

THE NURSING ROLE AND THE PROBLEM OF IMPLEMENTATION

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The concept of *role expansion* for the nurse practitioner hardly merits perpetual exploration, other than acknowledging that it has to be an on-going process. This is certainly the case if we believe that we ought to be sensitive to changing needs for health services and better ways of providing services. The process of *implementing role change*, where evidence suggests such a change is needed, is something else.

As persons who have struggled with nursing education for many years, irrespective of the changing scene essentially or situationally, however clumsy or irrelevant our attempts, one problem continues to plague us. This problem defined at different times and perhaps with changing degrees of sophistication by the social scientists, is what we simply call "role conflict." It seems to me that until we acquire some degree of skill in dealing with this phenomenon, our attempts at changing the focus of nursing education or improving present curriculums are futile.

The baccalaureate nursing program at St. Francis Xavier University builds on the basic premise that nursing is a personal service to persons and that the character of nursing intervention is shaped by the nursing needs of persons, families and communities. This philosophy of nursing practice presupposes cognitive, affective and psychomotor skills which allow for a systematic approach to health needs and problems and a relationship which, in itself, is deliberative and therapeutic.

The curriculum, using a health-needs model, is based from day one on concepts reflecting the above philosophy, and attempts to develop in the student competence in the use of process — interpersonal and "problem-solving" components included — as the framework within which the professional practitioner operates in any setting. The role of the professional practitioner as health teacher, and emphasis on assessment, including physical examination skills, are introduced during the first year of the program.

This approach, admittedly not unique, is challenging, provides an exciting model for exploring health needs, responding to developmental-situational crises, and encouraging flexible patterns of prac-

tice. Pedagogically, it "looks," "sounds," and "feels" good. The conflict, however, anticipated by students, experienced by former graduates, and constantly pricking the consciences of faculty, revolves around the *lack of opportunity to practice* and/or lack of support for the graduate who can practice and develop the skills she has acquired as a student.

It seems so unnecessary to keep repeating what has been said so many times — that certain changes have to be made in the patterns of nursing services in both institutional and agency settings if the skills of nurses — young graduates and veteran practitioners — can be used for the benefit of patients and their families. Nevertheless, evidence seems to dictate that we have not been too effective in operationalizing our conceptual designs for appropriate support systems for the nursing student as learner and the graduate nurse as practitioner of nursing.

As faculty we believe in the following:

1. That the test of our credibility as nurse educators rests on our success in establishing a genuine collegueship with our nursing service counterparts in both institutional and community settings.
2. That the learning of nursing does takes place where nursing is practiced.
3. That the student must see and experience, in the environment where she practices, the kind and quality of service which we talk about but unfortunately, not all of us have the opportunity to practice.
4. That somehow the "desirable role model" has to become the *Rule* rather than the *Exception* and that nurses in service must acquire a belief in their potential for such models.
5. That many more demonstration projects need to be encouraged and supported in both institutional and community settings so that what we have been preaching and teaching, what nursing service personnel have been struggling to provide, may be implemented.
6. That teachers of clinical nursing ought to be practitioners of nursing and vice versa and that, in the immediate future, we ought to be exploring the reasons why this may not be a reality. Such an examination includes exploring ways in which nurses whose primary responsibility may be in either teaching or practice may combine both.

Might we suggest that we are entering a period in nursing education and practice where precedence ought to be given to "pastoral strategies," where we descend from the "pulpit" frequently enough to "minister to the needs of people." And, in summary, if our ministry is to be effective, a great deal more energy needs to be directed toward a reasonable resolution of role tension, be it interpersonal, intrapersonal, between concepts and practice, or between the public and the profession. Until we can somehow approach some consistency between demands of the practice setting and the role for which we believe professional nurses ought to be prepared, much valuable energy will continue to be dissipated in unnecessary and useless conflict.