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THE EXPANDING ROLE OF THE NURSE:
HER PREPARATION AND PRACTICE

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Moyra Allen, *Editor*
Vivian Geeza, *Managing Editor*

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EDITORIAL

This issue on the position of university schools of nursing and their faculty on the subject of the expanded role of nursing is timely. Most schools have been thinking a great deal about this question; new educational programs are being developed, existing ones modified; demonstrations and experiments are being mounted across the country; briefs and statements are being written and published in the press as well as in various types of professional journals. Many groups — federal and provincial governments, physicians, nurses, citizens, others — have a voice in the present dialogue, and much money is being devoted to this subject. After such a noteworthy beginning, involving undoubtedly more research money than individual nursing projects have ever previously received: What do we think? Where do we stand? What path seems most fruitful for the future?

When our editorial board requested position statements from each university school, some seemed to display a type of fatigue, an ennui regarding the subject. They have done so much, talked so much, participated so much, there is nothing more to say. Never before, except in war time, has nursing been so obviously and intensively influenced by other groups. Surely, at this point, there are questions, problems and experiences to be shared and trends to explore and examine with a critical eye, for the benefit of us all. Statements on the expanded role of the nurse have been received from 13 university schools of nursing for a total of one letter to the editor and 16 individual or group papers.

From a perusal of the contributions to this issue, a few ideas stand out. First Phyllis Jones and Nora Parker from the University of Toronto have provided some historical material on this topic from the Canadian scene in the introductory portion of their paper; while Helen Glass *et al.* from the University of Manitoba have chosen to describe their position within a historical framework. Most papers reject the physician's assistant as the expanded role for nursing, although it is agreed that nurses can and should be able to perform effectively many of the functions previously viewed as within the realm of the physician (physical assessment, medical history, and some treatments). We have some research to support the similarity in performance of physician and nurse and the acceptability of this practice to clients(1). Other studies are expected to produce their results in the near future. This knowledge is needed in comparing medical and nursing performance on selected procedures and these demonstrations and evaluation programs seem reasonable, given our committment in Canada to comprehensive and universal health ser-

vices. Many have expressed in their communiqués, explicitly or implicitly, a fear that these additional skills are being viewed by both nurses and other health professionals, as well as by government and the public, as the expanded role of nursing.

Descriptions of the expanded role differ somewhat from school to school. However, there is a growing trend to the effect that the basic baccalaureate graduate is the person prepared to perform the expanded role of nursing. Some of the ideas which prevail in the papers are summarized here.

—The expanded function of nursing is the role the basic baccalaureate program was developed to fulfill in the past, but it is only recently that nursing is being asked to perform this function.

—The expanded role is nothing more than augmenting the preparation of the nurse: the B.Sc.N. graduate, as she gains experience, fulfills the expanded role; the Master's graduate (nurse clinician, clinical nurse specialist, or whatever) develops and expands this role in nursing further.

—Some perceive the expanded role at the B.Sc. and M.Sc. levels in all phases of health care, primary, acute, chronic, etc., others appear to limit the role to the primary care settings.

—What seems to differentiate diploma, B.Sc., and M.Sc. programs is that the graduate functions at different levels of assessment and skill. In other words, the expanded role assumes increasing ability to assess, thereby augmenting the capability of the individual in nursing. The graduate of each type of program may be an expert practitioner, but the basic nature of practice is a function of educational preparation. The assessment tools which are now being added to the basic baccalaureate curriculum are that of physical assessment and medical history taking, however efforts are being made to strengthen other assessment skills of the nurse.

—It would appear that our expanded role is directed toward those needs of people which, heretofore, have not been dealt with to any great extent, that is, family health over time stressing the features of comprehensiveness, universality, availability, and continuity. Might the expanded role in collaboration with other health professionals have as its goals:

> To build family health practices in ways that are constructive and developmental to the family as well as individually to its members and, collectively, to the community.
>
> To foster an environment in the family which supports the integration of illness when it does occur, both acute and chronic, in as healthful a fashion as possible.
>
> To care for sick individuals with all types of health pro-

blems within the context of their families in ways that protect life and develop the human potential for healthy living at all stages of development.

It may be seen from these goals that the expanded role of nursing takes place in all health care settings — hospital, clinic, health center, community, family, etc. As has been stressed in a number of the papers, we are now in a position to explore and examine what the expanded role of nursing can be in achieving these goals.

If the demonstration of the expanded role by the baccalaureate graduate is to be supported by government, other health professionals, and citizens, how do we go about it? It would appear that our present efforts are directed toward developing and implementing a curriculum to prepare the baccalaureate nurse for this role. We are encountering major difficulties in locating situations in which students can practice the role *in toto*. Furthermore, the nature of employment for the graduate poses a problem. Can we wait until we have prepared a sufficient number of graduates practising in the expanded fashion to show what nursing can do? We think not. Our developing health services cannot wait.

Concomitant with our emphasis on the educational preparation of the baccalaureate nurse, is our need for a few well-planned, adequately funded demonstration centres across the country so we may describe, assess, compare and evaluate the nature of the expanded role of nursing and the outcomes for health services and for people. We cannot hope for backing, receive sufficient moral or financial support, nor have our beliefs about the expanded function of nursing understood or taken seriously, until we can demonstrate within a research framework the nature of our services and their value to society. In collaboration with other concerned groups, the development and demonstration of new types of nursing services is a responsibility of the university school.

Plans to expand the role of the diploma graduate by adding physical assessment, medical history and appropriate treatment procedures have been expeditiously carried through with strong support from many medical faculties and from Health and Welfare, Canada. How do we proceed to demonstrate the expanded function of nursing in organizing new types of services designed to fill the gaps in the present health care structure and to meet needs which to government and health professionals are ill-defined and, to a great extent, largely ignored?

Reference

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LETTER

To the Editor:

I have some views on the future of the extended role of the nurse in New Brunswick although I have been in this position less than a year in my home province. But I have the distinct impression, from membership on the Health Services Advisory Council (to the Minister of Health) and from other contacts with New Brunswick physicians, that the doctors in this area regard the nurse in the expanded role chiefly as a physician's assistant whose major responsibility will be to lighten his load by taking histories and daily physical examinations.

It seems that they obtained this impression from a workshop in Moncton last year. And since our completely tax-supported medical care system is paying physicians so handsomely, New Brunswick appears to be attracting all the physicians it can use and most physicians in the Fredericton and Saint John areas seem to believe the "saturation point" will soon be reached, even in outlying areas. Therefore — if the nurse is to be only a physician's assistant in the sense of working in his office, lightening his load by taking histories and doing physicals — the physicians are saying that the concept of the nurse practitioner will die a natural death in this area because nurses acting as "physician's assistants" will not be needed.

I do not believe that a nurse practitioner or nurse in an extended role can best meet the health needs still unmet in Canada by working in a doctor's office or out of a doctor's office in the role described above. But, this is the way physicians and most practising nurses in this area seem to think at present. The faculty members at this university and some others in the community (including those on the N.B.A.R.N. committee to study the role of such a nurse in New Brunswick) believe the most useful role for her in this province would be that of primary care nurse in the community. The Department of Health personnel are referring to this person as a community health nurse at present.

Left to operate on my own perception of what is needed, I would tend to build in much more preparation in physical assessment and assessment of meaning of health history along with increased skills and depth in interviewing. But I would have the nurse so prepared also practising her "Extended Role" in critical care units (CCU & ICU, dialysis units, etc.) and emergency rooms (as well as in primary care settings) using this additional knowledge and the meaning of more relevant observations of physiological and emotional changes to make clinical judgments to be followed rapidly by appropriate nursing action in these settings.

I would not have the baccalaureate graduate assisting physicians in the practice of medicine, but would use additional curriculum content to improve the practice of nursing according to the type of clients served and the complexity of the health needs. However, the perceptions currently held by physicians and nursing service administrators influence what can be attempted by an educational institution if we are not to build frustration into the future of graduates prepared for positions which do not exist in their geographic area. The problem of salaries and lines of administrative authority would have to be worked out in this area in order to minimize confusion of roles and responsibilities.

Lois E. Graham
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July, 1974

STATEMENT OF CURRENT POSITION ON THE EXPANDING ROLE OF THE NURSE

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An explicit statement regarding the "expanded role of the nurse" is difficult to formulate as this pattern of nursing practice develops in Canada. However, we are in agreement with those who state that "the expanded role" represents broadening of the present role to include changed attitudes as well as additional knowledge and skills. Such broadening would provide a firmer basis for independent decision-making and for application of the concepts of responsibility and accountability in nursing care.

In contemplating the expanded role for nurses we are acutely aware that the practice will require an orientation by the health team that is not currently visible in today's health care. Nursing education programmes cannot prepare this practitioner without fundamental changes in role concept. The expanded role gives priority to nursing the client rather than providing service to an institution or to the medical practitioner. Present patterns in nursing education involve faculty members who, for the most part, were conditioned by situations wherein nursing practice was influenced significantly by the needs of the institutions and of the medical personnel. In spite of changing attitudes in faculty members and their efforts to create a changed environment, students still obtain their clinical experience in settings which are basically bureaucratic and hierarchical in structure, and procedure-oriented in nursing practice. It is difficult in such a setting for the student to apply the necessary independent nursing decisions based on her own observations and judgment, or to develop a deep sense of commitment founded on attitudes of responsibility and accountability. Furthermore, it is virtually impossible to expect the student to obtain experience in working independently or intradependently with colleagues or to learn the advocate role when the present system of education, especially the clinical setting, virtually precludes such a possibility. Priority must be given to initiating and maintaining a change in nursing education and practice so that the self-concept developed by the nurse is one of a provider of direct care to patients and families, one which is practiced in a way that is significantly different from the current pattern in this geographic area.

The nurse practicing in the expanded role should be, we believe, a graduate of a baccalaureate nursing programme. The university in itself can provide the climate for developing a self-directing indi-

vidual. Breadth of outlook is provided as the student has contact with a variety of faculty members who are well prepared in their particular areas of expertise. Because of greater depth and length, the four year programme can provide a greater opportunity than the two-year programme for the student to develop and perfect the skills which make possible comprehensive nursing care.

Current literature is placing great emphasis on the importance of learning additional physical assessment skills. We feel some apprehension about possible identification with medical (and therefore legal) responsibilities. Where the skills enable the nurse to make a more complete assessment of the client's health status and to plan, implement, and evaluate nursing care of a higher quality there will be real value to nursing in their use. However, a danger could lie in the association of these skills with medical rather than nursing care. Where additional physical assessment skills are included in baccalaureate programmes, such a problem might be avoided by ensuring that these learnings are an integral part of the undergraduate experience and are taught primarily by the nursing faculty. The physical assessment skills then would be more likely to be used in the nursing process and to strengthen and enhance such roles of comforting, supporting, preventing, and on through to teaching, collaborating, and advocating.

Given the opportunity to develop a nursing education programme incorporating the above concepts, how can this practitioner best be integrated into the health care system? Demonstrations, or pilot projects in each geographic area, would appear to be the best way to modify traditional patterns of medical and nursing practice and public expectations of health care. In such an environment the usefulness and advantages to clients could be made visible. As the nurse is enabled to practice this role, meaning and usefulness become clear, and as doctors and nurses learn to work as colleagues and partners in providing health care, modifications could be made and a clearer definition of the expanded role will emerge.

These pilot projects or demonstrations could have increased value if established in different locations. The expanded role could be useful in rural health as well as in urban settings. The emphasis would be on health maintenance and prevention of health problems for all age groups, as well as on initial assessment and ongoing supervision for acute and long-term conditions. Outpatient departments, medical clinics, or physician's offices could also be used to test and demonstrate the use of this expanded role, provided the nurse and doctor can collaborate. We also see the nurse practicing an expanded role in the acute care settings of hospitals. We believe that the actutely ill hos-

pitalized patient requires a high level of nursing care which is best planned, directed, and evaluated by a nurse clinician or clinical specialist prepared at the Master's level (in a clinical programme). However, we do realize that the possibility is remote of either preparing or acquiring a sufficient number of these persons in the Atlantic region in the immediate future. For the present, we suggest that the potential of the baccalaureate graduate could be used, and would be more clearly visible in the acute care areas if the philosophy, knowledge, and skills envisaged in the expanded role were utilized. For example, increased technical competence in physical assessment could contribute to improved judgments of nursing measures needed in care of acutely ill individuals as in I.C.U., C.C.U.

The legal status of the nurse in this type of practice will be more definitely defined as the role develops. In the interim it will be necessary for those involved to acquire and maintain attitudes and to develop policies which will enable the nurse to practice an expanded role with safety to the client and herself. This will require clear understanding (and written divisions of responsibilities) between physicians and nurses.

Open and honest collaboration among members of the medical and nursing professions will be required if nurses are to fill the expanded role effectively. The great need, as we see it, is for members of all major health-related professions (physicians, dentists, nurses, nutritionists) to collaborate first in assessing and planning. It seems clear that additional approaches are indicated to assure patients and families (and potential patients and families) the information and services needed to raise the currently poor level of physical fitness in Canada. The next step would be to decide who can best provide these services and under what conditions.

STATEMENT ON THE EXPANDED ROLE OF THE NURSE

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The term, "expanded role of the nurse", may be viewed within the historical perspective of nursing, and the roles nurses have assumed in the provision of nursing servies. But for an accident of history, nursing might have pioneered the field of preventive health care. Nurses in the pre-Christian era were concerned to a very high degree with life styles of people, environment and sanitation. Midwives and nurses practised their arts of caring and healing independently. It was not until the development of the science of medicine that nursing seconded itself to medical concerns. At this point the nursing role, as envisioned by its leaders throughout the ages, became subverted. A larger percentage of nurses followed the medical model related to illness care than those nurses who saw nursing in the broader perspective of health. As a result, educational preparation for nurses became oriented to a focus of illness rather than to aspects of prevention and promotion of health about which little had been scientifically determined.

Traditionally, in the Western world, the educational preparation and indeed practice of the nurse, has been geared for functions in a dependant role in an institutional setting. The classic curriculum of educational programs ordered content directly on the medical model, and practice was organized according to the hospital ward patient classifications. The major focus in such traditional education programs has been on providing the graduate with the knowledge and skills to provide care in episodes of illness, with only limited concern for health care directed toward increasing the patient's ability to prevent illness and increase his level of health. The result of such an approach is that 80-90 percent of nurses have been caring for the 10 percent of the population requiring institutional care, while only approximately 10 percent of nurses have been involved in the care of the 80-90 percent of the population in the community. This meant that while illness needs of the population have been, on the whole, adequately met, health needs have been provided for in only a limited way through community nursing and medical services. Preparation for health care in nursing has only been provided in university programs which were late to the educational scene.

Recently, advances in health knowledge and technology and increasing consumer awareness have combined to create a change in society's expectations of health care. Care during the whole of the health-illness continuum and throughout the life span is now seen as the right of each citizen. A demand for the redistribution of health services to enable the population to have direct access to health care services has been evidenced. These pressures have contributed to the formulation of primary health care and, with this development, what has been called the expanded role of the nurse. This is essentially a return to the early concepts of health care as practiced by nurses, but with the advantage of a scientifically based approach to all-encompassing health care, with the nurse seen as part of a team of health care workers. How nursing develops this role is in part dependent on its conception of health.

The phenomenon of health may be described as man's capacity for utilizing energy from within his being and the universe. In the utilizing of energy, man actualizes his potential for being in its many ramifications of growth and development(1). Health is a relative affair, that represents the degree to which an individual can operate with effectiveness within the particular circumstances of his heredity and his physical and cultural environment. Such a definition implies that deviations in health are episodes in the lives of people. Using this definition of health, and recognizing that individuals, families and communities may exist in varied states of health, the professional nurse can be seen as a primary contact for citizens' entry into the health care system. This is so at whatever point contact is made by the client within the system, or the client is contacted by health workers.

Nursing's concern is with man in his entirety, focusing on his health and the energy expenditure involved in coping with a multitude of events — biological, psychological, sociological and spiritual — which affect his health. Man is seen as moving through a growing complexity and organization of his being, and toward self-actualization. Concern for man at all stages of life, conception through death, is inherent in this concept.

Professional nursing is characterized by the one-to-one client-professional relationship in simple and highly complex care contexts. In that one-to-one relationship, the nurse is a part of the universe(s) of health in which an individual finds himself(2). The most consistent universe in which the nurse deals with the client is the family or living unit universe, but he/she also deals with groups of clients in various community and institutional settings throughout their life span and whenever the universe of health changes — for example, when social or environmental influences impinge on individuals or on

their living unit, and where illness or disruption of life style is a result. In this respect, the health field concept is appropriate and basic to provision of nursing care(3).

The functions of the professional nurse in the expanded role will include:

1. Assessment of the health status of individuals and families, and of communities to a limited degree.
2. Screening clients wherever encountered in order to identify and sort patterns affecting health, and make decisions regarding priorities of interventions related to identified patterns.
3. Participating in the joint evaluation of data gathered from such screening activities with all health professionals in order to develop plans of care for individuals, families, and groups.
4. Provision of family planning services, institution of care during normal pregnancies and deliveries.
5. Planning with individuals in regard to their personal health care needs, and those of the recognized living unit to which they belong.
6. Management of care within mutually agreed upon health care plans developed by selected clients and their health care personnel. (Selected clients are defined as those in a stabilized phase of a long-term health problem.)
7. Consultation and collaboration with health professionals and the public in planning and instituting health care programs.
8. Providing leadership in the use of health care facilities and in initiating innovative avenues of care for clients.
9. Management of care for groups of clients in collaboration with other nursing personnel.
10. Assumption of responsibility for involvement in research through identification of researchable problems, participating as appropriate in research projects arising from delivery of health care, and utilizing research findings in the implementation of the nursing process.
11. Involvement in professional service through active participation in organizations and agencies concerned with the quality of health services to society.

All of these functions are directed toward enabling the client(s) to use available resources in the environment and to alter life styles as necessary in the direction of maximizing potential for health. Because all the indices of health have not as yet been clearly delineated, the functions of the professional nurse are likely to change. It is the baccalaureate nurse who is best fitted from her background of knowledge and skills to identify such indices in the process of practising her nursing role. The baccalaureate nurse is prepared to work in any setting within the health organized system and to work in close collaboration with others or independently as the setting dictates.

There are two components to the professional under-graduate curriculum; nursing and general education. The general education component provides the student with a broad base of knowledge from the biological, physical, psycho-social sciences and humanities. This knowledge is applied and integrated with nursing knowledge in the nursing component. A nursing process model is utilized to provide for

integration through a systematic approach to the client(4). It enables the student to develop a high order of cognitive, psychomotor and affective skills. Learning experiences are designed to foster a sense of professional commitment and accountability for the quality of one's practice, based on a sound knowledge base. Such experiences enable the graduate to function interdependently as well as independently. To maintain quality of nursing care in practice, continuing education programs must be provided for the professional nurse to maintain and increase knowledge and skills in line with advances in all aspects of the health care field.

Adjustments in the health care system are necessary to enhance the ability of nurses to provide primary health care. The nurse must be accepted by all members of the health team as a collaborator and colleague. Such acceptance is fostered by interdisciplinary education at the undergraduate level, where students in the health professions share decision-making in the provision of health care. Changes in the organizational structures of agencies so that the nurse is accountable to the client for her decisions and care, and is subject to few of the hierarchical restraints of the organization, will further enhance movement of nurses into expanded roles.

Other needed changes include clarification of functions and relationships specified in nursing and medical practice acts, and creation of a system whereby nurses can receive direct remuneration from major third party payers. Whether the decision is made to provide nurses' remuneration through salary or a fee-for-service arrangement, the monies received should be commensurate with the level of responsibility assumed. As with any other professional worker, as skills are expanded and increased in number and quality, a new "practitioner" is not created, but a practitioner is simply enlarging her scope of responsibilities. This negates the need for a new "category" of worker being introduced into an already complex system of health care, with all its legal and economic ramifications.

We are coming full cycle in nursing. How we perceive our role depends on how we perceive nursing — health oriented and comprehensive in scope, or illness oriented and bio-physical in scope. Nursing has always recognized man in his entirety — bio-psycho-social and spiritual — and has prepared practitioners to provide what has been called comprehensive care. Expansion of the role of the nurse to include skills of assessment, management of clients with long-term illness and other care, hitherto the function of medical practitioners; health counselling and other such skills, is only taking advantage of the resources the professional nurse has to offer. Much of what has been considered an expanded role has been carried out by many

nurses in isolated areas. What is new is a serious concentration on mastery of these skills, adding some new ones and assuming responsibility for these actions as part of the nursing function. At the same time, accessibility to the nurse through all avenues of service, will provide the kinds of health and illness care now being demanded by citizens.

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4. Faculty, School of Nursing. *Guide to the Systematic Assessment of the Health Status of the Individual.* Winnipeg, University of Manitoba, 1973. n.p.

   Also, Canadian Nurses' Association. *Countdown 1973.* Ottawa, Canadian Nurses' Association, 1974, p. 131.

The QUERY AND THEORY column will resume in the Fall, 1974 issue, with responses to the question posed by Moyra Allen, on nursing demonstrations in community health, and to Irma Riley's query on priorities in post-operative patient care. What problems, issues, ideas occupy your thoughts at this time? Send your questions to the editors!

EXPANDING THE ROLE OF THE NURSE

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It is now widely accepted that improvement of efficacy and efficiency of our health services necessitates, among other things, a realignment of functions or roles of health workers. Considerable time has been devoted to thought and discussion of the roles of various members of the health team, and physician and nurse are often at the centre of controversy. There seems to be little doubt that these two members can in cooperation arrive at a more effective use of their respective skills and time in working to meet the health care needs of people. Many factors point to the necessity for nursing to take broader responsibility in the health field.

The School of Nursing at McGill University responded to this imperative by establishing a nurse internship of two months following upon the baccalaureate degree program. Experience for the plan is found in four ambulatory care centres and places are provided for sixteen interns. At the present time there is a nurse coordinator from the School in each area who is responsible for the planning and for a considerable amount of teaching.

Pre-eminent among the reasons for adopting the idea of the internship was the advantage of utilizing the nursing skills and abilities developed within the baccalaureate program as a most suitable base from which to expand the scope of nursing. It was also hoped that in clearly identifying and putting to use the skills acquired in the degree program, doubts regarding their usefulness could be allayed.

The nursing student in the university program with a base of physical and behavioral sciences learns to assess the state of health of individuals, taking into account the influences of family and community. This kind of health assessment requires a high degree of interviewing skill so that the nurse can elicit from the patient information which will lead to an effective plan of nursing. This intercommunication has a therapeutic aspect through which a patient or client can find tension relief or support. Although good interpersonal relationships rely somewhat on seemingly innate personality traits there is much to be learned about human behavior and the art of helping. How this base of knowledge and skills acquired by the student in the university is applied to the study of health and illness is of the utmost importance in preparing the nurse for a unique role in the health team. In the degree program various courses and nursing experiences are provided which will help the student appreciate the

human being as a dynamic integrated organism subject to internal and external influences on health and illness. This student learns to concentrate on individual abnormalities of function rather than details of pathology, although pathology plays a part in this understanding. This notion of "wholeness" is not necessarily acquired easily and is somewhat hard to test.

The ultimate goal of the degree program in nursing is that the nurse through an understanding of health and illness and the ability to assess health status will be able to provide appropriate nursing measures. Some of the information required by the nurse for this purpose must be gathered from other sources, especially the physician. The ability of the nurse to glean more of the information needed through the ability to carry out more specific physical examination would enhance the nurse's understanding of the patient's problem and could in fact provide direct assistance to the physician. With this in mind medical history taking and physical examination are being introduced into the basic nursing curriculum. These skills are not added onto the program but rather incorporated as the means of gaining as much information as possible in the investigation of health problems as a preliminary to planning nursing care. Thus the expansion of the scope of nursing is not seen in terms of an added technical skill or two, but rather in relation to the capability that the information acquired allows; capability to extend health care.

Briefly then the successful student arrives at the conclusion of the degree program with a comprehensive understanding of the significance of health and illness to the human organism which can lead to effective nursing intervention. It is upon these understandings and skills that the internship is built.

An internship by its nature is a reality situation in which a newly graduated student becomes thoroughly involved. This is the pattern of the nurse internship at McGill. Because the nurses' physical assessment and history-taking skills have not yet become incorporated thoroughly into the scheme and therefore into the student's approach, considerable time, at least sixteen hours each week, is spent with the physician in developing these skills. In addition the nurse intern spends time in working with new patients and in carrying out plans for health supervision and counseling. These interns are members of the health team — even though it sometimes has only two members — and carry responsibility for the provision of health care in the unit. They are expected to take a family-centred approach, backed by their previous study of human growth and development and sociology of the family in conjunction with repeated family contacts and continuous accumulation of family data.

The nurse-interns come together weekly with their nurse teachers and a physician consultant where indicated, for the study of specific health problems and nursing care situations. Videotapes, films, and other audio-visual aids are used. The interns are expected to spend time in the library following up on the day's experiences. For some students this is already a habit of learning. For the most part each nurse-intern has an individual learning program to the degree that the intern is able to identify learning needs. This is probably the essence of any learning experience, but is particularly important in the internship if the nurse is to arrive at a useful integrated base of knowledge. The nurse-coordinator plays an important part in the interns' learning and as nurse-teachers themselves become more experienced in doing physical examination they can carry the bulk of teaching. In the meantime the age-old process of passing on skills is proceeding and must be done to the satisfaction of the "passer".

Assessing the progress of the nurse-intern focuses on two interrelated aspects. Firstly, skills in sensitive and accurate history taking (developed in the nursing course) and in physical examination must reach the point where the nurse can recognize significant abnormality and conditions of instability. Secondly, the use made of the information gathered will in the long run depend upon the situation in which the nurse functions. Within the internship the nurse is expected to use this information to identify health problems and to decide upon an appropriate course of action. Progress in this area is monitored within the health team by the nurse-coordinator and physician, and a final examination is given.

For the most part the interns make use of the experience that is available to them. However, additional time is spent with a nurse interviewing anxious patients in an emergency setting, getting experience in pelvic examination and in the examination of children for those who were not finding this experience. No attempt is made to have interns acquire a mass of information about a variety of diseases, rather, the goal is a unified body of knowledge about the human organism and an understanding of manifestations of malfunction. This process begins with the nursing program, not the internship. With placements available for sixteen students, selection of those who are interested and ready is important. Lack of interest or lack of readiness means that the nurse will choose some other aspect of nursing, or some other method of preparation for expanding the scope of nursing.

In selecting candidates, emphasis is placed upon consistently good academic standing, level of achievement of skill in nursing, including interviewing, and the nurse's preparation in general. Nurses

from both the basic and post-basic programs are considered. These two groups have arrived at the degree level in markedly different ways and therefore have different qualities to assess and different needs to be met in the internship.

The intern program is not planned to prepare nurses to function in a particular role, but to provide a health service that is needed in many settings, a service which is not always available, that of health teaching, supervision and counseling; that of health maintenance. This nurse with an expanded role is found to be more valuable in association with the physician and other members of the health team. Where this nurse can most effectively function must be investigated through demonstration, experimentation and evaluation. Research is also a responsibility of the university and such investigation is under way.

THE B.Sc. (N) GRADUATE AS A NURSE PRACTITIONER

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Since the beginning of the basic baccalaureate programme in McGill University, the overall goal has been to prepare nurses who are capable of giving thoughtful nursing care to patients in any situation.

The curriculum was devised to ensure sufficient science content not only to fulfill the requirements for the degree, but also to enable the student to develop a scientific approach to nursing. The emphasis is on the way the student learns to nurse rather than on the nursing skills she acquires. This, to us, is the key to baccalaureate education in nursing. It also allows us to say that our graduates have potential as nurse practitioners that will help them to develop nursing in response to the need for health services.

Three years ago, we implemented a revised curriculum in accordance with changes in general education in Quebec. Students who enrolled in 1971 were enthralled with the literature pertaining to the nurse practitioner. In the announcement for the academic year 1971-72, a statement appeared which said that an internship would be planned for selected students following completion of the program. (This was initiated in 1972 and is described in the previous article). This paper relates, then, to the three years of the basic curriculum preceding the internship, which is now available for approximately one-third of the class.

The science component of the curriculum is composed of a minimum of 30 credits of biology, chemistry, physics and calculus taken as part of the sixty credits for the collegial diploma which is required for entrance into the university. Students take a minimum of 24 credits in science courses of the 90 credits required for the baccalaureate degree.

In the first nursing course, the development of the skill of observation as a professional tool is emphasized. The use of medical apparatus such as sphygmomanometer and stethoscope as extensions of the student's senses is encouraged. As the year progresses students become adept in using a stethoscope to listen to chests of pre- and post-operative patients whose surgery is elective. They learn to assess the effect of the patient's efforts to deep-breathe and cough. If the

patient's course is normal, the student has experienced hearing how healthy lungs sound. Some patients develop a post-operative pneumonia which allows the student to hear one type of lung sound related to illness. In brief, a student can use what was formerly thought to be exclusively medical examination to enhance her assessment of what is exclusively nursing — that of persuading the patient of the importance of deep breathing and coughing in relation to anaesthesia. If the student is able to use her science background as a way of learning to nurse, there is no problem in her study. Teachers select patients to increase the complexity of study each year. Students move from acquiring skills to assessing the outcomes of their plans. Their knowledge base continues to expand as questions are asked of their general courses which they then apply to the professional courses. By the third year, the student really focuses on examination of what is health to the individual and how he is maintaining that health. Families are also involved and this allows for an in-depth look at the variables which influence health.

Throughout the program, the student has had to develop interpersonal relationships which foster the type of milieu which supports the study of nursing. A basic baccalaureate student really "swims against the tide". She is a minority in the nursing world. She is prepared to be a responsible person in our society. Her satisfaction at the moment comes from patients. Slowly, the health professions are recognizing the worth of helping the person learn versus demanding repetition of a more traditional type of nursing performance.

There is some doubt that we need great numbers of nurse practitioners!(1) I would personally agree that we need to look carefully at this phenomenon as it mushrooms. However, there is no doubt that the baccalaureate nurse is needed in ever greater numbers not only to practise as a nurse practitioner, to do what has not ever been done for people in general in relation to health, but also to do what has not been done in nursing owing to the small number of persons prepared in basic baccalaureate programs.

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Projet de recherche sur l'étude des effets d'un rôle nouveau de l'infirmière à l'Hôpital Général

JANINE DRAPEAU

Dans le cadre de l'extension du rôle de l'infirmière la Direction du service du nursing du Centre Hospitalier de l'Université Laval a décidé de soumettre pour subvention un projet de recherche à la Direction des programmes de recherche, Ministère de la santé et du bien-être social, — année financière 74-75. La direction de ce projet a été confiée à Mlle Janine Drapeau, adjointe à la directrice du service du nursing (éducation et recherche).

Le projet porte sur l'étude des effets d'un rôle nouveau assumé par des infirmières au niveau des soins de deuxième et de troisième ligne en milieu hospitalier.

Ce rôle consiste, pour l'infirmière départie de ses fonctions habituelles et ayant bénéficié d'une préparation spéciale, à agir comme interprète et médiatrice du malade auprès de l'équipe de santé alors qu'elle assume chez ce même malade l'investigation des données de base traditionnellement confiée à l'équipe médicale (questionnaire et examen physique).

La conception d'un tel rôle origine des lacunes perçues dans notre système de distribution de soins chez les malades hospitalisés ; lacunes auxquelles nous croyons que des infirmières bien préparées pourraient pallier telles les données de base qui ne sont pas investiguées chez tous les malades de façon systématique, telle la coordination rendue plus difficile pour l'infirmière qui ne connaît pas beaucoup les problèmes médicaux du malade et les buts poursuivis par le médecin, etc.

Le centre autour duquel gravitent les activités de ces infirmières est donc le malade avec lequel et auprès duquel elles veillent à ce que les pré-requis d'information et de communication soient réunis pour que l'équipe de soins soit en mesure d'offrir au malade des soins de qualité optimum.

Dans l'optique de soins individualisés, complets et continus, leur rôle consiste plus particulièrement à :

—Faire l'investigation des données de base chez le malade hospitalisé, puis identifier les problèmes* qui en découlent et qui sont reliés à l'état de santé du malade ;

* Selon l'optique de Weed (1969)

—se faire l'interprète du malade hospitalisé auprès du médecin traitant d'abord, puis auprès de toute l'équipe de soins;

—se faire le médiateur, l'avocat du malade auprès de l'équipe de soins pour assurer que — coordination — les problèmes reliés à l'état de santé du malade soient solutionnés ou contrôlés au plus tôt selon un ordre de priorités et tenant compte des ressources du milieu.

Ne font pas partie du rôle de l'infirmière le fait de:

—poser un diagnostic

—instituer un plan de traitement

—établir un prognostic

Les fonctions qui dérivent de ce qui précède sont les suivantes:

—Faire l'investigation des données de base chez le malade hospitalisé, par le questionnaire d'admission, l'examen physique et les rencontres subséquentes avec le malade, puis identifier les problèmes* qui découlent de cet inventaire et qui sont reliés à l'état de santé du malade;

—établir selon un ordre de priorités la liste temporaire* des problèmes reliés à l'état de santé du malade et découlant des données de base;

—s'assurer, auprès du médecin traitant, qu'un plan d'action est élaboré* et modifié au besoin pour chacun des problèmes reliés à l'état de santé du malade;

—coordonner les interventions de l'équipe soignante afin que les problèmes reliés à l'état de santé du malade soient satisfaits au plus tôt, selon leur ordre de priorité et tenant compte des ressources intra et extra-hospitalières;

—collaborer à la rédaction du dossier du malade;

—explorer avec le malade les effets qu'ont sur son vécu les interventions faites par l'équipe soignante pour aider à la solution ou au contrôle des problèmes reliés à son état de santé;

—accepter à l'occasion d'être déléguée, en tant qu'infirmière, par l'équipe de soins pour exécuter, en totalité ou en partie, un plan d'action.

Des objectifs de formation ont donc été élaborés à partir de ce qui précède et quatre infirmières du CHUL (2 bachelières et 2 non-bachelières) ont bénéficié d'une période intensive de formation de cinq mois pour les préparer à assumer ce rôle.

* Selon l'optique de Weed (1969)

La recherche projetée pour étudier les effets de ce rôle nouveau de l'infirmière au niveau des soins de deuxième et de troisième ligne sera d'une durée d'un an — dont six mois d'expérimentation — et se déroulera dans un petit hôpital général qui ne reçoit pas en stage d'étudiants en médecine.

Ont agi comme consultants dans l'élaboration de ce projet de recherche :

—Mlle Rita Dussault, M.N., Dir. Ec. Sc. Inf., Université Laval.

—Mlle Thérèse Fortier, M.P.H., Assist. recherche, Département médecine sociale et préventive, Université Laval.

—Dr. Jean Rochon, Ph.D., Dir. Département médecine sociale et préventive, Université Laval.

—M. Paul-Marie Bernard, M.Sc., Assist. recherche, Département médecine sociale et préventive, Université Laval.

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POSITION ON EXPANDING ROLE OF NURSING

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The Memorial University of Newfoundland School of Nursing is in a university which believes that community service and reaching out to all areas of the province is as important as teaching, publishing and research for faculty members. The School is in a province in which nurses have worked in an expanded role in many small or isolated communities for years. Thus we believe the baccalaureate program should prepare nurses who will be able to increasingly expand and modify their role as the needs of the health care delivery system change. We further believe that a nurse with appropriate preparation can work in an expanded role in all settings, i.e., what a nurse can do safely and effectively in Jackson's Arm or Mary's Harbour, the nurse could do in urban settings. We believe this can only improve health care and help the health care team to meet the health needs of citizens better.

We are just finishing the pilot project of the Family Practice Nurse Program. Next year some of the content of this curriculum will be integrated into the basic baccalaureate curriculum. When our curriculum revision is complete it is expected that the graduate will have a better foundation of knowledge and skills to expand her practice as the needs of the people and the health care team require.

THE FAMILY PRACTICE NURSE IN NEWFOUNDLAND

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The expanded role of the nurse is not new to Newfoundland. Nurses in this province, working in public health agencies, health districts and in cottage hospitals, *had been* for many years, and in some places still *are,* working in an expanded role.

Organized district nursing was started in 1920 by the Outport Nursing Committee. The nurses came to the districts prepared as midwives, and no further formal training was provided(1). From 1935-1941, a course was available in Newfoundland for nurses who worked in areas without physicians. The course of instruction consisted of how to do T & A's and dental extractions with anaesthetic, how to run pre-natal and well-baby clinics, and lectures in "General Public Health" and "Midwifery"(2). Until the advent of the Medical Care Plan in 1969, the public health nurses did the initial health screening of patients who received social assistance, assisted in delivering babies, and treated minor ailments under physicians' standing orders. Today, there are still some public health nurses in rural areas who spend a part of their time in curative programs. Nurses in cottage hospitals continue to have a more expansive role than nurses in larger hospitals. The extra preparation required for this expanded role today is obtained on the job, either through self learning or through the help of a physician.

In April 1971, an advisory board was set up to look at the possibility of starting an educational program to formalize what many nurses were already doing. The project was to be a joint program of the Faculty of Medicine and the School of Nursing, Memorial University of Newfoundland. Since the impact of the nurse in an expanded role giving service in a rural area was already known, the project director, Dr. B. Suttie, decided to look at the role in an urban setting, working with a physician who was employed in a fee-for-service practice. The objective of the research project was to measure the impact on patient care, and the transfer of functions (from physician to nurse) by the introduction of a family practice nurse into an urban general practice.

A working party to define the role of the family practice nurse was set up in April 1971. Representatives were included from Memorial University of Newfoundland Faculty of Medicine and School of Nursing, the Association of Registered Nurses of Newfoundland,

Newfoundland Medical Association, College of Family Physicians and the Department of National Health and Welfare. The terms of reference included defining the existing expanded roles of nurses in primary care in Newfoundland, identifying areas of needed activities in health care and specific functions that the nurse could carry out to help meet these needs, and to construct an expanded role for a nurse, attached to an urban or rural general practice. Members of the working party visited many areas in the province and interviewed nurses and doctors with the intent to review the present needs and to receive suggestions as to the role of the nurse in primary care in the future. During the course of time spent surveying literature and making site visits, it became increasingly apparent that any course started should have portability between provinces. This would mean that it would be built of recognized components. It was also suggested that many of the courses would eventually become electives offered in the School of Nursing. Too many short courses, recognized only in the province where they are given, were being offered. Although these courses had some components in common, the content and the length of the course varied from program to program. The working party also shared the belief that social sciences should be included in the curriculum.

A second working party was established to build a curriculum, using as the basis, the role defined by the first committee. This nurse would learn to take a medical and social history, do an integrated physical examination, diagnose and treat (including medication) some common illnesses such as upper respiratory infections and common rashes, and monitor chronic illnesses such as diabetes and hypertension, and change treatments within predetermined limits. Thus the role would include preventive and curative aspects. The curriculum designed by members of the Faculty of Medicine and School of Nursing included psychology, sociology, therapeutics, nutrition, communication skills, as well as the necessary skills required to do physical examinations and treat illness. The working party preparing the curriculum believed the emphasis should be on learning the normal. The report of this Committee was completed in November 1972 and approved by the Advisory Board of the Family Practice Nurse Project.

The first students, from rural areas were admitted to the course in September 1973 by the request of the Newfoundland Government. This is a pilot program, allowing the project members to see if the curriculum meets the specifications of the defined role. It is not part of the research project.

During the year 1973, an evaluation committee of eight people,

from the College of Family Physicians, Memorial University of Newfoundland Faculty of Education, Community Medicine and School of Commerce, has been preparing the tools for the evaluation of the urban family practice nurse. The research strategies include a cost analysis, a study to determine the adequacy of patient care, the amount of function transfer, and patient satisfaction. The instruments to be used are household survey questionnaires, day sheet diaries in the study practices, duplicate prescription forms, indicator condition criteria, expenditure and revenue in the study practices, modified MCP billing form, mortality, and a questionnaire for practice personnel.

Memorial University of Newfoundland School of Nursing believes there is a place for the nurse in an expanded role in Canada. We believe the education for this nurse should be portable and be build from identifiable components that can be integrated as electives into a baccalaureate program for nursing. Thus we are jointly involved in a research project with the Faculty of Medicine to measure the impact of the Family Practice Nurse on patient care in an urban fee-for-service general practice.

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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 colleagueship 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.

POSITION PAPER: EXPANDED ROLE OF THE NURSE

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Why is it necessary at this time to articulate a position on the "expanded" role of the nurse? It is true that for some time now there has been a notable public outcry against fragmented and expensive health care, as well as increased public awareness of appropriate and satisfactory health care. The question, however, remains whether or not an expanded nursing role will have the desired impact on the health care delivery system. In other words, if nurses share a greater responsibility in heretofore medical procedures will public demands be more effectively met?

The question must also be raised as to whose role is expanding. For many years registered nurses in special settings have performed what are now seen as "expanded" functions. In remote areas, as well as other situations when a physician is not available, nurses have engaged in patient assessment and carried out primary care. One issue which seems to be open for debate now is whether or not nurses are to engage in primary care in settings when the physician is present and if, in fact, this will solve the health care delivery system dilemma. Perhaps, another alternative might be to lift the medical school student quotas which would bring many more doctors into the labor force; of course, with the well known economic consequences to the medical profession.

If, however, the solution of choice is the "expanded" role of the nurse, the key issue to be addressed is that of utilization. In the Maritime Provinces, there are few settings in which baccalaureate nurses are given the autonomy and independence to practice to their level of expertise, since nursing practice seems to always be legitimatized by institutions or other professionals. We must now redefine our professional norms and grasp our own autonomy in order to insure appropriate utilization of these new skills(1), as well as functions already included in the Dalhousie — Mount Saint Vincent curriculum.

In reviewing the Boudreau Report, it is increasingly clear that the only gaps which are currently present in our curriculum are physical assessment skills and the ability to make knowledgeable treat-

* This paper was prepared by the Special Committee on the Expanded Role of the Nurse.

ment decisions in collobaration with a physician. If these areas are included, how can we best assure implementation that will provide optimal patient care?

The key lies in interdisciplinary collaboration whether it be in episodic or distributive care settings. The client can best be served when two health professions join together to provide skillfull and comprehensive care(2). If we are not to lose sight of nursing's raison d'etre, we must address ourselves to our own professional liberation and establish our professional boundaries and norms in an effort to achieve legimate power and authority(3).

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A NURSE PRACTITIONER PROGRAM

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The College of Nursing is co-operating with the Saskatchewan Department of Public Health to prepare nurse practitioners who will work in four pilot project communities in Saskatchewan. The provincial government is providing financial support for the training program, is giving bursary support to the four candidates and will make funds available to the four communities for a two-year period in order to carry out the project. The Research and Planning Division of the Department of Public Health will evaluate the project to determine whether utilization patterns of those seeking health services have been altered.

The curriculum for the training project was developed by a committee of faculty members from the College of Nursing and the Department of General Practice of the College of Medicine. The program will take six months and will have a concurrent preceptorship with a physician in general practice. Courses include: (1) Diagnosis: History-Taking, Physical Assessment and Laboratory Procedures; (2) Management and Treatment of Disease Conditions; (3) Counselling and Teaching for Health Maintenance; (4) Ethics, Roles and Relationships.

The candidates were selected and the program began in March. They will start work in September, 1974 in their communities. Three of the communities do not have a resident doctor. The nearest doctor is 25 to 35 miles away. A physician in a nearby community will act as an advisor or mentor for the nurse-practitioner who will be the primary health care professional for the people in her community. The fourth community has physician services and the nurse-practitioner will be associated with a group of physicians and will travel out to several nearby communities to provide health services. In every case the nurse-practitioner will be expected to assess the client and determine a course of action which might include initiating treatment.

During the course of the two-year project a joint committee with representatives from the Saskatchewan Medical Association, Saskatchewan Registered Nurses Association, Saskatchewan Pharmaceutical Association, College of Medicine and College of Nursing University of Saskatechewan, and the Research and Planning Division of the Department of Public Health will monitor the service. Matters

requiring interpretation or policy decisions will be referred to this committee.

The College of Nursing will expect to gain a few tangible benefits from participating in the program. A number of audio-visual aids and auto-tutorial materials will be developed for the training program. Most of these can then be used in the two baccalaureate programs offered by the College. In addition the faculty will be assessing how preparation for the nurse-practitioner role can be incorporated into the basic baccalaureate program. We will be seeking to identify the principles and techniques that are presently included in our programs and then will determine the additional preparation that is required for the nurse practitioner role. It is hoped that within the next year or two this additional preparation can be offered at least on an elective basis to students enrolled in a regular program of the College of Nursing. Two important features of our present programs are to emphasize the rural nature of our province and to prepare graduates for the possibility that they may be working in isolated situations. An objective of offering preparation for the nurse-practitioner role would be to enable the nurse to work in a very independent way but with full knowledge of how she may use collaborative support from other health professionals including the physician.

THE EXPANDED ROLE OF THE NURSE: A POSITION PAPER

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This position paper on the expanded role of the nurse reflects the opinions of the director of the University of Alberta School of Nursing and the program co-ordinators.

For many years nurses in the rural areas of Western Canada and in the isolated area of the Canadian North have functioned in expanded roles, without these being designated as such. However, emerging societal and governmental pressures related to reducing health care costs, better utilization of health care workers and the need for selected types of physician substitutes to provide medical care in remote areas, have together created a trend toward greater formalization of "expanded" roles for nurses.

At the University of Alberta, we have tended to identify the expanded role of the nurse in terms of developing "independent" aspects of nursing in the care domain. Our focus is on developing greater depth of knowledge and skill for assessment, teaching, counseling and using judgement concerning nursing competency limitations. In effect, this approach prepares the nurse to function as a nurse practitioner in the realm of primary care. However, we are also cognizant of the additional need to prepare some nurses to fill an extended role, where they are capable of performing tasks which are "normally" considered to be the purview of the physician.

In conjunction with these differential roles we are also aware that the type of education needs to be relevant to the degree of responsibility demanded of the nurse. Ideally preparation should be at the baccalaureate level. The solid foundation of basic and social sciences acquired in the baccalaureate program enables the nurse to function independently and use high levels of decision making. Nevertheless if expertise is required for highly specialized areas specific additional courses may need to be taken.

Preparation for specific routine tasks, however specialized, can be carried out in short-term educational programs. Consequently clinical courses with an emphasis on skills could and should be taught in the college system. However, the critical question of location of such courses rests upon the resources available both selected clinical facili-

ties and skilled teaching personnel. In light of these factors we take a somewhat pragmatic view of the question of location.

There is increasing emphasis in the curriculum of the University of Alberta's baccalaureate program, on the process of nursing assessment together with the integration of critical thinking, skills basic to the nurse's being able to function independently. Provided with these basic foundations we are encouraging our graduates to work in positions which allow them to function in an expanded role. Faculty are also accepting the responsibility for self-development in assessment skills by working in local family practice units.

We have three on-going programs, and one proposed program in the School which illustrate our basic concern for and commitment to the need for well-prepared clinical nurses. The nurse-midwifery program (Advanced Practical Obstetrics) has been in existence since 1943 and is accepted as an elective for one course credit in the post-basic baccalaureate program. Secondly, the Northern Nurse program is part of a nation-wide demonstration initiated by Medical Services which commenced three years ago; this program is aimed at developing nurses' "independent" nursing skills as well as providing selected learning experiences in the "physician substitute" role. The graduating practitioners from this program are being extensively evaluated with respect to their competency and proficiency. Thirdly, the continuing education program is also helping nurses expand their roles, particularly in the areas of history-taking and physical examination.

In addition to the above, the School is actively participating in two extra-school areas. Firstly, we have, over the past five years, participated in the development of an interdisciplinary graduate program for health service administrators. The assumption is that improved utilization of all health workers is considerably dependent upon there being health care administrators who understand both the wide range of health care needs of the public (including identifying needs which are substantially unmet), and the complex dynamics of expanding professional roles which include those of nurses. Secondly, we have actively participated in the work of an Allied Health Professionals' Group which is systematically evolving expanded roles for nurses. Among the proposed roles is that of a Nephrology Nurse Clinician, currently in the research proposal (demonstration project) phase.

Finally the proposed (1974-75) M.N. in Nursing in Acute Illness program is specifically aimed at expanding the independent clinical functioning of nurses. Thus while we have not developed a comprehensive School position on expanded roles we are at present offering and are associated with courses and programs which constitute tangible, direct responses to changing community needs. These efforts

reflect our philosophy that the effective expansion of nursing roles goes far beyond merely making internal adjustments in education and practice in the nursing profession. A multiplicity of interrelationships with other professionals and agencies are involved in stretching beyond the educational walls per se.

The university schools have a decided advantage for interprofessional teaching and learning both at the undergraduate and graduate level. It is hoped that our proposed graduate program will be able to fully utilize our University's wide resources as it builds on the foundation of the baccalaureate program. If we can make the fences presently erected around specific professional groups increasingly permeable, the opportunity for greater flexibility of roles becomes both more apparent and more feasible.

The process of role change is being examined in a demonstration project presently underway in a satellite community. The purpose is to look at the processes occuring during the introduction and integration of "allied health workers" into a medical clinic: namely, nurses functioning in a so-called expanded role.

Opportunities for practice in an extended role may well be enhanced by the trend towards the development of community health centres in Alberta. Nevertheless we must still be aware of the need for highly qualified nurses functioning in an expanded role to care for the acutely ill. Emphasis should not be placed on one facet of the expanded role to the detriment of the other.

The trend at this University is to be responsive to the needs of the community and develop innovative methods for the preparation of nurses to function in expanded roles. We are of the opinion that a "final" position about the expanded role would be premature (i.e., given that the needs picture is only beginning to unfold), consequently we are maintaining a very flexible interpretation of what the "extended role" can and should involve.

THE BACHELOR OF NURSING PROGRAM AT THE UNIVERSITY OF CALGARY

The School of Nursing at the University of Calgary was established in 1969 and admitted its first class of students in the fall of 1970. Although these events predate the work of the Department of National Health and Welfare Committee on Nurse Practitioners chaired by Thomas J. Boudreau, the philosophy of the School is remarkably consistent with the views expressed in that Committee's report. This is probably not surprising given the increasing interest shown by the nursing profession in the changing role of the nurse in society.

The purpose of the School is to prepare nurses who are qualified to assume first-level positions in professional nursing. To this end the program is designed to provide students with the opportunity to gain knowledge and skills about, and a sensitivity to and understanding of, basic personal, social and professional problems and situations with which the nurse-citizen will have to cope.

The Bachelor of Nursing program at the University of Calgary is a four-year integrated program and is arranged so as to provide general education along with a professional component. By general education, we mean that a substantial number of the courses are selected from the humanities and the social, behavioral, biological and natural sciences, and these are taken concurrently with the nursing courses throughout the four years of the program.

The professional component of the program is based on the developmental approach. The beginning term of the first year emphasizes the discipline of nursing, a beginning understanding of nursing as a profession and its relation to the historical developments of the past and nursing today. This part of the course also deals with communication skills, such as observation, interviewing and interaction with the patient and his/her family or other significant persons. Two hours of laboratory per week are planned in order to provide experiences with these communication skills.

The second term deals with basic concepts, such as the family, the individual and the community. Concepts related to health-illness and the nursing process are also introduced. Students at this time are in the clinical areas for eight hours per week in a hospital and community setting where they are able to implement significant tasks of nursing, such as assessment of the patient's physical health, his environment, his perception of the illness and changes in his role as a sick person, etc. This also includes simple nursing measures, such as

providing comfort care (bed bath, back rub, etc.), assessing vital signs, communicating with the patient and his family. Each student is also assigned to a healthy, functioning family. The objectives for this experience at this time are to understand the dynamics of a healthy family, coping mechanisms of a family unit, a family's utilization of community resources in order to provide optimum care to its members. Understanding is also developed in group process by providing experiences under the leadership of a group leader in a lab setting. This enables students to understand group dynamics and develop sensitivity to each group member.

The second year of the program builds on the developmental framework. The emphasis during the first half of the academic year is on childbearing families, whereas, during the latter part, is on child-rearing families. Each student is assigned to a family where there is a pregnant woman in the last trimester of her pregnancy. The selection of a family is made with the consultation of the attending physician.

The emphasis is on the normal maternity cycle, factors influencing the outcome of a pregnancy with changing concepts in maternity nursing. The students gain understanding in the crisis theory, developmental tasks of pregnancy, role changes, tasks of new parents, integration of a new family member into a family, etc. The experiences are provided in the physician's office, patient's home, prenatal classes and hospitals.

Each student is expected to follow a single mother during pregnancy, through labor and delivery and the postpartum period. As a point of interest, the experiences continue with the same woman and her family during the child-rearing phase.

The skills acquired are: history taking, interviewing, physical assessment (vital signs, weight, urine testing, auscultation and palpation), nutritional assessment and counselling, and providing anticipatory guidance according to the assessed needs of a particular family, Students are also encouraged to involve any community support services, if necessary, in order to provide total care to the family under their care.

In the latter part of the second year, the objectives are geared to meeting the needs of child-rearing families and changing concepts in child care. Students develop understanding and appreciation of various child-rearing patterns, ethnic group differences and the role of parents in our contemporary society. They are assisted and encouraged to utilize the knowledge gained in developmental psychology in assessing the growth and development of children at different age levels, e.g. using Denver Developmental Screening Test. They are

also made aware of the supporting agencies, official and voluntary, in maintaining and encouraging the positive growth and development of children in a given community. Each student spends part of the clinical time in the paediatrician's office, well-baby clinic, pre-school screening tests in school (elementary and junior high) and studying agency structure and function in providing care for children with special problems. The clinical experiences are also provided in an acute hospital setting and long-term institution in order to understand the acute phases of patho-physiology in children along with implications of long-term illness to the child and his/her family. The emphasis is placed on changing concepts of child care in general and, in particular, in a hospital setting during this experience. The skills acquired are, again, of physical examination, interacting with children and parents, health teaching and various manual skills in order to provide total care to the child and his/her family.

In the third year of the School's program, the courses in nursing focus on the nursing care of adults. The emphasis is on the common illnesses (according to the Dominion Bureau of Vital Statistics) of adult life. The students develop understanding in the patho-physiology of different illnesses and specific nursing measures necessary. They also develop understanding and appreciation of developmental tasks of an adult, role changes with sickness, impact of illness on a family, etc. The philosophy and principles of mental health/psychiatric nursing are integrated from the first year of the program, but a significant number of hours are spent in understanding various mental health problems in the adult population of our society. Students' experiences are in general hospitals of the city, with careful selection of patients with acute episodes of illness and long-term illness. Experiences are also provided through the V.O.N. home care program, ambulatory care centres, physicians' offices, day care centres, and patients' homes. The skills which further develop are primary care skills, such as physical examination of an adult patient, interviewing and interacting with the patient, family and various health team members in planning care for the patient under their care.

The final year of the School's program involves student experiences which are planned with multiproblem families in the community who demonstrate a complexity of physical, cultural, social, economic, psychological and vocational problems. This includes a cross-section of problems representative of all age groups.

The nursing content further explores psychodynamics of family living, families and communities in poverty, group dynamics and group interaction, the interdisciplinary approach in delivery of health care systems, etc. The students develop understanding and skills re-

lating to physical health, nursing diagnosis, health maintenance, health promotion, management of common physical and emotional health deviations and development crisis solving. They also learn to function as part of a team in meeting all of the health needs of a specific situation.

During this final year they are involved in a course which attempts to help develop an effective and constructive approach to exploring issues and problems facing the nursing profession. Students are involved in identifying these issues and problems and then work in groups or individually on them. Extensive use is made of expert resource persons in the discussion of specific items. Some of the issues related to the development of the nursing profession which were explored this past year were the education of nurses for professional and technical roles, licensure, collective bargaining and the creation of change in bureaucratic organizations, to name a few. Other sessions have dealt with social issues and the general area of research.

In the light of the curriculum as designed, and experiences provided during the four years of the program, the graduates of this program should be able to function in various settings such as community health centres, ambulatory care centres, hospitals, nursing stations in isolated areas and wherever the delivery of health care is possible.

The graduates will have developed knowledge and skills relating to physical, emotional and psychosocial health, nursing diagnosis, health maintenance, and the promotion and management of common physical and emotional health deviations. They should also be able to assume responsibility in making independent and interdependent decisions regarding medical, nursing or other intervention required for a particular patient or a family.

In summary the baccalaureate program at the University of Calgary is striving to prepare nurse-citizens for a broader range of activities as they relate to the nursing profession in the light of changes in the delivery of health care in this country.

EXPLORATION OF THE "EXPANDED ROLE" OF THE NURSE IN A PRIMARY CARE SETTING

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During the past year an interest group of the Faculty of Nursing at The University of Western Ontario has been meeting with a view to delineating our position on the nurse working in primary care. Initially, we came together to discuss the "expanded role of the nurse." However, early in our deliberations we seemed to arrive at the conclusion that although there are undoubtedly some commonalities in the functions of nurses who are working in what are termed "expanded roles," in reality, what comprises the set of functions in an expanded role depends on the setting in which the role is being practiced. Our attention then became focused on the expanded role of the nurse in primary care settings. When we felt we had raised and discussed the issues related to this role, we decided to use the Delphi Technique as a means of achieving consensus on the issues relevant to the role.

At the time of writing this article, this is the process in which we are involved.

Although the faculty as a whole has not, as yet, taken a definitive stand on the role and preparation of the nurse in primary care, during the past few years individual faculty members have been actively engaged in looking at this role. Also, we have been keeping a finger on the pulse of the local, provincial, and national scenes as they relate to the nurse in primary care and the need for this role.

As one of our faculty who has the opportunity to be involved in a local project to develop a community health centre, I have been able to explore the role of a nurse in a primary care setting, both indirectly and directly. In the remainder of this paper I will be describing our experience in this project. I would also like to share with the readers some of my personal views about the role of the nurse in primary care, and to identify some of the problems we have encountered.

Approximately three-and-one-half years ago, as a representative of our faculty, I became involved in the development of a health centre to provide health services for a medically underserviced rural community which included an Indian Reserve, about twenty miles from London. Within the overall objectives of the project, the Faculty of Nursing was interested in exploring the facets and parameters of the

role of a nurse as an integral member of a primary health care team. What is an appropriate ratio of nurses to physicians on this team? Is this a setting that will afford the baccalaureate graduate the opportunity to utilize a wider range of her skills than in most traditional settings? What additional preparation does a baccalaureate graduate need to function effectively as a member of the primary health care team? These are some of the questions we hoped to answer. Although during this period of time we have worked most closely with two physicians who are members of the Department of Family Medicine, other university faculties and community health agencies have participated in the project.

I would like to interject here that the proposed centre is only now coming into being as a physical facility. Any practice to which I refer has taken place in the temporarily used facilities of the Health Centre on the Indian Reserve. The use of this Centre by personnel working with the project has strained its physical facilities, and these facilities have put some limitations on the way in which the team has functioned. These factors have in turn inhibited some of our explorations of the role.

When I began to work on the project in the spring of 1971, it was thought the centre would be built within the next year. The delays have been partly at the local level and partly at the provincial level.

In September 1971 I was assigned to work one-quarter time with the project, and from then until April 1972 the majority of this time was spent working with the other disciplines on the physical plans for the centre and in discussing with the physicians the role and functions of the primary care nurse. Early in 1972, the omens indicated construction of the centre would begin and completion was anticipated during June or July. A 1971 graduate of our basic baccalaureate programme, Ann (Harris) Bell, joined the project in April 1972 as our would-be primary care nurse. Prior to joining the project, Ann had been oriented to our current thinking related to the role she would assume. Apart from a few days spent with the Victorian Order of Nurses, with the Public Health Nurse on the Indian Reserve, and with the Public Health Nurse in the non-Indian community, Ann's orientation was predominately on-the-job. The service at the Centre was shared by the two physicians. The primary care nurse thus worked part of the week with one physician and part of the week with the other. My time with the project during this year was spent meeting weekly with Ann to discuss her activities, practice and problems, as we attempted to evolve and document the components of her role. We also met regularly with the physicians to discuss the evolvement of the role from their point of view.

The role that the Faculty of Nursing had envisioned for the primary care nurse was one that encompassed the preventive and curative functions of nursing, combining and expanding the traditional practice of office, clinic and public health nurse. She would work collaboratively with the physician and other members of the team, functioning interdependently and independently as appropriate to the needs of patients and her competence. Aspects of the role as we saw it included:

—primary contact

—health assessment, initial and ongoing, to detect deviations from normal

—management of care within her competencies, including non-threatening common illnesses

—consultation and referral to the physician for further assessment where medical diagnosis and treatment are needed

—monitoring of stable chronic diseases

—coordination of care

—health education and counselling

To facilitate coordination and continuity of care the primary care nurse should be free to move between the health centre, home and hospital as indicated by the needs of the individual patient and family.

Most aspects of the planned research could not be instituted because of the limitations of the temporary physical facilities, and because the projected service programme could not be fully implemented until the proposed centre was completed and adequately staffed. However, we did attempt to examine the practice of the primary care nurse and delineate the learning needs, using a semi-structured approach. We identified the functions and activities of the primary care nurse and compared the competencies necessary to carry these out with the compentencies which Ann brought to the role. The learning needs that we identified tended to fall into three categories: (1) review of previously learned knowledge or independent study of new knowledge (2) additional knowledge and skills requiring formal instruction (3) additional clinical practice of previously learned, as well as newly learned skills. The role of the primary care nurse as we were attempting to have it evolve required a breadth of knowledge and skills. Thus Ann felt the need to review knowledge, and practice skills so that she could feel competent to carry out the activities of the primary care nurse role with confidence. The two major areas we identified where a greater depth of knowledge and new skills were needed were in physical assessment and investigation of a problem where an organized, direct approach to interviewing is needed.

In June 1973, Ann left the project when she moved with her husband to another province. When the time came to consider her replacement, it was mutually agreed by our faculty, myself, and the physicians involved that I would be the replacement. We felt we had gleaned as much information on the learning needs of a graduate of our baccalaureate programme for the primary care role as was possible within the limitations of the temporary setting. In addition, it seemed to be an auspicious time for me to gain some first-hand experience in the primary care role and to look more closely at the problems we were encountering. Some of the problems, we thought, might have been related to my lack of credibility as I had not practiced in the role, and to the fact that we were asking a neophyte to pioneer a new role.* I was released from some of my faculty commitments so that I was, theoretically three-quarter time with the project and one-quarter time on faculty. During this past year I have spent four days a week working on the project with approximately three-and-one-half of these providing service and the remainder of the time in meetings and other matters related to organization and practice within the proposed centre.

Like Ann, I worked with each of the two physicians. The temporary facilities were the lower part of an old house with one room converted into an office-examining room, off which was the only washroom. A small sunroom had been converted into an office-examining room for the Primary Care Nurse. These two rooms were separated by a room which was shared by the secretary for Indian Health Services, the secretary for the practice, and the files and records. To wash my hands, to consult with the physician, or to have a patient collect a urine specimen necessitated a trek through the secretaries' office into the other office-examining room.

Initially, we made no attempt to differentiate which patients would be seen by the Primary Care Nurse. This was due, in part, to the fact that unless the visit was a requested return we did not know the presenting problem, and in part to the fact that I was interested in being exposed to the breadth of problems that were presented. This would enable me to look at the feasibility of the nurse being primary contact person and to see what types of problems could be most appropriately handled by the Primary Care Nurse.

The problem-oriented method was used to record a patient contact. In the majority of contacts I was able to elicit and record the patient's subjective description of his problem(s). There were, and continue to

* My experience included one year hospital staff nursing, eight years as a staff public health nurse with both Public Health and V.O.N. agencies, and four years teaching maternal-child nursing.

be, instances when the physician required and elicited additional information. In the next step of the process, I made observations and carried out examinations which I considered relevant and which were within my competence, recording the objective findings. Throughout the year I made an effort to learn additional skills necessary to investigate common presenting problems, such as otoscopic examination of the ears, auscultation of the chest with a stethoscope to identify abnormal breath sounds, and abdominal palpation for tenderness, organ enlargement, and masses. If I were unable to collect all the objective data or if there were indications of deviations from the normal or from a previous stable condition in either the subjective or objective data, I consulted with the physician. Usually, then, the physician saw the patient and we carried out the assessment and plan together.

After the first few months I usually managed independently the common non-threatening and stable chronic problems that did not require a new prescription. However, most of the patients were seen, at least briefly, by the physician, frequently because of the close working quarters. Early in my experience I began to see antenatal patients and well infants or children independently. The physician would perform the pelvic assessment for the antenatal patient, but apart from that, he would see the patient only if I identified a problem. Most of the patients knew the physician, so there was not the need for him to establish a relationship with the antenatal patient.

From our experience to date it does not seem feasible, with the ratio of one nurse to one physician, for the primary care nurse to be primary contact person for all patients and to carry a caseload of her own. Our current thinking is that working as a team, it is more efficient and appropriate, both for the patient and for the use of the respective skills of the physician and the primary care nurse, to have the primary care nurse assume the major responsibility for a defined group of patient problems, as well as for coordinating care and for education related to other problems. The group of patient problems could include antenatal and postnatal care, well infant and child care, care of chronic stable problems, common non-threatening problems, nutrition and obesity counselling, and problems of adjustment such as aging, grief and long-term illness. We will be looking at the primary contact facet of her role when the centre is fully functioning. There will not be limitations of space there, and a nursing assistant will be added to the team to assist both the physician and the primary care nurse.

At this point, in discussing the appropriate use of the skills of the team members, I would like to relate some observations on physical assessment skills. We initially had a lengthy list of physical assess-

ment skills we thought the primary care nurse should be able to perform. After two years of experience and many discussions with the physicians, the number of skills on the list has diminished. In deciding whether a particular skill was appropriate for the primary care nurse to learn we asked ourselves the following questions:

1. What would be the purpose in performing the particular assessment skill or procedure?
2. Would the examination using the skill or procedure reveal a deviation in the absence of any subjective symptom or objective data which the nurse is already competent to elicit?
3. Would it be a skill or procedure she would use frequently enough to justify the time required to learn and to maintain competency in the skill?

To justify learning the skill, we felt that its purpose should be to determine a deviation from normal rather than to identify a specific abnormality, and that the answers to the second and third questions should be "yes".

Rather than spending a great deal of time learning to duplicate the skills of the physician, it seems to me that the time would be more appropriately spent increasing proficiency in those skills that a nurse already possesses. For example, sharpening one's powers of observation and being able to make astute general and specific observations in an organized manner can reveal important information about a patient's physical and emotional status. Precise description of observations is an essential skill, both for one's own future reference, and for communication and collaboration with other members of the team. To describe the location of a lesion, pain or injury, requires a good working knowledge of surface anatomy. These are some of the skills in which we must be proficient to be an effective and credible member of a primary care team.

There are aspects of health care that have tended to be neglected in primary care settings for which a nurse, at least one with a broad preparation such as a baccalaureate, is competent and frequently better prepared and more willing to provide than many physicians. Some of these are counselling and education to facilitate health promotion and prevention of problems, as well as coordination of care. I have been performing developmental assessments on infants and young children, utilizing the information to discuss developmental needs of the child and offering the opportunity for the mother to discuss her child and any concerns she may have. This also provides the occasion to reassure and praise the parents(s) about their childrearing. Coordinating or assisting the patient to coordinate his care as he moves

from the primary care setting to a specialist, hospital, or to other parts of the health care system, can relieve a great deal of anxiety on the part of the patient and his family as well as facilitate continuity of care. It has been a common phenomenon for the patient to miss his appointment. Physicians tend to see "follow-up" as a patient responsibility, however, my community health conscience was bothered by this, particularly as we were seeing some detrimental effects of inadequate treatment. Although the physicians were not particularly keen on the idea, at least initially, I have initiated contact with patients who did not keep appointments given for return visits. The majority of these responded to a phone contact or a letter, by returning for the "follow-up" visit. I have a concern that if there is too much time and emphasis placed on learning the skills of physical assessment, we may find the nurse in primary care emulating the role of the physician, when, in order to bridge some of the gaps in the delivery of primary care there is the need for those skills of nursing which complement the role of the physician.

These comments related to the physical assessment skills needed by the primary care nurse are based on the assumption that the nurse is working in the same physical facility and has ready access to the physician who has these skills, plus a depth of knowledge in clinical sciences and pathology.

The introduction of the Primary Care Nurse into the health care delivery system is a change in the system that will effect changes in other parts of the system. With change comes the potential for problems. The problems which we have encountered in the process of putting into practice our concept of the primary care nurse could be categorized as "intraprofessional" and "interprofessional."

From the inception of this project the physicians have demonstrated an active interest in the role of the primary care nurse. They have assisted us with the learning of new skills and have spent countless hours in discussion of the role and activities; however, we have encountered, on a continuing basis, some of the traditional problems that have existed between the professions of medicine and nursing. When there has been disagreement about an aspect of the primary care nurse role or on other matters that related to or affected nursing, we have not passed the true test of collaboration. The administrative structure of the project is such that our power is mainly that of persuasion while the final decision-making power lies with the physicians. As a result most of the compromises have been made by nursing. The only major difference between the "interprofessional" problems experienced by Ann and those experienced by myself was a pressure which she perceived to concentrate on medical activities, and

which she felt result in a compromise of some of her nursing skills. She related this to the on-the-job learning from the physicians which, combined with her sense of relative inexperience in areas such as teaching and counselling, resulted in these nursing activities being neglected, particularly in the face of a crowded waiting room. I think my experience has helped me resist this pressure. This has been reflected by the physicians' change in emphasis on physical assessment skills and therapeutics. They now see teaching and counselling as a more important aspect of the role of the Primary Care Nurse.

The "intraprofessional" problems have been related mainly to the home visiting aspect of the Primary Care Nurse's role. From the early stages of the project, nursing personnel from the community health agencies have been participating in our discussions of the proposed role. Their input based on their experience and knowledge of the community has been of great assistance to us. There seems to be, however, some discomfort on the part of the community health nurses relating to the primary care nurse visiting in the homes. We are planning to coordinate the home visiting of the public health nurse and the primary care nurse so there is not duplication. The thought is that the primary care nurse would visit in the home, when indicated, for those patients with whom she has established a relationship through her contacts in the centre and for whom it seems more appropriate for her to visit than the public health nurse. I think that we are effect this coordination so that the central focus is the patient and that the skills of each nurse are used appropriately thereby avoiding "intraprofessional" problems.

We have encountered no problems related to patient acceptance of the primary care nurse. This may be partly related to the population with whom we are working. We have, however, always made it clear that the physician was available if the patient wished to see him.

I suspect that the long gestational period of this project, which in itself has created many frustrations, may have had heightened anxieties and thus increased the potential for problems. Hopefully, when the centre opens and begins to function, the anxieties will diminish and our problems may begin to resolve.

An additional problem area in which we have had, and continue to have problems is financial. The salary for the primary care nurse is part of a grant from the Ontario Ministry of Health. Initially we had problems convincing them that the role, as we envisaged it, required someone with baccalaureate preparation. There has been continuing reluctance to give approval for a salary which will allow us to be competitive with local health agencies for nurses with a baccalaureate preparation.

Despite the limitations of the temporary facility and the compromises we have had to make, we have gained some valuable experience and information on *a model* for the primary care nurse. The identified learning needs will be of assistance for curricular changes that will assist a graduate to move into this area of nursing. One important aspect to which I believe, based on my experience, we need to give careful consideration is the need to prepare our graduates to be "pioneers" and change agents. There would appear to be a great deal of interest in the "expanded role" for the nurse in primary care and one gets the impression that the system is waiting with welcome arms. This may be! However, I believe that there is still a great deal of pioneering to be done. To do this we need nurses who have a strong sense of identity as nurses. For, if nursing is going to make an impact on the primary health care system, I hope that it is in a role that is based firmly on nursing skills and is a role that complements, rather than emulates the role of the physician.

I would like to acknowledge that in writing this article I have liberally used ideas and thoughts gleaned through discussion with my colleagues on the Faculty of Nursing and from Ann (Harris) Bell who worked as a Primary Care Nurse with this project from April 1972 to June 1973. The views presented, however, are based on my personal perceptions and do not necessarily represent those of my colleagues.

THE EXPANDED ROLE IN NURSING

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First, because there seems to be a great deal of discussion about what the expanded role is, a few words about what the expanded role is *not*. One misconception is that the nurse working in the expanded role is a physician's assistant; another misconception is that the nurse is merely working as a physician substitute; another says she is a handmaiden to the physician. Nothing could be further from the truth. If the expanded role is not one of these, then what is it? The so-called expanded role is the nurse practising nursing in that area of the health care delivery system called the primary care area. It is an expansion of the practice of nursing to a part of the population with special needs not previously served by the nursing profession, a part of the population served traditionally by medical practitioners. Exceptions occurred in rural and sparsely populated areas and northern regions. These isolated nurses were and are mainly prepared in the school of experience and unrecognized for services rendered. It is indeed time that this area of function be recognized by the nursing profession and nurses providing these services in the community be well prepared to do so.

TERMINOLOGY

One accepted definition of primary health care is

> "all of those health services which are provided for individuals mainly on an ambulatory basis in the community or in their homes and includes presentation and health maintenance services in the community, diagnostic and therapeutic services offered in physician offices, in clinics or in health centers; home care services for those who are ill; rehabilitative services for those who require them. It provides care which is convenient, coordinated, continuous and comprehensive."(1)

Another accepted definition of primary health care is

> "the usual point of entry into the health care system: it is oriented towards the promotion and maintenance of health, prevention of disease and care of individuals with common health problems, uncomplicated illness, chronic latent illness and selected aspects of complicated illness in the home or outpatient setting. Care is given on a family basis with professionals providing guidance in the use of health resources and referring to other levels of the health care system."(2)

The nurse then working in the expanded role is

> "oriented towards the provision of Primary Care as a member of a health care team of health professionals relating to families on a long-term basis."(3)

She is oriented to providing care to clients rather than services to an institution(4). She practises independently or interdependently as the

setting dictates; she makes her own decisions, assumes responsibility and accountability for them(5). The nurse is performing as a professional should.

FUNCTIONS

The *Report of the Committee on the Nurse Practitioner* identified certain functions which the nurse in the expanded role having had suitable preparation and experience could undertake in the primary care area.

These were:

1. The nurse practitioner can be the initial contact for people entering the health care system, that is, she can be the first health professional the individual sees.
2. As first contact, the nurse practitioner should be able to assess the individual's health status to determine the need for medical, nursing or other intervention.
3. The nurse practitioner should be able to initiate treatment for patients with commonly occurring health problems which lie within her scope of competence or to arrange for the referral of patients to the appropriate health professional (or agency) as needed.
4. The nurse practitioner should be able to counsel people of all age groups in relation to health matters.
5. The nurse practitioner should be able to teach individuals and families the specific knowledge and skills they require to maintain health and prevent illness, or to care for themselves or a family member in the event of illness and assist in their recovery and rehabilitation.
6. The nurse practitioner should be able to undertake the care of normal healthy women throughout the maternity cycle, including antepartum and postpartum supervision and counselling and, with additional specialization in midwifery, perform normal deliveries.
7. The nurse practitioner should be able to supervise the health care of of well children.
8. The nurse practitioner should be able to supervise the health care of older people, except as they require medical intervention in the case of acute illness.
9. The nurse practitioner should be able to monitor patients with stabilized long-term or chronic illnesses and in consultation with the physician to adjust or modify treatment as indicated.
10. The nurse practitioner should be able to co-ordinate the health care of individuals and families through referral to appropriate health professionals and/or agencies as needed and follow-up of patients' post-referral.
11. The nurse practitioner should be able to intervene in crisis situations, that is, to take action within her scope of competence or to refer the individual (or family) to the appropriate health professional or health agency for assistance(6).

It is visualized that the primary care nurse working in the expanded role is concerned with the delivery of total health care service to help patients and families meet their basic health needs. A health care delivery system which will be individualized, accessible, and continuous to aid families and patients to become as independent as possible.

EDUCATIONAL PREPARATION

Until the present time the skills and knowledge necessary to prepare the nurse to work in an expanded role have not been included in basic nursing preparation. It has been proposed that basic baccalaureate programs include such skills(7). Changes in curricula are occurring slowly to include some of the assessment skills. In the meantime nurses who have already graduated, and have nursing experience upon which to build will require recognized educational preparation. Those courses which have been mounted for Registered Nurses at various universities in Canada and the United States share many common aspects. They are short four to eight month courses, physicians and nurses jointly share teaching and preceptorship responsibilities and the nurse is prepared to work as a generalist in a primary care setting. The problem solving approach is used, the data collection skills are increased and emphasized and the information gathered is utilized to analyse and assess individual and family health needs and plan for and manage the care indicated(8).

Educational objectives commonly found in courses to prepare the nurse to be a primary health care worker as an interdependent colleague of the health care team include:

1. Can make an initial assessment of the health status of an individual and recognize normal and deviation from the normal.
2. Recognize the significance of findings and make appropriate judgement re the management of the patient and/or referral to a physician or other member of the health care team.
3. Demonstrate independent health supervision of an adult/child and intervene skillfully in the event of disruptions from the normal.
4. Recognize the basic health needs of the normal mother and child, and recognize when medical intervention is necessary.
5. In consultation with a physician, administers appropriate drug therapy and monitors ongoing therapy.
6. Can counsel and teach patients to develop good health habits and can give them an understanding of their particular health problems and health needs.
7. Take part in and arrange for anticipatory guidance at stressful times of life.
8. Identify special problems of patients and know the appropriate community agency available.
9. Can record base line assessment data and communicate with other members of the health care team.

CONCLUSION

The nursing role continues to expand. This is not new to this or any profession. If we are to continue to be a part of that team meeting the health care needs of the population, we must continue to accept more responsibilities and perform more functions just as was done in the past. The first nurses under the leadership of Florence Nightingale were Army nurses — if the roles and functions had not

expanded to hospital nursing perhaps we would be still on the battlefield. However, there were unmet health needs in the cities so nursing accepted the challenge to prepare its members to meet these unmet needs. There are now unmea needs in the primary care area (9) and it is time the profession accepted the challenge to prepare its practitioners to make more and better health care available to more people.

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The opinions expressed in this article are the writer's and do not necessarily express those of the Faculty of Nursing of the University of Western Ontario.

EXPANDED ROLE? EXPANDED RECOGNITION, EXPANDED OPPORTUNITY

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To write a statement for a nursing journal in the summer of '74 on the expanded role of the nurse is like carrying coals to Newcastle. Articles and statements abound until the jargon has become jaded and one wonders what is expanded about the work of either a nurse-practitioner or a clinical nurse specialist.

The generally accepted definition of the nurse-practitioner as "a nurse in an expanded role oriented to the provision of primary health care as a member of a team of health professionals relating with families on a long-term basis"(1) recognizes abilities and skills with which nurses have been equipped, and which they have used for many years. The Boudreau Report in discussing the role of the nurse-practitioner, clearly indicates two viewpoints on the function of the practitioner: "the recognition of an expanded and well-defined role for nurses as nurses", and "the utilization of nurses to assist physicians in carrying out *their* functions"(2).

To assume that the nurse is an extension of the doctor is nothing new; medical care plays a vital role in health care through diagnosis and treatment of disease and nurses have long assisted doctors in this function. Medical care, however, is not the only component in the broad concept of health care, and other health professionals must assume parallel, not subservient, roles. Many reports and much attention have been dedicated to the nurse-practitioner attached to either a group or single physician practice. We must recognize that this is only one setting for primary health care and one which frequently focuses more strongly on illness than on health. Until more experiences are documented from a wider variety of settings, particularly with an emphasis on health, the definition of the role of the nurse-practitioner will tend to a narrow interpretation and the component of the "role for nurses as nurses" will remain confused.

A restrictive interpretation now, presents real dangers for nursing, especially as it relates to possible certification, payment and utilization of the services of the nurse-practitioner. It is premature to develop regulations which in the long run may have the effect of packaging nurses in the same boxes under new labels to fill roles which perpetuate a confined traditional approach to medical care. At a time

when "there has been an apparent increase in the awareness of the contribution which nurses can make to patient care at the primary level", coupled with "support for greater and more effective use of nursing skills,"(3) it seems opportune to try new innovative approaches. As Gilchrist states "we should not be content to follow along directions determined by others but should negotiate our position from a base which includes research, learning, administrative and above all, nursing practice knowledge"(4).

Like other university nursing schools, the Faculty of Nursing, University of Toronto has been deeply involved in discussions, reports, demonstrations and evaluation projects related to the nurse-practitioner. The Faculty has expressed the belief that preparation for primary care nursing should be included at the baccalaureate level. In examining the educational requirements for the nurse in primary care settings, the Faculty identified three levels of education essential to provide strong nursing input into health care services: initial preparation at the diploma and baccalaureate levels and advanced preparation at the graduate level. Preliminary data obtained by faculty members regarding learning needs of the baccalaureate students for functioning in selected primary health care settings support the view that baccalaureate graduates have the potential for functioning effectively in primary care settings(5). As roles and functions evolve it is to be expected that modifications in the curriculum will be required. While the major Faculty responsibility rests in the preparation of graduates at the baccalaureate and master's levels, recognition is given to the importance of short-term continuing education courses for graduates of all levels. This thrust is a reflection of the stated purpose of the Faculty "to advance quality in patient and family care through graduate, undergraduate and continuing education of nurses, and to gain increasing knowledge and understanding of patient care and community service by systematic investigation and research". It is further emphasized by the recently accepted priorities of the Faculty: to extend the graduate program, to expand and strengthen the baccalaureate program, to develop further the continuing education program.

Any consideration of an expanded role for nurses must include not only the nurse-practitioner prepared to work in primary care settings but also the clinical nurse specialist prepared to work in each of the primary, secondary and tertiary care settings. Again questions have been raised, whether indeed the clinical nurse specialist is functioning in an expanded role or whether the term is redundant. Simms indicates that "what the clinical nurse specialist is doing in patient care is based on advanced knowledge and experience that the

beginning practitioner does not yet possess. But to my thinking, every beginning practitioner in nursing should be a budding clinical nurse specialist, given the motivation, advanced education and practice conditions"(6).

Problems of terminology aside, the development of programs at the graduate level to prepare nurses to function effectively in this role must have top priority in nursing education. In Canada we sadly lack the numbers of nurses needed with advanced knowledge and experience to provide leadership in health care services, education and research. Our sights should be turned to the immediate task of developing educational programs to meet this need. We cannot afford to be diverted from this essential task. If indeed what has expanded is not so much the reality or potential of the role played by nurses of this calibre but recognition of it, now is the time to concentrate our resources and to elicit the support of government, health professionals and citizens in our efforts to provide the appropriate nursing education programs.

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EDUCATION FOR THE NURSE IN PRIMARY HEALTH CARE

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The provision of health care services in Canada is an activity which is presently experiencing pressures from a variety of sources. At least three recent and interrelated developments are identifiable as having marked implications for nursing education: 1. the many recent official studies of health services organization in Canada; 2. the proliferation of investigations at the operational level of segments of primary care services; and 3. the increased awareness of the skills which nurses can bring to primary care services. It is the purpose of this paper to sketch these three developments and to discuss their implications for the education of nurses.

STUDIES OF HEALTH SERVICES ORGANIZATION

Since the Royal Commission on Health Services completed its comprehensive study and published its massive report ten years ago, there have been at least nine national or provincial studies of the health services system or some part of it. Without exception, these reports have urged greater attention to the availability of health services outside of the acute care hospital; all have included, implicitly or explicitly, recommendations which would result in increased utilization of nursing skills in primary health care.

OPERATIONAL STUDIES OF PRIMARY HEALTH CARE

Although vast quantities of literature have originated in the United States and Great Britain, in Canada, (with two exceptions) reported attempts to bring more comprehensive nursing functions into closer association with private medical practice have been limited until very recently. Two early reported trials suggested two methods of employing nurses in private medical practices: direct employment of the nurse by physicians or attachment of an agency-employed nurse to physicians' offices. (1, 2) Many developments in primary health care services in this country have followed one or the other of these two patterns.

In recent months there has been a notable increase in Canada in the numbers of studies in the private sector of primary medical care

* The contents of this paper reflect the opinion of the authors and are not necessarily those of the University of Toronto Faculty of Nursing.

services. A search of the literature revealed that 27 Canadian reports had been published between 1971 and 1973 which included nursing functions as a focus of attention.* All of these investigations were carried out in general medical settings, in contrast to the United States where attention has, in the main, centred on the roles of practitioners in specialized ambulatory care settings. This difference may be attributable in part to the recent development by Canadian medical schools of clinical units for the teaching of family medicine. Many of the studies reviewed were based in these clinical units. However, a number were based in non-teaching practices; additional such studies were in progress and had yet to report at the time of the review.

The approach to these studies was commonly one of introducing innovation in the use of nursing skills in one of three ways: the employment of nurses by physicians, the attachment to doctor's offices of nurses employed by nursing agencies, or a specified change in the way in which the nurse functioned in the setting. The design of these investigations varied: some were descriptive and some experimental. Methods used also varied but were generally one or a combination of two or more of the following: participant description of experience, observation of professional activities, interview with professionals and/or patients and monitoring of service records.

Review of the reports of these studies showed that aspects examined included: time and activities of doctors and nurses, nursing caseload, productivity of practices, patient acceptance, professional satisfaction, and quality of care. Patient acceptance of the nurse in these new roles was the most frequently reported finding; functions of the nurses were also frequently described, as was the increased level of their decision-making in patient care activities. Practice productivity was reported by some investigators to be maintained or improved. Quality of care was reported by some studies to be improved although the limitations of measurement techniques were recognized .

INCREASED AWARENESS OF NURSING SKILLS

Partly generated by these published studies, there has been an apparent increase in the awareness of the contribution which nurses can make to patient care at the primary level. Other factors contributing to this heightened awareness have been the educational programs for nurse practitioners (3,4,5) and the work of the Committee on Nurse Practitioners, appointed by the Department of National Health and Welfare and chaired by T. J. Boudreau(6).

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* An article reviewing these studies prepared in January, 1974 by the present authors is available from them.

In addition, professional organizations have recorded support for greater and more effective use of nursing skills (7-10). Recommendations have been made regarding the functions of and the preparation required for these workers (11-14) as well as continued exhortation for increased supply(15). The Boudreau Committee recommend "that the basic preparation of nurses, both at diploma and university levels, be suitably modified to reflect this broadened concept of nursing"(16). Support for this view comes from influential sources: The Canadian Medical Association(9) and The Canadian Nurses Association(9, 10). In contrast to the situation in the United States, where physician assistants have recently emerged, in Canada there is no apparent serious disagreement with the view that nurses are the appropriate professional workers to be employed more effectively in primary health care.

IMPLICATIONS FOR NURSING EDUCATION

These three developments, government recommendations, operational research and a heightened awareness of available skills, taken together suggest that increased utilization of nursing skills in primary health care services is in the offing. There is some argument that the functions of a nurse practitioner do not, in fact, represent a "broadened concept of nursing"(16). The widely-accepted definition of a nurse practitioner as "a nurse in an expanded role oriented to the provision of primary health care as a member of a team of health professionals relating with families on a long-term basis"(17) suggests that she will be exercising skills which nurses have been equipped with and have been using in many settings for many years.

The authors do not in any way question the underlying concept of increasing nursing input into primary care services, although they are aware of the many financial and legal problems to be solved(18-21). It is their view that if primary health care means "preventive and health maintenance services in the community; diagnostic and therapeutic services offered in physicians' offices, in clinics or in health centres; home care services for those who are ill; and rehabilitation services for those who require them",(22) increased nursing input is an appropriate and desirable goal. Nor do the authors question the concept of the nurse-practitioner.

What is in question here is the educational route by which nurses will reach employment in primary health care services which, by definition, include physicians' offices. This paper argues for adopting an educational approach which will be sound in the long term rather than proliferating short-term educational endeavours. It argues that the approach taken to nursing education in baccalaureate programs,

including as it does an emphasis on the health-illness continuum and a problem-solving orientation and transcending the hospital setting in the giving of care is soundly related to the attitudes and skills required in primary health care services.

Many studies have examined a closer working relationship between private medical practice and preventive health services. The idea of bringing together preventive and curative services is not a new one. In fact, as Milton Roemer has recently pointed out, their separation has been a phenomenon peculiar to North America and Britain, largely "owing to the rising strength of private medical practice and the political influence of the independent medical profession in those wealthy industrialized countries"(23). The combination of preventive and curative services is a concept which is not foreign to nurses educated in university settings. In baccalaureate education, health and illness are visualized as being on a continuum, with nursing playing an important role at all points along the continuum, that is, promotion of health, prevention of disease, care during illness, and guidance during rehabilitation. In order to develop this concept of the health-illness continuum, along with skills in nursing all patients, students require a variety of planned learning experiences working with other than acutely ill persons, for example, chronically ill, ambulatory patients, mothers and babies, etc. In contrast, in diploma programs traditionally placed in hospitals, stress has been on the nursing requirements of sick patients in the acute care facilities provided by hospitals. While some change in emphasis in diploma programs is foreseeable in the future, it is probable that the main thrust of these programs will continue to be related to nursing care in hospital settings. Baccalaureate programs will continue to emphasize health care for patients and families whether the setting is within the community or within the hospital.

Moreover, a sound and broad basic preparation is particularly important for primary health care services, where nurses require a knowledge of health as well as disease processes, an understanding of social and cultural factors affecting health and illness behaviour, and an ability to assess the patients' and families' health status. With these factors in mind, it is not surprising to find some observers commenting that "public health nursing is possibly closest to the primary care role and in the future may be indistinguishable from it"(24).

Despite differences of opinion regarding the "newness" of the functions assigned to the nurse practitioner there is little doubt among the characteristics of the role which *do* make her a new entity are the expectations for more independent decision-making and the medical practice settings in which she is, with increasing frequency, being

asked to exercise this decision-making ability. Baccalaureate education emphasizes a problem-solving approach based on a depth and breadth of knowledge which it is not possible to acquire in a two-year program where technical skills and teaching of specifics are rightfully emphasized; the latter approach results in a nurse who functions extremely well within well-defined parameters. A part of the problem-solving approach on the other hand is the ability to make accurate, systematic assessments on which to base nursing decisions; it follows that this ability can be developed best in a university program where such an approach is stressed.

Also important in primary care settings, where interdisciplinary team functioning is increasingly possible, indeed inevitable, is a well-developed ability to make decisions not only independently but also interdependently with members of the health team. In both diploma and baccalaureate education, the student is expected to develop skills in working with other members of the health team. However, here again, the goals and therefore the required learning experiences differ. The difference may be best described as learning to comply with the directives of other members of the health team versus learning to collaborate with them. The dependent functions of the nurse are of paramount importance in diploma education; in contrast, baccalaureate education attempts to stress leadership skills and ability to work with others on a colleague basis.

For these reasons alone, university education is viewed as the appropriate, if not vital, route for large numbers of nurses in primary health care services in Canada. There are additional differences in the preparation of diploma and baccalaureate nurses which add weight to the argument. The development of research and teaching skills are other areas of competence emphasized in baccalaureate preparation, and these competencies are urgently needed in primary health care services. The predicted increase in patients being cared for at home and in other non-hospital facilities embraced by the definition of primary care will result in increasing need for specialized clinical nursing skills, available only through masters' preparation.

In primary health care, as in secondary and tertiary health care, nurses need a sound and broad basic education to provide them with knowledge and skills which can be transferred from one setting to another, within or without primary care. To provide less than this is a disservice to the student. Of even greater import, however, are the needs of the patients to be served; and since their future needs and demands cannot be reliably predicted in the present, future practitioners require a sound knowledge base for the required flexibility.

If, then, the expectations held for nursing in primary health care

services are, in fact, increasing, nurses must be prepared soundly from the beginning to contribute adequately of their potential. To do this requires that the attitudes, knowledge and skills identified above be developed through levels of increasing complexity as in university nursing education; because of (rightly) differing education objectives, diploma graduates must modify attitudes as well as acquire additional knowledge and skills. To deliberately plan to prepare nurses widescale by adding on supplementary courses to diploma education would distort that education and would surely be wasteful of the time and talents of candidates, of the scarce energy of faculty and hence of the limited resources of this country.

There is some evidence to support the belief that, as suggested in the Boudreau Report, some baccalaureate programs would require little modification. A study of the learning needs of students practising in physicians' offices in 1973 suggested surprisingly few gaps in knowledge and skills(25). Despite the findings of a survey of nursing educational programs in June, 1972, which indicated that only three taught how to do physical examinations(26), some universities have already reported success in integrating in their baccalaureate programs the learning experiences required for the functions of the nurse-practitioner(27-30), thus demonstrating the feasibility of this approach.

This approach to educating nurses for these evolving roles seems sounder in the long run and appropriate to the needs of this country. There are a number of characteristics of the Canadian scene which make it unwise to follow, without modification, developments in other countries, particularly the United States. In the first place, there is, apparently, no real shortage of doctors, except in certain regions. Secondly, the development of family practice as a medical specialty has reversed the downward trend of physicians in primary care. These facts suggest that, quite rightly, this country will not rely heavily on nurses as primary contact professionals functioning independently and in isolation. Thirdly, Canada's limited resources and population require that wise future-oriented policies be adopted for the sound preparation of professionals who can function in a flexible manner in a variety of settings.

SUMMARY

Studies of health services in Canada urging, as they do, increased emphasis on primary care services, and the recent proliferation of studies of nursing at this level of care, combined with dialogue regarding the nurse practitioner, have resulted in an increased awareness of nursing's potential contribution to primary health care. This

paper discusses these developments and argues for basic baccalaureate preparation for the role to meet the health needs of the population of Canada.

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