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HEALTH SERVICES TODAY — AND TOMORROW?

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The papers in this issue were presented at a Canadian Association of University Schools of Nursing (Western Region) Conference on "Health Services Today — and Tomorrow?" held February 24-26, 1973 in Banff.

INTRODUCTION

The idea for a conference focusing on the place of the baccalaureate graduate in the delivery of health services originated in Western Region during preparation of a response to the Task Force Reports of the Cost of Health Services in Canada in 1970, for that year's national Canadian Association of University Schools of Nursing meeting. As planning for the Conference went forward, the programs of the annual meetings of 1971 and 1972 looked at the functioning of the baccalaureate graduate in first employment positions, as seen by both the graduate and the employer, and the ideas of consumers of health services on the role the nurse does and could play in delivery of care. These programs provided the membership with

a background to discuss the Conference theme: "Health Services Today — And In The Future."

It was felt by the Planning Committee to be essential that nurse educators, nurse administrators, and nurse consultants have an opportunity to meet together to define the issues facing nursing today, and to formulate some plan of action to deal with them. To this end, the western provincial nursing associations were invited to sponsor delegates from service agencies, and federal government nursing consultants were invited to participate. To obtain viewpoints from other regions, all member Schools of C.A.U.S.N. were invited to send delegates, and representation was indeed achieved from all regions of Canada. Students at the undergraduate and graduate level from three of the western schools also attended, and their contribution was seen in the presentation of the groups.

Recognition should be given at this time to Miss Peggy Anne Field, Past-President of Western Region, and Miss Pauline Kot, past Secretary-Treasurer, for their great efforts in developing the original plan for the scope and funding of the Conference. That foundation enabled the Planning Committee, representative of all Western Region universities, to bring their efforts to what we saw as a most fruitful conclusion. Sincere thanks also to Dr. Helen Glass, Conference director, who brought together three stimulating, provocative thinkers for the program. The Western Region is able to pay the cost of printing this issue of *Nursing Papers* due to the generosity of the speakers in returning their honoraria.

And, lastly, thanks to all those who came, shared ideas, disagreed, agreed, and presented the total group with such a variety of approaches for consideration. The energy and enthusiasm with which the delegates approached discussion of the issues they had themselves defined, was most gratifying. It is hoped that those reading the following articles will find ideas for consideration wherever they may be meeting to discuss nursing and its place in the delivery of health care.

Joy Winkler, President
C.A.U.S.N. Western Region

THE NATURE OF NURSING IN THE HEALTH CARE STRUCTURE

BY JOAN M. GILCHRIST
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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.

PROFESSIONALS IN BUREAUCRACIES: AUTONOMY VS. INTEGRATION

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THE intent of the Banff Conference is to bring nurses from the areas of service and education together to examine some of their major conflicts, compatibilities, and common problems in relation to their ultimate aim of improving the nursing care of patients. On the premises, first, that the roots of many of our problems lie in the larger phenomenon of professionals working in bureaucracies, and second, that we can more ably examine the relationships of practitioners and educators if we keep such dynamics in mind, I should like to focus upon the tendency of large-scale organizations to try to integrate the professionals into their goal structures, and the tendency of professionals to behave as autonomous individuals and groups, regardless of the particular aims of the bureaucracies in which they work. Throughout, attention will then be given to nursing service/nursing education implications.

Many negative words are associated with the term bureaucracy, among them: red tape, depersonalization, rigidity, rules, regulations(1), and to a considerable degree, these negative associations are well deserved, as very often it seems that bureaucracies function and develop impeti of their own without regard to the goals to which they are purportedly committed(2). I remember one story told by Peter Drucker, pertaining to the Second World War, in which the R.A.F. bombed a very important German factory. The factory was designed like a wheel. The administrative tower was in the center of the wheel and the munition plants were located in "spokes" radiating out from it. While the R.A.F. managed to knock out all the munitions plants, the administrative tower remained undamaged. Apparently it

was three years before the people in the administrative tower realized the munition plants weren't working! Sometimes I think that our hospitals, community health agencies and schools of nursing function like that administrative tower, in that they could carry on for a considerable period without patients or students, for we, too, develop momentums which are frequently unrelated to our "raisons d'être."

As emphasized above, one of the central characteristics of bureaucracies is that of integration(3). A bureaucracy is in a sense like an octopus which reaches out and tries to absorb and neutralize the effects of any one individual, or any ideas that are not absolutely consistent with those of the organization. This phenomenon has important implications for professionals working in bureaucracies: On the positive side, this press for integration tends to channel professionals' energies into attaining the goals of the organization rather than attaining their own individual and/or sub-group goals. One must keep in mind that there is such a state as "underorganization," or put another way, "underbureaucratization," and realize that were it not for the structure and control of formalized institutions such as hospitals and public health units, individual professionals, however committed, could not give the range of complex health services which exists today(4).

On the negative side, however, bureaucratic pressures can seriously attenuate if not eradicate goals and behaviors of professional groups and individuals(5), to the extent that professionals either leave the system or "switch (to bureaucratic goals) rather than fight." While it is one thing for bureaucratic pressures to cause professionals to modify what might be regarded as "too idealistic" expectations toward more realistic levels (a process which can be functional for clients, professionals, and organizations), it is quite another matter when the effect on professionals is to quit asking "What is in best interests of 'my' client/'my' student," and ask only "What is best for the organization?" This tendency to press bureaucracy's norms on, for example, the student nurse and/or the graduate nurse can take its toll; but let it be underlined that head nurses and supervisors are also vulnerable, for some have already given up on demanding what is best for the patient. On the other hand, many have not, and the instructor who is inconvenienced by a head nurse who, for example, will not permit a particular student to look after a particular patient because the patient's needs are not consonant with the student's skills, should take care not to label the head nurse as "uncooperative."

In terms of organizations of the future, this tendency towards organizational integration is likely to be even more pervasive as more

and more specialized groups come into agencies, additional goals become more complex, and, in many cases, more conflicting in their nature.

Marlene Kraemer has conducted research on the impact of bureaucracies on nurses, particularly on newly graduated nurses. She has reported that in about six months' time after coming into an agency to work, the professional value conflicts of a large proportion of the new graduates is such that they leave the organization, succumb to the norms of bureaucracy, or leave the field of nursing entirely(6).

The above factors constitute a very serious social phenomenon because taking the extreme of the pathologies which can develop in bureaucracies, one can argue that it really doesn't matter how competent the nurse is upon graduation *if* she subsequently works in environments which cause her *not* to seek high goals of professional service to the clients. The education that she has undergone then becomes irrelevant, if not a source of conflict. On the other hand, if the impact of bureaucracy on professionals is so pervasive, it can be argued, too, that it doesn't matter too much how nurses are educated during their formal training period *so long as they subsequently work in bureaucracies with high standards of professional performance.* Indeed, we could argue that one could take a fairly mediocre nurse, put her in a very good working situation, thereby effecting positive changes in her behavior and attitudes — and really produce a fine "nursing product."

I think that a rule of thumb which proves to be the most useful in examining professional-bureaucratic conflicts is to ask, what is best for the patient? The competing demands of various professions within any organization and the demands of the organization itself are so great that one cannot reasonably approach problems by asking what is best for any group in the organization; yet I think we do not usually try to solve the problems in complex institutions by asking what is best for the client. Usually we ask what is the cheapest, or what will produce the least conflict, argument, or uproar. I think we have to be more determined and skillful in analyzing what constitutes "client benefit" — too often we construe that as being identical with what *we* see as "good" for clients.

Stevens has recently written an article about the law profession, and talks extensively about the accusations of legal practitioners that the education of lawyers today is not at all relevant to the problems of the outside world. Conversely, the legal educators state that they should certainly not teach what the practitioners advocate, otherwise, things will continue to be in the mess that they now are(7). We are,

then, faced with a kind of war, if you will, between teachers and practitioners in any profession; but I don't think that it should mean that we look at such tensions resignedly or give up trying to eradicate some of the basic sources of misunderstanding. The more committed we are to definite goals, toward doing what is right for the patient rather than for teachers, practitioners, and/or organizations, the more potential I think there is for resolution for some of these conflicts.

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THE NATURE OF THE EDUCATIONAL EXPERIENCE FOR NURSING

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THIS topic suggests, first of all, that there is something we call "education experience". Further, it suggests that this experience is educational and hence involves a learning process in the preparation for the practice of nursing. Lastly, the topic implies that there is a nature to this experience. Which would mean, it has characteristic constituents or traits of origin. However, the word nature may also mean — the entire material universe and its phenomena(1). Our topic confronts us immediately with a search for meaning — the meaning of what? The meaning for whom? — the the meaning of words which are the symbols of perceptions forming concepts that can be shared in their understanding.

What I really want to say is, look, the educational process is an extremely complex phenomenon and we must ask questions in order to gain an understanding of this process.

Only through careful analysis and a search for meaning can we gain the necessary insights which will allow us to take those actions which, to the best of our knowledge, will provide us with directives for the preparation of nurses. We need nurses who have personal strength and creativity and knowledge to cope with the complexities of the health care system of today and the inherent forces shaping its tomorrow.

We must ask, what do we mean by education and what is the meaning of experience? It seems that both of these words might mean an array of things, concepts to each one of us at different times and in different situations, depending on our encounters and our processes of internalization of the meaning of "education" and "experience" as they pertain to our life situation. We must reach con-

sensus on meaning, that is, beliefs and values, if we endeavor to construct a curriculum that has purpose in its entirety in preparing persons to practice a profession, this is nursing, in the context of a rapidly changing, highly organized, industrial commercial, technological society — the world we live in.

At this time, it is not possible to explore the meaning of essential concepts any further. There are, however, some basic premises which I must explore because what I have to say is based on my own perceptions of what nursing means to me and how I see the educational process. My perceptions might be shared or not shared by others. I, as anyone else, must be prepared to examine my beliefs and values in the changing context of nursing and society.

Nursing is one of the health professions that shares its concern and goals to some extent with the other health professions. The common concern is related to the health and well-being of mankind. Man is seen as a unique system within the context of the multiplicity of phenomena of his world engaged in a process of dynamic, continuous interaction, in shaping his world and being shaped by it. This view of man is further supported by a belief that man as a human being is progressively evolving, that is, he is in a process of becoming a more highly organized thinking, feeling acting entity with the potential for increasing comprehension of his own central position in and relatedness to the universe.

The unique contribution of nursing lies in its caring for and about man as a total being as he encounters stress, strain and threats to his health and happiness and his conditions for human growth in relation to time and space and the totality of his environment. More specifically, nursing concerns itself with nurturing, protecting and stimulating man's ability to cope with critical periods in his life so that his responses can be directed toward meeting his basic human needs thus leading to optimum health and continuing growth as a person. In a world characterized by technological progress and its effects of increasing mechanization, segregation, dehumanization and depersonalization, nursing as a profession endeavours to render a personal, humanizing service thus supporting and sustaining the evolution of the human race.

Education for nursing must be based on: first, a fundamental purpose, the beliefs and values which underlie professional practice; second, a theoretical, conceptual framework giving directives to the educational process; and third a concern for the process of becoming. To educate means to develop capabilities(2) usually in relation to a given field of knowledge and its application.

Education for nursing is a growth period governed by a unique purpose, constituting a unique experience which qualitatively and quantitatively forms the background from which we operate. This growth period, as any growth period of the human life-cycle, is governed by the principles of sequential, progressive orderliness in the building of attitudes, habits and knowledge. The meaning of perceptions derived from interactive processes in the educational environment constitute learning and therefore determine the resultant behavior. Learning is selective perception based on meaning and relevance within the time-space spectrum, and as such it is an internal process, individualized and an integral part of the growth process.

Those of us who devote our efforts to play a significant part in the educational process for nurses, for some reason may believe that students learn by osmosis, diffusion, memory and training from the various courses and "selected" experiences constituting the carefully designed curriculum. In other words, we think that content and clinical exposure will somehow fuse and enable the student to become a competent practitioner of nursing. I wonder, however, if we operate on something that might have been called "desired knowledge and skills" appropriate for the past and of little, if any, relevance for the role of the university prepared nurse for today's and tomorrow's health care needs of society. Educationalists have expressed concern and alarm for the tendency of our educational system to employ technological advances and sophisticated machinery without purpose and direction. They say, it is like driving a high-powered car at great speed with the eyes fixed on the rear-view mirror(3). Does this analogy hold some truth for the educational experience for nurses? How do we find out if this is so? Do we need to change existing conditions? If so, what is it that we need to change? Why? And how will we go about it?

To begin with, some basic questions are in order. For what functions are university programs preparing their students? To what extent are our university programs doing what they are supposed to do? Why has the university graduate had so little if any impact on the provision of health care? My physician colleagues have confronted me with the question, "Where are all these wonderful nurses that you prepare and why are they not apparent in the practice field?"

Either our graduates are not realistically prepared for the prevailing nursing practice in our society, or, the existing health care system does not know what to expect and demand from university graduates. The picture is confusing and complex. Both of the above propositions, if relevant, place the onus on those who design, adver-

tise and execute the educational programs. Do we in university settings practice isolationism? That is, do we sit in an ivory tower fostering an ideology which is essentially delusional? If so, why is this happening to us?

Helen Glass in her study of *Teaching Behavior in the Nursing Laboratory in Selected Baccalaureate Nursing Programs In Canada*(4) offers an analysis of the situation. Her findings are alarming indeed, especially since the selected programs are called "progressive" and "leading" for the country. This study, however, should help us to take a look at the quality of the educational experience to which we subject our students. Helen Glass is holding up a mirror and saying: "Please look." "Can you see the forces at work?" "Do you see how beliefs, values and conflicts are operational in the educative process?" "Look!" "The medium is the message!"

Also, we can turn to Olesen and Whittaker's study on professional socialization as portrayed in *The Silent Dialogue*(5). This study can add to our awareness and realization that the student is not a passive recipient of external influences but actively involved in defining, choosing and acting upon her personal and professional roles, integrating these as they pertain to her own life-style.

The Silent Dialogue may alert us to look at and examine the conditions for human growth and professional development pervading the educational experience. We need to become aware of the significance of the educational encounter and its consequences for self-respect, initiative and creativity, all essential elements for a professional career. We should add to these considerations that most of our students in under-graduate programs are involved in the stressful transitions from adolescent to adult, and from layman to professional. I would like to expand on the notion of transitional crisis by adding, not only does the student encounter the adolescent crisis of her own personal growth and development but in her professionalization she encounters a *profession* in the adolescent stage of identity crisis. It would appear, students in our educational settings are confronted with innumerable conflicts.

Conflict, if unresolved, can only breed contempt or avoidance. Both of these behaviors would seem incompatible with the leadership role and decision-making ability we desire in and expect from the university prepared nurse.

Let's examine some of the conflict areas. Much conflict seems to arise from incongruity in what teachers say, do and think — or appear to think. Teachers are the most important element of the educational setting. They are actively involved in interactional processes

with students, patients, colleagues and other health professionals. Not only does the student directly experience the meaning of caring for and about people as she interacts with her teacher, but she also observes and evaluates the teacher's responsiveness and ability in her interactions with others. Is the role-model a consistant one? Can it be consistent, when the teacher conforms to her "guest status" in clinical teaching situations? Students are "passed on" in their educational experience from one teacher to another perhaps within a time-span of a few weeks. How consistant is the message about "nursing", its meaning and its functions, as students interact with a number of teachers? My own experience has taught me that this is a most confusing issue for students. Some teachers appear to indicate to their colleagues and their students that it is a rather hopeless and time-consuming task to attempt a definition of nursing or the nursing process. How then, do we expect, students can arrive at a concept of nursing with meaning for their chosen career? I do not know how generalizable my own perceptions might be. There is hope for the faculty because students are beginning to confront their teachers with this issue.

Teachers, bringing their own backgrounds, their nursing experiences, values and beliefs with them, as they teach in the present anticipating the future, are not the only source of conflict. With great deliberation and considerable effort in time-scheduling and in gaining access to clinical resources, we devise a so-called "integrated" program of theory and practice. The immediate question should be, what theory, and what practice? It would appear that these ingredients of the curriculum are poorly defined in relation to the kind of nursing functions and the student-learning we wish to achieve. The dilemma the students encounter on this issue must be pursued in several directions.

First, much of the so-called nursing theory is offered within the spatial confines of the university setting and hence subject to a philosophy of freedom in the pursuit of knowledge and creative thinking. Practice, however, is still predominantly sought within service oriented institutions. These are subject to a highly organized hierarchial structure which defines rules and regulations in support of the curative functions of medicine. Patient-centered care, although talked about, is rarely seen in practice and hence would appear to be delusional. Nursing functions within the hospital are prescriptive and task-oriented and, of course, in support of the curative functions of medicine. In addition, they are structured by a rigid time-schedule. Consequently nurses are not held accountable nor are they rewarded

by the system for comforting a crying patient or listening to his concern for himself or relatives, affected by his illness. University students, carefully coached by their own instructors who are powerless in influencing patient care, find themselves in conflict as they face stated learning objectives and the reality of the setting which is essentially a bureaucratic institution geared toward economic efficiency. We ought to recognize that the media is the message, and that learning occurs in response to the total situation.

Second, not only do we designate hospitals as suitable settings for learning the decision-making process for patient care, but we also rotate students on a rigid time-schedule through a considerable variety of "services". This, we say, is to facilitate learning in all areas of nursing practice. We say, and the provincial licensing body says, the student must have "experience" on medical, surgical, obstetrical, pediatric, and psychiatric wards or services. In spite of attempts by both students and faculty to maintain a focus on patient-care-problems, the message that one must also learn about medicine, surgery, obstetrics, etc., is forever present and often receives primary attention. Students, as they meet the nurses who function expertly and efficiently in the various settings, get the message verbally and visually that their own learning goals have no place in the "real world" of nursing and that the tasks they do learn fall short of being "expert and efficient" in the eyes of the nursing staff. Students who feel that their sense of achievement, self-worth and professional image is being devalued and inferior, can hardly be expected to develop trust in their own ability. One source of reward and reinforcement of considerate care given, are the recipients of such care, who verbally and in their total response reflect gratitude and appreciation. But even this can have another side, in that the nursing staff may resent the favoured student-patient relationship and make their anger felt in their dealings with student and patients.

We need to add another consideration affecting student learning in a hospital setting. Students, generally speaking, tend to equate the efficiency they observe in the "know-how" of and the volume of work they see mastered by the nursing staff as being equal to success in passing the registration examinations. If they learn to view themselves as not measuring up to this "know-how" they become anxious and preoccupied with doubting their own chance for success in obtaining licensure.

The hospital could provide the much needed learning opportunity for conjoint decision-making by doctor and nurse in the care-cure continuum for patients. In university hospitals where medical and

nursing students learn together and use the team approach to patient care, this is becoming a reality. In many other hospital settings where the attitude of "all-powerful, God-like doctor" prevails there is little hope that students could learn to communicate with doctors and collaborate as colleagues on patient care. These do not operate in isolation. Nursing education is shaped by the curriculum with its three distinct parameters that independently and interdependently influence the educative process. First, there must be purpose and goals which give directive to the total design and its functions. Second, the setting has its own impact in relation to its relevant constituents, its space-time orientation and its human elements — the teachers. Third, the central parameter and sole justification of the entire construct, is the learner, who in essence is selected and admitted to fit the goals and the setting. The learner is seen as "passing through", being affected by and in turn, affecting the curriculum. Education is experience involving thinking, feeling, acting human beings who encounter each new situation by being influenced by their past and their anticipations for the future. The process of becoming a nurse, as it is experienced, will shape the contributions nursing can make to the health care needs of our society.

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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 turns 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.

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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.

SUGGESTIONS FOR PREPARING THE NURSE FOR THE FUTURE

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ONCE we define nursing as a science and a practice it is evident that the definition needs the support of a theoretical framework from which principles and practice can be derived. Research, in turn, into aspects of practice should continuously contribute to theory development. Opinions vary on what constitutes a theoretical basis of nursing. Preparing nurses for their evolving and future role in the health care system of society would, however, appear futile without a theoretical framework. It would be like asking a person to stand up on the basis of his muscles, viscera, circulation and nerves, yet without a bony skeleton. In other words, without a theoretical framework nursing cannot take its proper stand among the health professions and the ability of nurses to function on the health team is seriously impeded.

THE NEED FOR THEORY

The theoretical basis for present-day curricula of university nursing programs at the basic and graduate levels of preparation should be carefully examined and evaluated to determine what changes are needed and how these can be implemented. A conceptual framework appears imperative for the selection of supporting courses from the biological, physical and behavioural sciences and for the development of nursing courses. The fact that nursing needs to be the centre of the theoretical construct, and not a by-product, needs to be firmly established.

It would be my guess, that in many of our baccalaureate programs across Canada, First Year students of Nursing are minimally exposed to an opportunity to develop a concept of what nursing is, and what it contributes to the health care of people in our society. Without this basic concept of nursing, how can students perceive the relevance of

the supporting courses they take? How can they gain an identity as nurses? Most nursing curricula designate the first course in nursing as "Fundamentals of Nursing". What is considered fundamental to nursing? Are the "fundamentals" highly prescriptive in nature, preparing the student for hospital practice rather than nursing? If so, how will this affect the creativity, self-directedness and self-reliance of the learner who should be prepared to function as a contributing member of the intraprofessional health team?

THE NEED FOR DEFINED PREPARATION AND PRACTICE

In preparing the nurse of the future the total realm of educational programs needs to be considered in delineating the kinds of preparation appropriate for the health needs of society and the role of nursing as a member of the health professions. In searching for directives which may permit delineation of kinds of preparation, we must not only determine the goals and purposes and objectives which provide the future orientation of the educational activity, but we must also examine and identify the values and traditions of the past in considering those aspects of professional evolution in time which are worthy of maintenance and transmission. The basic question is one of balance between the degree of continuity necessary for change and the amount of change necessary for continuity. In planning for the future it is not possible to escape the dynamics of change which require awareness of historical perspectives and engagement in social and political actions. The identification of kinds of preparation for nursing will be futile unless these are relevant to the values and traditions of the profession and are relevant to and can be operationalized in the ever changing context of social and political determinants of our health care system.

The existing hodge-podge and conflicts of basic nursing education in both the diploma and baccalaureate programs in each province and the country as a whole, should be viewed as a significant threat to the existence of the nursing profession. How can we justify the cost of a four- or five-year program versus a two-year program when "a nurse is a nurse, is a nurse" for all intents and purposes? At least, this is so in the eyes of the public and I would like to add, in the eyes of the medical profession. As long as nurses among themselves hold a notion, based on value-judgment and attitudes, that one or the other type of education or practice makes the individual practitioner superior or inferior, or, more or less valued as a person and a nurse, little progress can be made. Kinds of preparation and kinds of practice can

only be meaningful if the variety of abilities and interests of nurses and the preparation they have obtained, are respected and valued for the contribution and expertise each nurse can bring to the situational complexities of human life at times of stress, illness and crisis.

Almost ten years ago our nursing neighbours to the South presented their position on kinds of nursing. This has led to discussion, changes and development of nursing in the United States. Somehow, we are reluctant to learn from the pattern of progress which we can so readily observe in our neighbouring country.

In Canada now, as in the United States some ten years ago, nursing education at the diploma level is beginning to emancipate from hospital controls and is entering the main stream of the general educational system. Previously hospital-based schools of nursing are moving, or have moved into the Community Colleges of Applied Arts and Technology. Students who pay for their education, and a country which subsidizes its educational system, will demand clearly defined guidelines for their choice of educational program based on interest and ability and assessment of feasibility for expenditure of time, effort and money. Guidelines for kinds of practice and kinds of preparation for such practice should be the responsibility of the profession. Kinds of function and kinds of relevant education cannot be determined in isolation by any one educational institution or service agency, but only in collaboration and cooperation of all, with a felt and unifying commitment to the purpose of nursing as an essential service within the health care systems of our country. This does not happen by magic but by hard work. The question is, who has the power and the wisdom to take the needed action? Will nursing determine its own future, and construct its own legal guidelines? Will medicine decide how nurses are to be prepared and used and what their rights are to be? Will the government decide what role nursing is to play in the health care system of tomorrow?

Not only is there a pressing need to delineate clearly the various kinds of nursing education, but there is also the related need to design nursing programs in such a way that they provide flexibility and upward mobility in their articulation with the next level of preparation. Uprichard in her article "The Education of Nurses"(1), provides an outline of an eight-year program in which four closely knit two-year programs articulate with each other allowing for exit or entrance at each two-year stage, but the total program encompasses education for nurses from the basic to the doctoral kind of preparation. From the outline it is conceivable that graduates from a two-year community college program could enter the basic degree program

at the university at the first two-year level and proceed with their education for a B.Sc.N. or higher degree without loss of time. The proposed program provides possibilities for progressive education and specialization, however, realization of such a plan will require intensive work and the fortitude to meet and resolve problems in the usual course of resistance to change.

THE NEED FOR EFFECTIVE TEACHING METHODS AND LEARNING OPPORTUNITIES

While nursing is striving for reorientation and reorganization of the structure and function of its educational system, there is a need for simultaneous introduction of new and more effective teaching methods and learning opportunities which will allow our students of today to become more effective practitioners in the evolving health care system.

A. DIPLOMA EDUCATION

The main work force of nurses who staff our acute and chronic treatment centres is apt to be prepared in two-year diploma programs in community colleges. The primary focus of learning in these programs is on factual knowledge and skills to be applicable to the institutional setting where patients need expert care when acutely ill, debilitated or undergoing complex and highly technical diagnostic and/or treatment procedures. The purpose of the program is to prepare nurses who can render expert and efficient care in assisting patients to respond to and cope with diagnostic and treatment goals, and the impact of illness and isolation within the circumscribed nature of the institutional setting and its curative functions. Teaching methods and learning opportunities of diploma education should progressively aim for self-directed learning, especially in the use of library, audio-visual resources and the development of skill in handling diagnostic and therapeutic procedures commonly allocated to nursing practice. Students need opportunities to recognize and deal with their own abilities and responses as they encounter disease in patients who struggle with the stresses and changes brought about by failing health and illness; and, as they encounter the situational stresses of the institutional setting. The nurse, as the patient, at any level of functioning is first and foremost a human being.

B. BACCALAUREATE EDUCATION

University education for nurses needs to refocus its aim on preparing nurses capable of being change agents and capable of assuming a peer and leadership role on the interdisciplinary health team as it functions in community or hospital settings.

Current trends toward ambulatory care, primary health care, and community health care centres call for a nurse who is knowledgeable and has a repertoire of decision-making ability and interpersonal skills enabling her to function independently and interdependently in primary care settings — be it in health centres, clinics or homes. Since nurses prepared in baccalaureate programs are most likely to become the main nursing force of primary care settings now evolving in our health care system the educational process must foster those qualities, abilities and skills required for effective functioning.

A primary need for the educational process and the educational experience lies in the reorientation of the curriculum and of those who teach in it, toward process, and being involved in process, rather than the mere transmission of content. Teaching activities which are subversive in nature, that is, if they cultivate fear, distrust and dependency must be recognized and exterminated. Teacher-student interactions and learning opportunities should foster creativity, self-learning, self-esteem and enthusiasm for the process of inquiry. Teaching methods used should be based on a process of inquiry — the learning of how to learn. In this students learn to ask their own questions which lead them to integrate knowledge they possess, and to seek and pursue additional knowledge now readily available in libraries and audio-visual resources. By being actively involved in communication, in assessment, in problem-solving and the decision-making process, students not only learn skills and the use of relevant knowledge, but they also gain assurance that they can deal effectively with the situations they encounter. We as teachers tend to underestimate the resourcefulness of our students and their ability to take responsibility for their own learning.

The use of simulated patients and simulated situations involving persons who are programmed to present given problems, and who are paid for their work, is beginning to find its way into nursing education. This allows for the development of communication and assessment skills before the student has to encounter the complexities of situations in active treatment centres. With a simulated patient or situation — the whole group can be involved in the assessment process. Merits and demerits of approaches used can be openly explored. Suggestions for alternatives can be offered — not as an afterthought, but as they evolve from the situation. The concern for time used and endurance for the patient is eliminated. Students and patients can receive the necessary feedback in how they experiencd each other. In this teaching method, students learn to trust their own ability before they encounter the "real" world. In the assessment process, students

become aware of what they need to know and then seek to augment their understanding or their skills by using available resources.

I would think, that videotapes of students involved in teaching-learning and in group work are used in most educational settings today. Videotapes help the student view her own behaviour, its effects on others and the interactive skills she uses or needs to develop. Group process, its affective quality and its instrumental tasks can be analysed and assessed. The use of videotapes in teaching sessions is a form of confrontation-learning for both teacher and student. Seeing oneself as seen by others leads to awareness of behaviour and a readiness to attempt change. Videotapes which reflect one's own behaviour are an effective way to enhance the development of social interaction skills so badly needed in all areas of nursing.

Throughout the educational process, students encounter their own responses and feelings as they interact with teachers, patients and other professionals. They meet, and render care in, a range of stress-producing situations, for example, premature birth, traumatic accidents, deformity, and death, all highly charged with human emotions as the threat of loss — loss of life, loss of function — is real or anticipated. The most essential element in the nurse's functional repertoire in such situations is the use of self as a thinking, feeling human being with the ability for a deep sense of caring and responsiveness to others. The helping process requires the ability to respond in the most appropriate way at the most appropriate time. Students need opportunities to enhance self-awareness and self-control in developing their ability to respond on the basis of observed behavioural cues and anticipated responses to the threat of loss. They need an understanding and supportive teacher who will permit expression of feelings and opinions as students learn to handle themselves in their efforts to care for others. Verbal expression of feelings can be difficult and perhaps, feelings could be more adequately expressed in art or movement. The latter, of course, would require creativity and expressiveness on the part of teachers, — a rather rare commodity in people who most likely are the products of a constraining educational experience.

The nurse of the future who engages in a decision-making process on patient care, needs to be assertive in her ability to collaborate with those who engage in a decision-making process on the cure of disease — the medical profession. Medicine and nursing need to work hand in hand as they strive for care and cure in assisting patients to achieve an optimal level of health and well-being. However, to accomplish

this, traditional attitudes held by nursing and medicine will have to be overcome.

Opportunities to learn about each other's roles and to gain respect for each other's expert contributions to the care-cure continuum should ideally be sought as part of the educational process for both professions. Such opportunities exist where Health Science Centres provide a common meeting ground. Nursing and medical students are apt to meet and exchange opinions and experiences wherever they share a common practice field and common dining and recreational facilities. But this is not enough. Nurse and physician educators must combine their efforts to engage their students in shared learning activities. Sitting together in a lecture hall listening to a speaker will do nothing for the enhancement of interprofessional understanding. Many areas of learning can be effectively shared. For example, groups composed of medical, nursing and social work students can be involved together in the learning of interviewing skills and techniques, and these students can also share a course in group work on human sexuality. Similarly, the learning of growth and development encompassing the human life cycle can be accomplished through shared observations and discussion. Nursing and medical students can make joint visits to homes during the pre-natal and postnatal phase of family expansion. In these they share their opinions on what they observe, what it means, and what they think needs to be done, or not done in the interest of family growth and development. In the hospital setting, medical and nursing students can share a patient assignment in which they actively assess the problem and plan jointly for care and treatment.

Encounters among medical and nursing students during their undergraduate education is one way to facilitate interprofessional understanding and collaboration. Another way can be sought in form of joint seminars for interns, residents and senior nursing students in the clinical setting. These seminars focus on an encountered care and/or treatment problem, a given situation, and explore the relevant perspectives of physician and nurse. The issues of interprofessional communication, attitudes, value-judgment, and professional ethics are brought to the fore. In the process of discussion, doctors and nurses learn to respect each other's thinking and expert knowledge. Such seminars are difficult to initiate and require teamwork and effort on the part of medical and nursing faculty. Nursing students are more than eager to have such discussions but interns and residents tend to feel it is below their status to discuss patient care with nursing students. This is not surprising, since many of them have never had

an opportunity to be confronted with thinking and concerned nurses, let alone have ever sat and discussed matters of attitude and ethics with nurses. The consequence of such seminars is, however, that they greatly facilitate nurse-doctor collaboration on patient care in the ward setting. Interns actually seek the opinions and the advice of the nursing students as they face problems in the handling of patients and their families. In turn, nursing students lose their fears of the "almighty" doctors and seek to discuss treatment goals with them.

On the whole, the educational process needs to foster more independence for students. Students in their senior years of study are more than ready to assume responsibility for developing their own objectives in relation to specific learning experiences, and for adjusting their own time-schedules to meet their learning needs. In this, faculty assumes an advisory role and not a supervisory one.

C. NURSE PRACTITIONER EDUCATION

In the meantime, as we struggle to prepare self-reliant, independently functioning baccalaureate graduates, as we strive to define the different kinds of functions for the nursing profession, and, as we search for a theoretical framework for nursing, — the government and the medical profession exert pressures for the preparation of yet another breed of nurses, the so-called nurse practitioner. This nurse is to function in primary care settings, in rural areas and in the far North. The nurse in the expanded role, we are told, is to fill the gap in the health care delivery system. It seems as if these pressures create the hazard of hasty development of courses; courses that are poorly defined and planned, with inadequate screening of applicants, and educational experiences which suit the needs of doctors rather than the health care needs of people.

The Boudreau Report(2) clearly defines three kinds of functioning for nurses in expanded roles who give primary care in relation to their geographic placement and the unique health care needs of segments of our population. Already existing programs, such as baccalaureate education and graduate preparation in clinical specialization at the master's level, would meet the specified requirements. The new ring to an old word "nurse practitioner" carries once more the notion that "a nurse practitioner is a nurse practitioner is a nurse practitioner." This is not so. In failing to delineate the kinds of functions and the associated preparation, we only perpetuate an already existing problem which threatens the professional development of nursing.

The need for nurses who can function in primary care settings is indeed a pressing one. In response to pressures, continuing education courses are being developed. These provide learning opportunities for

additional skills in dealing with people and their health problems. Here, as in the other areas of education for nurses, the quality of programs that can evolve or do exist hinges on the availability of prepared faculty who do and can teach nursing. If we allow doctors to play a major role in the planning and teaching of nurse practitioner courses, then we must be aware that graduates of such courses will be prepared for a doctoring role and not nursing. What has been a major factor in the development of hospital nursing a century ago is about to repeat itself, as nursing emerges into primary care functions; dependency on, and subservience to physicians carries grave consequences for nursing and its interprofessional role on the health team.

D. GRADUATE EDUCATION

Higher education for nurses at the master's and doctoral level is the most pressing issue facing the profession. Without adequate numbers of highly educated and skillfully functioning faculty, practitioners and professional leaders, the future of nursing is in jeopardy. The very skills, so badly needed for the advancement and development of graduate programs, are sadly lacking in the preparation of nurses in such programs. These are the socio-political skills essential for effective conduct in the present day arena of complex and diverse social and political systems. The study of Social Psychology, Educational Psychology and Political Science could supply the knowledge base from which socio-political skills can be developed and integrated into the functional repertoire of graduate students.

First and foremost, opportunities for graduate education in nursing must be sought and provided in our own country. Emphasis here, as elsewhere in education, should be on process learning in relation to interactional skills, self-development, and decision-making. We must be aware that most graduate students because of their own educational history, face the difficult task of unlearning confining beliefs, concepts and practices based on a hierarchial value system. The whole educational experience needs similar efforts to those identified for the preparation of nurses at the baccalaureate level, only more so. Graduate preparation has a major objective in stimulating interest and ability in research and its contribution to the theoretical basis of nursing. It is the person, in whom scientific knowledge and concepts, beliefs and values are integrated and activated, who becomes the facilitator of change and professional development. Hence the educational experience must be person-centred, enhancing personal integrity and self-esteem essential for the purpose of nursing, and essential for learning and human growth.

Those of us involved in preparing the nurse for the future might be served by the following poem.

To teach is to feel—
feel for the other's groping
and steady the exploring hand
but not to rob the hand
of its searching
and finding

To feel and share the feeling
of the joy of discovery
of not merely what is sought
but the vast aura of little things
that colour the learning experience —
not least the joy of looking back
to see the gap 'tween me and knowledge
was not so great
nor the chasm so deep
as I see it now —

but that the self leap to self-fulfillment
gave the self satisfaction
that makes me now so anxious
to help so much.

But feel too
that my leap can give only
me my satisfaction
as theirs to them.

To teach is to feel
and respond
but not to leap the leap
for the learner
who wants to be led
not transported
but wants adventure of
discovery as his own.

To feel
to be sensitive
to guide, to lead
to catalyse the development
of young minds into a discovery mode
where within, is that learning proceeds.(3)

References

1. M. Uprichard. "The Education of Nurses," *Canadian Nurse,* 68:30-36, June, 1972.
2. T. Boudreau. *Report of the Committee on Nurse Practitioners.* Ottawa, Department of National Health and Welfare, April, 1972.
3. B. Pigott, *Medic,* McMaster University, August, 1972. Reprinted by permission of the editor of *Medic.*

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.