environments, and to identify what nurses would do in response to those needs. Are there differences in the way that patients' needs would be identified, assessed, and care implemented and evaluated?

Problems to be considered might be:

— Lack of commitment by everyone in the agency to the projects because everyone might not have been involved in the planning.

— Difficulty in funding the project.

— Problem of the researcher going into an agency and being accepted while there. Threat to those involved in the project.

— Timing of the project, in regard to introduction; readiness of the institution and people; the impatience of the researchers and participants to see results and an ending.

— Lack of skills of participants in regard to: Research, socio-political aspects; interpretation of the project to colleagues; economic factors; communication generally.

Post-study results:

— University educators might have to deal with the possibility that baccalaureate graduates could not indeed do all the things that for many years we have said they could do.

— Developing a support system for dealing with crisis during the period of disequilibrium resulting from changes made, and ensuring that it goes on long enough.

What groups or individuals should be involved in deciding what is "best" for a client or community? How will differences be reconciled and priorities established?

We assumed that we were a group of health professionals dealing with the subject, and that our client could be an individual, group, or community. How do we find out what the needs of our client is or are? Basically, we have to establish a milieu or climate where they

can get together with the health professionals to identify what their needs are, to find out who they can consult. This means involvement with action groups, and using the arts of politics and politicking in groups. The milieu has to be one of trust; we have to be able to take risks, and to interpret to the people what we have to offer. Then it comes down to decision-making. The client has to decide what is best for him.

Can we define and describe the nurse practitioner role? If so, what is it? If not, what functions might be incorporated?

We questioned whether anyone currently practicing is in a primary care situation. Our working definition is a nurse who has the required expertise and preparation to make independent nursing decisions, either in a technical or community setting. This is a person who should be willing to take responsibility for decisions, to be accountable for them, and who understands the processes that are going on. As nurses, are we comfortable in setting limits on our evolvement? in defining priorities? Nurses need to evolve roles, and identify the role for the situation. We questioned how she would expand from the curative to the health role, if this is the focus of the future. We came back to what we should take home, and it came through that we needed to confer with colleagues, to look at allocation of time, to involve small groups in identifying needs of client groups, and to set priorities. One member suggested the impact from here might be in decreasing some of the emphasis on technical work, and increasing emphasis on family life development.

II. THE NURSE'S PREPARATION

What do the concepts "comprehensive patient care" and "priority care" mean? Are they reality-based? What learning experiences might be appropriate in relation to the above concepts?

Priority care is part of comprehensive care and cannot be separated, and we must differentiate between comprehensive patient care versus comprehensive health care. Here Miss Gilchrist made a marked impression on the group, because we defined the former as viewed from curative aspects, and the latter from that of health continuum.

Priority care is based upon the hierarchy of needs, and these are identified in consultation with the patient. We recognize that sometimes patients are not aware of their needs, and this is influenced by the nurse's teaching role, and communication skills. If you asked a

student if this is realistic in terms of the present setting, the answer is "no", not under the present level of standards, because of planning functions, but what we are here for is to work for what should be. We decided that the only way to look at learning opportunities from a comprehensive health care approach is in terms of interdisciplinary situations. The nurse must communicate from the attitude that she is an autonomous practitioner as she comes in conjunction with patients, families, and the health team and community. It is suggested that there is a need to provide demonstration models for interdisciplinary role definition, where teacher, student, and practitioner collaborate to meet health care requirements. We considered that Miss von Schilling's suggestion for simulated experiences is one approach to teaching comprehensive patient care.

What are the settings for the learning of nursing, given the thrust toward the primary care contact person? What can each contribute to the learning process?

We identified the primary care contact person as including in her responsibilities the preventive aspect as the first step of care, and the promoting of healthful actions as another. Inherent in this person is knowledge of resources and other health professions, and that promotion of health care of Canadians is her responsibility. We felt she had to be out in the community and known as a resource person to whom people could turn and discover if and what their problems were. The primary care person should be the first person contacted for problems of growth and development, counselling, problems of illness, and for screening. Her role is to overcome ignorance and help people use resources for appropriate reasons. It isn't a case of waiting for people to come, but of being out there available, including the awkward times of Friday night and weekends.

Our first thought on settings was that they definitely had to be out of the hospital, but then we recognized that many departments, such as the various intensive care and out-patients' departments could be used differently. Settings that we knew someone was using somewhere were physicians' offices, day care centres, low-income housing for the elderly and others, senior citizens' self-help centres, and so on. Others that might be used are the family court, funeral parlours, the drug store and supermarket, church groups and sports groups. These would be very good areas to stimulate observation, to provide opportunities for assessment and screening programs, for focusing on particular health needs. About families — why are we sending students to them? Communication, the one-to-one relation-

ship, are acceptable reasons. The inadequacies that students feel are related to their perception that they must *do* something to be a nurse, and where do they get the idea that they have to offer something? What we hope the student will see are healthy, coping families.

Professional functioning has to be emphasized more in the use of settings, to help the beginning nurse differentiate roles of other health professionals. Home visits could be used to identify problems of mutual interest that require mutual working through, and should be implemented more widely.

We also considered the settings for the nurse in graduate education. Opportunities for the graduate student to practice primary care activities, leadership and collaborative roles within the inter-professional team, need to be provided. Maybe the graduate student should hang out her shingle and be the primary care contact for a group of families. These must be identified as graduate students prepared to become teachers of the undergraduate primary health care person.

How do we develop the security within the teacher in her role that allows the student to feel free to try out innovative approaches without fear of down-grading or loss of self-esteem.?

We defined the teacher as a facilitator and a learner, and attempted to identify potential sources of insecurity in the context of new experiences for her regardless of how long she has been a teacher. Sources of insecurity are:

—Competency in human relations. Going from a large group to small group process, and feelings of inadequacy *re* small group learning.

— Clinical expertise. This is not only for the beginning teacher, but for those concerned with maintaining skills, and increasing knowledge.

— Lack of support in the clinical area or faculty group.

— Isolation within clinical areas.

— Lack of concept of the student's potential for individual growth, which has much to do with ability to assess, and assist the student in assessing learning problems.

Possible Solutions are:

— There needs to be an understanding of the philosophy of adult learning, of shifting from identifying the student's learning needs, to getting her to identify these herself.

— Inservice education for faculty, an area neglected for far too long.

— Provide time for the teacher to orient herself to the learning environment in which she is going to be with students, to develop a beginning relationship with the agency in which she will be working.

— Providing opportunity for the faculty to commit a certain amount of time to practice skills on a yearly basis.

Service needs to be acceptant of the educational process, and this is dependent upon teachers interpreting to them as clearly as possible what it is. There needs to be a shift to indirect supervision of the student, and this can be a threatening thing for the teacher and practitioner.

What we are looking at is process — and this is the same whether it is teacher-student, patient-student, or other. This has to do with developing trust relationships, and is particularly important if teaching in a team approach. This would help us to accept the fact that as individuals we do not have all the skills, neither do we have all the knowledge, but sharing as a group in a supporting atmosphere will give us freedom, and time to learn new skills.

How can we develop a receptive climate for change between education and service that enables the teacher to broaden the scope within creativity can operate?

We assumed that we wanted change in nursing, and that to develop a climate for creativity we had to identify the forces that are at work in the system. For example, if the head nurse is accountable through a hierarchical system, how much expertise she has, how much input to the decision-making process, the trust in her by the client, and whether she has enough security to risk making change. The same factors apply to teachers, to students, and to the consumers. We then considered ways to achieve this climate:

— Continuing education programs that involve the whole group on the assumption that the more exposure there is to each other, the less isolation there would occur.

— Case and tell method — try it out and share results.

— Shirley Stinson's suggested strategy-exchange positions in service and education.

— Use of clinical nursing specialists as resource persons for students and staff.

— Use of change agents — nurses whose particular job is to bring about change, demonstrate results of change to the resistant, and demonstrate a comfortableness with change.

— Use of reward systems that give positive recognition, positive evaluation, and utilize contributions of all members of the team.

— As a last resort, the system might be manipulated through lost directives!

Three research projects were suggested:

— An exchange program between nurse educators and service personnel in either hospital or community agency services.

— Continuing education programs for the interdisciplinary team when they have identified needs.

— Satellite seminars for health care personnel to learn together, in which assignments would be relevant to their respective areas.

III. THE MILIEU IN WHICH THE NURSE WORKS

Is there a conflict of goals between practitioners providing care and educators preparing the nurse to provide care? If there are conflicts, what are they? How are they resolved? How does the client fit into the picture?

Practitioners are identified as anyone providing nursing services in any setting, and educators as teachers preparing nurses at the diploma and baccalaureate level. We felt that the long-term goals are not in conflict, as they are determined by the needs of clients, but the short-term may be. For the teacher the objective is really the learning experiences for the student to learn care, while the practitioner is trying to provide the care. The need for job satisfaction of practitioners if often undermined if there are too many learners in the setting. Although senior people agree on philosophy and goals, there may be conflict at the staff level because they have not been involved in decision-making, and in the process of passing plans down, distortions may occur. Perhaps nursing service does not always demonstrate what is taught, and thinks students are too idealistic. Demands on the practitioners may result from more than one nursing program in the setting, or from several health disciplines receiving clinical experience in one setting. This can produce a tremendous work load for the service group, particularly if physical facilities are inadequate. Sometimes educators do not clearly identify what different students in different programs should do in a meaningful way to the practioner.

There is also the question of times when both groups see using clinical facilities and the rules both groups impose. Ways in which we see that this conflict may be resolved are:

— The service organization's accepting the responsibility to develop a climate that is educationally-oriented and allows the student to function.

— The school's recognizing the philosophy of the agency providing service.

— Working together to develop mutual respect, to prove expertise.

— Involvement of all levels of staff in the preparation for change. Overall policies may be developed at the administrative level, but even that can be questioned. Implementation and valuation are at staff level.

— Education and support for staff nurses to enable them to increase their involvement with students.

— Controlling numbers of students in any one clinical setting.

— Again, exchange of function between teacher and practitioner. This should be a research project for true evaluation of value.

— We would like to put on record that we are sick of the term "the educator is a guest in the house." We need to be working together if we are really going to be doing our job.

— Let the staff know what employing agencies think of graduates. Give feed-back from the school on results of, for instance, R.N. exams, so that practitioners who have been involved in their preparation begin to think of students using facilities as "our" graduates.

Is the focus of health care delivery worth changing? Do we accept that man can or cannot change from an illness to a wellness orientation? If we accept that he can, how do we provide the operational structure for him to change? How can clients actually become participating members in the system?

We established that man has a basic orientation to wellness, supported by the theories of Maslow, Erickson, and Dunn. Man's apparent orientation to illness is a learned response to the existing health care delivery system, and learned behaviors can be changed. The concept of health occurs when needs are met, and disease occurs when they are not met.

Significant factors that interfere are the socio-economic discrepancies such as lack of educational opportunities and cultural deprivation. Problems such as inappropriate coping mechanisms and maladaptation occur under interpersonal stress. In looking at an operational structure to meet health needs, we put the emphasis on colla-

borative roles in the contributions of the professions and community groups in a community resource centre permitting integration of services. The way to start would be through community planning by public and professional groups to assess needs, and plan for health promotion. We believe in public education to community services, and that the need is for prevention and promotion programs. How could the nurse function to a larger extent than she does now as a resource person and consultant? How should she use herself in community groups? How do we give guidance and assistance to community and para-professional groups? We must if we are to see an alternative to disease.

Individuals receiving care could participate in teaching students to carry out care plans, particularly in such areas as respiratory and dialysis therapy. It would be the practitioners' responsibility to act as the patient's advocate to assure that the patient is protected and not over-used by learners. The patient may be afraid to refuse students' care because of the subtle punishments that can occur if he isn't part of the health game.

How can the focus of care, of both clients and professionals, be change from a cure focus to a healt focus? Is the introduction of the family practice unit the answer? What other ways can the focus be changed? Does changing the focus change the locale of health care distribution?

Health care is seen as a continuum, it isn't an either/or system. Suggested proposals for changing the focus are:

— Emphasizing the nurse's primary health care role.

— Planning and co-operation between client and professional, and the latter means anyone bringing an impact to the health care system.

— Family practice is an essential way to change, but not the only one. It is essential that physicians and nurses interpret to clients and other members of the health team that there is a need to change focus.

— The role of government in responding to social changes, through the funding of health care delivery.

— Design a project to evaluate the nurse's role in family practice and its effectiveness in the continuing health care system. The evaluation should be in some depth in order to develop the role to a greater degree.

— Educating society to focus on health, and designing projects that focus on health. An example here was a project to change the attitude

of people to the use of drugs. There is some work being done in Canada on this, but again, findings have not been shared.

— Change the public's expectation in relation to the nurse's role in primary health care, to understand that the nurse in fact has the knowledge and ability to do *health* care.

— Changing the focus from illness to health would change the locale, and move it out from the hospital. This starts in the home, and it may end in the home.

CONCLUSION

We need to do some prospecting, to have the courage to discard present models, to question, to defy, to become more flexible. The problems are known to all of us. We need to loosen up the self-established images we have made for nursing, and prepare the kind of practitioner we need to prepare for the future. Nursing is in a crisis situation. It has to make its own decisions before other groups make them for us, and lead us where we do not want to go.

A new column, QUERY AND THEORY, will appear in the next issue of Nursing Papers for the first time. If you wish to describe a problem in research, education or practice and send it to the editors, we will "field" it to an appropriate source somewhere in Canada and print both the question and reply or replies together in the magazine. Send questions! And if you are willing to answer questions, please let us know your area of expertise.