In the Summer, 1974 issue of Nursing Papers, position statements were made by many of the University Schools of Nursing concerning the expanded role of the nurse. The article which follows describes how one group studied a particular approach to this question. Perhaps your institution has been developing other approaches to the expanding of the nurse's role. What have your experiences been? Your descriptions and evaluations of innovative approaches to nursing are a sort of "natural resource" which, when shared, enables us to fashion new ideas of nursing itself, identify research problems, etc. What do you think? What are you doing? Let us know, soon. — Ed.

THE EXPANDED ROLE OF THE NURSE: A SYSTEMS ANALYSIS

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Psychiatry today has moved far beyond its narrow medical domain and is in the midst of a social revolution (Laing, 1969). The traditional prerogatives of the physician-specialist (psychiatrist) of diagnosis and treatment, have been diluted and diffused by two emerging trends: one, the phenomenological and ideological changes, due to application of alternatives to the medical model; secondly, a concomitant social change in terms of the "opening up" of the field to other professionals who have assumed a colleague role in the practice of psychiatry. Whereas the medical model was, at one time, exclusively the *modus operandi* in all psychiatric settings, it is now evident that other models are being considered and implemented very often in conjunction with the interdisciplinary team approach (Bry, 1972).

The study reported here was undertaken in order to explore the implications of the interdisciplinary team approach, primarily in regard to the aspect of most relevance at the present time: the expanded role of the nurse. It was conducted at the Health Sciences Centre Hospital, Dept. of Psychiatry, U.B.C. This hospital, located on the campus of the University of British Columbia, is a sixty bed teaching and research facility. Here, selected nurses have assumed

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the role of primary screening interviewers, primary therapists, primary nurses, and day care programme co-ordinators. On one inpatient unit, nurses have also taken on additional teaching and orientation functions with medical students.

GENERAL SYSTEM THEORY: A FRAMEWORK FOR ANALYSIS

In order to study the phenomenon of role change within psychiatry today, it is important to consider the context of that change. The field can no longer be considered as a branch of medicine but rather must be analyzed as a social system that functions as a component or subsystem of the larger health care delivery system in society. It is a social system in the sense that it is composed of groups of human beings in society, interacting together in an organized fashion over time, in identified settings, and for specific purposes (Berrien, 1968).

In analyzing any system a crucial distinction must be made between abstract and concrete levels of reality. Buckley (1967) makes this distinction clear by defining an abstract system as "a continuous boundary maintaining, variously related assembly of parts." He continues by defining a concrete system as "the structure of organization its components may take on at any particular time".

General system theory assumes the existence of both open and closed systems. The essential difference between the two is that open systems receive inputs from other systems, while closed systems function without responding to such inputs (Berrien).

A system, by definition, is "a set of components interacting with each other and a boundary which possesses the property of filtering both the kind and rate of flow of inputs and outputs from the system" (Bertrand, 1972).

Feedback, both negative and positive within the system, is an equally important construct. Buckley defines feedback-controlled systems as being *goal-directed* and not merely *goal-oriented*, since it is the deviation from the goal-state itself that directs the behaviour of the system, rather than some predetermined internal mechanism that aims blindly.

A final construct of general system theory to be considered is that of the steady state of the system. At all times, there are ebbs and flows of activity within the system. This leads to the accumulation of tension, and subsequent tension-reduction within the system. If tension becomes too great, disequilibrium occurs, leading to an unsteady state. It is only through the maintenance of some degree of equilibrium that allows the system to remain in a steady state. This is a dynamic state, implying a degree of balance and movement to-

ward a goal. It does not imply a fixed, rigid, or unchanging state over time (von Bertalanffy, 1968).

General system theory is a complex organization of constructs some of which have just been defined and discussed. These constructs have particular application for the analysis of psychiatry as an open social system.

METHODOLOGY

The first step in designing a methodology for the study was to review the literature related to the topic of the expanded nursing role. The literature review explored three different models of nursing practice: primary nursing, team nursing, and the nurse as primary therapist. Each model suggested a differing degree of responsibility and accountability within the nursing profession.

In order to obtain a comprehensive picture of the expanded nursing role, it was necessary to collect data relating to the nurses, and the system of nursing, on each inpatient unit. In our opinion, it was vital to receive input from all members of the nursing staff. The following methods of data collection were utilized to obtain this input:

1. A questionnaire to all nursing staff.
2. A self-recorded diary of nursing activities for a selected period of time — requested from all nursing staff.
3. A sociogram illustrating the roles and interactions of the staff on each unit.
4. Participant observation for selected periods of time on each unit.
5. Interviews with nurses functioning as primary therapists.
6. Reviews of selected patient records.

QUESTIONNAIRE

We compiled a 30-item questionnaire based on an agree-disagree continuum. The purpose of the questionnaire was to survey the opinions of nurses regarding many different aspects of nursing practice on the inpatient units: job satisfaction; accountability; decision making; communication and consultation; utilization of time; nurses' perception of physicians' view of their professional nursing role; satisfaction with the nursing organization; work load; and competence and professionalism.

In order to establish some assurance of the validity of the placement of the thirty items into the above nine categories, five expert nurses were asked to take the questionnaire and assign each item to the appropriate category. There was 71% agreement among these nurses on the placement of the items into the nine categories.

28

All members of the nursing staff were asked to respond to the questionnaire. The percentage of response to this task was 89.7%.

Staff members were given the questionnaire in small groups in a conference room. They were instructed not to discuss it among themselves, and were given fifteen minutes to complete it. All staff members were informed that the results of the questionnaire would be tabulated and identified by unit, but not by individual. This identification allowed us to determine the degree of intra-unit and inter-unit agreement.

SELF-RECORDED DIARIES

All nursing staff were asked to supply a record of their nursing activities over an eight-hour period of duty. Although the actual utilization of nursing time was not a primary focus of this study, we felt it to be a significant dimension which could not be entirely ignored, since the very real demands on nurses' time have obvious implications for a study concerned with the expansion of the nursing role. We wished to ascertain the amount of time spent on direct patient care and time spent on indirect care, i.e., staff meetings, rounds, conferences and inservice activities. In addition, it seemed that a more representative and comprehensive picture of nursing activities would emerge if each nurse documented an actual eight hour duty period.

These nursing activities were grouped according to direct and indirect care activities. The data were then examined for evidence of decision making, and grouped according to type: independent, interdependent, or dependent.

SOCIOGRAMS

Initially, we requested the Unit B nursing staff to examine the job descriptions for staff on the Unit (i.e., head nurse, care coordinators and staff nurses) and revise them to make them more congruent with the primary nursing system. The staff examined the job descriptions, and thought them broad enough to include the expanding role they have been taking as primary nurses on the unit. To further exemplify their concept of the expanding role, they prepared for us a sociogram constructed to illustrate the interactions of the primary nurse and the total ward staff and patients.

We found these data useful and asked the other two units to provide us with a sociogram, illustrating the structure and interrelationships of the total ward staff and patients.

The sociograms were analyzed in relation to (1) total configuration; (2) nursing system configuration; and (3) communication patterns relating to individual nursing system positions, i.e. head nurse, team leader, staff nurse and psychiatric assistant.

29

OBSERVATIONS

During a three week period we attended ward rounds, staff conferences and staff-patient meetings on each Unit. We also interviewed selected members of the nursing staff. Some of the time during this period was left unstructured to facilitate additional observation.

The purpose of the observational visits was to gather first-hand information on the professional nursing practice on each unit. We were looking for evidence of independent decision-making and accountability by nurses. We also attempted to document interactions between nurses and other health professionals on the unit.

While on the inpatient units we attempted to keep our focus on observation, rather than participation, in the situation. We engaged in minimal interaction with staff while in meetings, and avoided assuming an active role in any discussions involving patient care. However, staff did interact with us and often tried to solicit our participation.

A content analysis was done on all observational data, looking at the dimensions of accountability and decision-making. The data were examined for correlations between the type of decision and the nature of the decision (i.e. independent, dependent and interdependent). Other possible correlates were also looked for as the data were analyzed.

THE PRIMARY THERAPIST

At the time this study was undertaken, there was only one nurse functioning in this capacity on an inpatient unit. Therefore, in order to collect data about this type of expanded role, it was necessary to utilize (1) interviews with those nursing staff members who had previously been primary therapists; and (2) record reviews of those patients whose primary therapist was a nurse.

During the period of data collection, the inpatient unit that had been experimenting with the nurse as primary therapist had a staff meeting to evaluate their experiences. We attended this meeting and recorded our impressions of it.

Further data were gathered through observations on two occasions of the nurse-therapist in ward rounds, discussing her patients. These data were analyzed for content relating to decision-making and accountability.

RECORD REVIEWS

To supplement our observations we selected a sample of patient records from each inpatient unit. Three such records were taken from each unit. We were interested in ascertaining the scope of
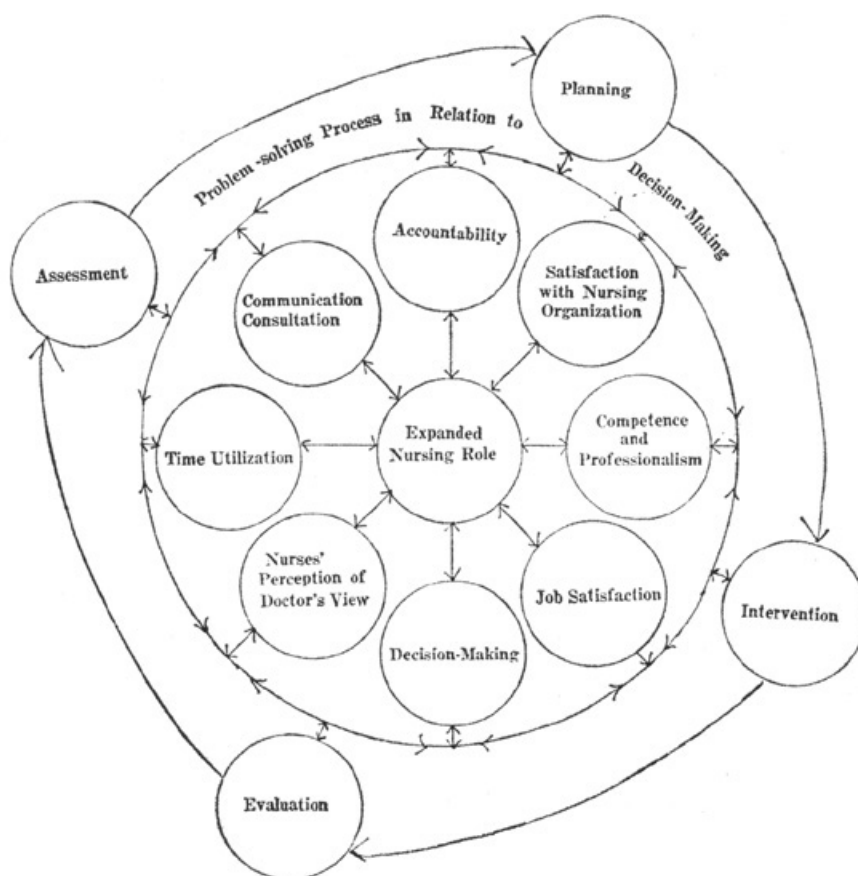
Fig. 1.: Schema of Interrelationships Among Concepts Under Examination

nursing practice as documented in the patients' records. The record review also was done with a view toward comparing similarities and differences between this aspect of nursing on the units.

Patient records were reviewed in relation to:

1. Decision making: kind of decision, how it was arrived at (dependent, independent, interdependent), clarity of rationale, and other health care personnel involved.

2. Accountability: which members of the health care team recorded in the various component areas of the record.

The methodology for this study was designed with a view toward examining what we considered to be many interrelated components of nursing practice. Figure 1 illustrates the interrelationships between the concepts under examination and the expanded nursing role. It is to be interpreted only as an attempted conceptualization of nursing practice, but it is not in any way intended to represent all the factors in operation in any given situation.

31

Decision-making and the elements of the problem-solving process were conceived as the basis of professional nursing practice, and therefore are integral concepts on which this schema is based. The other seven identified concepts are also closely related with each other and the problem-solving process, forming a matrix in which nursing practice may be analyzed.

FINDINGS

The findings of this study were delineated by means of a qualitative data analysis of material gathered from a variety of sources. As nursing researchers, our challenge was to use the integrative framework of systems theory in order to arrive at a valid interpretation. Our approach was to consider the various groupings of data as separate categories of analysis. These units are reported by category in the following section, with data from each nursing unit separately considered.

ANALYSIS OF QUESTIONNAIRE RESPONSES

Questionnaire responses focused on nine areas:
1. accountability
2. decision-making
3. communication and consultation
4. satisfaction with nursing organization
5. perception of workload
6. competence and professionalism
7. nurses' perceptions of doctors' views
8. time utilization in direct patient care
9. job satisfaction

Unit A had the lowest percentage ratings of the three units for agreement regarding the cateories of "job satisfaction," "communication/consultation," and "satisfaction with nursing organization." These categories had significantly lower ratings than those of the other units.

The agreement ratings for the categories of "accountability" and "decision-making" were in close approximation to those of Unit C. The category of "reasonability of work-load" had the highest mean agreement rating. "Nurses perceptions of doctors' view of professional nursing role" had a rating similar to that of Unit B with 52.96% agreement that doctors were cognizant of, and fully utilize the skills of the nurse. "Utilization of most of time in direct care" received only 50% agreement.

The questionnaire responses indicated considerable dissatisfaction with the unit nursing organization, and job satisfaction was lower than on the other units. Communication problems existed and nurses'

32

perceptions of doctors' view of the professional nursing role was incongruent with nurses' perception of themselves. While the nurses agreed staffing was adequate, there was only 50% agreement that most of the nurses' time was spent in direct care. While both accountability and decision-making received high ratings, the lower ratings in the other specified areas indicated dysfunction within the total unit organization.

Unit B. The agreement percentage ratings for most of the categories fall between those ratings for the other units with the exceptions of the categories of "accountability" (62.75%), and "decision-making" (47.07%), both of these categories have the lowest percentage ratings for agreement.

The lower ratings for "accountability" and "decision-making" along with the relatively high rating for "communication/consultation" reflect that these first two are shared phenomena with other health care personnel.

Unit C had the highest percentage ratings for agreement in "job satisfaction", "accountability", "decision-making", "communication/consultation" and "satisfaction with nursing organization". It had the highest percentage of disagreement (20.83%) for "workload reasonability'. "Nurses' perceptions of doctors' view of professional nursing role" had a significantly lower agreement rating than those of the other units. There was 52.64% agreement that most of nurses' time was spent in direct care.   The higher ratings in the first five categories indicated an overall higher degree of satisfaction, responsibility and communication on this unit. Although the rating of 61.12% for "satisfaction with nursing organization" was higher than the other units, still the percentage of disagreement indicated considerable dissatisfaction with the present nursing system.

SELF-RECORDED DIARIES

Nurses were requested to keep diaries of their activities on the units over an eight-hour period of duty.

Analysis of the diaries by unit revealed an overall similarity in the kinds of activities engaged in by nurses throughout the inpatient units. It was not possible from the data to compute any frequency regarding various activities nor to determine the degree of importance of one activity in relation to another.

The only significant differences in diary content was in Unit B diaries under the Indirect Care components. These activities were related to time spent with medical students in teaching and orientation functions. Specific entries under this were:

"remind medical students to write medication orders"

"show medical students how to chart in POMR"

"taught medical students re: management of psychotic patient"

"met with medical students to plan care, suggest lowering medication dosage for one patient, order EEG, EKG..."

From the diaries it could be seen that nurses were spending roughly one half of their on-duty time in direct patient care on all three of the inpatient units and that the range of their functions was very wide. Many of these functions involved independent decision-making in all phases of the problem-solving process. Interdependent decision-making was involved with overall assessment of individual patients and planning for their total care, and also with planning of daily patient care (interpersonal, chemotherapeutic and milieu components of management) for both individuals and groups.

It could also be seen that nurses on Unit B had taken on much responsibility for the orientation and teaching of medical students in that area.

SOCIOGRAMS

Unit A. From the analysis of information received from the sociogram, the nursing system was portrayed as two separate sub-groups within the multidisciplinary health care team. It was decentralized, with the two team leaders most involved in clinical and organizational concerns. The head nurse functioned in a non-clinical capacity and was concerned mainly with the nursing system. As indicated by the subgroupings of nursing personnel, there were two teams that were concerned with the nursing management of patient care. In this subgrouping, registered nurses were given little overall patient responsibility, for their interaction patterns were placed mainly within the nursing system.

Unit B. The total configuration of the sociogram was that of a wheel with the head nurse at the centre, the other health care personnel relating directly to her and to the patients who were placed on the circular periphery.

The nursing system was shown as a unified group with the team leader as the pivotal person. All members of the nursing group had direct two-way contact with patients, though placement of nursing group members in proximity to patients was varied; the head nurse was placed farthest away from patients and the registered nurses and psychiatric assistants were placed closest. Communication within the nursing system was via the team leader. There was no direct communication shown between the head nurse, registered nurses and psychiatric assistants.

The head nurse was in a central position, providing nursing direction and coordination of the health care team while the team leader
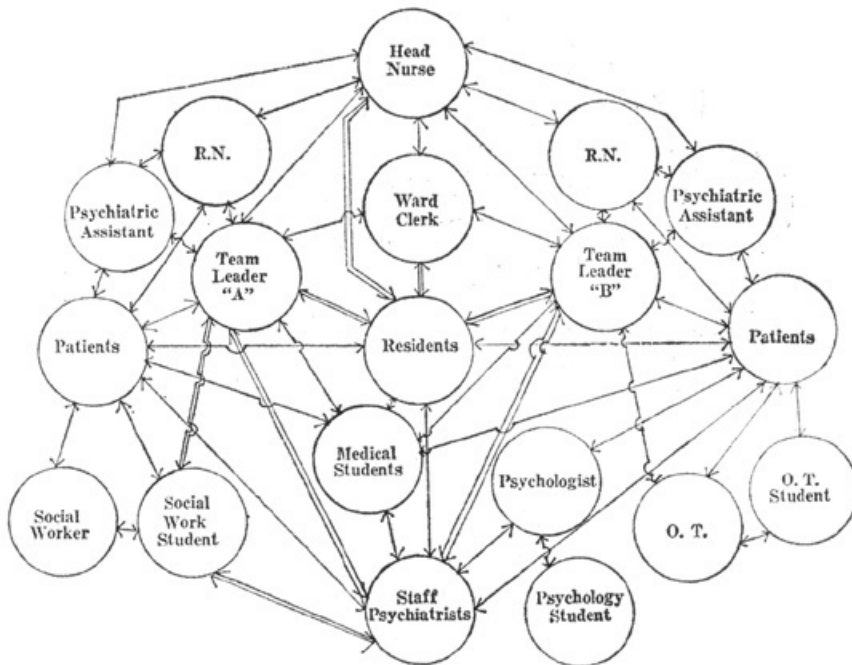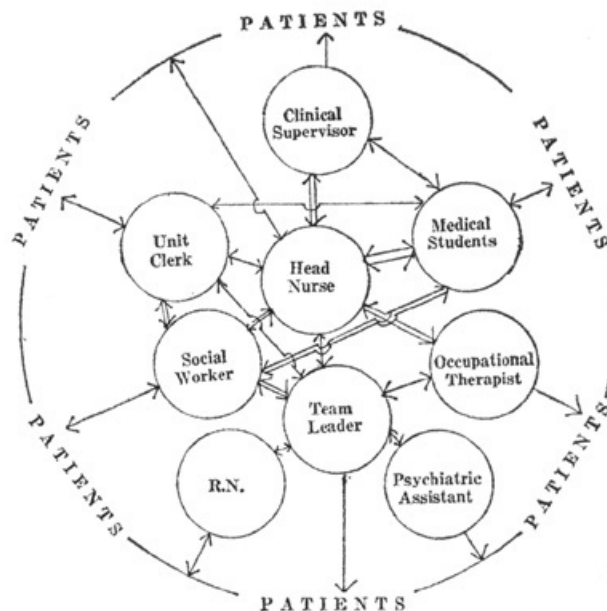
Fig. 2: Sociogram — Unit A
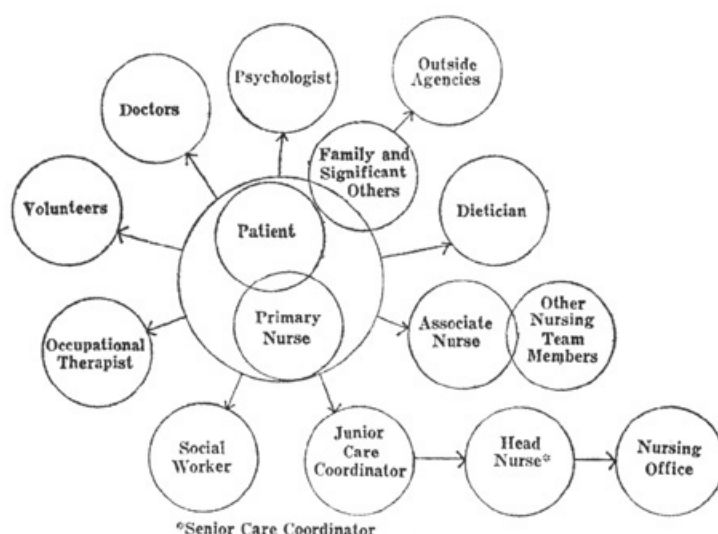

Fig. 3: Sociogram — Unit B

Fig. 4: Sociogram — Unit C

was involved with coordination of the nursing team. Registered nurses and psychiatric assistants relied on the team leader for information relay and exchange.

The nursing system interfaced with the health care team at the head nurse and team leader levels with minor participation in total team functioning engaged in by the registered nurses and psychiatric assistants.

Unit C. This sociogram differed from those of the other two units in that it depicted communication channels from the viewpoint of the primary nurse, while the others represented total team interaction patterns.

The patient was placed at the centre of the complex, very closely aligned with his/her family and the primary nurse. The patient and the primary nurse together formed the major interacting unit with the other health care workers, who were placed in a circular fashion around them. Lines of communication with extra-unit systems were shown (i.e. nursing office, outside agencies).

The nursing organization appeared as a decentralized structure with much of the communication about patient care taking place at the primary nurse level. The head nurse was shown as a liaison between the nursing office and the unit nursing organization, with no direct contact with the primary nurse- patient unit. Similarly, the care coordinator served as an information relay person with no other "conrdinating" functions. Associate nurses and other team members received communication regarding patient care directly from the pri-

36

mary nurses. The primary nurse was the main personnel focus of the sociogram directly involved with the patient and his family and relating to other health care personnel.

Primary nurses served as coordinators of the patients' total care. They interfaced directly with other personnel, using the care coordinator as consultant on clinical matters and giving direction about care of their patients to associate nurses.

OBSERVATIONS IN RELATION TO DECISION-MAKING

The observations related to decision-making were categorized according to the nature of the decision: independent, interdependent, or dependent. This section discusses the pattern of decision-making among nurses in the presence of other health care professionals at interdisciplinary conferences.

Unit A. The nurse therapist consulted with other members of the health team, but made independent decisions regarding the patient's overall treatment plan. The nurse therapist observed was prepared at the master's level. In situations where the nurse was not a primary therapist, interdependent decisions were reached regarding overall treatment plan. On two occasions, one nurse was found to make independent decisions concerning family therapy, and initiated this topic in meetings with other health professionals. Nurses also acted independently in areas relating to ongoing daily management, e.g. structuring activities on the ward. Nursing participation in ward rounds was active. Some nurses interviewed patients. They also contributed information about patient behaviour on the unit.

Unit B. On this unit, the pattern of decision-making varied. In ward rounds decisions were made interdependently, or deferred to other health professionals. On these occasions nurses made one out of twelve decisions which related to weekly goals of patients. Planning for daily management was cited as an area of independent decision-making. The overall picture presented was that regardless of the level of decision-making, decisions were made either interdependently with other health care personnel, or else decisions were initiated by nursing personnel and deferred to medical personnel.

Unit C. The impressions of the data collectors were that nurses, in the absence of other health professionals, made independent decisions regarding ongoing daily management, e.g. patient privileges; therapy modality, in particular family therapy; and ward management. However, in the presence of other health professionals independent decision-making decreased, e.g. in ward rounds, only one out of twelve decisions was made independently by nurses. One pattern observed was that nurses deferred decision-making to other

health personnel, particularly the physician. On other occasions, nursing input was minimal in the plan of action presented by other health personnel. In community meetings decisions were made either interdependently, or independently, and then deferred to other health personnel.

It was obvious that decision-making by nurses was influenced by the presence or absence of other health professionals. On their own, nurses tended to act interdependently. However, in group situations, they were less assertive and deferred decision-making to others.

NURSES AS PRIMARY THERAPISTS

From the interviews and meetings with the four nurses who had functioned as primary therapists in the hospital, a number of impressions were recorded. Interested nurses had assumed the primary therapist role as a consequence of the decreased number of medical staff. The nurses indicated that there were both pros and cons to being a primary therapist. On the positive side, they felt pleased with accepting total responsibility for patient care and felt they learned more about the patient as a whole. Also, the responsibility for presenting cases in a clear succinct manner necessitated that they conceptualized and formulated their rationale for decision-making. Some nurses expressed that they had difficulty finding sufficient time in which to effectively fulfill their expanded role responsibilities. Some nurses perceived a problem related to the staff's acceptance of the expanded role. When a nurse-therapist was assigned to a patient with complex problems, she observed the staff's uncertainty in regard to her ability to handle the situation. Some nurses were not given 24-hour responsibility for patients, as staff members were reticent to call the nurse-therapist during the evenings. Two of the nurses were team leaders and experienced administrative conflicts when becoming over-concerned with one patient, instead of taking into account the total needs of the unit. There was also a status conflict in that the role of team leader was formally recognized, whereas the nurse-therapist role was not.

The nurses identified the need for extra training for the role, particularly in regard to increasing their knowledge of psychodynamics and psychopathology. They further indicated a need for more intensive supervision.

RECORD REVIEW

The records were reviewed using methods of content analysis to identify the decision-making patterns and examples of accountability of nurses.

Unit A — Decision-Making. All decisions recorded related to the assessment-planning phase of the problem-solving process. Decisions made independently related to daily interpersonal management on some occasions and once to discharge planning. Rationale for these decisions was mainly unclear. (Whenever the SOAP* approach of recording was used in the records, rationale for decision-making was clear). Interdependent decisions made in rounds and recorded by a nurse related to overall treatment plans and in one instance to on-going daily interpersonal management. Rationale for these rounds decisions was unclear.

Accountability. No consistent member of the nursing staff recorded on any of the patient's records. Nurses did, however, make entries in the progress notes and recorded family interviews.

Unit B — Decision-Making. The records were generally more complete than those on the other units and the SOAP approach to record-keeping was used throughout. Records were used often as a means of communication between health team members (e.g. questions and suggestions relating to the treatment plan were recorded there and then responded to by the primary therapist.) Most of the decisions recorded were interdependent decisions or were decisions reached independently by the nursing staff and then deferred to other health care personnel for ratification and/or action. Types of decisions made ranged from overall treatment plans through ongoing daily interpersonal management.

—Accountability. Nursing personnel recorded on the histories, progress notes and documented information from family interviews. No consistent recording by any one nurse was observed in these records. It was noted as well that entries in the records were often jointly signed by nursing staff and other health team members.

Unit C — Decision-Making. The records reviewed reflected little documentation of decision-making. In instances where decision-making was documented by the primary nurse, it was related to on-going daily management, and discharge planning. Nursing orders were written in these instances.

— Accountability. Primary nurses and other nursing staff recorded assessments, patient's progress and family interviews. The three records did show that one consistant nursing staff member (primary nurse) recorded on them and contributed to the problem list in each case.

* SOAP: Problem-oriented terminology denoting subjective data, objective data, assessment and planning.

39

SUMMARY OF FINDINGS

The overall findings revealed a complicated communication network on all units, but this was particularly evident on the two units with the team nursing system (Unit B, Unit A). On the unit with the primary nursing system (Unit C), communication patterns were more direct among those health professionals providing individual patient care.

The questionnaire responses revealed wide variability of agreement among staff on all three units in the area of communication. On Unit C there was the highest degree of agreement on the effectiveness of communication between the primary nurse and health professionals on the unit.

On all units, there was a high degree of agreement among nursing staff that the workload was reasonable; however, the findings indicated that only 50% of nursing time was spent in direct patient care. Therefore, there was a high indirect care component in this hospital. Observations documented that most of this time was spent in staff meetings, and this, more than any other fact, determined the amount of time available for direct care.

Regarding job satisfaction, and satisfaction with the nursing organization, ratings were highest on Unit C. The ratings on the other two units showed less agreement. The findings documented high overall agreement that nurses viewed themselves as competent professionals; however, the majority of nurses perceived that this view was not shared by physicians.

The findings further indicated that patterns of decision-making and accountability differed among the three units. Observations and written records demonstrated a high occurrence of independent decision-making by nursing staff in the area of ongoing daily management. It was also demonstrated that independent decision-making decreased when other health professionals were present. In fact, on two of the units decision-making was repeatedly deferred to others by the nursing staff.

The degree of accountability varied among the three units as described by nurses' perceptions, and such indicators as written records and observations made on the units. On Unit C, individual accountability was demonstrated on the records where primary nurses consistently charted on their patients throughout hospitalization. These statements included care plans and orders. Joint accountability was evident in the Unit B records by co-signed progress notes. Accountability was less clearly documented in the Unit A records. According to the questionnaire responses, primary nurses (Unit C)

40

perceived themselves as more accountable than did nurses on the other units. However, there was little variability among the scores on Unit A and Unit C, with greater variability from the Unit B responses.

The primary therapist role reflected a greater degree of accountability and decision-making. In keeping with this increased responsibility was an identified need for specific preparation and ongoing development of personnel engaged in this role.

In addition to the findings relating to the areas under investigation, the study revealed that no one unit consistently engaged in evaluation of patient care. This became obvious from the record reviews and observations.

The primary nursing role on Unit C deviated in some significant ways from the model outlined in the literature, specifically in the following areas:

a. Individual nurses' preferences, workload and availability were the factors that determined patient assignment, rather than the skills needed by the patient.

b. Direct communication between the primary nurse and other health team members was impeded by staff rotation patterns. Primary nurses were frequently on shift when other members of the team were not available.

c. According to the model outlined in the literature the head nurse was in a crucial role as leader, clinician, validator and communication facilitator. As practiced on the unit this role was shared between the junior and senior care coordinators.

These factors indicated that primary nursing practice in this hospital had some inconsistencies with the model outlined in the literature.

There were similar deviations between the practice of team nursing in the hospital and that outlined in the literature. Team nursing was originally designed for those settings in which there are multiple levels of nursing personnel. However, in this hospital, where there are only two levels of nursing personnel (registered nurses and psychiatric assistants), this type of organization is less suitable to the needs of the staff.

DISCUSSION

The findings of this study are both diverse and intriguing. They clearly indicate the communication problems that are encountered by professional nurses who are part of a complex, interrelated system of communication. Nurses in our study commonly experienced the

41

effects of "communication overload" due to their location at the center of the patient-ward level of the organization.

The phenomenon of "communication overload" undoubtedly accounts for decreased feelings of job satisfaction, ability to utilize time efficiently, and to maintain satisfactory standards of patient care. It is clear that nurses in this setting experienced frustration due to the relatively limited amount of time spent in direct care. It is clear that nurses in this setting experienced frustration due to the relatively limited amount of time spent in direct care with patients (50%). And yet, this may be a reflection of an unrealistic expectation on the part of nursing personnel. To maintain a complex organizational structure, it is necessary that a great deal of time be spent in communication among staff members, and between various units and levels in the organization. Communication between and among professionals in a psychiatric setting is intrinsic to the therapeutic endeavour. Our data, however, reveal that there is less value placed on this communication function than on direct nurse-patient interaction.

The data from the study also clearly document the trend toward more responsibility and accountability on the part of nursing personnel. This trend is most significantly reflected in the data drawn from Unit C, where nurses were functioning as primary nurses. Their job satisfaction is high, which is probably a reflection of the increased challenges and involvement of their role; however, they are lowest of the three units in perceiving doctors as accepting and supportive of their new role.

Within a systems analysis, this apparent contradiction can be understood by applying the concept of equilibrium. By expanding one role, (and, by implication, the structure and function of the subsystem) other roles are necessarily redefined as well: what is added to one is subtracted from another. In an hierarchical system, this redistribution of roles and role relationships, is most disturbing to those higher up in the structure, since they are, in a sense, "losing" a portion of their role (Buckley). This results in disequilibrium within the nurse-physician subsystem, and is clearly manifested in the perceptions one group holds of the other.

We discovered, in the course of data collection, that both the primary and team nursing systems of organization had been modified within the hospital, and thus did not totally conform to the models described in the literature. Of the two, primary nursing, according to the nurses' perceptions, offered many advantages. One major

advantage is that it provides for a less centralized system of communication for all nurses, and accountability for those nurses functioning as primary nurses.

IMPLICATIONS FOR THE NURSING PROFESSION

Having undertaken this study in one selected psychiatric setting, we were naturally concerned with the broader implications that might be drawn from the data. Clearly the expanded role is a phenomenon that is becoming well-established, and it can be predicted with some assurance that this trend will continue. The problem for nursing will be to administratively develop an efficient system for the implementation of the role, a system that maximizes the potential contribution of the nursing personnel. The primary nursing systems meet these criteria if they are implemented as described in the literature. Our data reveal problems inevitably result if modifications in the system are introduced.

A further implication, of equal importance for the nursing profession, has to do with nurses assuming the role of primary therapists. Because of the great degree of responsibility and accountability that this entails (as documented in our study), it is clear that most nurses require some kind of formalized instruction before assuming the role. This preparation might vary in nature from an inservice training program to an academically-based course. In either case, the educational input must include training in dealing with the pragmatic problems inherent in clinical practice. These are the needs reflected by the primary therapists in our study.

Nurses, who proportionally represent the largest body of mental health professionals, have much to offer the field by virtue of increasing their competencies and assuming an expanded role. Obviously some clarification is needed of the nature of that role and its future direction. This study has attempted to take a step in that direction by documenting the development of the expanded role in one psychiatric setting.

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