Nurses and Health Care

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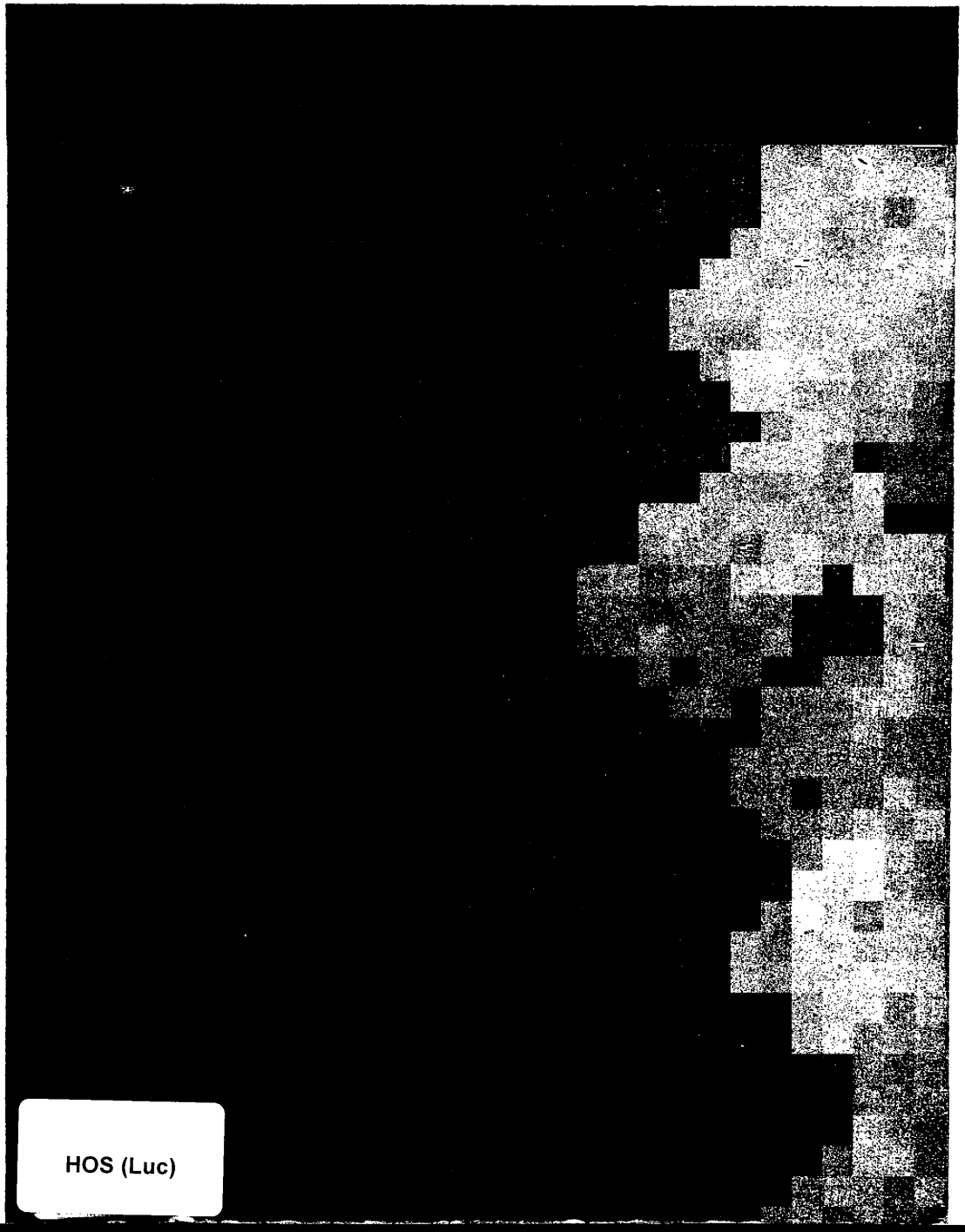

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Nurses and Health Care

Collected papers from the second **King's Fund Transatlantic Seminar of Nurses**

Edited by **Elizabeth Lucas**
Foreword by **G A Phalp**

Published by King Edward's Hospital Fund for London 1976

DEDICATION

Anne White died in February 1976. This publication is dedicated as a memorial to her, with the affection and admiration of her colleagues.

Acknowledgments

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Foreword

The nursing profession in recent years has had to face very difficult problems of role and self-identification. Far-reaching changes in the techniques of medical and surgical practice; an increasing contribution to patient care by those who are not, in the traditional sense, nurses; the demands upon nurses participating in management; the involvement of nurses in new professional procedures: these and other concerns seem nowadays to require a fresh approach and a re-appraisal of what was once regarded as a clearly recognised pattern of duty and service.

Perhaps understandably such profound and inevitable changes have brought in their train a deep-rooted anxiety lest new demands and attitudes should diminish or possibly even destroy the central purpose of nursing as it has traditionally been accepted, that is the care and, in a special sense, the protection of the patient – what Miss Nightingale called the 'art of nursing'.

These problems are by no means unique to the United Kingdom. They concern many countries, particularly those in the western world.

It seemed therefore that there might well be value in providing an opportunity for senior and experienced nurses in the United Kingdom to meet for professional discussion with colleagues of similar status and interest from the North American continent.

It was thought essential for the success of such a meeting that the participants should come together in circumstances of quiet and privacy in which there could be free and unrestricted exchange of ideas and critical opinion. Moreover, for ease of communication it was agreed that the number of those taking part should be small, and that they should meet as individuals and not as representatives of systems or of specialist professional interest.

On this basis a seminar was held in the King's Fund College during the last week of May 1972 and was attended by three nurses from Canada, seven from USA and twelve from the UK. Those who took part were unanimous in their opinion that it had been a unique and valuable experience. They asked that it should be repeated in due course and the King's Fund was glad to respond to this suggestion.

A second seminar was accordingly held in the King's Fund College in 1974. The papers contained in this report have been revised by the authors from those which collectively formed the basis of discussion. They are published here in the hope that they may provide interest and stimulus to nurses generally, and to those outside the nursing profession who are nevertheless concerned with present-day problems of providing acceptable standards of care for the sick.

G A Phalp
London 1976

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Contents

	page
Organisation and Objectives	9
Opening Address - Some New Frontiers in Health Care Helen K Mussallem	10
1 **An Overview of Primary Care in the United States** Mary Elizabeth Dunn and Jessie M Scott	13
2 **Primary Care in the United Kingdom** Jenny I Jones and Margaret Elizabeth Lindars	22
3 **The Role of Canadian University Schools of Nursing in Education for Primary Care** Dorothy J Kergin	25
4 **The Health Field Concept - The Canadian Framework** Huguette Labelle	30
5 **Some Nursing Problems in Responding to Science and Technology** Christine Brown	36
6 **Orbital Organisation of Nursing Management** Rosamund C Gabrielson	40
7 **The Clinical Specialist** Constance Biddulph	43
8 **Clinical Specialisation and Management in General Hospitals within the Newly-developed Health Services in Quebec** Helen D Taylor	46
9 **Nursing Practice - Role Description and Definition** Eleanor C Lambertsen	52
10 **Nurse Therapist - An Inherent Part of All Nursing Practice** Eileen M Jacobi	57
11 **Developments in Psychiatry, the Community and Other Services** John Greene	60
12 **Nursing Management and Primary Care in the Local Health Unit** Dorothy M Mumby	63
13 **The Changing Role of Nurses in Management in England** Anne M W White and W A Lloyd	69
14 **Management in Community Nursing Services** Eva M Reese	73
15 **The Relevance of Multidisciplinary Education in the Health Care Team** Margaret Scott Wright	77
16 **The Status of Continuing Education Programmes for Nurses in the United States** Eileen M Jacobi	84
17 **The Open Curriculum in Nursing Education** Margaret E Walsh	89
18 **Basic Education of Nurses in Canada** Helen K Mussallem	93
Closing Address Jessie M Scott	97
References	100
Index	109

page

Figures

1 Total Active Nursing Personnel – 1973 (United States of America) 14

2 Organisation of the Ministry of Health, Ontario 64

3 Some of the Committee Structure of the Reorganised National Health Service (United Kingdom) 70

4 Visiting Nurse Service of New York: Assistant Directors' Assignments 75

Table: Comparative Statistics of Health Care Provision 95

Organisation and Objectives

The seminar was organised in London by a steering committee; Anne White (chairman), Catherine Hall, Jenny Jones, Dame Muriel Powell, Frank Reeves (director of the King's Fund College), and Elizabeth Lucas (secretary). Helen Mussallem (Canada) and Eleanor Lambertsen (USA) coordinated arrangements overseas.

Both the seminar programme and the preparatory arrangements took shape from objectives drawn up and agreed by the steering committee.

Objectives

A study of the re-alignment of roles involving, among other things, interaction between nurses and physicians and other professions, and the advancement of nurses, either in institutional or organisational management, or in clinical expertise, to produce the nurse specialist.

The study included

a the changing role of the nurse –

in primary care

in clinical specialisation

as a therapist

arising from technical and scientific advances

in the management of institutions and services

the implications for relationships with other professional groups in each of these situations

b the relationship between nursing education and nursing service – safeguarding educational freedom but ensuring relevance to service needs and commitment to the ethos of professional service.

Pre-seminar Arrangements

Members were asked to set up study groups in their own settings, selecting topics from the stated objectives for study. Whatever topic was selected, it was suggested that members base their studies on four simple questions which had been formulated by Eleanor Lambertsen.

1 Where are we now?

2 What is projected?

3 What problems or issues remain?

4 What are the proposed solutions?

Members provided background papers on their special interest for circulation.

Programme

Each session had a main topic; primary care, technical and scientific advances, clinical specialisation, the nurse therapist, management of institutions and services, relationships with other professions and, finally, education. For the penultimate session, members were joined by six guests; an expatient, social worker, surgeon, psychiatrist, general practitioner and administrator.

Many members of this seminar had also attended the first. All are in active and important work, and most know each other and the Fund well. This, and the circulation of background papers beforehand, meant that most of the time was spent in discussion – free, wide-ranging, intense and geared to practicalities.

Publication

Members agreed on the last morning that the background papers and the opening and closing addresses could form a useful publication, though most wished to revise their papers in the light of discussions. This publication is, therefore, a collection of the revised papers. Each is complete in itself, but together they provide a composite record of the seminar. They are arranged in the order in which they were presented.

EL

Opening Address - Some New Frontiers in Health Care

Helen K Mussallem
executive director
Canadian Nurses Association

The task of addressing this opening session is a responsibility I accepted with grave misgivings – knowing that I would be speaking to the 'Who's Who of Nursing in the Western World'. I will never erase from my mind the magnificent opening remarks of the first seminar in 1972, by Dame Muriel Powell, the inspiration she gave the delegates and the tone she set for the seminar's productive deliberations. Now I have inherited this responsibility. My one qualification is that I offered a few comments at the closing session of the 1972 seminar. I tried then to be prophetic but, from the vantage point of two years later, I can say with certainty I was not forecasting but describing what was already happening.

I saw on the horizon features such as

extension of the scope of nursing practice

blurring of categories of role diffusion

nursing time-lag in influencing policy decisions

trends of living in a post-industrialised society

the stresses of change.

That was not the horizon, but right here. Perhaps the one prophetic note was when I recalled a well-used phrase that 'the only true happiness comes from squandering our lives for a purpose'. I suspect that in the two years a great deal of 'squandering for a purpose' has gone on.

We witnessed in just those two years many changes in a world burdened almost beyond endurance by incredibly complex problems. Yet through it all has been the search for solutions, and there is reason for optimism because the process of finding solutions in an increasingly complex universe will continue.

The health services in our countries have experienced shifts and changes – none more dramatic than the reorganisation of the National Health Service in the United Kingdom. Yet we have learned that the differences in our health services relate to the means of attaining our goals – not to the goals themselves.

In wondering what to say to you, I had great flights of ideas. At one point, I was going to forge bravely through all the significant changes in nursing and health in our three countries, draw out the similarities and differences, and identify the impact of these changes on the nursing profession. On reading the summaries of papers before the seminar, I realised this would be done very capably by delegates. I then thought that something on emerging trends might be appropriate or, perhaps, an overview of the phenomena in health care systems. But all this seemed to be in the past tense and I thought that thinking in the future tense would be more appropriate.

As the 24 delegates have already prepared excellent papers related to the specific objectives, I plan not to slice the 'health cake' into wedges but rather to cut through a layer and expose a general view. I also want to cast a small light on some of the frontier thinking as it relates to our socio-economic structure.

Looking at the statement of seminar objectives, I was struck by terminology that was almost non-existent in nursing literature ten or 15 years ago. It was conventional then to stress nursing education, nursing service, social and economic welfare and research. The extent of change in the vocabulary or nomenclature reflects, I believe, the success achieved by nurses in responding to the changing health milieu – indeed, in acting as a 'change agent' or catalyst in developing new avenues in the whole realm of health.

Although the terms may not be used in precisely the same way in each of our countries, and although the concepts may not be exactly the same, our common language, our historically and educationally shared background have created a setting in which our links become increasingly stronger. Although one can never evaluate the intangibles of a seminar, one can speculate not only on the extent to which the King's Fund seminar of nurses has created new and meaningful international relationships, but also the development and understanding of a new vocabulary.

One area that may be of significance to future decision-makers in health, and where some frontier work is being carried on in our three countries, concerns the development of social indicators, especially health indicators, as related to the socio-economic milieu.

Performance Indicator Framework

Measures to gauge the status of our society have been, for the most part, economic in nature. While unquestionably essential, they do not adequately reflect many of the major dimensions of the social system. Although economic growth is still important, a variety of other issues now demands more attention from economists. As noted in a report of the Economic Council of Canada

> '. . . the concerns of our society have greatly broadened in recent years. Economic growth and stabilization are still important but . . . a variety of other issues has come to demand increasing attention'.[31]

In taking account of these concerns of our society, we need a framework broader than the traditional economically oriented one. There is a need

> 'for a broader framework within which it should be possible to say something concrete from the viewpoint of overall well-being about the ultimate ends of the socio-economic activity of the nation, the means to achieve these ends, and the degree to which they are being achieved'.[32]

It would be ideal to treat the social system in an integrated way but the capacity to do this implies the existence of an overall model or theory of the social system.

In fact, and despite claims, there is no widely accepted model of a society that permits a simultaneous, comprehensive examination of the impact of particular activities on all facets of the social system.

There is agreement that a model which would permit some form of 'social accounting' has not been developed in any country. Because of this, there is an identified need for an alternative approach to the examination of a broader spectrum of a country's socio-economic activity. One approach, being employed in Canada, involves a delineation of society's basic goals, and the division of the social system into areas that together form the spectrum of society's concerns. These areas are then considered within the context of their own ends and objectives, with a view to gaining a better understanding of their internal processes and of developing indicators that measure the state of change in these areas.

Although the indicators for the economically oriented areas are more closely interrelated and advanced in their development

> 'in principle both economic and social indicators are part of the same basic continuum of social system'.[32]

The development of a performance indicator framework has been evolutionary and is now gaining momentum. A number of tangible benefits has resulted, such as, providing a systematic, comprehensive basis for assessing emerging economic trends. However, the present performance indicators do not cover all matters for all decision-makers in the entire economic field. It is recognised that the achievement of economic objectives is regarded as a quite incomplete representation of the full compass of desirable social achievements.

Horizons in economic projections are now extended through the use of econometric models. They are of considerable interest and assistance to those engaged in medium and long-term economic planning. However, economists are now broadening the scope of their work to include social indicators. In Canada, a small number of 'first approximation' social indicators has been presented. Although the limitations of the performance indicator framework were recognised early, there was reluctance to attempt any major extension beyond economic concerns without some preliminary research. A Canadian study, *Social Indicators: A Rationale and Research Framework*[94], presents a basic plan of development. Preliminary research by the Economic Council of Canada has resulted in the establishment of 'first approximation' social indicators. These are health, housing and environmental indicators.

In the development of any performance indicator, the first step in the analysis of a particular area is to select the outputs corresponding to the area's basic objectives. In our present knowledge, this task will be easier for some areas (such as health) than for others (such as individual rights and responsibilities). Once the outputs of an area have been defined, the next step is to determine the instrumental factors associated with changes or differences in these outputs. These outputs and inputs are referred to as the social indicators for the area. Thus, from a quantitative point of view,

> 'social indicators are those variables that play

an active role in a particular area of socio-economic concern'.[32]

In other words, the development of social indicators involves the measurement and analysis of aspects of social welfare that enhance our understanding of a given area.

What use are social indicators in health care and nursing?

One could identify many benefits of social indicator development, but the most significant potential benefits relate to possible improvements in planning and decision-making. These are of importance to all nurses who are involved in decision-making in the governmental and private sector. Social indicators will help us trace the progress towards specific policy objectives, as well as emphasise the distributive aspects of this progress. As a consequence, problem areas should become more visible. Another benefit is the result of inputs associated with a particular output. This information is important since it indicates the factors that should be treated by policy and programme action.

Of all the problems facing policy-makers in health care, the most crucial is the allocation of resources. How much of the national pie should be allocated to health? How much to nursing? What tools can be sharpened to permit wise allocation of national resources? Can the use of health indicators provide a more scientific and rational approach?

I find it difficult to accept that, in the early stages of developing health indicators, mortality, rather than morbidity, will be used as a basis for developing first approximation indicators. The reasons given are that the use of morbidity would pose the very difficult problem of assigning weights to various diseases in accordance with some appropriate rationale; and mortality data are essentially complete, detailed and consistent, while historical morbidity data are largely oriented to hospital morbidity, which leaves many aspects of morbidity uncovered. However, some study is now underway on the development of indicators related to morbidity with a view to using data emerging from the universal 'Medicare' plans.

As decision-makers in health care we are concerned with its status. But this must also be related to the economy of the country. The phenomenal escalation of annual health costs in Canada, 12 per cent to 16 per cent, is in excess of the economic growth.[115] Yet there is no documentation that suggests that improvements in health care or maintenance are also escalating. Indeed, the present state of our knowledge does not allow a precise measurement of health. In our three countries, the various influences that have contributed to changes in the nature of sickness and death have been intensively studied. Of interest is a statement of Thomas McKeown, professor of social medicine, University of Birmingham Medical School, who evaluated the effects of several influences on the health level.

> 'Past improvements have been due mainly to modification of behaviour and changes in the environment and it is to these influences that we must look particularly for further advance.'[132]

Another author wrote: 'At this point in time, I am convinced that major improvements in health will come *only* from changes in life-style through self-motivated health-related behavior.'[95]

A working paper, *A New Perspective on the Health of Canadians*, proposed a 'health field concept'.[115] One relevant quotation is

> 'A basic problem in analysing the health field has been the absence of an agreed conceptual framework for sub-dividing it into its principal elements. Without such a framework, it has been difficult to communicate properly, or to break up the field into manageable segments, which are amenable to analysis and evaluation. It was felt keenly, that there was a need to organise the thousands of pieces into an orderly pattern that was both intellectually acceptable and sufficiently simple to permit a quick location, in the pattern of almost any idea, problems or activity related to health: a sort of map of the territory.'

Such a health field concept involves dividing the health field into four broad elements: human biology, environment, life style, and health care organisation. These were identified through an examination of the causes and underlying factors of sickness and death, and through an assessment of the parts the elements play in affecting the level of health. One of the evident consequences of the health field concept has been to raise human biology, environment and life style to a level of categorical importance equal to that of health care organisation – this latter accounting for expenditure of 95 cents of every 'health dollar'.

It seems reasonable to me that nurses, by virtue of their preparation, experience and numbers involved in family care, will provide a major portion of the impetus for improvement in life style – to reduce the 'diseases of choice' of an affluent society which are rapidly becoming the major problem of the western industrialised nations.

As we begin this seminar we are assured of one thing – as a result of the seminar, we will have changed our perspective on health services in our own countries and on the changing, or re-alignment, of the role of nurses. We will never think about nursing and health in the same way again; this is a prospect and a privilege we share.

1 An Overview of Primary Care in the United States

by Mary Elizabeth Dunn
executive director
Visiting Nurse Association
of Northern Virginia Inc

and Jessie M Scott
assistant surgeon general and director
Division of Nursing
Department of Health, Education and
Welfare

Definition

Nurses, a national resource which constitutes the largest single health manpower group, are the keystone in the delivery of health care for a population of more than 200 million in the United States. A look within the ranks of nursing personnel reveals a disturbing distribution of skills. Roles in expanded practice are intrinsic to the development of a nationally effective health care and health maintenance system, and the reformulation of the nursing role in the direction of primary care cannot wait. It is a simple socio-medical necessity that nurses assume primary care responsibilities.

It is extremely difficult to find a working definition of primary care in the literature. Although it constitutes a valid subject heading, the computerised 'Medline' approach, used by the National Library of Medicine to index most health related literature, fails to include one definitive work on the subject.

The medical literature seems, generally, to have equated primary care with general practice. A great deal has been and is being written about the broad concept, particularly because medicine now regards this area of practice as a highly desirable one to cultivate, one which young graduates of medical schools should be encouraged to consider. In addition, the Comprehensive Health Manpower Training Act, passed by the 92nd Congress in 1971 (Public Law 92-157), established a Health Professions Special Project Grant to fund primary care preceptorship training programmes for medical students. This has provided additional incentives for increased activity in this field.

Concurrently, the Nurse Training Act of 1971 (Public Law 92-158) provided two mechanisms to spur the development and production of specialised nurse practitioners, especially family health nurses, paediatric nurse practitioners, and nurse midwives.

Family practice is often used synonymously with primary care, and the increasing varieties of specialty practitioners (paediatric, obstetric, adult, psychiatric, and so on) are frequently considered as separate entities. In this paper, we shall consider them all as primary care providers.

Regardless of the term applied to the concept, there seem to be certain assumptions consistently used in discussion on the scope and nature of primary care. Chief among these are

direct access of the patient and provider to each other (an indispensable condition)

a wide range of knowledge of those providing service

personal knowledge of, and interaction with, the community of patients served

screening procedures providing accurate, quick differentiations of sick and well

a decrease in the responsibility of the practitioner for the acute health care needs of his patients, with corresponding emphasis on ambulatory care services

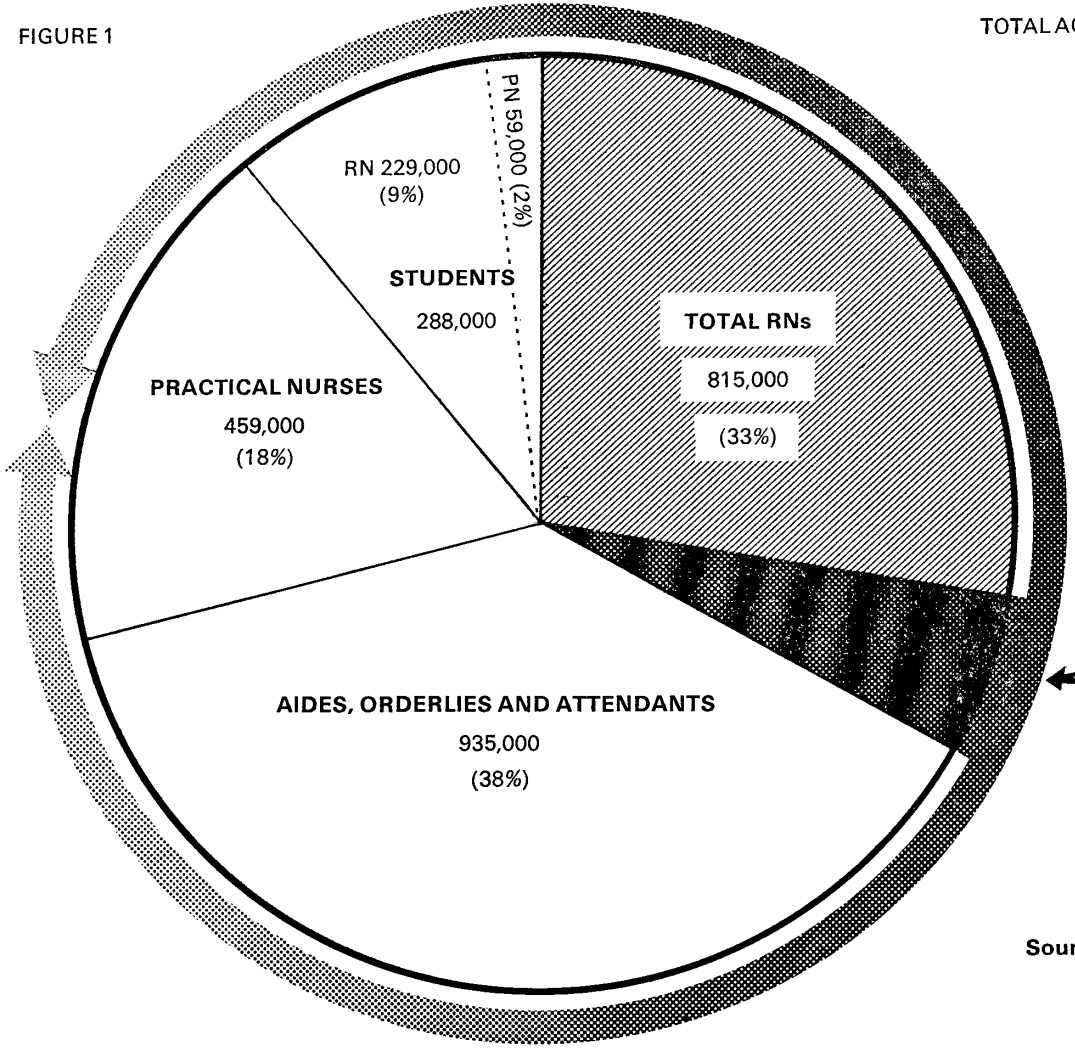
active participation in a health team.

There is strong emphasis on personal responsibility and accountability on highly decisive and independent contributions to the care and teaching of people, well and sick alike, and on professional commitment to the achievement of equitable

FIGURE 1

TOTAL ACTIVE NURSING PERSONNEL—1973

2,497,000



144,000 RNs
prepared for special care, teaching, and supervision

Source: Division of Nursing
Department of Health, Education and Welfare
United States of America

conditions of quality health care for all people in all locations and economic circumstances.

To be more specific, this requires professional commitment to accountability for

> detection of disease before it becomes acutely debilitating
>
> prevention of crisis situations
>
> follow-up to ensure optimum health status for individuals, their families, and their communities
>
> redistributing our ranks and expertise so that medically denied people, particularly in inner cities and isolated areas, have fair access to resources for health care delivery.

During the 1960s, nurses began to look seriously at their role in primary care, and to experiment with attempts to make explicit and demonstrate the potential value of their contribution. The results of several programmes were gratifying, and the studies that documented them clearly indicated that nurses, properly prepared, could assume a significant responsibility for primary care.[68,69,124,125,134,166,170,186]

The *Journal of the American Medical Association* responded warmly to one report[2], stating that the AMA Committee on Nursing supported the premise that a role reorganisation was necessary, and that this could be accomplished

> 'only in a separate, structured, formal educational experience, in a setting which allows and encourages the evolution of an expanded role for the nurse'.[162]

It became clear that this new direction, as well as others being looked at by nurses, sought to extend the scope of nursing practice and even to redefine it.

In 1971, a committee to study extended roles for nurses, called together by the Secretary of the Department of Health, Education and Welfare, treated the total health care enterprise in a trichotomous fashion. It defined primary care as two-dimensional, involving patients' entry into the system and responsibility for continuing care, setting it apart from the two realms of acute and long term care.[176] It would seem that primary care is quite broad in scope, and includes whatever condition or circumstances are presented by patients that fall within the purview of 'responsibility for the continuum of care . . . and management of symptoms . . .' It may be thought of chiefly as care provided to the ambulatory patient.

Our own definition of primary care is offered.

> Primary health care consists of those preventive, evaluative, therapeutic, rehabilitative, and counselling services afforded patients who are not in need of institutionalised care, but who present themselves to the health care provider in extra-institutional settings, or who may be seen and followed in their own daily living situations.

Change

A brief look at changes that have brought us to the crossroad in the history of health care will illuminate our perspective.

Nursing, like the world it was made to serve, is alive with change. It is affected by, and therefore must be responsive to, new social conditions, new developments in health care – including developments in health economics, new challenges and opportunities for demonstrating nursing accountability.

Social Change

As we look about us, we see that people have changed and, moreover, the composition of the population is changing rapidly. Certainly in the United States the numbers of the young, the aged, and the chronically ill are increasing far more rapidly than other groups of the population. These are the very groups which make specially sharp demands on nursing.

People in our time are also extremely mobile. Their awareness of the world about them is very acute, prompting new social concern. They are interested and involved in population control, and in action to counter such destructive forces as environmental pollutants, drug abuse, and alcoholism. They want to see action to ensure the quality, safety, and sufficiency of the food supply.

Being more fully informed, they have increased their expectations of health care, and have also developed somewhat altered attitudes toward health practitioners. People want help and health care, to be sure, but not in the old voiceless way. They want to have something to say about the thoroughness, the timeliness, and the tone, of health care delivery.

Moreover, they are themselves helping to create a style of health service which they feel is congruent with their style of life. The free clinic is a good example. Basically a development of this decade, free clinics first came into being to serve dissenting youth. Now we find that they are a refuge for many groups of people who are disenchanted with the old conformities and rituals.

The free clinic epitomises a philosophy of service that has particular concern for patient-advocacy. It adheres to the principle of non-judgmental acceptance of the patient as a person whose health

needs must be met. And it has strong concern for the prevention of health crises. For staffing, this form of health resource generally relies on a mix of professional and lay personnel. Those who come for help get help; and because they have a comfortable feeling of belonging and participating, they keep coming. They participate because they want to be heard, and because they know that the tenor of health services has inescapable effect on the quality of their lives.

How Nurses Themselves are Contributing to Change

Just as we find new consumer attitudes toward health services, so we see that nurses have changed. The flux and turbulence of our society does not escape them – nor do they seek to escape. Rather, they seek to contribute to the new order. No longer can health personnel live, think, and work apart from the churning of political and social currents.

It seems strange indeed that the health field has traditionally been considered above the battle – removed, as it were, from the tumult of society. Nursing, which is so inexorably riveted to the high drama of life and death, is not in any way *apart from*, it is *a part of* the battle. Clearly now, the separation of nurses from social involvement is no longer an actuality. They are using their collective wisdom to shape the forces that affect the health care environment. In very considerable number, professionally inactive American nurses are returning to practice. All over our country, even in rural areas, nurses are participating in continuing education programmes.

One of our more rural states has a continuing education programme by telelecture. Leased telephone lines have been installed at more than 80 sites – hospitals, schools of nursing, colleges, health agencies, and nursing organisations. Of necessity, many of the lectures are pre-taped. The telephone lines, however, facilitate live exchange between lecturers and students. Such exchange does more than give spontaneity and life to learning, it helps nursing to achieve solidarity as a community force.

And, as a community force, nurses are instigating timely change in our nursing statutes. In the United States, we do not have federal regulatory power on who should be licensed to practise nursing, or on the functions a nurse may independently initiate and perform. These are matters left to individual states. But in some states, nurses have helped to rewrite nursing statutes which have limited nursing functions and responsibility. What they have done is to make better nursing legally permissible.

In the revised statutes, many interventions which were formerly the sole province of physicians are now considered proper nursing functions as well. Assessment and diagnosis are regarded as parts of nursing; moreover, nurses are considered accountable for care provided by auxiliary personnel. Accountability is the benchmark of consummate achievement in nursing. It means that the nurse is accountable not only for the immediate well-being of her patients, but also for instigating timely change in the socio-medical environment.

Health Care Today: Its Emphases and Its Economics

Some important changes in medical care are the continuing upsurge of group practice, concern for evaluation of health care, and a notable shift away from the involuted, encapsulated, arcane sphere of medicine toward the broadly human sphere of total health care. The economics of health care have an equally important influence on the changing medical scene.

The trend toward group practice is helping to change the secluded atmosphere of the single physician's office into an atmosphere of a community resource for the health-minded consumer. People who patronise group health practices do so in a spirit of *keeping*, as well as *getting* well.

For economic reasons, the great medical and technological advances of this day are often more readily applied in group practice. They are part of the movement to put total care – not mere palliation – at the command of greater numbers of people. Wherever there are people, the concern of our time must be not merely what to do should disease break out, but how to help people capably to resist disease.

Nursing, therefore, is putting great emphasis on prevention. We are preparing nurses – family nurse practitioners – to perceive covert needs as well as to minister to overt complaints and conditions. Nurses in the community work largely alone. They must have an enviable degree of clinical competence; they must additionally have *savoir faire* in the teaching, counselling, surveillance, protection, and treatment of all the people – not just the community's sick or sick poor.

Prevention, which in bromidic terms may be translated to 'a stitch in time saves nine', is essential to avert both medical and financial catastrophe. Medical costs continue to skyrocket; and large numbers of economically deprived people just cannot buy any health care at all.

For people who can count on some stability of income, there is a proliferation of health insurance plans. Recently, legislation was passed in support of health maintenance organisations which we familiarly call 'HMOs' (Health Maintenance Organization Act 1973: Public Law 93-222).

We think we may be on our way to ensuring that health services have the quality that people have the right to expect. In October 1972, federal legislation established the professional standards review office, located within the office of the assistant secretary for health in the Department of Health, Education and Welfare. This office is now responsible for PSROs – a nationwide system of locally-run physician organisations to review quality and effectiveness of medical care. As a result of this new socio-medical development, we expect to see far-reaching change in medical practice to benefit the people who are the patients. Nursing equally needs to assess its quality and impact.

Still another movement appears to be winging into the health care horizon – the movement toward national health insurance. We have been talking about this for some time. First it was looked upon as a socially progressive notion; then with persistence it took on the aura of benign threat; soon, we hope, it will be a certainty. We hope this ideal will be reached in the quality and effectiveness of its operation.

Issues in Nursing

While responding to flux in societal demands and views, nurses must also deal with some strictly nursing issues which require solution by the *nursing* profession. For example, we have in the United States three kinds of educational programmes to prepare nurses for beginning nursing practice. Traditionally, there was the hospital-operated programme, usually a three-year course; then baccalaureate nursing education took hold; and in recent years, there has been a mushrooming of two-year junior college programmes.

Consequently, we have nurses prepared in various ways, and at varying levels, and with differing degrees of competence, all taking the same examination for licensure. All these nurses do not always speak the same language. They sometimes seem like separate tribes. They do not communicate with each other very well.

We are hoping before too long to settle on one unified system of nursing education that will be responsive to the abilities, aspirations, and economic capabilities of *all* recruits to nursing.

We also face the problem created by the growing numbers and types of paraprofessional personnel. Nurses must spend much of the time that might be devoted to patients, supervising auxiliary staff.

Nurses also have economic problems and have waged a somewhat successful struggle to achieve a more equitable economic base. But the struggle inevitably takes up energy that nurses would rather devote to patients. We hope it will not be necessary much longer to continue the economic battle, and that nurses can instead concentrate more on their commitment to patients.

Nurses now have a deepened sense of accountability and keener responsibility for the full sweep of nursing practice. They are committed to expanded, primary care roles, and we have ample proof that primary care is the way to bring better health care to greater numbers of people. One of our states, for example, initiated a demonstration in primary care nursing for a three-town area that had neither physician, nor dentist, nor any kind of organised nursing service. The people of this medically deprived zone were so well satisfied that they formed their own corporation to ensure health protection and treatment on a permanent basis. Many research projects and projects to evaluate specialised nurse training have also served to document the value of primary care. We are deeply involved in building a corps of nurses capable of highly independent activity in protection, surveillance, treatment, and counselling, so that people in all areas of our country, and in all economic conditions, will be able to realise their birthright to quality health service.

But we shall have to do more than train nurses for responsibilities in primary care. To assure equitable care for all our citizens, we shall have to deal with the problem of maldistribution of nursing personnel – a double-edged problem that reflects two kinds of shortages – that of numbers of nurses, and of specific expertise. Sometimes these shortages exist side by side. For example, nursing care is shifting from the institutional to the community setting. Yet most nurses are prepared for institutional nursing.

Moreover, the states vary widely in ratios of nurses to population. For example, in 1972 we had a national ratio of 380 nurses to 100,000 people. Some states, such as Pennsylvania with 519 to 100,000, far exceeded the national ratio: one state fell far below, with only 190 nurses for the same size population.

Where We Are Now

Nurses have begun to demonstrate their capabilities in providing primary care in a number of settings, and with differing population groups

health maintenance organisations

nurse clinics with conventional medical clinics

specialty practice and private practice of primary care.

Preparation for primary care practice has now been attempted in a number of ways. Although definitive research has not yet indicated which of these is the method of choice, it seems clear that the nurse who

provides this highly demanding level of care must be among those best prepared in the profession. It is not an appropriate role for the least common denominator among our ranks. Careful screening of applicants is essential.

Early Support of Expanded Practice

Interest in the specialised nurse practitioner role was evident in the mid-1950s, and led to some of the earliest reported studies of the, then, new concept.*

A research project initiated at Yale University in 1957, some years before the enactment of comprehensive nurse training legislation, clearly showed that a nurse-conducted interview designed to assess students' health conditions could safely replace a physician's examination in the student health clinic (Study A:36).*

Research supported in the early 1960s at Presbyterian Hospital in Philadelphia showed that the nurse, aided by modern monitoring equipment, was the key to saving patients' lives in intensive coronary care units (Study A:53).* The resulting system of nursing care reduced the hospital mortality rate of heart attack patients from 30 to 20 per cent. This research also supplied the physical design broadly adopted for intensive coronary care units.

In the mid-1960s, a project in a medical centre demonstrated that ambulatory women patients, aged 50 and over, who received all their care, including certain medical procedures, from nurses equipped for primary care roles, made better progress than those who received routine outpatient treatment (Study A:50).* In the late 1960s, a 'nursing hospital' was successfully established at Loeb Center for Nursing and Rehabilitation at Montefiore Hospital in New York, with a nurse as chief therapeutic agent (Study A:99).*

Paediatric nurse practitioner training resulted in one of the more well-publicised primary care areas. That first programme was a 17-months' course of academic study and clinical experience for registered nurses supported by the Commonwealth Fund. An evaluation showed that 75 per cent of the paediatric patients at a health station were independently handled by graduates of the programme, and further that 90 per cent of people who obtained private paediatric care for their children readily accepted the nurse practitioner.[166] Other reports have described how graduates of the programme overcame cultural barriers to gain acceptance and trust among the Spanish-speaking residents of a poor, isolated, and medically-deprived community.†

Support in Several Practice Areas

Family/Community Nurse Practitioner The emphasis on developing the role of the family/community nurse practitioner is now evident. In one state, for example, a college of nursing and a hospital began in 1969 to cooperate in a master's level training programme to develop health nurse clinicians for primary care of adults in public health agencies and hospitals. This project resulted in new role responsibilities for the students: some are taking their places in practitioner training programmes; some are participating in practitioner research; and some are practising as members of an interdisciplinary team.†

Two other projects were initiated at universities in 1970 to prepare comprehensive community nurse clinicians in a master's programme,† and to prepare experienced public health nurses as independent counsellors and coordinators of family oriented health services.†

Four additional master's level programmes were started in 1972†: to prepare nurses as family nurse practitioners to meet the health care needs of the aged, indigent, and black members of an inner city; to prepare nurses as family health specialist members of health teams delivering comprehensive family health care; to develop an expanded role in primary health care facilities for the community health nurse; and to prepare nurse practitioners for practice with strong emphasis on prevention of disease and maintenance of health, and largely directed toward continuous care of people not confined to health care institutions.

In an undergraduate programme, primary care nurse practitioners in urban and rural ambulatory care settings are providing role models for baccalaureate nursing students. In addition to demonstrating the expanded role, the project will evaluate role learning and its effect on professional practice.†

A study was initiated in Alaska to ascertain the type of preparation public health nurses need for work with families in the Alaskan bush. A continuing education programme provided two week periods of intensive training. Now a university will prepare nurses for expanded roles in Alaska.†

Among other projects concerned primarily with increasing the number of nurses training for expanded roles are some designed to prepare family/community nurse practitioners.† One undergraduate programme has a set schedule of bi-weekly conferences to foster the collaboration of nurse practitioner students and doctors. In another undergraduate programme, students go to the emergency rooms of hospitals and to the offices of physicians for clinical experience.

One university school is conducting a master's degree programme to train nurses for independent

primary care of children and adults living in rural and urban communities. The training emphasises expertise in clinical skills, teaching of health maintenance, strategic use of resources for health care and rehabilitation, and professional teamwork with physicians and other health workers.†

In three projects, the family nurse practitioner role is being evaluated. At one university, the first systematic evaluation of the role and effectiveness of the family nurse practitioner is in progress.† A school of public health is evaluating the public health nurse as family nurse practitioner, as the students work with community sub-groups to arrive at joint identification of community health problems.† In a rural area, a pilot project is underway to assess primary care nursing for the 13,000 members of 3500 medically deprived families, being provided by the four nurses assigned by the state department of health to each of four counties which have no resident physician, no dentist, nor any kind of organised nursing service. Comparisons of 'before and after' data in the last project will afford a basis for assessing the impact of primary nursing care, and for designing curricula to prepare nurses for extended practice in rural settings.†

Paediatric Nurse Practitioner The effectiveness of the paediatric nurse practitioner for expanding and improving health care services is now well established. Reports indicate that paediatricians in private practice who employ a paediatric nurse practitioner are able to increase the size of their practices, in some instances by a third. The American Nurses' Association and the American Academy of Pediatrics have worked together to develop guidelines for short term continuing education courses for this type of nurse practitioner, in recognition of the need for collaborative efforts to increase the quality, availability, and accessibility of child health care in this country. The guidelines, released in a joint statement in 1971 by the two associations, recommended a minimum of four months' training.[6]

According to the American Academy of Pediatrics, by July 1973 there were about 1000 graduates of paediatric nurse practitioner programmes throughout the country.†

At one university, the competencies that could be expected of a professional nurse functioning in ambulatory child health care are being studied, and the additional knowledge and skill necessary for a nurse to achieve these competencies are being identified. The schools of nursing and medicine are collaborating to effect re-alignment of the roles of nursing and medicine.†

In another, a two-year master's degree programme to prepare paediatric clinical specialists is being developed, implemented, and evaluated by the school of nursing. Graduates are prepared to take expanded responsibilities for well-child supervision and parent counselling, and to provide clinical expertise and leadership in paediatric nursing.†

In other approaches to effect expanded roles in paediatric nursing, one school is developing a method for nurses to assess growth and development of young children and to determine appropriate nursing actions.† Another is conducting an evaluation study to establish criteria for selecting and training paediatric nurse practitioners.†

School Nurse A long term interest has been to document and expand the role of the school nurse in supporting health and preventing illness among the school-age population.† On the premise that health practices learned by children can contribute to the health of their families and their own well-being as they grow into adulthood, this activity has important implications for the future health status of communities throughout the nation. A study, in one state, of illness and absence among 2000 school children has to date revealed that only about 14 per cent of the children had 40 per cent of the school absences; that three-fourths of the absences were due to illness, particularly respiratory, and that frequency of absence tended to become habitual.† On the basis of the findings, efforts are underway to devise and test new modes of school nursing practice that will bolster the health of the children.

Issues and Their Problems

Issue:	Adequate redefinition of practice
Problems:	dearth of research in practice lack of adequate standards number and diversity in content of current legal definitions
Issue:	Development of appropriate and adequate standards
Problems:	number of and diversity in educational programmes competencies still undefined lack of critical mass of qualified researchers

*These studies are completed and are listed in the document, *Research in Nursing 1955-68*, US Department of Health, Education and Welfare.[180]

†These are on-going studies supported by the Division of Nursing and listed in *Special Project Grants and Contracts Awarded for Improvement in Nurse Training*, US Department of Health, Education and Welfare.[182]

Note: For UK readers, copies of these documents may be seen at the library of the King's Fund Centre, 120-126 Albert Street, London NW1 7NF.

Issue: Restructuring of delivery system

Problems:
- traditional philosophy about entrance of individuals to the 'system'
- current concept and attendant structure and process which deal chiefly with sick, acute, or episodic care
- difficulties in enabling consumer involvement

Issue: Assumption of control and accountability

Problems:
- traditional role and relationship to other health professions
- lack of intra- and inter-professional consensus
- encroachment of statutory and regulatory requirements of existing pieces of legislation
- paucity of leadership

Issue: Reimbursement

Problems:
- reluctance of physicians
- gap in understanding of planners, legislators, insurers, for recognising full potential of nurse practitioners in the care of people

Issue: Development of cost-benefit methodology

Problems:
- traditionally not a concern of nursing except management in public health nursing
- criteria are not clear
- confusion generated by variety of payers for care
- few standards for measuring cost-effectiveness
- acceptance of necessity and determination about where and how to bargain in the marketplace
- reluctance of planners, legislators, insurers, fully to recognise need for methodology

Issue: Initiation and implementation of evaluation

Problems:
- inadequately defined standards
- lack of measurement and tools
- governmental constraints and requirements
- need to understand the issue
- developing professional standards review organisations

What To Do

It appears that in our present socio-economic and political climate in the United States, renovation and reformation of our health care system require deliberate interlocking strategies. If the mission of nursing has, in fact, grown from Margaret Mead's well-known phrase 'protector of the vulnerable' to 'advocate for the people', the expansion of the role of the nurse is mandated.

There must be changes in philosophy and behaviour that relate to direct access to the patient. Both nurses and physicians must be willing to abandon their traditional patterns of practice, organisation, and funding. There must be commitment to function on the health *team*, and focus on the overall objective of *health* care rather than enhance the divisiveness resulting from separation of each profession into generalists and specialists. Collaboration between nursing and medicine, as well as with the other health professions, is the goal. Nurses must have a firm commitment to the achievement of equitable conditions of quality health care for all people in all locations and economic circumstances, and must give evidence of concern for cost-effectiveness in delivery of care.

One of the first actions already being taken in some states is the legitimisation of primary practice by bringing about indicated amendments in nurse and medical practice acts. Aside from the obvious imperatives of public education and sophistication in the legislative process, there must be specific redefinition of nursing practice.

This, in turn, assumes the establishment of adequate standards and qualifications which will need to be assisted by additional and more definitive research. The results could be more practice models, the validation of nursing education outcomes, and hard data for making quantitative analyses.

In addition, broad dissemination and implementation of research findings already available should provide for development of some realistic measurement for determining the relative values of quality, quantity and cost.

Of growing concern is the matter of the profession's control of practice which dictates a certain amount of determined vigilance. It is threatened at intervals by statutory and regulatory restraints. Certification of practitioners by the profession, which is underway, can also serve as a means of retaining control.

Credentialling, of course, is an essential of certification and should be an educational process in an educational institution. It is better able to provide a broad based preparation in basic related sciences; credentialling found in it imposes quality controls that protect the practice of nursing; and this type of credentialling enables the practitioner to have more mobility within the health delivery system throughout the country.

Organisational changes will have to be made in the various practice settings to facilitate practitioner

skills and foster full participation of primary practitioners in decision-making at operational levels. It has been urged that there be promoted the concept of consortia between health agencies and educational institutions, and that the latter employ more practitioner teachers.

It is obvious that innovations in curricula have a high priority. Not only must changes be made in basic curricula so that initially all nurses can be adequately prepared for primary care, but continuing and short recurrent programmes have to be developed. Most of the more than one million registered nurses should be prepared as some kind of primary practitioner, and credentialling must be sustained by appropriate and adequate preparation or renewal.

There remains great need to expand the scientific base; for example, increased efficiency with the primary care practitioner has been demonstrated, but who benefits most – physician, patient, or practitioner – still needs to be demonstrated.

The enlistment of the public, the consumers, as advocates – their *real* involvement in this evolutionary process – could produce the best change agent. They will certainly influence the system of payment for care.

Nurses can exert enormous influence on decisions that affect delivery of care. This influence at the same time assumes responsibility for the effect it has on societal and political decisions that affect the health care system. Above all, nurses are accountable for the consequence of nursing practice and, therefore, bear the chief responsibility for assessing performance.

The concept of judging or evaluating is not new; it has simply become a major issue again. It is demanding new or better approaches, more valid tools and improved standards for measurement. But first and foremost, it is incumbent upon nurses to grasp the initiative in this responsibility.

Evaluation of nursing practice, client outcomes, or whatever is being so studied

> '. . . is in conceptualizing each of the major domains* adequately. A good conceptualization of nursing practice is comprehensive and reveals the inter-relationships among the parts of what is called nursing process. It is also based on either knowledge about or hypotheses about the effects of nursing practice on the patients or clients. Thus, a good conceptualization of nursing practice should make it easier to conceptualize and define the domain of patients outcomes. As one engaged in these processes, he should remember the important and central role of values and value systems'.[88]

Thinking in terms of concepts, this may be the time to conceptualise the future of nursing. If those who prophesy are correct, we can expect to see an 'anti' attitude toward organisation, technology and increased specialisation. But it is suggested that the current trend toward role distinction in nursing gives evidence of a different and deeper concern with how people live, what their functional needs really are, and how these needs can be effectively and efficiently met.

As part of the 'anti' attitude, health professionals may lose some of their sacredness, educational programmes may suffer confusion and instability. Also, we are certain to see a heightening of economic problems and the obsolescence of some health workers.

But the futurists remind us that 'The future is not a matter of inevitability, but rather of choice'.[133] Inasmuch as the leaders guide the choices, it is urgent that those willing and able to risk it be appropriately prepared for leadership. The force of their commitment will determine the impact of primary care on a waiting and listening society.

*The three major domains are the practices or interventions that constitute professional nursing, the characteristics of the setting or conditions under which nursing care is delivered, and the effects of nursing care on the patients or clients.

2 Primary Care in the United Kingdom

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The Primary Health Care Team — A Philosophy or a Liability?

The Leicester born author, C P Snow, in his book *The Two Cultures*, crystallises one of the critical problems of the century – the failure of two cultures, the scientists and the intellectuals, to communicate. The gulf between them is created chiefly by excellent – but highly specialised – educational systems. He summarises

> 'Persons educated with the greatest intensity, we can now no longer communicate with each other on the plane of major intellectual concern. This is serious for our creative, intellectual and above all our normal life. It has led us to interpret the past wrongly, to misjudge the present and to deny our hopes for the future. It is making it difficult or impossible for us to take good action.'[168]

In the course of working together we are becoming more aware of a similar failure in communication between nursing and medicine. Its cause may be the same – separate educational systems: its risks *are* the same – the impaired ability to cooperate effectively, leading to mutual misunderstanding and sometimes antagonism.

To deliver comprehensive care, no one health professional is going to be able to serve the total needs of a patient in isolation from other professionals. Our total thrust must be on team delivery of care. This does not necessarily mean that the whole team is going to be at the forefront all the time. It *does* imply open communication and team participation in decision-making. The criterion of the maturation of this team will be its sharing of accountability for the quality and the delivery of care.

Educational Needs in Team Care

If the primary care team is to use its members to the full and allow for this collaborative problem-solving, it is not enough merely to place professionals together on the same site and expect them to function as a team. There has to be a conscientious effort to educate professionals to function effectively together. Most professionals come into the team with a high level of independent functioning. This is a strength in many ways, but it can create an obstacle to the development of team spirit or interdependence of team members. Professionals appear to feel that perhaps working in a team means giving up power and autonomy in decision-making.

Traditional role images and professional stereotypes are other obstacles to team development. Many members have a rigid conception of their own role and a stereotyped conception of the roles of their team colleagues, and these can make them inflexible in looking for new approaches to care and more effective use of resources.

'Teamsmanship' requires a willingness to confront traditional values and our teaching of professional roles, leadership and the decision-making processes developed early in our professional education and reinforced throughout our professional practice. This is not an easy process if we have no experience in looking at our own behaviour and our relationship with other professionals.

The issue is not whether we are to have primary health care teams: they already exist. The issue is whether or not we are going to prepare the members of those teams to deal effectively with reality. How can we prepare them?

Three criteria appear important.

1 Students of all health professions should have a sound knowledge about key professionals in the team and the knowledge and skills they possess. Preferably, the student should have some experience in working with the professionals and seeing their skills in action.

2 Students should be exposed to the content, and have experience of, basic group process skills; particularly, those basic to effective team functioning – leadership, negotiation, establishment of group priorities, group decision-making and communication techniques. The students need to be helped to look at their own behaviour in groups both as group leaders and group members.

3 Students should have practice in working as members of an interdisciplinary team and in applying their knowledge and skill in this group situation. This would facilitate a greater understanding of how knowledge and skill can be integrated for the benefit of the whole, and would allow the student to develop the added skill of functioning as a team member.

Extension of Nurses' Work

The attachment of community nurses – health visitors and district nurses – to medical practices to form the core of a primary care team has resulted in extensions of their work as gaps in the community care provisions have been identified and filled. This development, however, was a response to demand and was not planned. We need to know more precisely what it is we are dealing with both in quantitative and qualitative terms. The selection and evaluation of alternative solutions then become more logical processes. Unfortunately, little detailed analysis of nursing work content is available and few general practitioners document their workload, while fewer still maintain a diagnostic index.

As in any other area, community nursing staff structure must reflect function and the needs to be met. Community health needs are seen to comprise

1 a preventive health care service, including the development of presymptomatic screening

2 developmental paediatrics, and the early ascertainment of both physical and mental handicap

3 health supervision of children up to school leaving age

4 ascertainment and provision of health care and attention for families at risk

5 care for the chronically sick, handicapped and disabled

6 treatment and care of the mentally ill and the frail elderly, both of which are becoming more community- than hospital-based

7 development of public understanding and support for community health measures and environmental hygiene.

There is a growing realisation of the importance of health education. The health visitor's main concerns 20 years ago were antenatal and child care, prevention of accidents at home, and advice on immunisation, diet, hygiene and infectious disease. Today the health visitor is concerned more with the care of the elderly, advice on family planning, cytological testing and other aspects of cancer, drugs, alcoholism, mental breakdown and venereal diseases.

The primary care team's function is now extending to the patient who needs more comprehensive care. The report, *Organisation of Group Practice*, described a nursing unit of beds available to general practitioners for patients who should be nursed at home but could not be, mainly for social reasons.[80] The idea has been extended and a pilot scheme in the Oxford region has been described, following which a prototype community hospital has been opened. Such may be the answer to the use of cottage hospitals which often receive much local voluntary support and could fulfil a very real local need.

Some primary care teams are looking for support from specialist therapeutic teams outreaching from hospital to the health centre surgery and patient's home. All these developments will affect the mix of the team and nature of qualifications and expertise upon which it needs to call.

As a result of the deployment of health visitors and district nurses into primary care teams, the syllabus of their post-basic courses has been restructured with more emphasis on the emotional and social aspects of illness in the vulnerable groups in society, and to provide opportunity of gaining experience of working as members of the interdisciplinary team. But the shift of the vocational work has not been matched by educational opportunities. Those already working in the community are very much in need of specialised courses which relate to their new sphere of activities; cardiovascular disease, chronic sick, family planning, genetic counselling, health education, screening and early identification.

Preventive medicine is receiving increasing recognition as a prime function and responsibility of a health service, and developments are given frequent coverage by press and television. The only member of the nursing profession who is prepared for a full role in this field is the health visitor, but she appears to be somewhat reluctant, certainly

hesitant, to accept it. Her tendency to emphasise the medico-social aspects of her work is largely influenced by the way others have or have not used her in the past. In preventive medicine she now has opportunity to identify herself as a nurse with a specialist function, supported by an advanced post-registration course and training in health education techniques.

Staffing levels need continual review by nurse managers. Guidance on staff ratios to population, though so far unprecise, serves as a basis on which to plan. There is an urgent need for criteria to be laid down, probably on a demographic basis. The total nursing workload of a practice must be taken into account if the employment of private practice nurses by doctors is to be shown as unnecessary.

Planning for Primary Care

In a vast bureaucratic health service, tidy management structures are based on functional divisions. Management thus finds itself in a dilemma. In a health district, the division will not stem from the requirement of primary health care but from existing hospital divisions whose scope will extend into the community care field. Primary health care does not concern itself solely with individuals of various age groups or diagnostic categories but with the whole family. There is a great value in the mother's pregnancy, the toddler's temper tantrum and grandfather's bronchitis being dealt with by members of one team based in the local health centre. The family builds up a relationship of trust so that health education is imperceptably a part of the service received.

In planning a health service for the new town of Milton Keynes, the intention has been to base the service on health centres built in each neighbourhood as the town grows, and with the secondary (hospital) care facilities being phased in over a longer period. While the family doctor remains an independent contractor, and if the health care groups do not become too large, there will be a variety of concepts of service needs and patterns of work, and the primary care nurses must be free to develop the nursing potential within the team. The contribution of the generalist primary care nurse or health visitor will also be an invaluable asset to health care planning teams of all specialties. Management plans must take these factors into account.

The Family Nurse Practitioner Model

Smith and Mottram described how their nurse visited all patients who asked for a call and selected those she thought the doctor needed to see. She appeared to be working firstly as a diagnostician of the gravity of illness and, secondly, as a therapist of those patients whose illnesses she thought did not require consultation by a doctor. The patients appeared to accept and be satisfied with that method of medical care.[167]

A recent study undertaken in Glasgow compared decisions made on first contacts in general practice by a nurse and three general practitioners.[138] A hospital nurse accompanied each of the three members of a group practice on a total of 111 new house calls. Doctor and nurse individually made an assessment of the urgency of each case and chose the course of action they felt to be most appropriate in dealing with the patient's problem. The pattern of decisions made by the nurse did not differ significantly as a whole, either statistically or clinically, from that of any of the three doctors. There were nine cases where differences between the recommended actions might have had serious consequences for the patient. But these differences could have been removed by an instruction to the nurse based on the age of the patient and on certain clinical features.

It is said that medical climate of opinion in this country does not at this time favour the radical innovation of the North American model of the family nurse practitioner, but these studies seem to show a growing acceptance of the concept in practice if not in principle.

3 The Role of Canadian University Schools of Nursing in Education for Primary Care

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The role and functions of nurses in primary care settings are the subject of extensive assessments in Canada today. The Ontario report, *The Expanded Role of the Nurse in Primary Health Care: A Summary of Current Developments*, reports 15 projects which are devoted to the educational preparation of nurses for primary care or to the study of functions and activities of nurses in these settings, as they, in cooperation with physicians, assume a wider range of responsibilities.[38] In Ontario and the other provinces, additional projects have been undertaken to establish and evaluate pilot educational programmes or demonstration practice models.

The Committee on Nurse Practitioners was assigned the task to define the role(s) and functions of nurse practitioners in the field of primary care and to identify the necessary skills and knowledge in the forms of educational guidelines. The committee, in its report (known as the Boudreau report), defined primary health care as

> '... all those health services which are provided for individuals mainly on an ambulatory basis in the community or in their homes and includes: 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 rehabilitative services for those who require them. It provides care which is convenient, coordinated, continuous and comprehensive'.[29]

The committee assumed that the public wished to have a health care system that possessed four basic characteristics; accessibility, comprehensiveness, continuity and personalisation.

The report, and its recommendations, added support to educational programme changes already underway in some university schools of nursing and stimulated further programme development and evaluation. In particular, the committee recommended that the development of the nurse practitioner category be given highest priority in meeting primary health care needs in Canada, that educational programmes at diploma and university levels be broadened to reflect the priority accorded primary health care and that supplemental educational programmes be planned, in educational institutions affiliated with university health science centres, for candidates interested in careers as primary care nurses.

Changes in educational programmes are directed toward developing in nurses the appropriate knowledge, skills and attitudes to enable them to work as team members and colleagues with physicians who have the legal responsibility for the medical diagnosis and management of a wide range of health problems which patients and families present in ambulatory or primary care settings. In Canadian cities and towns, nurses, physicians and other health team members are generally in close enough proximity to work side by side. In isolated rural and northern locations, nurses are frequently the only health care workers continuously in the district; physicians, dentists and others may visit on a regular or irregular basis. As well, patients whose illnesses require more skill than the nurse can provide, are transported to acute care settings. Education programmes must therefore prepare for different practice locations.

Educational Programmes

Programmes offered by the 22 Canadian university

schools of nursing can be placed broadly in three categories:*

1 those leading to the baccalaureate degree in nursing, including basic (initial preparation in nursing) and post-basic (following a diploma in nursing)

2 those for registered nurses leading to a certificate or diploma, including supplementary programmes for which the Boudreau report described a need

3 those leading to a master's degree in nursing or a related field, which generally provide the opportunity for specialisation in clinical nursing and increased skill in research methods, administration or teaching.

Programmes within all three categories prepare nurses for positions in primary health care. The Canadian university schools have, for years, prepared nurses for public health or community nursing, and argued strongly about the abilities of the baccalaureate graduate in family counselling, health promotion and health education.

New emphasis on changing conditions that relate to environment and life style faces the university nursing schools with some difficult problems.[115] The challenge is increased by the acknowledged importance of planning learning experiences that expose learners in the various health fields to well-functioning inter-professional teams and encourage students to learn their practice roles together.

Issues and Problems

The Canadian university schools of nursing have always endeavoured to keep abreast of, if not ahead of, changes in practice settings that require new nursing skills and abilities, or new applications of established skills and abilities.

A survey of Canadian universities in 1973 showed the kinds of programmes either underway or planned.[100] All 22 university schools of nursing reported that curriculum changes were underway for their basic and post-basic degree programmes. The schools indicated that these changes were either to implement the recommendations of the Boudreau report or to prepare graduates for increased responsibilities in primary or ambulatory care.

*For a detailed description of the development of Canadian university educational programmes in nursing, see, Carpenter, Helen M., The Canadian scene. *International Nursing Review*, XXI, March/April, 1974. pp. 43-48.[40]

Twelve universities with schools of nursing reported programmes to prepare graduate nurses for additional responsibilities, principally in rural and isolated settings, through non-degree certificate or diploma programmes. Two Quebec universities without schools of nursing (Loyala and Sherbrooke) reported similar programmes. Of these 14 universities, five offered programmes specifically designed to prepare nurses for northern locations under federal jurisdiction, and two were planning programmes designed specifically to meet the needs of isolated communities served by their own provincial departments of health.

Today, the rapidity of change, the need to 'second guess' several levels of government, along with the attempt to bridge discontinuities between various parts of the health system, have placed considerable stress upon schools in all provinces. Most schools, and the faculties that represent them, have shown remarkable resilience and ability to cope with stress, as well as providing leadership within their provincial jurisdictions.

The issues and problems in strengthening programmes to prepare nurses for primary health care concern educational resources, restrictions in practice, pressures for immediate action, and beliefs about nursing and teaching.

Educational Resources for Primary Care Education

Faculty Difficulty in securing a full complement of qualified faculty is not a new phenomenon. Recruitment is particularly acute when nurse teachers are sought who have the skills and knowledge required for practice in primary health care settings, along with an understanding of the problems of role change. In addition, programmes preparing nurses for stressful primary care positions demand a partnership between nursing and medicine in teaching as well as practice. Capable physician teachers who are sensitive to the problems of primary care are difficult to secure, especially when many medical schools are also placing greater emphasis on the preparation of family physicians and are therefore recruiting from the same group of primary care physicians.

Clinical Practice Settings There are relatively few nurses who can serve effectively as role models for students, particularly in a co-practitioner role (referred to by others as the 'physician associate'), rather than a 'physician assistant' relationship, and who demonstrate in their practice that psychosocial and family care are given equal importance.

The high priority given to the preparation of primary or family care practitioners by a variety of educational programmes – nurses (diploma and degree), physicians and social workers, in particular – results in heavy demands on primary care and other

ambulatory services. These are also rarely designed or staffed to accommodate any more than very few students at any one time.

The practitioners also recognise that their roles are changing and that continuing education is necessary to maintain competency. Many nurses, along with physicians and other health workers, seek continuing education programmes that will extend their abilities and scope of practice: nurses ask especially for those programmes that lead to formal credentials, such as a university diploma. These continuing education programmes use faculty and clinical resources which are already participating in other university degree or diploma programmes and thus compound an already tight situation.

While there may be under-utilised and highly appropriate clinical practice locations at some distance from the university, schools are faced with the question of how far away can they afford to send students and faculty, in relation to travel costs as well as faculty and student time. McMaster University places degree students in a family practice unit 23 miles by road from Hamilton, and no means of public transport to reach it. The University of British Columbia makes extensive use of clinical resources in communities along the Fraser Valley. Very desirable practice settings can be secured at even greater distance; for instance, Queen's University, Kingston, Ontario, sends students and faculty to Moose Factory on James Bay – over 500 miles by road followed by 186 miles by train. Our 'prairie' university schools send students to equally distant communities in Canada's north.

Financial Support Because of lower student-faculty ratios in primary care units, a thrust by an educational programme into the extra-hospital settings requires more faculty and is a major financial consideration. For new and intensive programmes, such as our family nurse practitioner programme, the ratio of students to faculty is low, approximately 4:1, and even less if one counts the important contribution made by physician preceptors in medical practices used for clinical experience.

In Ontario and other provinces, teaching hospitals receive financial support for educational programmes through the ministries of health; for instance, payments for resident training in the medical specialties. Additionally, teaching hospitals acknowledge a responsibility to accommodate and contribute to educational programmes preparing many health workers. Outside the hospital, official and voluntary health agencies accept this educational responsibility but it may not be reflected in their budgets and space provisions. As well, private medical practices, which provide a real life practice setting, are most frequently paid on a fee-for-service basis. Thus, they lose earnings when they accept learners, with the educational programme seldom in the position to provide subsidies.

Restrictions in Practice

While similar issues are problematic in other provinces, the following remarks primarily concern Ontario.

Economic Consideration Unless a community health centre or family practice unit is on a global budget or capitation arrangement, payment for services, under the Ontario Health Insurance Program, remunerates for physician services only.* It is highly unlikely that the fee-for-service basis of payment will be extended to include health professionals, other than those now included. While arrangements have been made to provide salary support for nurses employed by fee-for-service physicians in geographically isolated regions, and global budget physicians in more populated communities, the Ontario Ministry of Health is proceeding with exceptional caution. This has placed our own faculty in the position of trying to mediate between the registered nurses who complete our family nurse practitioner programme and the Ministry of Health, along with trying to develop the programme graduates, as a pressure group, to present their own arguments regarding conditions of employment and responsibility.

Legal Aspects The transfer of procedures from medicine to nursing has long been established in Ontario, based upon agreements between the professional regulatory bodies, the College of Nurses of Ontario and the Ontario College of Physicians and Surgeons. A definition of the scope of nursing practice has not been established. The grey areas between the practice of medicine and the practice of nursing cause many uncertainties for practising physicians (who are accountable for all acts performed on or for patients cared for by the practice). As well, there are uncertainties for practising nurses, who are not sure for which acts they are accountable, or, in some situations, are not sure how far they wish to be accountable, or how far they prefer to be dependent upon their physician employers.

Attitudinal Considerations The presenting features of underlying attitudes concern the acceptance of

*Fee-for-service remains the predominant method of payment of physicians in Ontario. In some rural settings and a few urban locations, the Ontario Ministry of Health has negotiated with individual physicians, or physicians participating in a group practice, a global budget which reimburses the practice for salaries and expenses, and which is based upon the practice experience under fee-for-service payments. The negotiated sum remunerates the medical practitioners and provides operating expenses, including the salaries of practice employees, including nurses who may be assuming extended roles.

accountability. In addition, many nurses have been conditioned to defer to physicians, physicians have traditionally assumed a role of dominance in any health team, and both these roles have been supported by the public, including people who seek health services. The problem of attitudes is probably the most important and the most difficult to resolve.[113]

The nurse and physician teachers associated with programmes that prepare nurses for re-delineated or co-practitioner roles with physicians, are placed at the cutting edge of change. They become the counsellors and advisers of both nurses and physicians who are wrestling with the problems of change in activity and accountability. Serving as an intermediary between practice team and government, and frequently between nurse and physician, subjects nurse and physician teachers to considerable stress. They are continuously exposed to the anxieties of the nurse student and the physician sponsor, when the programme requires physician sponsorship.*

Pressures for Immediate Action

Without adequate faculty resources, clinical facilities, and strong support from medicine (aside from support in principle), some Canadian university schools have been under vigorous governmental pressure to develop educational programmes to supplement the skills of nurses employed in medically under-serviced regions, for which the particular province has responsibility. One or two schools are experiencing similar pressures from their associated faculties of medicine.

Employers of nurses, including teaching hospitals, public health agencies and private medical practitioners, are pressing the university schools to offer 'challenge examinations'† and other means of assessing the competency levels of practising nurses, as well as to provide short courses to develop, for instance, physical assessment skills. Nurses who desire to extend their responsibilities in their present positions or who wish a career change within nursing are making the same requests.

*When the educational programme does not require participation by the physician, one must presume that the nurse and physician are left to find their own counsellors.

†A challenge examination is an examination designed to assess the level of knowledge and skill of students so that they are required to take only those parts of an educational programme or course that represent new learnings for them. While knowledge can be assessed through written examination, techniques are inadequately developed that can test the application of this knowledge to practice.

Beliefs about Nurses and Nursing

Within and between the university schools there is vigorous debate about the whole extended role of the nurse (or 'expanded' as some would call it). Primary questions are

1 Has the new role for the nurse developed, or is the re-delineated role really a fuller application of the nurse's existing abilities, with the addition of some tasks the physician wishes to transfer?

2 What is the conceptual framework that supports curriculum changes or new educational programmes?

3 What terminal objectives should be stated and how specific should these be?

4 Are, should, or can, all baccalaureate graduates be prepared for all primary care roles? Can the schools prepare effective beginner practitioners who have the competencies needed for practice in both primary and secondary settings?

An Attempted Solution

One enlightening feature of administrative integration of health sciences educational programmes is the recognition that nursing is not alone in having to deal with these issues. McMaster has recently confirmed such an administrative arrangement for medicine and nursing through the establishment of a single faculty of health sciences which combines the former faculty of medicine and school of nursing. Both medicine and nursing experienced initial anxieties when reorganisation was proposed and it is not surprising that some anxiety remains. The new organisation is designed to promote effective use of health sciences, clinical, educational and research resources in the Hamilton region, in order to meet the objectives established for learners enrolled in both university and community college educational programmes. Coordination in planning and operation of clinical services, a much more complex task, is progressing slowly. As well as the educational institutions, this involves all the health agencies and institutions in the Hamilton district, under the aegis of a district health council.

The McMaster University experience is an example of how one health sciences centre is attempting to tackle the problems faced by educational programmes in the health field today. It is hoped that voluntary coordination will provide both the climate and the strength to resolve these problems. Certainly, the organisational structure, and the policies and programmes that develop, will be watched with interest by other university affiliated health professionals in Canada.

Conclusions

This is a stimulating time for Canadian university schools. In many ways, they are being asked to demonstrate what they have long said they were doing; preparing nurses for beginning practice, particularly in the community ambulatory fields which require practitioners who can view the patient and his family from a wide perspective of humaneness and well-being. Most Canadian university schools of nursing are dealing with the issues and problems that have been described. Because of separation by geographical distance and, for many, provincial boundaries, opportunities to share successes and failures are infrequent, but they are important for professional stimulation and growth.

This is also an exciting time for the development of the full potential of nurses who have the attitudes, knowledge, and skills to perform as full team members within the organised health services of the future.

4 The Health Field Concept - The Canadian Framework

by Huguette Labelle
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For a number of years now, Canadians have benefited from a government-operated, universal, prepaid insurance system of medical and hospital care. It has substantially removed financial barriers to these services, but there is a growing awareness of some difficult problems that need immediate attention. Among the major areas of concern are

1 escalating costs of health care services which, at 12 per cent to 16 per cent annually, exceed the economic growth of the country, the major portion of these costs being generated by acute care services

2 maldistribution of health manpower with concentration in urban centres, leaving rural and isolated areas without adequate services

3 a disproportionate emphasis on treatment of disease, as illustrated by the increase in hospital building in the last 20 years and by the provisions of health insurance without comparable activities aimed at the maintenance and promotion of health.

It was in this spirit that the staff of the Department of National Health and Welfare scrutinised 1971 mortality and morbidity statistics concerning possible causes and underlying factors.* During this analysis, a conceptual framework evolved which divided or 'mapped' the field of health into four major elements: human biology, the environment, life style and health care organisation. This framework, entitled the 'health field concept'[114], will be described briefly. Some of its implications for health and nursing will be identified along with current and possible future uses in the planning of national health policy and programme development. Finally, it will be used as a background for identification of other technological and scientific advances that currently affect health and nursing.

*This document is available from the Information Services Division, Health and Welfare Canada, Ottawa. For UK readers, a copy may be seen at the library of the King's Fund Centre, 120-126 Albert Street, London NW1 7NF.

The Health Field Concept

The terms, 'environment', 'life style', 'human biology' and 'health care organisation', are certainly not new. They are probably part of the everyday vocabulary of most health workers. However, the conscious use of such a framework as a basis for evaluating and planning national health policy has not been common practice. It is also evident that these four elements could be rearranged under two major areas: first, one which includes human biology, the environment and life style, and second, health care organisation. The former represent the origins and causes of the state of health; the latter relates to interventions at the level of the first three elements that can prevent or cure certain health problems and conditions. The principal divisions of the framework are defined as follows.

Environment includes all that surrounds an individual, over which one has little or no control; for example, the air one breathes, the water one drinks, the noise that surrounds one at work.

Life Style consists of the accumulated decisions made by an individual which have a significant effect on his health. In this case, each individual is the decision-maker and has the choice of changing certain aspects of life which reflect on health. Eating habits, physical activities, sleep patterns, are

examples of decisions over which the individual has control.

Human Biology is endogenous to each individual and includes the genetic inheritance, the maturation and aging processes, and the metabolic equilibrium.

Health Care Organisation encompasses the quantity, quality, arrangement and relationships of people and resources in health care services. In other words, it is the sum of the health care services provided to Canadians by the health professions and institutions.

A major advantage which can be anticipated in using this concept is its integrative effect. It is hoped that it may cut through the more traditional divisions of mental health, public health, clinical medicine and research. These divisions have had the unfortunate effect of sometimes creating parallel systems of health services and of dissecting mankind into unrelated segments. It is now generally agreed that we need a more holistic approach to health care. Thus, this framework should permit the use of functional matrices which depict relationships, and which no longer look at a single element without considering the effect of the other elements. Another feature of the concept is that it forces users to give due consideration to all aspects of health, including contributing factors to health and to disease.

In a discussion paper prepared by the office of the principal nursing officer, National Health and Welfare, Boivin[21] has utilised the general system theory[19] to look at the health field concept. The four elements may be viewed as the major components or subsystems of an open system—curative, behavioural, constitutional and environmental. These subsystems interact constantly with other subsystems constituted by factors promoting health—professional, administrative and legislative. The professional system is the dynamic whole represented by all professionals in the field of health working independently, as a multidisciplinary team, or as professional corporations. The administrative system is the sum of all sources of financing and decisions, that is, contributing governments, private enterprise, executive offices and administrative modules. The legislative system consists of the different levels of government competent to legislate in matters of health.

The constant interaction between these subsystems takes place on four levels—prevention, promotion, remedial treatment and research, which ensure auto-regulation and auto-reparation of the system as a whole. Complete health is the result of smooth functioning of the system; illness and death result from the intrusion of noxious elements or imbalance within the system. The possibility of either result is inherent in the nature of the system and the 'regular condition' can only be transitory.

The plan for systematising a health system in this way underlines the fact that everything affecting a part inevitably has a general effect on the whole. Consequently, changes introduced in the legislative and administrative subsystems will, of necessity, affect the professional system within which nursing has a place.

Use of the Health Field Concept in National Health Policy Planning and Programme Development

The health field concept was first used to review the distribution of Canadian health funds in relation to each of the four elements. The review revealed that 95 per cent of current direct public expenditure on health was devoted to health care organisation, and that the sum total of health care services was primarily curative. This situation will, hopefully, lead governments into intensive planning greatly to increase health promotion programmes in Canada.

The preliminary review was used in the preparation and publication of a working document on health released by the Minister of National Health and Welfare on 1 May 1974.[115] This publication introduces the health field concept and its possible use in health care planning. It also highlights the major health problems of Canadians and recommends two broad goals and 74 proposals leading to their attainment. The proposals are divided into five strategies: health promotion, regulatory, research, health care efficiency and goal-setting. The major thrusts are

1 the development of health programmes that would favour a better equilibrium between cure and prevention resulting in new emphasis on health maintenance and health promotion activities

2 the detection of high-risk populations and development of programmes which will reduce risk factors among these groups

3 increased research to fill knowledge gaps and help us to understand and solve health problems

4 continued support for health care reorganisation in order to seek a better balance between accessibility, quality and cost of services.

While awaiting reactions to the working document, officials of National Health and Welfare are using it and the health field concept to review current programmes, to define specific objectives and propose programmes to attain them. Additional activities have already been initiated either to implement some of the proposals of the working document or to identify processes that would facilitate implementation of alternative proposals.

Examples of these activities are

1 planning for a national health survey

2 task forces to study evaluation and methodology of health education and school health education

3 studies to look at social marketing

4 a national conference on fitness in industry

5 development of new priorities for awarding national research grants.

A national health survey, using a generic approach rather than disease categories, is being planned to assess health levels of the population. According to Austin,

> '. . . our health statistics have become a negative feedback mechanism, basically rehabilitative, which help maintain the status quo'.[11]

Similarly, Belloc and her colleagues state,

> 'Just as mortality will not suffice as a measure of health neither will rates of certain diseases or of disability alone.'[16]

In attempting to implement a greater number of programmes directed at health promotion and research activities, some problems may be foreseen.

1 resistance from people who are being asked to forgo unhealthy 'pleasures' for the sake of a healthier life in the future

2 pressure from people for continued increase in personal care, which has been primarily disease oriented, at the cost of being unable to fund new health promotion programmes

3 ambivalence of governments to mobilise resources and to utilise them in programmes with low immediate visibility

4 social marketing techniques which may offend some people's sense of individual freedom

5 utilisation of the health field concept as another kind of classification, which categorises health problems according to each of the elements without regard for the interfacing of each of the elements

6 lack of appropriate knowledge of life and behaviourial sciences, engineering, and so on, to utilise this concept since health workers have been trained chiefly in the field of detection and treatment of disease.

Some Implications for Nursing

Boivin suggested that a change in the federal government's health policies will require nursing and the other professions to make a qualitative and/or quantitative adjustment in either their internal or external functions: education, professional practice, professional organisation, and research. It may be hypothesised that the health field concept would promote integration in the health system, resulting in improved balance between the various parts of the system with a consequent shift in equilibrium in the nursing sector.

It could also be postulated that a major area of shift would be towards increased health promotion activities, and that a positive contribution by nurses as they work with other health workers would include

1 becoming pro-active and reach out to non-seekers of services instead of being primarily reactive to demand for services

2 providing group services as well as individualised services

3 utilising different approaches in teaching groups including use of existing media and a wider range of media resources

4 identifying populations at risk and establishing necessary preventive programmes (These subpopulations could be, for example, prospective and new parents, the aged, those experiencing marriage breakdown, new immigrants.)

5 setting goals and developing programmes to make the people they serve more self-reliant and responsible for their own health

6 being able and willing to set priorities in services to be given and to reconcile conscious decisions to forgo certain programmes, in order to move forward to others which potentially promise more improvement in the general level of health

7 being willing and able to spend more time on analysis of records to assist in detection of populations at risk and detection of patterns of health problems

8 initiating, undertaking and/or participating in research to evaluate effectiveness of new developing programmes

9 being able to share in, or being responsible for, policies and programmes that may have a positive effect on health, especially those being developed by municipal and regional governments, school systems and industry

10 following analysis and study of alternatives, being able to develop (with built-in evaluation)

programmes that will be geared to maintaining health (for example, fitness programmes, programmes promoting healthy use of leisure, programmes preparing individuals and groups for various maturational crises in life, programmes of genetic counselling, nutrition, safety precautions including mental health practices)

11 working through others, such as teachers, school principals, voluntary groups, municipal councils, union representatives, to seek a 'multiplier' effect, a reduction in social distance between the provider of service and the client, an increase in self-reliance in the population

12 developing new approaches in motivating people to follow a life style conducive to better health

13 developing cooperative relationships with additional workers such as the physical educator, community developer, communications expert, ergonomist, hygienist, safety officer

14 establishing ways of monitoring changes, identifying trends, making the information available to consumers and other providers of services in order to provide a basis for the selection of future alternatives.

This list is in no way exhaustive, but provides an idea of the role modification that most nurses may need to undergo, in order to participate in a programme of health services with a better equilibrium between cure and prevention. Many nurses are, of course, already functioning in varying degrees in roles with an increased health promotion component. It is also evident that role modification has repercussions for changes in basic and continuing education, including the development of new programmes. Curricula, with a component of health promotion, where most of the learning reinforcement takes place in a hospital, could not claim truly to prepare nurses for health promotion activities. Basic nursing training, as well as continuing education, should place greater emphasis on evolution of needs of the population and on establishment of priorities, and should include preparation for group counselling and for health education.

Another effect of increasing the role of the nurse in health promotion is a change in the work milieu for nurses. One should find a larger number of nurses working in primary health care as part of government, with local governmental agencies, and with industry. Further, these agencies may see fit to operate within an 'open service' concept, by providing health services at a time and place convenient to the people being served. It is therefore likely that nurses who participate in these programmes will be called upon to work more flexibly, in time and place, when groups and families can participate in health care information services or the like.

Some Technical and Scientific Advances

Automation, transportation, communication, and certain medical developments, are continuing to have a serious influence on the individual and his milieu. Singly or collectively, advances in these fields are transforming the environment and changing life style, with possible effects on the biology of individuals. They are also changing the nature of health problems and dictating new approaches in the delivery of health care services. Nurses must understand the impact of these advances and utilise them to the full.

Automation

> 'A decade ago, our machines were capable of twelve billion computations per hour; today, they can do more than twenty trillion; and by 1976 – a decade from now, they will attain four hundred trillion or about two billion computations per hour for every man, woman and child.'[63]

Automation is having an important effect on the life style of individuals, mainly on their work habits and leisure. As this continues, human biology is also being affected. Bertin predicts

> 'The work will continue to shrink, leaving the bigger population with more leisure time and more inclination to travel for pleasure. Some have suggested that conditions will be so changed by automation that work will be a luxury and a privilege in the city of the future and that only 10 per cent of its population will hold down full time positions.'[20]

Automation is not only having the effect of reducing working hours, but it is affecting the nature of work.

> 'It is the object-oriented work in our society that is being replaced by mechanization, automation and cybernation. In the years ahead, it is the people-oriented type of work that is likely to increase.'[63]

By relieving man of physically and mentally boring tasks, therefore, automation may have a direct positive effect on self-realisation.

As automation increases people's leisure time, it may also increase stress by undermining the work ethic and one's need to produce. It seems that we have reached the threshold of a time when leisure is finally possible for most of our population. Yet, we are doing almost nothing to prepare people for this new dimension of human life. There should be no more delay in coming to some sort of personal

judgment concerning the kind of mores, institutions and systems of law that will need to be initiated, developed and implemented in a society where work may become a privilege only for a few persons, and where this may bring a society in which *not* working will be not only socially acceptable but highly desirable as a way of using human time. This last concept seems distant from the present situation as Leroy Augenstein has pointed out.

> 'In our society, at the moment, we reward and thus challenge a man on the basis of whether he produces goods, or capitals, or services. If we literally get to the situation of abundance, this will no longer work. How do you determine the value of a human being then?'[63]

Automation is not only increasing leisure, changing the work ethic, relieving man of physically and mentally boring tasks, it is also increasing the number of people working in sedentary occupations, with development of related health problems. These problems are probably increased by use of elevators, cars and other mechanised means of transportation. Using 1971 mortality statistics, the principal cause of death in Canada between ages 35 and 70 was coronary heart disease. It is difficult to know whether it is the individual's genetic inheritance or his life style which has contributed the more. Perhaps both equally. It is known that there is some degree of relationship between, on the one hand, obesity, smoking, stress, lack of exercise, and the individual's endocrine balance, and, on the other hand, coronary heart disease.

It is also difficult to know, at this time, to what degree automation is contributing to the dramatic transition in the life of nations by accelerating the speed of change. According to Sorokin, changing norms and standards, inconsistent and unintegrated ideas, beliefs, emotions and impulses lead to disintegration and derangement of personality. He suggests that such clashes of values in society produce an increase in crime, brutal punishment, riots, revolts and revolutions along with an increase of mental diseases and suicide.[169]

Is there any relationship between these thoughts and the fact that 1971 mortality statistics in Canada give suicide as the third most important cause of death between the ages of five and 35?

Similarly, health workers are also faced with acceleration in speed of change leading to rapid obsolescence and need for constant upgrading of skills and knowledge. Increased mechanisation is introducing new types of work, altering functions of health personnel and imposing new work relationships. In nursing, skills that may have been used for some of the caring and supportive functions may be carried by a monitor. Care and support are still essential to the patient; the nurse now has to readjust her approach in providing them.

The wide use of monitors, especially in critical care units, has increased safety and relieved nurses of time-consuming tasks. It seems also to have increased the double standard in delegated nursing responsibilities, with consequent increase in stress and frustration.

Nurses have direct responsibility to participate in the planning of computerised client-record systems. They also should see that such systems become integrated in the overall plan of providing health care services instead of being merely added to the existing programme. The objective of improving outcomes of services should remain a prime focus in order to prevent such an activity from becoming an end in itself.

Canadian colleges and universities are using the computer to a greater extent in computer-assisted learning. Some transfer of expertise from education may be anticipated, and health care centres will use similar 'hardware and software' for teaching clients. This may be seen as a way of making health information available directly to individuals instead of always planning for continuous filtering through health workers.

Multiphasic screening and the use of computers in verifying medical diagnosis and treatment prescriptions will most likely continue to expand with greater similar use by other health workers such as nurses. The cost and long term impact in improving nursing care services still need close scrutiny.

Transportation

Increased and improved transportation by road and air has had an impact on the use of leisure, on health, and on health care services in Canada. Some of the benefits are

1 a capability for more rapid development of regionalisation of health services

2 greater facility in development of mobile diagnostic and treatment units in bringing teams of experts to more isolated areas and to poorly served areas

3 greater opportunity to travel for business and pleasure within Canada and to other countries

4 a capability for improved air and ground ambulance service.

Concomitantly, these same improvements are bringing about

1 urbanisation, with increased density of city living

2 replacement of green space and agricultural land by roads and airports

3 modification of people's life style in fostering sedentary modes of travelling

4 increased migrancy.

Perhaps the greatest effect relates to traffic accidents. Canada's 1971 mortality statistics give these as the principal cause of death for the age group of five to 35.

These changes are bringing about major alterations in the nature of health problems, as well as a need for new health workers such as ergonomists.

Communication

In Canada, the Department of National Health and Welfare has used television to raise the level of awareness of such issues as the hazards of smoking and the importance of physical activity in health maintenance. Television has also been used for health education in nutrition and industrial safety. It is becoming increasingly evident that the use of mass media is primarily to inform and to raise the level of awareness, and that one cannot expect that programmes for public information and sensitisation will necessarily change people's life style or attitude. It is becoming more evident that complementary programmes in the community need to be available through schools, health units and the like, in order to modify life style.

In October 1975, a high powered communication technology satellite will be launched by the Communications Research Center of the Department of Communications. This satellite, apparently designed as a forerunner to a new generation of satellite communication systems, will be aloft for two years. One of the four experimental series relates directly to the health field with time and channel allocations dedicated to health applications. It is likely that these will be launched in Canada's northland and that the following aspects will be looked at.

1 to determine whether satellite communication is better than radio communication in the provision of health care in the north

2 to determine whether visual contact will improve the systems in diagnosis of health problems in the north

3 to determine the effect on communities of such communication systems.

Health services in Canada's northland are provided to a great extent through nursing stations operated by nurses. These nurses have ready access to radio communication and to air transport for patients. It is hoped that they will have an opportunity to assist in the programming of the forthcoming studies in order to determine the use of such communication systems in the assessment of care.

It can be postulated that improved communication systems will

1 increase the opportunity for individualised and self-learning approaches including learning at home

2 create a better informed population

3 contribute to the homogenising of populations

4 change people's expectations of health care services.

Communications facilities can also be used by nurses to monitor consumer's needs, identify 'critical' publics, and to help families have ready access to information which will help them to make decisions about daily living.

Specific Medical Advances

Medical advances such as diuretic therapy, anticoagulant therapy, organ transplant and immunological therapy are having a direct and important influence on prolonging life. More people now require care for chronic conditions and there is an increase of the population over age 60. The words of Dr Hans Selye ought to be foremost in the minds of health workers.

> 'In reflecting about the probable future of medicine, it may be well to keep in mind that the great prolongation of life expectancy will undoubtedly put more emphasis upon aging and the ravages of wear and tear resulting from greatly extended use of human machinery.'[165]

The educational preparation and experience of nurses have to a great extent been taking place in acute care centres. The changes that are now prolonging life should have a direct influence on the basic and continuing education of nurses, and specialty programmes in chronic care should be introduced.

The advances are having multiple effects on the population, health workers, and governmental health programmes. Although some of these effects become a source of new health problems, and of stress and frustration for health workers, many other effects offer great promise for improving health. By understanding the dynamics of these advances, nurses can mobilise their positive capabilities toward betterment of health care services.

5 Some Nursing Problems in Responding to Science and Technology

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Technology and science have altered the lives of ordinary people in a way that could hardly have been imagined 50 years ago. The products of technology become commonplace, and the possibilities of further advances soon become public knowledge through television and radio, newspapers and journals. Interspersed with this information come details of current and projected advances in health care and the development of medical science. Equipment used in space travel, for example, can be adapted to bring new hope to people whose future in terms of health, mobility, or the ability to communicate, is limited or non-existent.

It is in this context that the changing role of the nurse must be examined.

Mrs N Mackenzie, in her preface to *The Professional Ethic and the Hospital Service*, notes

> 'It is now accepted that we are living in a technological age. Advances in technology and in the natural sciences contribute much to the comfort, efficiency and well-being of mankind and to meeting the needs of human society, but they can overlook and fail to meet the needs of the human individual in the mental, emotional and spiritual spheres. Since the end product of any hospital organisation is twofold, the well-being of the patient and, equally important, the well-being of those who are responsible for the services rendered to him – in any department, be it medical, nursing, physiotherapy, paramedical or clerical – it would appear to be desirable that an examination of mental, emotional and spiritual needs should accompany and supplement the contribution made by technological skills and advances.'[131]

The role of the nurse in the clinical sphere, as a manager and as a teacher, is changing so fast that nurses themselves are questioning just what their role is. The ambivalence of many nurses at all stages of their careers comes partly from the impact of technical and scientific advances in medicine, but is also due to change in the world at large which is having an impact on the way organisations and institutions are run, on educational methods, and on the expectation of the general public of a high level of expertise and knowledge from the professionals. The nurse sees change all around her in her own profession and, as a citizen, also hears and feels the public reaction to change in the health services.

Clinical Role Changes

Although technical and scientific advances are changing nursing education and nursing administration, it is their effect on the nurse's clinical role that tends to have the greatest impact because they most closely affect the patients and their families.

The nurse is increasingly involved in medical research, in the work of clinical investigation departments, and in the specialised work of intensive therapy, coronary care, neurology and neurosurgical and cardiothoracic units. Medical specialisation has led to the development of further subspecialties, and a consequent demand for nurses with specialised expertise. Nursing in these specialties and subspecialties includes the basic care of the patient, but to play a full part the nurse needs specialised training to enable her to deal with the topics in greater depth. Doctors now expect a standard of knowledge and expertise which was previously only required of the 'experienced' ward sister, or of

fellow doctors. This degree of specialisation also brings with it an expectation of the patient and his relatives that the nurse is as expert as the doctor in some parts of his care and treatment.

The Concise Oxford Dictionary defines 'role' as 'one's function, what one is appointed or expected or has undertaken to do'. This definition emphasises the dilemma of the nurse. What she was appointed to do may not be the same as what she subsequently is expected to do in a changing situation, or what she undertakes to do in a situation of shortage of staff.

Technical advances have led to the use of more machines in the investigation and treatment of patients, both in hospital and at home, and to the involvement of nurses in work in which they, and their patients, are surrounded by mechanical and electronic devices. The outcome of investigations, and often the patient's life, depend on the vigilance of the nurse and on her ability to interpret findings and, if necessary, to adjust treatment accordingly. As a result of improved investigation and treatment, patients may spend a shorter time in hospital but have a longer time at home receiving treatment. This brings greater independence for some patients, but a greater, and sometimes total, dependence for others. Nurses working in hospitals and in the community have to adjust accordingly.

Advances in drug therapy and controlled research of drugs have resulted in nurses recognising and, where possible, taking steps to alleviate unpleasant or dangerous side effects. The nurse must know enough about the condition, the drug and its effect to be able to reassure and support the patient.

The development of investigation units which operate as five-day wards has led to a situation in which a high proportion of qualified staff give minimal nursing care to a group of patients who largely look after themselves. In the programmed investigation unit in Manchester Royal Infirmary the philosophy is explicit.

> 'The number of nurses is geared to the concept of minimal nursing care but recognises the important need for a high proportion of qualified staff.
>
> 'The exclusion of patients who are confined to bed by illness is in line with the modern concept of progressive patient care and also allows staff to concentrate their energy and thoughts on the techniques of investigations, thus promoting a high standard of accuracy.
>
> 'The unit explains to each patient the general nature and sequence of investigations, the pattern of cooperation needed, and the possible date for discharge. He is also warned of any effects the test may have on his comfort and well-being. We have found that this explanation is always desirable, improves all aspects of work, and is well done by specially trained nurses.'[128]

The Machine and the Patient

In some specialised and highly technical units, nursing observations have not changed, though the method of recording them may have become more mechanised. Nurses in a neurosurgical unit are adamant that machines have not changed the need for basic nursing; what has changed is that because developments, especially in theatre techniques, have made things safer for the patients the nurses are *less* worried by the machines and *more* concerned with nursing the patients. But technical advances tend to 'keep the relatives out' and there is, therefore, a greater need to develop and foster better nurse-relative relationships. This is an added burden on nurses who not only have to care for and support the patient, but also have to care for and support the relatives. Doctors tend to leave nurses to act as interpreters for both the patient and his relatives, and while the patient seems to expect and accept this situation, he and his relatives still expect the nurse to match up to their image of the 'angel of mercy' rather than the technical expert.

Machines used in investigation, treatment and monitoring are becoming so complicated that technical experts are needed for maintenance and repair. Failure to keep the machines in service adds to the nurse's task. She is seen by the patient as being in charge and therefore responsible if the machine breaks down. So the nurse, sometimes in spite of herself, learns about the machine and adopts the role of technician, unwillingly and unconsciously fostering the image of the nurse who is more interested in machines than people. In most situations it is vital for the nurse to 'know the machine', but the danger, as she sees it, is that she becomes regarded as a technician rather than as a nurse. The amount of machinery that can surround the patient can create a physical and psychological barrier. The nurse can neither get near enough to the patient to carry out essential nursing care, nor can she hold his hand, either physically or metaphorically – and, more important, neither can his relatives. The nurse's responsibility here is to arrange the placing of the machines and to create an atmosphere of trust that keeps the physical and psychological barriers to a minimum.

Helping patients to help themselves, an increasing philosophy in treatment, has brought further change to the nurse's role. Technical and scientific developments help many patients to be more independent. The nurse is often no longer a 'doer' but a teacher and supporter, not only of staff but of the patient and his relatives and friends. Who resents most this change of role? Is it the nurse who may feel that she is abrogating her right to 'nurse'

as she has been taught? Or is it the patient who may feel that the nurse has rejected him because she is not 'nursing' him? This change of role is very apparent in renal units where patients are taught to dialyse themselves, and where the whole emphasis of treatment is on helping them to become independent enough to manage and maintain their machines at home.

Nurses in Medical Research

As clinical research progresses, the more nurses become involved in research projects. One sometimes wonders if the involvement of nurses in medical research is due to the shortage of medical and technical staff. If it is, perhaps more consideration should be given to repairing the shortage than to directing and developing the skills of trained nursing staff – also in very short supply – to this type of work. There is no doubt, however, that many experienced nurses welcome the opportunity to be involved in such projects, if they are given the time and support to allow them to contribute fully.

Failures are inevitable in the experimental stages of research and the nurse then changes her role from that of technical expert to that of supporter of her staff, as well as of patient and relatives, through the period of disappointment, resentment and self-doubt that follows. For it is she, rather than the doctor, to whom the staff tend to turn for support and reassurance. The ethical implications of medical research and progress are among those factors which have developed the nurse's role as a counsellor and philosopher, and are a direct result of technical and scientific advances.

Work in specialised hospitals and departments gives nurses the opportunity to be involved in the design of equipment and buildings, and in the use and monitoring of equipment during the experimental stages. As a result, some nurses have developed expertise in the assessment of new designs and inventions from the points of view of patient and nurse, both of whom may have a vested interest in the equipment. Does this special knowledge and interest make the nurse less of a nurse because she has become more interested in the means of helping patients than in bedside nursing?

Some advances have altered the nurse's role to such an extent that she no longer provides some of the basic services for treatment or care; specialised catering equipment, methods of delivering supplies, sterilising techniques and pharmacy routines, are among those advances which have relieved nurses of so-called 'non-nursing' duties. All this may make life simpler for nurses, and in some instances arguably safer for patients (though that still largely depends on the expertise of the nurse), but there are difficulties when the industrial system breaks down or when industrial disputes disrupt delivery routines. Such problems in society at large have shown what a devastating effect they can have on a highly technically oriented organisation such as a hospital. Perhaps one of the more interesting observations made as a result of such events is the reversal in the role of the nurse from that of technician in highly specialised areas to the more traditional one of 'Jack-of-all-trades'!

Although attempts have been made to define 'non-nursing' duties and to relieve nurses of such duties in order to allow more time to teach and supervise other nurses, the development of machines and techniques, which might be regarded as labour saving, has had almost the opposite effect. The demands for accurate observation, accurate interpretation and frequent record-keeping take up much of the nurse's time at the expense of her time with the patient. She finds herself torn by conflicting loyalties – of caring for the patient and of contributing, however indirectly, to the advancement of medical science.

The members of the clinical team have changed with advance in technology and science. They bring skills of disciplines and backgrounds different from and wider than the traditional doctor-nurse team. Greater understanding is needed of the contribution of each to the whole. The nurse, with the others, has to learn about the other people and their responsibilities in the team, as well as about the patients and their conditions, and has to accept that she is not necessarily the key person either in the team or in the patient's regard. Other people interpose between the nurse and the patient and have the right and responsibility to do so. It may be more important for the patient to know that the technician will maintain his life-saving machine than that the nurse will attend to his bodily needs, and some nurses find this very difficult to accept. Even so, the nurse tends to be seen as the leader and coordinator of the team, and in this role has the added responsibility of attracting other nurses to work in it – an especially difficult task if the team comprises members of professional equals.

The Nurse as Teacher and Manager

The major change in the nurse's role is seen in the clinical situation, but advances in technology and science have also influenced her teaching and managing roles.

Not only have teachers to recognise the need for specialised training programmes for those working specialised areas, but also they have to understand implications of technological and scientific advances on teaching methods. One outcome of the development of technology is the inclusion of technology for teachers in the post-experience courses of the Open University. The preamble to the course syllabus states

'In an age of accelerating technological change, schools and teachers are becoming increasingly aware of their responsibility for developing an appreciation of technology in their pupils and for introducing technological activities into the school curriculum.'

Nurse teachers are availing themselves of the opportunity to take part in these courses.

The first report of the Joint Board of Clinical Nursing Studies recognises the same effect on nursing education.

'The traditional role of the nurse is changing. The nurse as well as the doctor needs to keep abreast of the rapid scientific and technical advances in medicine so that her professional skill of caring for the patients can be developed accordingly. Nurses working in highly specialised units will need to study the subject in depth and to acquire expert skills. In some specialties, a different type of skill may have to be learned and previously held attitudes modified to meet the patients' needs.'[104]

Fundamental to the expectation of the board is that teachers will also need deeper knowledge and understanding of the subject matter, of patients' needs, and of the needs of students. Each course curriculum highlights not only the changing role of the nurse, but the changing role of the nurse teacher.

Nurse managers are faced with providing a nursing service to meet the demands of technical and scientific advances. They have to learn to recognise the potential of colleagues for new and developing types of work. They also have to help create an environment in which participation in change can be encouraged and where opportunities for training can be fostered.

Advances in clinical work may bring change to work patterns which in turn may affect staffing patterns. The nurse manager has to be aware of development. In midwifery, for example, scientific advances have changed the management of labour; labour is induced, delivery is shorter and less exhausting for the mother and safer for the baby, and can be timed to take place during the day. As a result, duty rotas can be adjusted so that the maximum number of staff are available when the deliveries take place.

Technological advances have made available a whole range of facilities to aid management and have brought new development of management techniques. The nurse manager should take advantage of these developments and encourage colleagues to do so too, not just to keep up with the technologically minded Jones's, but to make the best use of resources. The use of computers, for example, has brought an added dimension to nursing management, not least in that it demands an understanding of the need for accurate and logical presentation of material to be included in the programme.

Conclusion

These changes, some of them quite dramatic, have all occurred within two decades, with acceleration within the past five years. Closer attention is being paid to what nurses do and why and how they do it. The role of the specialist clinical nurse could be said to be becoming narrower in content, that of the nurse teacher and manager to be expanding.

The effect on the recruitment of nurses has yet to be assessed. The job of the junior nurse is more difficult; nursing is not what she expected; patients are not all in bed – some of them do not even appear to be ill. There is not always a lot of 'magic equipment' to be seen, for, in spite of all the 'exciting' events described above much of the nursing in reality seems dull in comparison with nursing as portrayed on television or in films. How does the profession reconcile to the public the extremes of nursing in highly specialised units and the humdrum routine of a geriatric ward?

The assessment of the needs of the individual is perhaps the most difficult principle to implement in the pressure of modern society. Mrs Mackenzie concludes in, *The Professional Ethic and the Hospital Service:*

'We are all at the mercy of pressure of numbers, pressure of time, pressure of new inventions and techniques, even, in some cases, pressure of social and sociological generalisation . . . only skilled observation, clinical and psychological, together with increasing knowledge gained with patients and devotion to one's art, will enable the doctor, the nurse, the physiotherapist, the speech therapist (and possibly those in managerial posts) to meet the needs of that particular patient instead of his being at the mercy of an impersonal – and sometimes irrelevant and careless – application of new techniques and advances.'[131]

This writer cannot say it better.

6 Orbital Organisation of Nursing Management

by Rosamond C Gabrielson
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As man's life span, capacities, and creature comforts increase through technological advance, so does he question the value and effectiveness of the systems and institutions he has established to meet his basic needs. There is dissatisfaction with church, government, education and health care. Because the demands upon our health care system have reached explosive point, and the relevance of current delivery of health services has been questioned, we must be able to alter or create new methods for delivery of services. Nursing administrators must assume their role and responsibilities in this process.

A statement from a speech I gave three years ago, entitled, 'If I Were Dean', is still valid and will perhaps bear repetition.

> 'The land of "unlimited opportunity" is seen to be a place where many of our citizens are deprived of their right to receive adequate health care. The hospital and the health care professionals are at the center of the storm and how could it be otherwise? While on the one hand we speak of our health care system in glowing terms, disillusion and skepticism pervade the ghettos of the nation, and these feelings are contagious so that more and more segments of our society are questioning the cost *and* the services they are receiving. Because of these misgivings, their concerns have been carried to the Federal Government. Health professional authority is suspect. For the health care system of the country, the crisis is both internal and external; internally we still dispute what our rights are as health professionals, and we have not cooperated or collaborated enough in agencies to avoid costly duplication of equipment and services; and externally the crisis involves delicate issues about the health professional's responsibility to society and the rights of the consumers. Health care arrangements, as they did exist and now exist – to a great extent, are now declared intolerable by many.'

The changing concepts of both management structure and the patterns in the delivery of services to the patient necessitate the increased involvement and recognition of community needs by nursing administrators.

If nursing services are to keep up with the dynamic changes occurring in the health field while delivering quality care, it is imperative to take a look at what is being done in managing nursing services. In too many instances the current philosophy, policies and modes of managing nursing care are severely challenged in the face of dynamic organisational changes, wide variation in the preparation of nurses, and the introduction of new health careers.

Myrtle Aydelotte, in *Survey of Hospital Nursing Services*, identified these problems.

'1 In a number of hospitals, the department of nursing service was assuming the administration and management of some of the other services and departments of the hospital on a full time basis and also was taking responsibility for their functions at times during the 24 hours. In effect, the nursing service in these hospitals was serving a twofold function: to provide the nursing care of patients, and to provide continuity for other services.

'2 A limited number of directors held membership in professional and community organizations.

'3 In a large part, the leadership for nursing service resided in basic diploma graduates, a high

proportion of whom have not sought advanced preparation, who were relatively senior, and whose length of stay in the present position tended to be short.

'4 In the majority, the inservice education programs were limited and non-clinically focused.

'5 The hospitals were providing and/or controlling a large number and variety of educational programs for preparing nursing personnel or auxilliary personnel.

'6 The major problem reported by directors of nursing service was staffing and more time was being devoted to this aspect of the job than was felt should be given.

'7 The kinds of activities and the kind of participation engaged in by the director of nursing service and her assistants varied among the different sized hospitals, suggesting that there is a need for considering different requirements for the job in varying sizes of institutions.

'8 The aspect of the job of the director to which an overwhelming majority believed most time should be given was policies and standards for nursing care of patients and their families.'[12]

Because I believe the nursing administrator must be a facilitator of change, I would like to elaborate upon an organisational change I believe is imperative in nursing services.

Many times, changes are initiated without enough advance planning, without knowledge of the situations and problems that will be encountered, and without consultation with those who will be expected to carry out the routines.

Each of us attending this seminar would be surprised if a questionnaire were sent to our employees attempting to discover attitudes towards working conditions, participation in decision-making and internal communications.

In our particular agency, when such a questionnaire was sent to the staff, six out of ten nursing employees felt they were not adequately informed on matters concerning them, and five out of ten felt their opinion was either not asked or not listened to. This led us to do some real soul-searching about our organisation, because we had believed we were doing a rather good job.

At the Good Samaritan Hospital we are in the process of working through and developing what we call an 'orbital organisation'. The purpose is to link the individual and the organisation. To do this we know we must locate the individual in the organisational relationship. Each person has a unique point in organisational space.

So we start from three basic precepts.

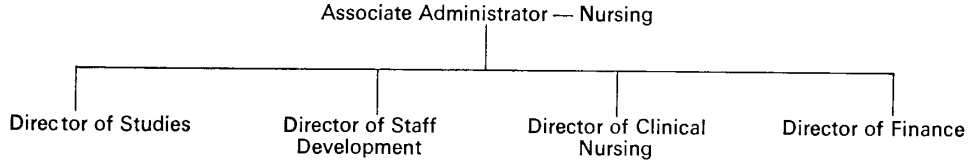
1 The roles of the nursing service administrator and other administrative staff will be changed.

2 The assumption is, that *all* nursing employees are highly developed human beings and want to do a good job.

3 The potential for change in the entire hospital hierachy is great.

There is, then, a philosophical commitment to involve the nursing staff in those decisions that affect them and their practice, and in the necessity for change – as it were, *internalising* the change within the nursing staff so whatever changes are contemplated would be put into operation. I am convinced that those who call themselves leaders in nursing have not always utilised the human resources available to them and, as a consequence, regardless of what edicts are issued from administration, change does not really occur.[72]

Our first discussions were between the administrator of the nursing department and assistants who, in our agency, are called 'directors'. The organisational structure is shown in the diagram.



This group, called the 'executive committee', has the tasks of solving problems, sharing information, making decisions in the operation of the nursing department, and making policy. Every decision must be reached by consensus agreement – not majority opinion or vote. We felt that consensus agreement would create one *mind* and one *voice*, and each member would be committed to support a decision without reservation.

We knew this was not the easiest way, because consensus requires involvement, frankness, critical listening, tolerance, time, and energy. Discussions have been intense and sometimes emotional, but they are conducted in an atmosphere conducive to problem-solving, because the directors are free of the restraints that customarily inhibit the individual in group situations. Weekly meetings are held. Anyone of the group can put in an agenda item – but there must be an agenda. Those matters considered by the members to have high priority are taken up first. Leadership for the topic under discussion is provided by whoever introduces that topic. The meetings may last one to two hours. Whoever has the responsibility for carrying out a decision takes the necessary action.

The directors have been kept fully informed of my activities on the corporate level, or 'high' level management meetings within the hospital. Nothing goes on at the top of which they are not aware. They can see copies of all incoming and outgoing correspondence along with newsletters, journals and other materials. Conversely, I have been kept informed of happenings with the nursing department that I might otherwise be unaware of.

While the concept of the orbital organisation has been introduced in the Good Samaritan Hospital's nursing department, the hope is to generate this same kind of organisation at unit level, where there will be many 'orbits' in nursing. The assumption is that problem-solving be assigned to that area of the nursing department where the best informed, most competent, and most concerned authority can be brought to bear, and by involving all staff members in decision-making. The orbits should be patterned after the executive committee, and all decisions reached by consensus. If there is no consensus, there will be no change, no problem-solving. However, we believe the most important business of the orbits may be the exchange of information; their most important benefit may be derived from group discussions, the 'getting-to-know-you' that is essential to all peaceful coexistence.

The problems, as I view them at this time, which can be resolved are

1 Nursing services are provided 24 hours, so staff are working three shifts.

2 The executive committee will have to be composed of more members.

3 Where do the clinical specialists and the registered nurse practitioners, who are in a staff position and unassigned to a particular unit, fit into the scheme?

We need to proceed slowly with the concept and do some experimentation, in one unit perhaps. The essential issue as I view it, however, is one of 'operationalising' a basic belief in staff and their importance in the decision-making process that affects them, their practice and the care patients receive.

With all our marvellous technological advances, we need to seek out new ways to humanise our working relationships. If we believe in individualising the nursing care of people, we have to give more than lip service to the value and importance we place upon all the staff who assist us.

7 The Clinical Specialist

by Constance Biddulph
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This paper is based on the discussions of a small group of nurses* in Manchester who set themselves two main objectives.

1 to discuss clinical specialisation in nursing and explore the role in depth in specific clinical fields

2 to provide a forum for discussion of an experiment whereby one member of the group was seconded from her post as a ward sister in charge of a neurosurgical ward to explore the role of a clinical specialist in neurosurgical nursing.

The first part briefly discusses the clinical specialist roles of the members of the group and some current issues. The second part is devoted to the author's thoughts on clinical specialisation and the extended role of the nurse in a time of rapid change in health services and in society.

Three Clinical Specialist Roles

The current roles of the three nurses in the group must be viewed within the traditional pattern of British nursing, and the changes emerging from the implementation of the recommendations of the Committee on Senior Nursing Staff Structure.[82]

1 The senior ward sister, with over 20 years experience in neurosurgical nursing, was given opportunity to explore a role in a clinical area, specialising in the care of patients with neurosurgical conditions and patients admitted to the hospital with head injuries. The main objectives were to improve the quality of patient care, mainly by monitoring specific patients and by a sustained programme of teaching of nursing staff and others.

2 The psychiatric nurse, in charge of a university department of psychiatry of 20 beds with day hospital attached, was given the opportunity to extend her role. Her main function was the nursing management of the psychiatric unit, together with a clinical and teaching function. The trained staff in the unit were increased to enable her to provide a consultancy service to nurses in the teaching hospital, a 700-bed general hospital, a quarter of a mile from the psychiatric unit. Initially, the requests were for assistance with disturbed and confused patients but this has gradually changed to 'Teach me how to manage the patient'.

3 The departmental sister in charge of a large university department of orthopaedic surgery, has over 25 years experience of orthopaedic nursing, including outpatients, accident and emergency work, and the provision of a service to the major orthopaedic theatres. She manages a busy, complex department but a major part of her time is concerned with direct application of clinical skills to the treatment of patients.

The three members cover different specialties and function as clinical specialists in different ways. The group discussed these variations and attempted to isolate common factors in the belief that this would help to establish principles. Factors worthy of further study include

*Jean MacFarlane, professor of nursing studies, Manchester University (for part of the discussion)
Ruth Martin, ward sister, neurosurgery
Elizabeth O'Neill, psychiatric nursing officer
Elsie Tushingham, departmental sister in charge (orthopaedics)

a the relationship between the length of time spent in a specialised field of nursing and 'experience'

b the need to examine the method in which skills are acquired by nurses in the team. (Increased staff turnover deprives nurses of the opportunity to acquire skills by repetition and by working closely with an expert, normally essential in the development of craftsmen.)

c the need to examine the roles of doctors and nurses in areas of specialisation. (The nurse specialist role is not of itself an extended role.)

d the need for further study of the team concept in the health services. (Though the concept is generally accepted it is often associated with leadership of the team, and the traditional concept of the doctor as leader is being challenged.)

Current Issues in the Three Specialties

In neurosurgical nursing, we felt that more time was needed for clinical teaching and for counselling of relatives. We learned also that trained nurses were seeking further help and guidance in developing their clinical role and were wanting more post-basic clinical courses.

Our psychiatric nurse member saw her own role changing, her teaching function increasing and her clinical skills used more in problem-solving situations. The clinical content and pattern of care in the unit placed greater emphasis on community care and the identification of the patients' nursing, medical and social needs.

In the orthopaedic department, nurses, doctors and the other professionals were becoming more aware of the need to pool ideas and develop the team concept. The nurse in charge found her greatest need was to pass on her skills to nursing staff in the department, and to find enough time in a busy department to meet the expressed needs of doctors for her advice and skills – not only to doctors in the department but to general practitioners throughout the city.

Clinical v Administrative Skills

One of the problems in hospital nursing in the UK is that the implementation of the Salmon structure[82] has resulted in the creation of a hierarchy where the ladders of promotion are in administration or education. In community nursing the hierarchy has been less apparent, but the introduction of a senior nursing staff structure as recommended by the Mayston report[79] has raised fears which have been reinforced by some aspects of the reorganisation of the health service.

Questions raised by these organisational changes are

How can clinical nurses achieve promotion and remain in the clinical field?

Do senior nurses need to practise nursing to retain credibility with their peers?

What contribution can the clinical nurse make to manpower planning and nursing education?

Some UK and North American Comparisons

Definition

The terms 'clinical nurse specialist' and 'clinical nurse consultant', used increasingly in recent years in the UK, lack precision and are interpreted in a variety of ways; for example, as a 'third avenue' of promotion in a clinical field in the nursing hierarchy, or as a means of using clinical skills and experience more effectively. Since the report of the Briggs committee on nursing in 1972[83], the professional commitment to develop the role of the clinical nurse consultant has strengthened. The pressing need is for informed discussion by nurses, and studies of clinical areas as the means of defining the role. It is perhaps pertinent to consider some American definitions based on practice and research.

The American Nurses' Association issued some definitions in May 1974.

'**Nurse Practitioners** have advanced skills in the assessment of the physical and psychosocial health-illness status of individuals, families or groups in a variety of settings through health and developmental history taking and physical examination. They are prepared for these special skills by formal continuing education which adheres to ANA approved guidelines, or in a baccalaureate nursing program.

'**Nurse Clinicians** have well-developed competencies utilizing a broad range of cues. These cues are used for prescribing and implementing both direct and indirect nursing care and for articulating nursing therapies with other planned therapies. Nurse clinicians demonstrate expertise in nursing practice and ensure ongoing development of expertise through clinical experience and continuing education. Generally, minimal preparation for this role is the baccalaureate degree.

'**Clinical Nurse Specialists** are primarily clinicians with a high degree of knowledge, skill and competence in a specialized area of nursing. These are made directly available to the public through the provision of nursing care to clients and indirectly through guidance and planning of care with other nursing personnel. Clinical

nurse specialists hold a Master's Degree in nursing, preferably with an emphasis in clinical nursing.'[5]

These definitions re-emphasise the need for British nurses to explore the roles in depth. Nurse practitioners have not received serious consideration in the UK, in my view, mainly because of the differences in medical practice in Britain compared with the USA and Canada. It may be that nurse practitioners in the community may be considered in the future, and could be linked with the extended role of the nurse. Such development would need to be considered in partnership with the general practitioner.

The work of the Joint Board of Clinical Nursing Studies may be the prerequisite for the development of clinical specialists. For example, the stated aim of the course in stoma care nursing for State Registered Nurses (Course No 216) is 'to prepare a registered nurse to function as an expert in stoma care'.

The specialist does not necessarily have an 'extended' role. We need controlled studies to explore the scope of the role, the preparation required and the expertise needed.

Standards

The subcommittee of the progressive future development group, in the department of nursing service administration, Good Samaritan Hospital, Phoenix, Arizona, put the issues clearly and succinctly in the introduction to their policy document, October 1971.

> 'These standards for the nursing care of patients at Good Samaritan Hospital are based upon the philosophy of patient-family centered care stated in the Philosophy of Nursing Service Administration. That is to say that we believe that the patient is the center of our concern and care, and that he and his family contribute greatly to the plans we make to care for him.
>
> 'There are three elements considered throughout these standards: Cure – the instrumental functions of nursing, including implementing direct physical care; Care – the expressive functions, which include communication skills, socio-emotional aspects of patient care; and Coordination – the management of nursing care involving decision-making, leadership skills, and the whole process of nursing care planning. The interrelatedness of these standards of care and practice must be recognised and considered.
>
> 'These standards are divided into two sections, standards of practice and standards of nursing care. Standards of care are the ultimate outcomes related to what the patient can expect to receive when he contracts for nursing care. Standards of practice are related to the nursing behaviors directed toward accomplishment of patient care goals. These behaviors are expressed in terms which are measurable. The patient's needs determine the priority of the standards.
>
> 'The patient and family are considered a unit. The family input to elements of patient care are valuable and necessary in total patient care.
>
> 'Definitions of each term as used in these standards are given as the terms are used. In reference to the patient, the meaning includes not only his physical body, but his whole physiological functioning including excreta, discharges and drainage.
>
> 'The standards in many cases are not specifically stated but are more general in nature. They are meant to serve as general overall standards and guidelines. Each individual Coordinator and her staff are expected to expand and explore each standard to fit the type of patient cared for in the unit. These statements then will be applied to evaluation of the staff's performance in the caring for their patients.'[72]

In the UK emphasis used to be placed on the experienced ward sister in hospital, and on nurses working in the community. The changing pattern of medicine and health care, together with changes in nursing with a higher turnover of staff and a change in the career pattern for nurses, call for urgent re-appraisal of the nursing role. The development of the role of the clinical nurse specialist is one important aspect in quality nursing care.

8 Clinical Specialisation and Management in General Hospitals within the Newly-developed Health Services in Quebec

by Helen D Taylor
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Health care delivery systems are changing notably in the ten Canadian provinces, with relative caution in some, while in others provincial government structures and methods of organising health care have changed radically and new systems are already well underway. The impact and far-reaching implications are truly exciting. Of great importance to nurses is the unique opportunity to participate, experiment, and exert some influence on how health care is brought to the population. Although methods may be somewhat different from one province to another, from one community to another, many of the basic principles and components of the new proposals for developing population oriented services are similar.

The Province of Quebec was considerably slower than others to adopt hospital and medical insurance for all its residents. Eight years ago an appointed commission revealed a picture of greater need of, and lesser access to, health service than in most other provinces.[34,35] The infant mortality rate was much higher, and life expectancy lower, than the average. A high proportion of the population was in low income categories and the unemployment rate was very high. A relatively low proportion of the population carried any form of private insurance. High risk groups, such as older citizens, rural groups, low income groups and the unemployed, were not covered, yet their needs for health services were greater. A shortage of general practitioners and health facilities combined with maldistribution of both facilities and personnel. The province was also experiencing a broad social movement at the time, and the growing middle class started to make unprecedented demands for improved goods and services, including health and welfare.

The population of Quebec numbers about six million. Most of the acute care centres and personne are concentrated in only three cities. Within the past eight to ten years a great deal has been done. The two ministries, of health and social welfare, were fused to become the Ministry of Social Affairs; Medicare was implemented; every piece of legislation dealing with health and social welfare and education was rewritten; and the entire health care system was revised.[36] Then a redistribution of services was begun.

The newly-enacted legislation establishes a structural framework to ensure that all health facilities are adequately supported by health and social welfare professionals who, in turn, must be responsible to community needs. A unified system of health and social services should ensure closer links between the constituent parts and facilitate administration.

Undoubtedly the new system will take another 10 to 20 years to be operationally complete, and this is our immediate challenge as we adopt and adapt to new nursing roles. Nurses have been conscious for a long time of the interaction between health, social conditions, and environment. Illness constitutes an imbalance in interaction of the individual and society; and equilibrium can only be restored when the concept of total health includes the environmental conditions of individuals.

The newly-described local community health centres, in which an increasing number of nurses will work, cannot be developed all at once throughout the province; present facilities, mainly in hospitals, will continue to be used for some time and may, if they develop as envisaged, become permanent. Thus the director of nursing of a general hospital is becoming integrally involved in the development of family practice units, departments of ambulatory care and

of community health which are being established. These are some of the first steps towards integrating preventive and curative care.

There is also a sharper focus on family health. This presents a new challenge to the hospital director of nursing and her staff. New patterns of supervision are based more on the supportive and consultative approach. Some people question whether primary health care services can be successfully provided by a hospital, in the belief that a hospital's objectives and goals and those of a community health centre are too dissimilar. Others believe that a clearly defined purpose and new attitudes and behaviour, will make for a successful 'marriage'. Since the new units are developing rapidly, not all can be closely monitored; but in some, pilot educational programmes in nursing are being established, and others are serving as demonstration models in nursing practice.

The hospitals' need for nurses qualified to work in a variety of specialties is still very great. Directors of nursing are pressing for clinical courses to prepare registered nurses to work in intensive care and other highly specialised units. To staff such units we have often been obliged to rely on inservice methods of orientation and education; while we believe such courses should be provided by the colleges, with concurrent experience and practice in hospital.

With our hospitals now reorganising to include family practice units and departments of ambulatory care, we are again concerned lest these departments develop faster than nurses can be adequately prepared. Nurses in the new units will have to respond decidedly differently than most 'outpatient' clinic nurses have done in the past in our hospitals. At this moment, nurses are deeply involved in interprofessional teamwork, and they are required to demonstrate *now* the full range of their capabilities to the other health professionals.

The following discussion covers two aspects of clinical specialisation. The first illustrates some expanded roles for hospital nurses in ambulatory care; the second concerns some of the expanded role activities in specialised hospital areas with a greater emphasis on management of patients and cure.

Departments of Community Health in Hospitals

Certain hospitals in Quebec have been designated by legislation to develop departments of community health to replace the many, scattered, and uncoordinated, urban and rural health units. Each hospital has been relatively free to develop the services in accordance with the needs of the local population. Existing programmes have generally not been dropped by the hospitals unless the need was no longer apparent, or, as in some instances, services were being duplicated.

School health nurses responsible for primary and secondary schools, as well as for junior colleges, have been reassigned to the hospitals from the school boards. The transfer was difficult for both the school health nurses and the hospital director of nursing, but now, three years later, distinct advantages are emerging. School health nurses who rarely, if ever, met in the past because they reported to different school boards and colleges, now meet frequently together to plan more unified and complete programmes of screening, health appraisal, health teaching, referral and follow-up of their students. Many feel their programmes are now greatly improved while others have renewed personal enthusiasm for their work.

One typical hospital has responsibility for the school health programmes of 38 schools in its region. These schools are administered by eight different school boards and cover primary and secondary schools as well as junior colleges. A nursing coordinator with public health preparation assists the school nurses in planning and establishing their programmes, and since all are part of the nursing staff of the same hospital, they maintain a close link with the parent institution. The director of nursing of the hospital has been able to budget for, and acquire, the resources which the nurses have long needed to carry out better programmes. The school nurses also participate in the hospital inservice education programme and can share in other training programmes. They can use the hospital library as a reference source; many had no access to a good library in the past. They are more sure of their own legal protection which can be more clearly defined through the director of nursing of the hospital and, best of all, they are free to plan programmes together. In the past, their programmes were largely regulated by school principals, and the nurses did not answer to professional nursing.

Other community oriented programmes are being developed in the hospital's department of nursing. Nursing students are participating in school health activities for the first time. The schools and the hospital are cooperating better. School nurses are better informed of the range of hospital services and are making improved referrals. They have influenced the obstetrical unit to become more sensitive to family centred care. Thus the father's importance is now recognised, and 'rooming-in' has been encouraged. As the hospital serves a fast growing community with many young families, the need for prenatal counselling is great. The school health nurses helped to identify this need and the head nurse of the hospital's obstetrical unit was instrumental in organising prenatal classes in the hospital. She has also started to give lectures to families.

The hospital staff are now more interested in the mental health of the community. Adolescents in the psychiatric unit are followed more closely by the school nurses and there is a freer exchange between the hospital, school nurses, and the family. Religious leaders asked for knowledge on the referral and management of their parishioners with emotional disturbances. The nursing supervisor of the psychiatric unit has held weekly ward conferences to which the clergy are now invited, and this led to specially established classes for them conducted by doctors, nurses, and social service workers.

The department of nursing of this hospital has participated in another community oriented project. An association for retarded citizens has maintained a sheltered workshop for retarded teenagers, but the association was also searching for ways in which the teenagers might become more independent and more fully integrated into the community. A very successful programme has been established whereby teenagers are assigned to work in the hospital from four to five months as laundry workers, as dietary aides, or as aides in the department of nursing. To date, every one of these carefully selected young people has obtained a full-time job following this experience. Through programmes such as these hospital nurses are learning how they can participate more fully in the health care activities of the community.

Family Practice Units in Hospitals

Several hospitals have established family practice units which serve as teaching units, generally in affiliation with university programmes. They received initial government approval for construction and ongoing financial support. While the main focus is on preparing doctors, nurses are beginning to experiment and define new nursing roles.

In one large urban area a community (public health) centre recently integrated with a family practice centre to become a new hospital department. These two centres decided to merge to provide better health care, avoid duplication of services, and use local resources to the maximum. Its orientation is toward preventive medicine and maintenance of health and it has a concern for families rather than individuals. This has brought together public health nurses from the health centre and hospital nurses assigned to the family practice unit; they coordinate their activities and plan programmes with other members of the health team. Some of the baccalaureate level nurses have received additional preparation to work in an expanded role and are skilled in carrying out physical examinations and history-taking. It is hoped that the doctors will learn to accept these nurses as colleagues, not as nurses with an extended role to the physician, but as nurses who can perform as educationally qualified, independent practitioners of nursing, skilled in interviewing, observing and assessing health care needs of the family on a long term basis, capable of contributing to diagnoses and of recognising when a client needs the services of other professionals. Each nurse is presently free to plan and carry out home visiting and it is anticipated that she will be able to monitor and care for her families in the long term. She can select families she believes require nursing follow-up at home; and she is supported by, and provides input to, her team which meets daily in the family practice unit. Regular evening hours at the centre permit a working member of a family to be seen at a time convenient to him.

When her clients are admitted to hospital the nurse in the family practice centre is immediately notified and she can easily visit him and follow his progress in hospital. She knows her patient and his family well and she can also give important information to the head nurse which should assist in his hospital care. She is well known to the ward staff and her suggestions are generally readily accepted by other nurses. She is frequently able to attend patient-care conferences.

The work of these nurses has naturally aroused interest among others in the hospital and some have asked to attend conferences in the family practice centre. One head nurse in the outpatient clinic subsequently returned to her department and raised some profound questions on her own activities and those of her staff nurses. This led to a rearrangement of staffing in the department to make better use of resources.

When this family practice centre was being established, the questions of the nature of nursing supervision was discussed. Four of the six nurses have baccalaureate preparation and the other two have additional courses in public health and considerable experience in other primary health care settings. All speak English and French, which are essential, and some have a third language. The medical director of the department of family practice considered these nurses to be well prepared and he was worried about possible 'interference' by supervisory nursing staff. The nurses themselves wanted a link with the nursing supervisors and therefore a nursing supervisor on the hospital staff was selected, and the nature and extent of her responsibilities were defined by the nursing staff concerned. There has been no difficulty whatsoever with this arrangement. She is used mainly as a consultant, and the nurses frequently use her to test out their ideas. She is supportive to a group working in a new situation where questions on organisation are frequently raised. Each nurse uses her in a somewhat different way, according to particular needs.

The nurses recognise that perhaps their greatest

challenge is to demonstrate, as a group and individually, the unique contribution they can make to the health care of the families coming to the centre. They are working in a large metropolitan area where there is no shortage of doctors, and they feel the necessity to demonstrate to others on the health team the independent functions of nursing in addition to the interdependent role.

Regionalisation of Health Services

The two organisations just described are part of one province's plan to provide comprehensive health care, that is – complete, continuous and personal care. To integrate preventive, curative and community social services for a sounder health management, all ten Canadian provinces have considered regionalisation of their health services.[28] Manitoba, Ontario, Nova Scotia and Quebec fully support the concept of regionalisation of health services, and it would appear that the concept will ultimately be accepted in one form or another in the other six provinces. The general consensus is that health services are the responsibility of the state but that local initiative and responsibility must be encouraged. Since to date only Quebec has actually enacted legislation specifically establishing regional councils, it has not yet been proved that such a system will provide the best care for Canadians. It would seem, however, that a knowledge of local problems is of paramount importance. Since the local health centres must respond to the particular needs of the community, they may vary considerably from one locality to another.

Should some communities express a predominant need for nursing and social services, it is possible that local health centres could be established with these groups representing the core of the centres and physicians called in for consultation as necessary. One such region has already identified this need and currently a charter is being sought for a health centre where nurses and social workers would be the main resource people. The centre would also serve as an important demonstration model for nursing.

Psychiatric Consultation Team

Psychiatric services have been established in all general hospitals in Quebec. This specialty has demanded a great deal of attention and concern. It is estimated that one-third of our hospital beds are occupied by patients suffering from mental illness, and each hospital is now obliged to provide a whole range of psychiatric services. It is no longer possible to arrange for a patient's quick transfer to the psychiatric hospital and the general hospital must be prepared to care for him in all phases of his illness.

One large general hospital has developed a psychiatric consultation team of two residents, a psychiatric nurse, and the medical consultant in charge.[139] Each new referral is seen first by the resident and then by the team. Daily meetings are held to discuss problems and assess reports. The consultation service emphasises concurrent psychiatric treatment while the patient remains on the referring ward. All patients are followed until discharged from hospital. In one six-month period, 226 patients were referred for consultation and only eight were transferred to the inpatient psychiatric ward.

The psychiatric nurse specialist in the team has lessened many of the problems which would otherwise confront the team. This nearly 1000-bed hospital has a wide geographical dispersion of patients. There are varying degrees of tolerance among medical and nursing staff of the different specialty units towards the patient with emotional problems and to psychiatry in general. They are frequently inexperienced in handling psychiatric patients, in observing and recording behaviour, and in using psychotropic medication.

The psychiatric nurse specialist makes daily rounds to the wards where the team's patients are being followed. The average daily census of the service is 22 and about nine new patients are referred for consultation each week. The psychiatric nurse specialist discusses problems with the head nurse and other nurses, advises on particular approaches in dealing with the patients, and points out the kinds of observation pertinent to the patient's condition that the team is interested in having recorded. She then presents a daily report to the consultation team. She believes that one of the major reasons she is used so readily by the nurses throughout the hospital is that she is the one who personally reaches out to them and who has established daily contact with so many of the wards. The nurses are not obliged to go searching for her, although she still receives three to five calls a week from the general nursing staff on patient-management problems.

Many patients seen in consultation (about 35 per cent) require tranquillisers. Nursing staff not familiar with psychotropic medication express undue concern over minor side effects, and in the past their identification with a patient's cardiac and other medical conditions often resulted in their failure to administer the psychotropic medication, even though the dose and frequency had been spelled out in detail by the psychiatrist. Often the nurses relied too much on reasoning with the grossly psychotic patient to take oral medication instead of seeking an order to give it intramuscularly. The psychiatric nurse specialist thus plays an important role in advising on the use of psychotropic medications, or the kinds of side effects to expect, and their significance.

Alcoholics have comprised ten per cent of all referrals and the psychiatric nurse specialist plays a role in motivating them to attend AA meetings held in the hospital and to follow through with treatment.

With certain patients she is assigned a direct therapeutic role by the medical consultant, particularly patients with a transient situational disturbance or neurotic illness. From time to time patients seen in consultation are only able to relate to the psychiatric nurse, and she then becomes the important therapeutic figure for them.

She also makes nursing assessments on patients who are eventually committed to a mental hospital, and she serves as a liaison between nurses of different departments when a patient is being transferred to psychiatry or from psychiatry to another department. She also has liaison with various community agencies and other psychiatric facilities to which some of the patients are referred. She performs a similar function with the social workers on the medical and surgical services.

The way that the psychiatric nurse specialist performs as a member of the team has greatly contributed to the success of its consultative service. Unnecessary transfers to the inpatient psychiatric ward have been avoided and patients with a variety of psychiatric illnesses on the general wards have been successfully treated.

Development and Implementation of the Nurse Clinician Role

More nurses prepared at master's degree level are needed to work as clinical nurse specialists, consultants, models, innovators, change agents, and researchers. As we search to improve patient care in hospitals, the need becomes increasingly apparent.

In one large general hospital in Ontario, a clinical nurse specialist conducted a 22-month pilot project to develop and implement the nurse clinician role in four clinical specialties, paediatrics, obstetrics, medicine and surgery.[49] She served as role model to four nurses with teaching and administrative experience who had demonstrated knowledge and skill in their own clinical fields. She worked with them as role model for ten months and then withdrew to allow them to function independently, to determine how they worked and whether their performance improved in the clinically expanded role. She selected cardiac surgery patients in her own clinical specialty for her demonstrations of nursing care.

The findings supported the basic assumption of the project which was that nursing in different specialties has a common core, so that applications and study of the role model in one specialty could be made to others. This study demonstrated that a role model working with the nurse clinicians during the first year brought about a role change in them which lasted through the second year after the role model had withdrawn. The demonstration was more successful in the cardiac surgery unit (the role model's own specialty), and where the nurse clinician role had been successfully developed before the project began. The cardiac surgery unit was designated the model unit for this study and was used for comparison of findings, as were designated control wards. At the end of the project, the hospital staff expressed appreciation of the clinician role and the changes instituted by the four nurses.

Nurse clinicians were found to be involved in nine of the fifteen established nursing activity categories used in the study, all of which represented essential elements of an expanded clinical nursing role. They concerned themselves with

- nursing history and assessment
- planning nursing care
- giving nursing care
- nursing patients' families
- teaching nursing
- work with doctors
- work with paramedicals
- introducing innovations
- administrative clinical activities.

A major contribution of the nurse clinicians to their units was to shift the distribution of clinical nursing from the over-burdened head nurse towards nurse clinicians and general staff nurses. The nurse clinicians perceived their role to have its primary emphasis in planning and teaching. In this latter, the clinicians were responding to the expressed need of the staff nurses.

The nurse clinician's role was not so patient-centred as that of the clinical nurse specialist. Differences appeared to be primarily in degree and depth of role activities. For example, the clinical nurse specialist demonstrated more specialised skills, greater commitment to giving direct patient care, more freedom from ward administrative responsibilities, great flexibility in hours of work, more time spent in direct consultation with other team members, more time spent in interpreting the role and learning about community resources, and greater skills in assessing how the patient experiences illness, hospitalisation and treatment.

A final suggestion for training nurse clinicians included careful selection of applicants, with established criteria for evaluation, and also possession of experience and skills as were required of the four nurses who participated in the project. It was proposed that nurse clinicians be given an initial three-month period of formal courses in their clinical specialties and in the behavioural and physical sciences, possibly in a technical college. This would be followed by a three-month period of practice in the specialty in hospital under the guidance of a clinical nurse specialist.

The summary of the findings suggests there is a place for both clinical nurse specialists and nurse clinicians and that the roles complement each other. In the absence of enough clinical nurse specialists with university education, it would appear advantageous to educate nurse clinicians who can guide the large number of nurses who give care, and thus improve our nursing.

9 Nursing Practice - Role Description and Definition

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Definition of Terms

The assumption that the terms 'nurse practitioner' in primary care, 'nurse therapist' in psychiatry, and the 'clinical nurse specialist', are similar in orientation and basic concepts continues to create problems in communication among nurses as well as with significant others in the health field. A major premise underlying the three terms is that of reference to the nurse's role in the practice of nursing. Intrinsic to any deliberation of clarification of practice roles is the premise that the three terms refer to nurses who provide direct care to individuals, families or special population groups along a health-illness continuum. In the United States, the nurse therapist is the clinical nurse specialist in mental health psychiatric nursing.

In a statement issued 8 May 1974, the Congress for Nursing Practice of the American Nurses' Association presented the three definitions believed to have constituted the first steps toward an orderly process to insure uniformity of definitions for practitioners, employers and consumers.[5]*

In each instance the nurse works in a collegial and collaborative relationship with other health professionals to determine health care needs and assume responsibility for nursing care. In the course of their practice they assess the effectiveness of actions taken, identify and carry out systematically investigations of clinical problems, and engage in periodic review of their own contribution to health care and those of their professional peers.

*These definitions have been reprinted in Constance Biddulph's paper, Chapter 7, *The Clinical Nurse Specialist*, page 44.

The intent of the three definitions was to identify the scope and nature of practice as well as the scope and nature of education which would facilitate achievement of requisite competence.

A phenomenon clearly evident in the evolution of nursing practice roles is that of simultaneous introduction of educational opportunities for the acquisition of knowledge, skill and competence through continuing education, undergraduate and graduate education programmes. The rationale is self evident for there is always a need for an immediate pool of nurses recruited from those already in the practice setting as well as for the future practitioners currently enrolled or to be recruited for undergraduate and graduate programmes. I shall focus on the nature and scope of practice and assume that questions and issues of education for the practice roles must relate to the distinctive educational system of each of the three countries represented by the participants in this seminar.

General Nursing Practice

Before any discussion of the similarities or differences among and between nurse practitioners and clinical nurse specialists, it is necessary to describe the general domain of nursing practice as endorsed through custom and general legal sanction. Nursing practice, similar to medical practice, has retained a base of general knowledge and skill considered to be universal to clinical judgment and clinical competence for generalised services to individuals and families. The central focus of the practice of nurses has been perceived to be care, comfort, guidance counselling and helping individuals and families to cope with health problems that lie along a health-illness continuum.

The functions of nurses have encompassed assessment, case finding, health counselling, health education, preventive, restorative and curative measures.

Diagnostic assessment has generally been defined as 'reporting signs or symptoms' and has been interpreted to be limited to techniques of observation, inspection, interviewing and making use of such instruments as the thermometer and the sphygmomanometer with the use of the stethoscope generally limited to blood pressure readings or monitoring the status of the foetus-in-utero.

Health counselling and health education have in the majority of instances been recognised as within the prerogatives of nurses. There has always been an overlap in the 'treatment' areas or modes of intervention common to nursing and medical practice in preventive, restorative or therapeutic services. The physician, under certain circumstances, may execute the prescribed regimen; under other circumstances delegate the prescribed regimen to the nurse for execution; in still other circumstances the same regimen may be prescribed and executed by the nurse. The instances of a nurse prescribing and executing a regimen are most common in the areas of preventive and restorative services and remains controversial in the area of therapeutic services.

The interdependence as well as the complementary nature of the independent areas of the practice of nurses and physicians is clearly evident in any analysis of the nature of services provided in a holistic approach to health care. The position of the majority of nurses has been that, traditionally, nurses have forwarded the purposes and programmes of the physician but that in addition they have the potential to function with autonomy in selected areas of the health-illness care spectrum.

It has been the observation of our nursing and medical faculty that issues of medical supervision, delegation or perceptions of individual physicians of the potential for relative degrees of independent scope of practice for nurses are negligible and non-controversial when the scope of practice

- is specialised and therefore circumscribed
- can be described with precision and tasks can be programmed procedurally
- depends upon overt rather than covert descriptions and interpretations of signs and symptoms
- requires constant monitoring of patient progress
- encompasses tasks at high frequency intervals and thereby are inordinately time consuming
- is based in a hospital or the physician's office.

Nurse Practitioner for Primary Care

It was hypothesised in the research associated with our nurse practitioner programmes in primary care, that the issues of potential scope or practice were those related to the nature and scope of clinical judgment, influenced by the complexity of the phenomenon, rather than to task delegation, as has been the prior general orientation to manpower personnel. The scope of practice and optimal role of the family nurse practitioner and the paediatric nurse practitioner were deemed to be inclusive of the customary domains of nursing practice with an extension of this role as described in the Secretary's (Health, Education and Welfare) Committee to Study Extended Roles of Nurses.[176]

Primary care services represent a range of complexity of services provided in a variety of ambulatory care settings. A critical dimension in analysis of the complexity of the phenomenon of the patient mix in primary care is the ambiguous area of first contact in a given episode of illness or injury. The subjective sensations or physical complaints of the presenting patient predispose an illness or maladaptive state requiring diagnosis. It is the potentiality for multiple causation of presenting symptoms or complaints that are of critical concern in issues of scope of practice of nurses. Distinction must be made between first contact care for those minor conditions which are self limited and short in duration (unlikely to cause any permanent after effects and which frequently affect individuals at some time in their lives) and those problems which are predictable of serious disease or disability. A further distinction is required in differentiating between symptoms having their origin in a behavioural disorder as compared to a physical disorder, since most patients with behavioural disorders present with physical complaints and do not regard themselves as in need of psychiatric services. This first contact group include the anxious, depressed, and hypochondriacal.

The supportive management of patients with long term or progressive illness is not assumed to represent an ambiguous area of practice. The condition has been diagnosed, the medical regime established and potential complications can be predicted and precisely monitored. The populus consists of those with long term reversible illnesses who require intermittent manipulations of therapeutic regimens and those with chronic irreversible illnesses who require on-going comprehensive management and monitoring for cues of remission.

Informed supportive care of individuals who are well, but who wish to allay concern and/or prevent future illness, represents a need for health maintenance services. Assessment of the physical and psychosocial health status is to ascertain the

adapting state of the individual under given genetic and environmental conditions. Discriminating between normal or abnormal findings on the screening assessment is assumed to be within the realm of the scope of practice of the nurse practitioners. The emphasis of care is upon health maintenance through such services as health counselling, health education and preventative measures.

Primary care services encompass services provided for individuals in a variety of ambulatory care settings. Part of the confusion in interpretation of the scope of practice nurses may assume, relates to selected strategies the nurse may employ in ambulatory care settings compared with inpatient settings.

Clinical Nursing Specialisation

Specialisation in nursing had its origin in the *place* in which a nurse provided her services: the hospital and the home, or hospital nursing and public health nursing. Operating room nursing was the initial specialty in hospital nursing, closely followed by labour and delivery room nursing. Both had their basis in control of the environment to prevent infection, and in assisting the physician in the act of surgery or the process of labour and delivery. Monitoring the physiological status of the post-surgical and anaesthetised patient and the women in labour through sustained observation and interpretation, were significant nursing functions.

Visiting or public health nursing in the United States had its origin in 1877 when the New York City Mission employed a Bellevue graduate to give care to the sick poor at home. These nurses were expected to adopt techniques learned in the hospital to the home, as well as to assume a broader responsibility for instruction in health education of the general public.

Public health nurses and operating room nurses were considered the élite among practitioners. The significant paradox is that, in one instance, public health nursing derived prestige through the independent nature of the practice and practice setting from physician supervision; in the other instance, operating room nursing derived prestige from the power and status of the surgeon in the hospital and the constant proximity of the nurse to the surgeon in the practice setting. The issues are still those of proximity to a physician or supervision from physicians. The interpretation varies from 'over the shoulder' supervision or the physical presence of a physician in the practice setting, to access to a physician through various communication media. Within the concept of access, it is implied that the nurse has the requisite competence to determine need for referral to and intervention by the physician.

The chronology of nurse midwifery in the United States is representative of issues and concerns reflected currently by some physicians, policy-makers and health service administrators in scope of practice in both primary care roles and in clinical specialisation of nurses. A confidential report prepared by the research staff on the Committee on Costs of Medical Care[47] supported the recommendation for the preparation of nurse midwives at the White House Conference of 1930. In its recommendations, the committee pointed out that the ultimate solution for good obstetric care rested with the medical schools, but that under the then existing conditions the nurse midwife was a necessity. For economic reasons the need was especially urgent in communities having large industrial and Negro populations – Negro nurses with midwifery training, it was suggested, would find an expanded field of opportunity.[156] (Note the similarity to the current concepts of the expanded scope of nursing practice.)

The first school for nurse midwives was established in New York City in 1931. At issue was the disparity between the development and acceptance of nurse midwives. The committee reported

> 'Contrary to the generally accepted opinion, the nurse midwife should have a position in the scheme for providing maternity care. It remains for the medical profession to define what the position should be.'

Physicians in general were strongly opposed to the idea because they believed, as do many currently, that nurse midwives intruded on medical practice. In the current era, nurse midwives in the United States are being rediscovered for their potential for primary care in addition to the traditional role of monitoring the woman in labour and conducting the delivery for uncomplicated pregnancies.[116]

Specialisation in the current era continues to be categorised in national statistics by the setting or place in which the nurse practices: hospital, public health, school, doctor's office, industry, and so on. But nurse education programmes initially differentiated specialisation, for teachers or supervisors, in the broad categories of paediatrics, obstetrics, mental health and psychiatry, medical, surgical, and public health.

Formalisation of the concept of the clinical specialist as a master practitioner of nursing was recognised in recommendations for change in legislation at the time of the 1963 evaluation conference of the Professional Nurse Traineeship Program of the US Department of Health, Education and Welfare. Before that time, federal funds were limited to preparation of nurses in functional areas of practice: teaching, supervision of clinical areas and

administration of hospitals, public health agencies and educational institutions.

Although the concept of the clinical specialist had been developed and tested in a number of situations and graduate educational programmes preparing for the role were introduced in several university schools of nursing, the role had not been universally defined. For purposes of the proposed federal legislation the definition accepted was

> 'The clinical nursing specialist is to nursing what the "specialist" is to medicine. She is academically and clinically prepared (preferably at a master's level) to function as a nurse practitioner in a specific area of specialisation such as medicine, surgery, mental health, maternal and child health care, and rehabilitation, in hospitals, clinics, community and public health agencies, and in other settings where special skills are indicated.
>
> 'This nurse not only gives direct care to individuals and groups of patients within her specialized area of competence but also helps other nurses to give the type of intensive therapy the patient needs, and in a consultative role works with other nursing personnel. She may also work independently of nursing with physicians and members of other disciplines in the health field.'*

Several factors provided stimuli for this role for the professional nurse. Included were rapid technological, clinical and theoretical advances, increasing numbers of persons requiring a variety of health services, new methods of health care delivery, public demand for quality health care, and emphasis on prevention of dysfunction and maintenance of mental and physical health. Inherent in the initial experimentations of role definition was the assumption of colleagues in nursing and medicine that nurses were in a position to make a distinctive contribution.

> 'Leadership in nursing practice is essential. This leadership is needed to provide a clinical role model to continually improve nursing practice and to create new dimensions in the diagnosis, intervention and evaluation of health needs. The clinical nursing specialist has been prepared at an academic level which stresses the importance of the integrative aspects of nursing care and methods of implementing within the clinical specialty. Thus, the clinical nurse specialist is the ideal person to assume leadership as liaison between theoretical constructs and nursing practice.
>
> 'In summary, it can be stated that the clinical nursing specialist with extensive preparation in theoretical and practical aspects of patient care, knowledge of methods and techniques of research and leadership capabilities is the most appropriately qualified person to stimulate and promote quality nursing practice as it relates to the expanding health care of the nation.'†

In our setting, a large and complex urban medical centre, we have clinical specialists in cardiology, nephrology (children and adults), mental health (children), neurology/neurosurgery, ostomy care and rehabilitation, respiratory care and rehabilitation, eye, ENT (ear, nose and throat), mastectomy care and rehabilitation, obstetrics and gynaecology, high-risk infants, oncological nursing, and chemotherapy. The clinical specialists function in the outpatient department as well as inpatient services.

In the hospitals in the United States, the most dramatic shifts in specialised areas of practice for nurses were in special care units; such as intensive care, shock, coronary care, burns, respiratory care, neurology, renal dialysis, and paediatric pulmonary. The purpose and objectives of these special care units clearly demonstrate the significance of skilled nursing care in the therapeutic plan of a selected patient population housed in a highly controlled environment, especially designed to provide life-saving and life-sustaining human and technologic resources.

In these instances the primary purpose of nursing care is to provide a therapeutic regimen for patients who require continuous, comprehensive observation and detailed intensive care in an atmosphere of compassion and understanding. A characteristic feature of these units is the condition of the patients. They are either critically ill or have a potentiality for becoming so, and increasingly they are the ones experiencing innovations in surgical procedures and technology as yet in the 'wonderment' stage of predictability. There is, therefore, a constant potentiality of crisis, demanding exquisite skill in human monitoring and instantaneous human reaction and action. Nurses specialising in this intensive special care service must have an understanding of the aetiology of the patient's dysequilibrium, a perception of the medical and therapeutic goals and an understanding of clinical data and medical science.

Because the nurse knows what evidence is essential to effective therapy, she is sensitive to relevant cues, continues to search for evidence and is capable of discriminating between relevant and irrelevant data.

*From the statement prepared by the staff of the Division of Nursing, US Department of Health, Education and Welfare, and distributed to participants during the Evaluation Conference for Title II, Professional Nurse Traineeship Program, 1963.[178]

†From the Position Statement on the Clinical Nurse Specialist, issued by the New York State Nurses' Association, January 1972.

The critical nature of physiologic changes and the recognition of requirements for clinical judgment and clinical competence constantly available in the environment have been determining factors in defining and accepting the nurse's role. The issues of diagnosis and clinical management became blurred in these environments.

Numerous examples appear in the medical and nursing literature of the role of clinical specialists in the acute care setting (the hospital); a role requiring expert clinical management of the symptomatic or physiological response of the patient to illness or disability. In the 'caring and helping to cope' role of the nurse, common problems are: social deprivation, sensory deprivation, sensory overload and sleep deprivation.

Issues and Problems

There is relatively little relationship between the employment classification of clinical specialist in the various hospital settings and positions of organised nursing or pronouncements of nurse educators. The posture of organised nursing on the national and the New York State level is that a master's degree is desirable, if not requisite.

The 86 graduate programmes in nursing at the master's degree level place emphasis upon a clinical specialty for teachers and supervisors in addition to those which offer separate programmes for clinical specialisation as an area of advanced practice. In addition short term continuing education programmes or hospital-based inservice training programmes provide intensive training in selected areas of clinical specialisation such as coronary care, respiratory care and haemodialysis. There is a wide range in the quality of these programmes.

In the practice setting the title of clinical specialist ranges from a nurse without any additional preparation functioning in the traditional role of assistant head nurse, to a nurse 'on call' for consultation to nurses and physicians for patients with particular complex nursing care problems in the inpatient or outpatient service.

Major problems I perceive are those related to

expectations of a clinical nurse specialist's contribution to nursing care from individuals with a wide disparity of competence

the relationship of the clinical nurse specialist to staff nurses, head nurses and traditional supervisors

clarification of the placement of the clinical nurse specialist in the nursing service hierarchy of a particular institution

justification of their position in terms of reimbursement by third party payers or insurance carriers.

Proposed Solutions

The advent of the clinical specialist is an attempt to reconceptualise nursing as a practice discipline. It also represents a trend in the United States to attempt to reverse the exclusive emphasis upon management in isolation, or as the singular status position within the nursing service organisation. The caution I perceive to be essential at this time is related to the need to maintain a position of balance and gradualism. Unfortunately the 'hard sell' of the clinical specialist has tended to relegate other significant roles for nurses to less than desirable status in our highly verbal nursing culture in the United States. A primary example is that of administrative roles in service or educational institutions. A major problem we face in the United States is that of a continuing supply of leaders for these administrative roles.

10 Nurse Therapist - An Inherent Part of All Nursing Practice

by Eileen M Jacobi
executive director
American Nurses' Association

'Nurse therapist' is a comparatively new title for a nursing activity that has existed at least throughout this century.

Many individuals are under the misconception that therapeutic intervention is a tool used solely by the psychiatric nurse in his/her dealings with cases of mental illness. However, all registered nurses have major strengths that stem from the basic nursing programme. The nurse is able to observe and to distinguish a broad range of problems of a physical and socio-psychological nature. The help the nurse offers can frequently begin with a response to a concrete physical complaint and then evolve to include investigation and interaction associated with the less tangible.[7] In many respects, it is unfortunate that the therapeutic role is not reflected in the basic nursing title.

Today some form of nursing therapy is an inherent part of all nursing practice. The goal in all fields of nursing is to participate fully in comprehensive health care. This requires consideration of both biophysical and psychosocial aspects of the patent's/client's problems. As Joyce Travelbee points out in her book, *Interpersonal Aspects of Nursing*,

> 'Nursing is an *interpersonal process* whereby the professional nurse practitioner assists an individual, family or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences.'[173]

Every nurse must deal with the emotional dilemmas experienced by patients and their families. It is estimated that between 30 and 50 per cent of all symptoms for which patients seek medical aid are caused by emotional factors.[42] A primary goal of a nursing care plan is to reduce any stress which interferes with the patient's/client's optimal functioning.

Each physically ill patient has a set of attitudes and feelings about his illness. Nurses must deal with the fears, agitation or despondency of a patient about a physical disease. For, in some instances, the patient's feelings and attitudes cause more difficulties than the illness itself.

There are many situations that bring unhappiness and psychic pain to the patient's family. Death is the most obvious. Those individuals who are unable to accept the death of significant persons are not psychologically well. A nurse may intervene to assist such individuals in understanding and coping with their feelings.

Some 50 years ago the nurse, as one of the few health workers, practised in a more obvious therapeutic capacity as she maintained a one-to-one relationship with patients, utilised the case method, provided 24-hour care and promoted health teaching and health maintenance for the entire family. Today nurses must define the role of nurse therapist in relation to other disciplines as they collaborate and interact with health workers to provide total patient/client care.

In recent years, as specialty nursing roles such as paediatric nurse practitioner, family nurse practitioner, community health nurse and many others, have evolved, interest in the therapeutic aspects of nursing has increased. As Travelbee points out in the introduction to her book,

> 'All professional nurse practitioners strive to improve their practice and to develop more effective means of rendering care. Because

nursing is always concerned with people, the more knowledgeable and skilful a nurse is in the area of interpersonal relationships, the more likely it is that she will be able to meet the nursing needs of others.'

Therapy must be viewed on a continuum. Therapeutic intervention is a vehicle by which the nurse seeks modification in the patient's/client's health status. This status may range from a state of physical and mental well-being (neutrality) to varying degrees of physical and mental disturbances. It is between these two spheres that the nurse therapist must function.

Nursing therapy is usually designated as direct patient/client/family care. Most health crises occur in a family context. What influences one person also affects those persons with whom his life is intertwined, and the primary group of any individual is his family. As Hall and Weaver point out in *Nursing of Families in Crisis*,

> 'Nurses, because of their accessibility to families, are in a position to offer preventive, supportive, and therapeutic intervention. By combining their knowledge of crises, their understanding of families and their skill in the nursing process, nurses can effectively influence the quality of the human experience by assisting families in . . . situational crises.'[89]

Direct patient/client/family therapy involves the collection of data, assessment, planning, execution and reassessment of care with the patient/client and family who require the specialised knowledge and competence of the nurse therapist. Such therapy includes aspects of research, teaching, counselling and clinical consultation.

It is essential to involve the patient/client/family in setting health goals. The therapeutic goal is, of course, behavioural and attitudinal modification; for example, increasing or decreasing anxiety, stress and motivation and encouraging constructive modes of behaviour.

The emphasis in therapy is doing *with* rather than doing *for* the patient/client. The therapeutic relationship between the nurse and the patient/client as well as his family is one in which all must work to bring about changes that are deemed appropriate in the patient/client. In this context, the nurse therapist can be described as a social engineer, not a manipulator.

An individual who defines his/her role as that of nurse therapist works from a conceptual framework gained from the natural, social and behavioural sciences. A nurse therapist must understand sociodynamics, psychodynamics, psychopathology and pathophysiology. Moreover, the nurse therapist must be well grounded in theory of the clinical nursing which he/she practises. Competence in clinical nursing is maintained through formal and informal continuing education.

In addition to the appropriate knowledge base, the nurse therapist must cultivate a level of maturity and degree of objectivity that allow for empathy. Empathy can be an invaluable tool in nursing. The ability to empathise involves skill in reaching out and trying to understand the thoughts and feelings of others. This requires that the nurse be cognisant of personal feelings in order to recognise whether they reflect those of the patient/client or are personal reactions stemming from experiences outside the immediate situation. Orlando identifies the nurse's own reaction as an essential element of the nursing process.

> 'A nurse's reaction consists of three aspects:
>
> perceptions of the patient's behaviour
>
> the thoughts stimulated by the perceptions
>
> feelings in response to these perceptions and thoughts.'[148]

In nursing therapy, these three elements of the nurse's reaction must be expertly utilised in response to the patient/client.

One such response to the patient/client is the therapeutic use of self. One author has defined this technique as

> 'a personal relationship between the nurse and her patient/family – one that is initiated by the nurse, controlled by her, and purposefully directed toward improving the patient's condition'.[43]

Some would suggest that the therapeutic use of self has become standard nursing technique.

To use oneself therapeutically requires such traits as self-insight, self-understanding, an understanding of the dynamics of human behaviour and the ability to intervene effectively in nursing situations.

Another technique employed by the nurse therapist may include positive reinforcement, one of the most important and frequently used procedures in behaviour modification. LeBow defines positive reinforcement as

> 'a method for increasing the frequency of a desired behavior by presenting a pleasant event, continguent on the occurrence of the behavior'.[119]

In utilising this technique, the nurse therapist must arrange the patient's/client's environment so that

the desirable behaviour produces the positive reinforcer.

The individual who engages in nursing therapy must recognise that certain relationships prohibit effective therapeutic intervention. Such relationships include student-teacher, supervisor-staff, colleague-colleague, husband-wife and mother-child. In these instances, the nurse therapist may be unable to deal objectively with certain personal feelings and insights. Moreover, such intervention may generate a therapeutic form of anxiety which could interfere with the social intercourse required.

Nursing therapy is characterised by a great deal of flexibility. Individuals tend to think of therapy in relation to a time span – the 50 minute hour, three to five times a week has been the traditional time element. However, the nurse therapist takes into account the patient's/client's tolerance for therapy and his/her particular needs. The nurse therapist may have frequent, short intervals of therapeutic intervention with the patient/client and/or family. The therapeutic intervention may simply occur in combination with traditional nursing activities. The nurse therapist may engage in some form of family therapy in an attempt to improve the interactional behaviour within the patient's/client's primary group. In such an instance, the therapist serves as a resource person. The nurse therapist may conduct a form of group therapy with two or more families or two or more patients/clients. Therapeutic intervention may also occur in a variety of settings, from counselling in a formal institutional setting to a conversation over the telephone.

Regardless of the type of therapeutic intervention or the setting, the nurse therapist is accountable to the group or patient/client/family for the nursing care plan. Responsibility to the patient/client/family takes precedence over any other activity in which the nurse therapist may be otherwise engaged. Confidentiality is mandatory. The methodology necessary to fulfil this responsibility may vary according to the setting as well as the age, level of maturity, nature of the crisis and degree of pathology of the patient/client. In any case, the nurse therapist must have the autonomy to identify and define patient/client/family problems, to establish goals which include limit-setting with the patient/client/family and to provide ways or alternatives to achieve these goals.

'Nurse therapist' is one of many new professional nursing tags. To focus one's nursing practice on therapeutic measures requires an understanding of sociodynamics, psychodynamics and psychopathology as well as a firm foundation in the clinical area of practice. Being a nurse therapist entails a commitment to the healing arts, a commitment to the consumer and a commitment to humanity, as it is a giving of the self.

Although the role of nurse therapist has evolved as a distinct area of practice, it should not be forgotten that every registered nurse has the basic knowledge which enables him/her to engage in therapeutic intervention.

11 Developments in Psychiatry, the Community and Other Services

by John Green
area nursing officer
Gloucestershire Area Health Authority

> 'When a mental nurse stands up at a conference organised by the British Association for Behavioural Psychotheraphy and describes how he treated a 21-year-old girl suffering from agoraphobia, obsessive compulsive neurosis, partial paresis and temper tantrums, with very good results, then the cynical observer is forced to admit that psychiatric nursing could be on the verge of a major leap forward. When psychologists, psychiatrists and more psychiatric nurses get up and describe the work of nurse therapists with the long-term mentally ill, the mentally subnormal and with disturbed children, then the cynic is in danger of becoming an enthusiast.'[22]

This happened at a conference in 1973, and since that time there has been a growing interest in the subject. It now seems there are some five clinical areas in psychiatry to which the concept of the nurse therapist can be applied; child psychiatry, the neuroses, long term disorder, behaviour modification and community psychiatry. It seems worthwhile to state the known facts in summary and to examine the implications.

The extending role of the nurse in diagnosis and therapy is a subject of discussion in community nursing and is referred to for the purpose of comparison. Perhaps nowhere in the health services are nurses assuming greater responsibilities than in psychiatry, and this is probably the result of experimental courses in psychological treatment in child psychiatry, mental subnormality and mental illness both in hospital and the community.

Child Psychiatry

The child with psychiatric and emotional problems has a special relationship with the nurse. In hospital the nurse more than any other member of the therapeutic team is part of the child's habitat. Situations arise throughout the day and night in which therapeutic nursing techniques can be applied, as the nurse is the person most likely to be present, and the opportunity should be fully exploited. It is now recognised that a vast source of therapeutic potential is available if nurses are trained to use their initiative in supplying on the spot emotional first aid and clinical expertise in the interpretation of behavioural disturbances.[112]

The Adult Neurotic Patient

Widespread attention has been drawn to the involvement of psychiatric nurses in the psychological treatment of neurotic patients in a project carried out by doctors, nurses and psychologists at the Bethlem Royal and Maudsley Hospitals, London.[48] The nurses were given an intensive course of preparation in the theory and practice of psychological treatments. The patients coming into treatment with nurse therapists during the project were listed.

April 1972 - April 1973

Main diagnosis*		
agoraphobia	27	(+3)†
social phobic	14	(+1)
specific phobic	26	(+2)
obsessive compulsive	16	(+1)
personality disorder	2	(+1)
habit disorder	6	
obese	1	
enuretic	1	
	93	8

*Several patients had multiple difficulties.
†Patients who withdrew from treatment.

In the early stages of the experiment, psychiatrists and psychologists were closely involved in the referral, assessment, and plan of treatment. Gradually the nurses have come to the stage of being able to plan and carry out the whole programme of treatment but they still rely upon the psychologists and psychiatrists for advice and assistance when necessary.

Operant Treatment of the Long Term Patient

Psychiatric nurses have always been agents of change in psychiatric patients' behaviour patterns. There has been little scientific study of the nurses' influence, and the main credit for therapeutic success has been given to the doctor. The introduction of psychologists into psychiatric hospitals resulted in some appraisal of the nurses' role in treatment. What is emerging is that nurses can, when given an active therapeutic role, play a much more significant part in treatment than was generally realised. Operant treatment of the long term patient ranges from very basic methods of habit training by reward and punishment to behaviour modification by sophisticated psychological methods.

Among the experiments is one at Stanley Royd Hospital, Wakefield, where token economy awards were established to tackle the problem of improving the behaviour and performance of long stay institutionalised patients.[90] Nurses were specially selected to undergo a period of training designed to cover different approaches to operant conditioning, the skilled use of rating scales, the giving of token awards, and the changing of attitudes. The atmosphere of experiment, the successful collaboration with other disciplines, and the enthusiasm of the nurses themselves, led to a high degree of nursing independence in planning and in carrying out programmes of treatment. A contrast indeed with the traditional custodial method of nursing in long stay wards.

The Mentally Handicapped/Retarded Patient

For a variety of reasons, of all nursing groups, nurses in hospitals for the mentally handicapped have tended to have the most custodial and basic care role relationship with their patients. This has been changing as more medical interest and social concern have been directed towards the whole problem of mental handicap.

The extreme shortage of doctors and psychologists in these hospitals has to some extent enabled nurses to play a key role in teaching, training and behaviour modification by psychological means. Where psychologists, doctors and nurses have critically examined their respective roles it has been evident that to an increasing degree an independent therapeutic role has fallen to nurses, and there are very encouraging signs that they are fulfilling this role.

The recently formed Institute of Mental Subnormality, the King's Fund, the staff of Lea Hospital, Bromsgrove, Borocourt Hospital, Reading, Queen Mary's Hospital for Children, Carshalton, Surrey, and many hospitals for the mentally handicapped, have given notable stimulus to this subject.[108] Set against this is the view expressed in the Briggs report that a new caring profession be established with a leaning towards social rather than nursing care for the mentally handicapped.[83]

The Psychiatric Patient in the Community

Psychiatric nurses first moved into the community to follow up patients who were discharged from hospital. Gradually, their specific skills have been enhanced by community experience and help from community nurses and doctors. Their role is widening from one of basic psychiatric nursing to include decisions on treatment at home, admission to hospital, and suggestions on medication almost amounting to actual prescribing.

From early pioneering experiments, the role of the psychiatric nurse in the community has been developing and the service has now virtually extended to all psychiatric hospitals.[85] Because of the independent nature of the nurses' work and the need to make quick decisions on variation of treatment and medication, it can be said that the community psychiatric nurse is acting as a therapist. This is particularly true of the work at the Bethlem Royal and Maudsley Hospitals where nurse therapists work both in hospital and in the community.[48]

Comparison with Other Branches of Nursing

Other branches of nursing where the term 'nurse therapist' could be applied are community nursing, midwifery, and general hospital nursing.

Community Nursing

Two recent studies on the role of the nurse as a diagnostician/decision-maker in the community make interesting reading.

A paper in *The Lancet* in 1973 describes a project in which a staff nurse from Glasgow Royal Infirmary was compared with a group of three doctors in making first-contact decisions on patients in general practice.[138]

The following extract from the *Guardian* newspaper of 4 July 1974 refers to a controlled study carried

out in Ontario, Canada.

> 'The object was to find out whether patients seen in the first instance by a "nurse practitioner" (a nurse with some four months' additional training) fared better or worse than patients seen initially by a GP in the usual way. To avoid bias, families were allocated at random to a nurse or GP. The only important difference in allocation was that nurses were only given half the caseload of the GP. All the families were informed of the study and given the opportunity to decline involvement. Perhaps surprisingly, only a handful objected to their allocation and about half of this handful actually objected to having to see the GP initially rather than the nurse!
>
> 'Naturally, the nurses were not expected to be as knowledgeable as the doctors, but in practice they handled two thirds of all cases without having to ask for further advice from GPs. Their activities included prescribing drugs as well as diagnosis.
>
> 'The study showed that in every respect, patients seen by nurses did just as well as those seen by GPs. Less than 1 per cent of families in each group left the practice because of dissatisfaction; indeed, satisfaction was equally high – about 96 per cent – in both groups.'[25]

Midwifery

Midwives in Britain jealously guard their privilege as practitioners in their own right. Their freedom from medical direction is, however, limited to professional attendance upon a woman during pregnancy, labour, or the lying-in period, and the list of situations relating to treatment outside the midwives' province is substantial.[73] Nevertheless, they enjoy a professional status which is often the envy of general nurses.

General Hospital Nursing

Nurses in general hospitals deliver nursing care to patients and carry out treatments prescribed by the doctor. What happens in reality in numerous situations is that the experienced clinical nurse suggests the treatment and asks the inexperienced doctor formally to prescribe it. There is a need for some rationalisation of hospital regulations, and of nursing and medical codes of practice, in order to give greater recognition to the expertise of the nurse in relation to treatment.

Summary

The concept of the nurse therapist is established in psychiatry; it ranges from basic methods of treatment to advanced and sophisticated techniques. The recognition of the nurse's role in therapy by psychiatrists and psychologists adds a new dimension to what has been happening in a very informal way for some years. The contribution of the nurse as a diagnostician/decision-maker/prescriber in primary care is also becoming the subject of study and debate.

Important ethical and professional considerations arise.

Is it good for the patient? Is it good for nursing? Is it a means of filling a gap in the medical structure? Or are we using another title for the 'clinical nurse specialist'?

12 Nursing Management and Primary Care in the Local Health Unit

by Dorothy M Mumby
director of public health nursing
Middlesex-London District Health Unit

General Setting

Health has been the responsibility of the provincial governments in Canada since the British North America Act of 1867. In most provinces, local health services are administered by provincial health departments. In Ontario, however, the local health units are autonomous, with the province providing from 25 to 75 per cent of the budget. The provincial health ministry in Ontario was reorganised in 1972 (see Figure 2, overleaf) and now has its focus on the development of standards, evaluation of programmes and provision of consultant services.

With their local autonomy, health units in Ontario have developed varied programmes under the direction of local medical officers of health. Although some programmes have been given priority for development by the provincial ministry, this responsibility is left to the local health unit. Consequently, the Ministry's intentions are not always implemented. For example, in 1968 the provincial ministry stated that development of family planning clinics was a priority. Today, however, only 15 of the 44 health units in the province have family planning services, and those in operation vary from information centres to full clinics with counselling and the provision of all contraceptive methods.

The Middlesex-London District Health Unit is a local government health facility, theoretically autonomous but centrally controlled by the provincial health ministry which pays 75 per cent of the approved budget. The health unit serves a population of 291,680 and covers an area of about 1250 square miles. Services include preventive dental health and dental treatment, environmental health, and personal care services such as conception control, communicable disease control, school health and public health nursing. Included in nursing are programmes in maternal and child health, education for expectant parents, and home visiting of the mentally ill, mentally retarded and the elderly. Promotion of health and prevention of disease are the main objectives.

The City of London and the County of Middlesex are also served by the Victorian Order of Nurses, London St Thomas Branch. The VON is a national visiting nurse organisation whose primary function is to provide nursing care in the home under the direction of the attending physician. Promotion of health and prevention of disease are also the concern of these nurses.

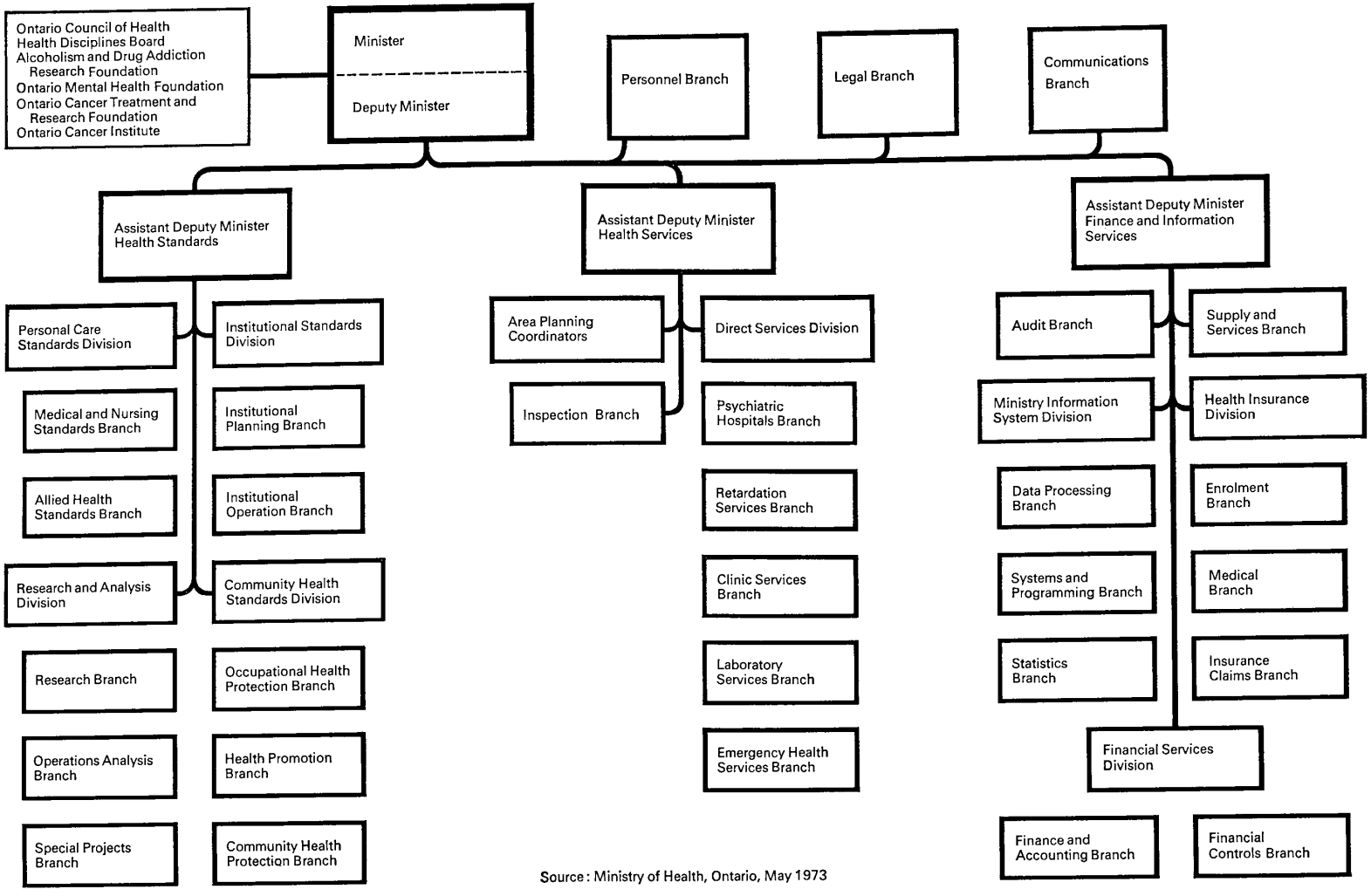
Other nurses providing primary care, besides those in hospitals, institutions and occupational health, are those employed in physicians' offices. From data recently collected in London for a study of primary care, it was noted that of all primary health care contacts with nurses, office nurses had 64 per cent, public health nurses 31 per cent and VON nurses 5 per cent.[129]

In Ontario, in 1968, less than 35 per cent of the family physicians' offices had even one full time registered nurse. A recent survey in London revealed that 54 per cent of the family physicians' offices had registered nurses; the rest of the primary health care in nursing being provided by those with less education who had usually been trained on the job.[37]

Changes in Nursing Organisation in the Local Health Unit

The director of the Middlesex-London District

FIGURE 2 ORGANISATION OF THE MINISTRY OF HEALTH, ONTARIO



Source: Ministry of Health, Ontario, May 1973

Health Unit is the medical officer of health, to whom the director of nursing reports. Five supervisors are responsible to her for 72 public health nurses as well as 18 others employed in the nursing division (registered nurses, a registered nursing assistant and health room assistants).

The director of nursing has authority and responsibility for administration of the nursing service and is accountable for the quality of nursing care provided. With limitations in budget, the continuous review and changing of priorities, planning, and the development of new programmes, her role is both challenging and changing. Some of the areas that affect nursing management and changes in nursing management in the health unit are discussed below.

Collective Bargaining for Nurses

It is only within recent years that collective bargaining through nursing organisations set up for that purpose has become a reality. The Nurses' Association, Middlesex-London District Health Unit, was certified as recently as 1971. As we look at the delivery of primary care and the necessity for service around the clock, what are the implications for our nursing contract? It allows for staff to work a flexible working week, thereby facilitating evening and weekend visiting as needed. Another health unit has instituted split shifts for public health nurses to cover evening classes. This arrangement had to be negotiated with the nurses' association whose contract had stated that daily hours of work must be continuous.

Review of Priorities

One of the major tasks of any director of nursing is the constant review of priorities to meet demands for health care. Some of the administrative arrangements designed to improve coordination of health services are discussed later. As coordination is improved and those involved become more aware of the potential of public health nursing, more demands are made on our services. Without increase in budget or curtailment of programmes already established (school health, education for expectant families, care of the mentally ill, mentally retarded, and the elderly), how can quality care be provided in generalised public health nursing? One looks at priorities for the community, and decides that something must be curtailed because additional monies are not available; and the next thing that happens is that another branch of government picks it up and finds money to provide the service that could best be provided by the public health nurse in the first place.

Joint Appointments

The director of nursing must also keep updated and knowledgeable about community trends through membership on various boards and committees. Exchanging updated knowledge about education in health sciences, and about service trends and problems, is facilitated by joint appointments between service agencies and university faculties. The director of nursing of the Middlesex-London District Health Unit has a part time appointment to the department of epidemiology in the faculty of medicine, University of Western Ontario. This appointment carries some responsibility for participation in seminars for community health for both nursing and medical students. The arrangement helps the director of nursing to develop mutual respect with the medical community.

In London, the nursing director of the VON branch and the nursing director of the health unit have worked together in the education for expectant parents since 1964, first through a committee structure and then in 1971 through the appointment of a part-time prenatal coordinator for both agencies. In summer 1974, a full time coordinator of education for expectant parents was appointed.

Changes in the Middlesex-London District Health Unit

Three of these changes have been

provision of health services to separate schools (1968)*

amalgamation of Middlesex County Health Unit and City of London Health Department (1971)

provision of health services in public schools in London (1972).*

An Exploratory Study

These changes made necessary a look at the running administration and in 1973 an exploratory study with three purposes was commissioned

to explore the supervisory process in the health unit

to determine the most effective methods of supervision as perceived by staff nurses and supervisors

to identify factors related to satisfaction and dissatisfaction of nurses at work.[57]

*In Ontario, 'separate' schools are supported through property tax by Roman Catholics whose children attend these schools; 'public' schools are non-denominational. Both school systems receive monies from the province.

In 1968, in anticipation of increasing responsibilities, and to facilitate administration and communication, the geographical area served by the health unit was divided into six, each served by groups of four to six public health nurses who chose their own coordinators. By 1973, there were ten groups, each composed of four to ten nurses. The supervisors had increased from one in 1968 to five in 1973, each supervisor being responsible for two groups of nurses as well as having programme responsibilities.

The study indicated relatively high job satisfaction, higher than that anticipated when one considers that over 50 per cent of the staff surveyed had been employed less than one year.

Both supervisors and staff nurses saw the most helpful function of supervision as assisting the individual staff nurse in her role as an informal teacher. The individual nurse supervisor conference was seen as the most helpful method of supervision. Many nurses said that they would like the supervisor to be a role model, a method of informal teaching which some supervisors used.

Staff nurses and supervisors generally felt that the number of supervisors and coordinators in the agency was about right at the time of the study. However, many nurses added that there should be an assistant to the director of nursing to lessen the administrative responsibilities of supervisors. While staff perceived supervisors to have fewer administrative functions, supervisors felt they should have responsibility for both clinical and administrative functions.

In discussing the study with the staff, it became evident that staff use peer support in day-to-day work. Members of the staff, without formal organisational changes, seem to emerge as the 'specialist' – in geriatrics, child care or family planning. No-one can be up to date in all areas; the supervisor is in any case a generalist. Thus, peer support is to be encouraged; the staff 'specialist', able to pass on knowledge and skills, achieves satisfaction from this role.

Though clinical nurse specialists in primary care would be ideal, the number of nurses so prepared educationally is minimal. Other nurses must be encouraged to achieve preparation at this level; and the peer 'specialist' must be supported and allowed to develop by attendance at workshops and courses in her area of interest.

Primary Care Delivery

The definitions of 'primary care'* and 'nurse practitioner' used in this paper are those of the Boudreau report.[29]

> 'The nurse practitioner is a nurse in an expanded role oriented to the provision of primary health care as a member of a team of health professionals, relating to families on a long term basis . . .'

If the primary health care system is to be accessible to all, we must ensure that community health services are on a 24-hour schedule, through collaboration with other professionals and coordination of services. One problem identified in our study was the lack of referral services other than between 8 30 am to 4 30 pm. Nursing is provided day and night by the VON and the possibility of our health unit providing a similar service is under review.

Public health nurses in our unit are generalists, involved in family health from birth to death at all levels of well-being and sickness. Just as we initiate programmes to screen those in need of nursing service, we are using nursing skills to screen those in need of medical attention. In some Ontario health units, public health nurses do complete nursing assessments of children entering school. Nurses in our own unit concentrate on health history and observations of the child to determine the necessity for medical referral. Public health nurses use their assessment skills extensively in school health services as well as in work with infants and pre-school children.

Pre- and post-abortion counselling and family therapy, both fairly new to public health nurses, have been included in their work in the past four or five years. The implications of this trend are extremely important for educators.

The public health nurse is no longer only a teacher of health. She has to have the ability to make nursing diagnoses to assist the physician in the management plan for the patient.

A philosophy developing in Ontario is the need for role models within the supervisory staff to assist the staff nurse as a nurse practitioner. Seven supervisors in Metropolitan Toronto have taken nurse practitioner programmes at the University of Toronto or McMaster University, Hamilton. Discussion is underway to provide this programme for selected experienced public health nurses to develop their skills in assessment and history-taking.

The nursing division of the Middlesex-London District Health Unit aims not only at promoting and improving health and preventing disease but to do so by collaborating with other professionals. The objective is the improvement of health care delivery; and the trend is towards attachment to

*See Dorothy Kergin's paper, page 25, for the Boudreau definition of primary care.

family physician practices, development of community-hospital liaison programmes, and work in multidisciplinary teams.

Attachment

An 'attachment' nurse is one seconded to a group of physicians (or a physician) to do the public health nursing component in the case of families who attend that medical practice. In 1968, the first nurse from the health unit was attached full time to St Joseph's Hospital Family Medical Center. The impetus was the result of a study in 1965 which showed that the public health nurses and physicians (with rare exceptions) were working independently even though their activities centred to a large extent on the family. In a six-month period, of the 410 visits made by nurses to families or individuals receiving medical care when required from the family physician, there were only ten instances in which nurses had had any direct contact with the physician.[24]

Attachment gave opportunity for physicians and public health nurses to collaborate. As St Joseph's is also a teaching centre for family medicine, it provided an opportunity to help family physicians understand the role of the public health nurse.

Since 1968 we have attached a nurse to the Victoria Family Medical Center, another teaching centre, and to seven other groups of family physicians. The attachments are part time or full time. By the end of summer 1974, there were attachment arrangements with ten groups, representing 33 physicians, or over 25 per cent of the family physicians in the City of London. In addition, a nurse is seconded to the University of Western Ontario Student Health Center. All the nurses in the attachment programme maintain some district involvement such as school health service or the teaching programme for expectant parents.

The service provided by attachment nurses differs somewhat from that of the district nurse. The attachment nurse has earlier access to prenatal cases and therefore knows many new expectant mothers before they deliver. The district nurse, on the other hand, has more new cases in the newborn period. However, the major differences seem to be related to the interests of the nurse and the type of practice of the physician. Some activities seem to be carried more frequently by attachment nurses today than they were when reviewed in 1971. These include dressings, inspection of throats, taking swabs for culture, listening to chest sounds, and urine testing.

Across Ontario the move has been accelerating from 1971, when there were 12 attachments, to 57 by March 1974. Thirty of these are in Metropolitan Toronto, and of them the City of Toronto itself has 14 for a population of approximately 680,000. Included in the 57 are some that would be classified as liaison arrangements according to the definition presented below.

Advantages of Attachment

1 Better communication between public health nurse and physician through regular face-to-face contact. The nurse has access to the physician's medical records and can use these to improve her nursing plan. She can follow through specific teaching to the patient and family initiated by the physician.

2 She can promote health and teach preventive medicine among the families served by the medical practice.

3 The team concept extends to professionals other than the physician and nurse.

4 The public health nurse knows the community resources and acts as consultant to the physician in these matters.

5 She also acts as consultant to the physician about public health.

6 She sees families who otherwise might not come to her attention.

7 She is well accepted by patients and families; her rapport is quickly established when they know she works with their physician.

8 Nurse, physician and patients like the arrangement.

9 Supervision, inservice education, and support through colleagues are available for the nurse in the health unit.

10 Opportunity is provided for public and private sectors of health care to work together.

Disadvantages

1 Constant reinterpretation to the physician about the role of public health nurses is needed. This can be a source of frustration to the nurse, but can also assist in improving her ability to articulate.

2 Budgetary restrictions make it impossible to provide enough nurses to physicians to achieve full potential of this type of arrangement.

Two colleagues have reported specific problems which resulted in termination of the arrangment. In one situation, the physician changed medical orders, did not convey this change to the nurse and

told the patient to 'never mind what the nurse says'. In the other, the physician did not have time to confer regularly with the nurse and appropriate referrals could not be effected. These problems have not been perceived in our health unit.

General Trends in Attachment

The report of the Health Planning Task Force of the Ontario Provincial Ministry, published in April 1974, recommended that primary health care be provided by primary health care groups.[33] If implemented, one further suggestion from the report that I should like to see implemented is that public health nurses be seconded from local official health agencies to the primary care groups. This would provide the basis for a comprehensive plan necessary to meet the health needs of the people of Ontario.

Another report, the Hastings report on the development of community health centres, suggested that primary health care be provided through multidisciplinary teams in community health centres.[30] The inference is that the public health nurse would be employed by these centres. I feel this would be a step backwards; the public health nurse would no longer be part of the public health team and would quickly lose her expertise in preventive work as pressure for curative health care would easily reduce the time available for it.

Research underway in Nova Scotia, Manitoba and British Columbia is reviewing different types of attachment arrangements with nurses employed by provincial health ministries. The VON is also involved in research programmes.

> '. . . VON nurses work as "co-practitioners" with one, or a group of family physicians. A current example is in Beaverton, Ontario, where a physician has attached to his practice another health professional, a VON nurse, who with added knowledge and skills gained through a six month course for nurse-practitioners at McMaster University, is able to accept increasing responsibility for independent clinical decision-making and with her expertise in public health nursing, complement the medical care services to the physician.'[183]

Community-Hospital Liaison Programmes

In Canada, specialists and family physicians admit patients to hospitals. To improve continuity of care, various types of hospital-community liaison programmes have developed. Administrative arrangements vary from one hospital to another but the goal is to ensure that people needing the nursing services on discharge are referred to the proper resources – community health nurses, visiting nurses, home care service or other community and social agencies.

A 'liaison' nurse works with a group of physicians or in a hospital to accept referrals. For the provision of public health nursing, she refers patients or families to the health unit's public health nurse working in the district where the patient lives. Information from the district nurse is then directed to the medical practice or the hospital through the liaison nurse.

In the City of Toronto, hospital health services have for many years, provided liaison between hospital and the community. Public health nurses sometimes visit homes directly, but in most situations the patient is referred to the nurse assigned to the district where he lives.

In London, our public health nurses are assigned to hospital-community liaison functions in the paediatric hospital and the three general hospitals. The psychiatric hospital and the Children's Psychiatric Research Institute employ their own public health nurses to carry out the same functions.

Across Ontario, in addition to hospital-community liaison nurses, home care coordinators who are community health nurses employed by the health unit or by the VON, are assigned to the major hospitals to provide liaison for home care programmes.

Multidisciplinary Teams

In Middlesex-London District Health Unit, we have joined in an experiment to attach public health nurses to a team of health and welfare personnel who serve one geographic area. The team includes a social worker and community school leader.

The unit is presently negotiating with a similar group of professionals under the leadership of the Family and Children's Services of London and Middlesex to develop another model for delivery of social and health services to a community.

Another example of interdependent professional working arrangements has developed in the Borough of Scarborough Health Department where a public health nurse is attached to a group of physiotherapists.

Conclusion

Nursing management exists to ensure the delivery of nursing services to individuals, families and groups in the community. In primary health care, the organisation of a health care delivery system must assist health professionals to work interdependently to the benefit of the community they serve.

13 The Changing Role of Nurses in Management in England*

by Anne M W White
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and W A Lloyd
area nursing officer
Hereford and Worcester Area Health Authority

Unknown to most of its patients, the British National Health Service has undergone the biggest administrative shake-up since it started in 1948. From 1 April 1974 the three previously separated branches of the service – hospital, family doctor and public health – were brought together in one integrated service. Collaboration machinery has been set up to deal with those aspects which remain the responsibility of local government, notably personal social services and environmental health. Figure 3 (overleaf) shows some of the committee structure of the reorganised NHS and its relationship to the local authority services.

To patients in the waiting rooms and the wards, the new administrative structure means little more than an ultimate promise that the health needs of all geographical areas in the country will be better appreciated and better planned.

Inside the service we can expect this upheaval to reverberate for a number of years. To many of the 800,000 staff involved, the whole complex operation is already looking like a bureaucratic nightmare.† Even the Department of Health and Social Security would not deny that the exercise has been a serious drain on morale in a labour-intensive organisation which is subject to uncoordinated demand. This major change also had to be undertaken within an unacceptably short timetable, with almost no extra resources and in the face of increasing militancy amongst health service staff.

*This paper is a distillation of papers prepared by five small study groups of senior nurses in hospitals in Liverpool.

†Figure obtained from the Office of Health Economics, 1972.

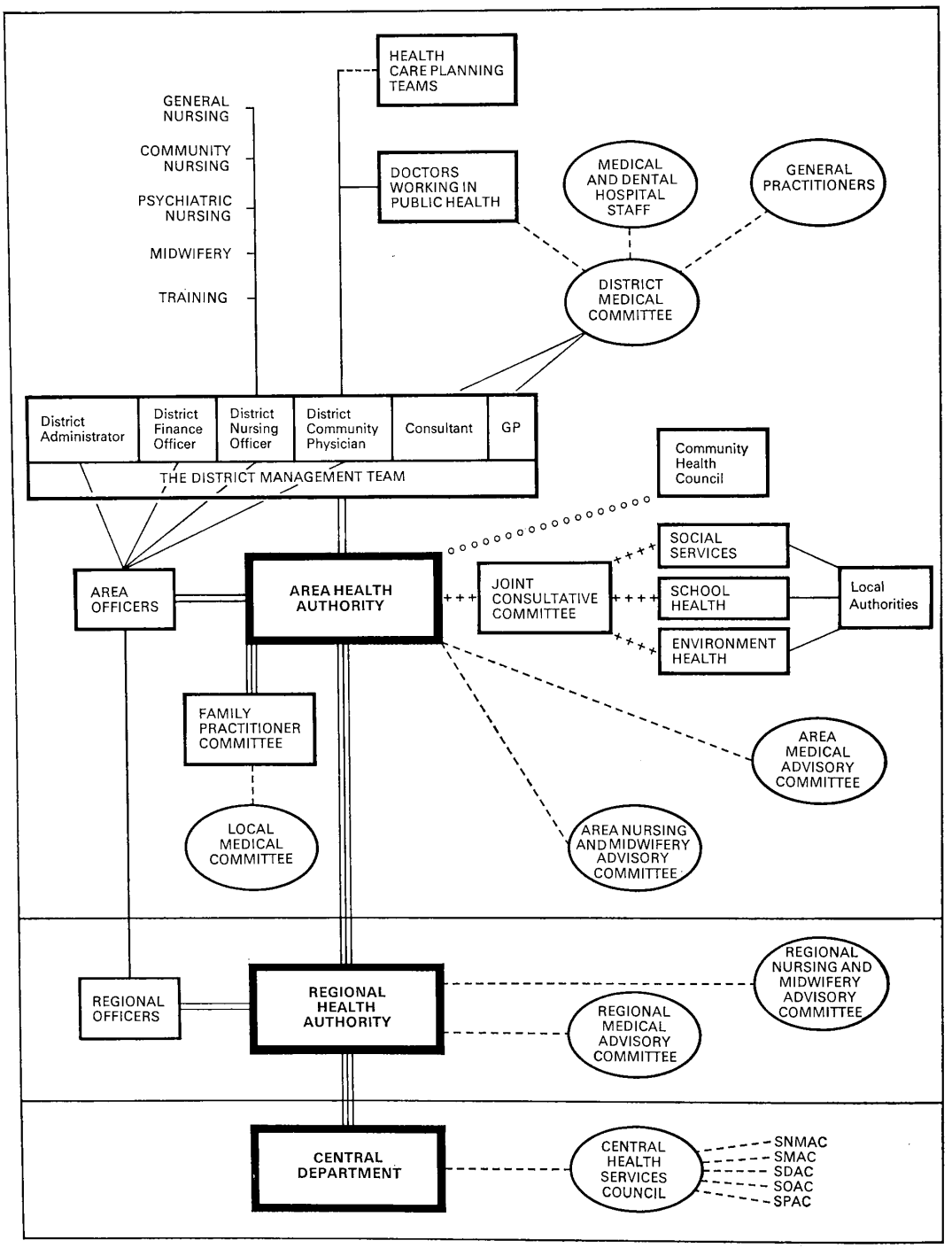
In theory, reorganisation should not adversely affect the standard of patient care; but in practice, the extent of the changes and the turnover of personnel are likely to have some impact – probably not always beneficial. The acid test of the reorganised service is not whether its administrative systems are more or less acceptable, or work better, but whether those systems are such as to allow better care to be given more readily to anyone who needs it.

We have no method of measuring the effectiveness of the service previously provided and no real hope of discovering a method which will make comparisons possible. Acceptance of the whole package is, therefore, an act of faith, with the pay-off, if there is to be one, very much in the future.

Intelligently interpreted and sensitively implemented, it provides us with an opportunity, perhaps no more than that. As with all blueprints, the working model will depend very much on the goodwill, enthusiasm and performance of the people involved, particularly those who manage the service.

This managerial revolution is likely to be less difficult for the nurses than for the other disciplines. The Salmon[82] and Mayston[79] reports gave the nursing profession the opportunity to scrutinise its management personnel and training arrangements over the last six years. In effect, below district nursing officer level the reorganisation of nursing management will take the form of a fusion of the Salmon and Mayston structures, and will allow for local flexibility and phased progression by the use of interim structures, leading eventually to complete integration of hospital and community nursing services. The nursing service has gained considerable experience, during the implementation of Salmon and Mayston, of the problems of

FIGURE 3 SOME OF THE COMMITTEE STRUCTURE OF THE REORGANISED NATIONAL HEALTH SERVICE



Source: adapted from *Health Trends,* 1974, Volume 6

Note: The authors have included area and regional nursing and midwifery advisory committees, and the standing advisory committees of the Central Health Services Council, not originally included in the chart published in *Health Trends.*

restructuring, decentralisation, assimilation of staff to new posts and the necessary communications and training back-up services. This is likely to be valuable experience and gives nursing a clear organisational advantage.

No-one, it is assumed, could possibly disagree with the principle of an integrated health service which provides comprehensive care for each person in need. But most people can, and frequently do, disagree with some aspect of the arrangements for putting principles into practice. With jobs and a way of life threatened, it would be surprising if this were not so. The forebodings of chaos on 1 April 1974 were, in fact, unfounded and the service to the patient continues very much as before. What chaos there has been was, and is, wholly administrative, and it already seems reasonable to suppose that as uncertainties and anxieties are slowly and sometimes painfully resolved, the reality of integration will be seen in terms of opportunities for better care of patients.

We emphasise the importance of the multidisciplinary team, consensus decision-making and recognition of the nursing manager as an equal partner. The guidance document, HRC(73)3, *Management Arrangements for the Reorganised NHS*, refers to coordination by multidisciplinary teams –

> 'The Secretary of State will require RHAs* and AHAs† to establish small multi-disciplinary teams at District, Area and Region, on the lines described in the report (paragraphs 1.25 – 1.27). These teams will be jointly responsible for formulating plans for their Authority's services and for coordinating implementation of approved plans. Their members will also bring to the teams for decision matters for which individual accountability has not been clearly allocated or which significantly affect functions for which other members are responsible. Each team will have a chairman or coordinator, chosen by the team, subject to the approval of the Authority or appointed by the Authority after such consultation with the team as the Authority thinks fit.'[76]

The intention would seem to be that the line of command will pass from region to area authority and thence to officers of the district management team. The area team would have a staff rather than a line function. Area officers will advise the area health authority on matters of policy, prepare budgets for the approval of the area health authority, review district proposals and monitor the performance of the district management team. Yet they will have no power to direct or issue instructions nor will the district officers be accountable to them.

That then, is the theory. But is that the way such matters are settled in real life?

Will this relationship between the teams impose insupportable strains upon individual human beings? Will the relationship reshape itself into the more familiar relationship of superior to subordinate? Or will it develop into the more difficult relationship of mutual trust and helpfulness? Whatever the outcome, it is certain that there will be a period of uncertainty.

There may even be a certain amount of jockeying for position with less than objective assessments of the manner in which teams should 'gel' together and the quality of working relationships developed between the teams.

The district management team replaces a hospital management committee of appointed, mostly lay, members and a local government health committee of elected lay members. We now have a team of professionals with the responsibility of providing health care for a local population of 250,000 or thereabouts, within the limits of a budget and policy constraints delegated by the area health authority. The team will also be expected to answer, through community health councils, public questions and criticisms about the level and standard of that service.

Several thousand staff responsible to the district management team, particularly the prescribers and the providers of service, will undoubtedly continue to expect from 'them', 'management' or 'the administration', the provision of adequate resources to enable them to provide their professional skills and an efficiently coordinated organisation to bring those resources to them when needed. In the reorganised service, as never before, 'them', 'management' or 'the administration', is a nurse! A nurse who, on the one hand, controls all the nursing services in a district with perhaps several thousand staff and who, on the other hand, has an equal voice in the consensus decision-making about choice options and the distribution of health care provision. The two responsibilities will be increasingly difficult to handle – may even be incompatible. They will certainly require management education and skills of the highest order, and will present the district nursing officer with problems of identification within her own profession. It is indeed asking a good deal of the district nursing officer to be a service manager heading a large, complex, staffed organisation using modern management techniques, and at the same time to understand and use techniques associated with group dynamics

*Regional health authorities
†Area health authorities

in order to contribute to consensus decisions in the district management team. She will also require to maintain an informed interest in the whole broad spectrum of health care.

These functions will be undertaken very much in public and under extreme pressures – shortage of staff, uncoordinated public and medical demand, unrealistic expectations, industrial disputes, militancy and shortage of money. The district nursing officer may on occasions, faced with an enthusiastic team bent on innovation, be seen as a restricting element if she has to deny a staffing redeployment because of her much wider total staffing and training commitment.

The National Health Service in 1974-5 had a spend in excess of three and a quarter thousand million pounds, with 75 per cent going to hospitals and 25 per cent to community health services. The intention is to redress the balance, and the district nursing officer will be under pressure to bring about changes in the deployment of the nursing labour force which may not be possible for many years.

There is a long-standing division between hospital and community nursing services in which different sets of skills and different career structures have developed.

To what extent can they be combined? Is there a core of knowledge common to both? Is there a danger of nursing falling into the trap of developing only a generic concept?

It seems reasonable to suppose that reorganisation of nursing education will reverse the trend towards complicated, piecemeal patterns of hospital-based training which fail to produce a nurse capable of understanding the environment from which the patient goes to hospital and to which he returns. Future training will extend to the patient's home and will also need to make a meaningful contribution to the management development of the ward or community care sister.

'Maximum delegation downwards matched by accountability upwards' is the phrase which embodies the whole philosophy of the reorganisation of the National Health Service. The nurse administrator can delegate downwards to the sister, but it is her ability to manage effectively the resources provided which will ultimately determine the quality of nursing care given to the patient. The district nursing officer will have to balance these factors in a rapidly developing situation.

There is an abundance of evidence that the real and most important problem is that of demand outstripping supply not only in terms of money to pay for facilities but much more significantly in terms of pairs of hands, particularly pairs of trained hands, to do the work.

Allocation of the nursing resource has, up to the present, generally followed medical prescription or medical demand. It is now likely that decisions to expand services or start new ones will be consensus decisions made against the background of availability of staff, with the district nursing officer playing a major role.

To the internationally accepted reasons for a shortfall of nursing manpower must be added a new one for the district nursing officer, and that is the need to restructure nursing to allow for the phased introduction of an educational system on the lines suggested by the Briggs report[83] in order to achieve, eventually, integration at clinical level.

Will the short term sacrifices be acceptable to the nurses, to the doctors, to the public? Will they be understood by the doctors and by the public?

There will be major problems of role definition. If job descriptions are too detailed and too strongly emphasised there will be a danger of achieving minimal standards only, with a consequent restriction of innovation. Innovation will clearly be necessary and desirable in the reorganised service and nurse managers will increasingly have to deal with the managerial aspects of innovation, personal growth and development.

The challenge of the reorganised National Health Service must be the getting together of the health professions, supported by management, to achieve the best possible deployment of resources.

Some cherished illusions about the rights, duties and privileges of some professions, including nursing, are bound to be brought into question. Nurse managers are now placed in a very powerful position to influence not only the future of their own profession but also the provision of health care to the nation.

14 Management in Community Nursing Services

by Eva M Reese
executive director
Visiting Nurse Service of New York

This paper is based on the premise that a community nursing service, under whatever sponsorship, must offer a range of services broad enough to permit people a true choice between care at home or in an institution. It also pre-supposes that home health services are best operated as an identified separate entity, closely aligned with ambulatory (clinic) health services, and quite distinct from hospital operation. Obviously, there can be an overall administrative umbrella, but the interests of patients and families seem to me to warrant separate identity when the patient is not in an institution. The paper confines itself largely to programmes for care of the sick.

Management of a multifaceted community service involves several different areas

programme determination

staffing and administrative structure

professional relationships

staff development

costs.

Programme Determination

Relatively few community nursing services provide a range of services wide enough to permit all patients for whom home health care would be appropriate actually to be cared for at home. Many agencies offer nursing plus one or two other services, most often home health aide service and/or physical therapy. The breadth of programme can be much more easily extended in a concentrated population than in very rural areas. And yet, if we believe that all people should have access to health services, ways must be found to achieve it. Most patients can be cared for at home if they have some or all of the following available: medical and nursing care, home health aide service, physical and speech therapy, social service, laboratory and x-ray services, equipment and supplies (including pharmaceuticals), and transportation. Many other services can, of course, be added to good advantage for many people, but the above will cover most needs.

The importance of having these resources available through one agency takes on real significance when one realises that the need for them comes at a time when most families are least able to cope with an uncoordinated structure of health care, and also that rendering quality service at home requires experience and orientation in assessing needs and adapting functions to the setting.

In our agency we have at least the beginnings of all these services, but at the moment laboratory and x-ray equipment and supplies and limited transportation are available only to those with certain insurance coverage. Direct medical service will be available through staff physicians in the near future, but policies and protocols have yet to be worked out in detail.

Programme determinations about the settings for service have led us to a considerable investment in clinic type services in housing projects and single room occupancy dwellings. These lend themselves to efficient use of time and to effective staff teamwork.

We project for our agency the development of the complete range of services described above to be

available on the basis of need to the entire community. Without this, we will continue to hospitalise people inappropriately, both from a humane and an economic viewpoint.

One of our problems has been a lack of recognition nationally of the need for well developed home health services. We have put our resources into hospitals and have failed to recognise that most people with long term health needs spend a very short time in hospitals.

As a result, we have very few people prepared by experience for managing a broad scope of home health services, and university courses in management are not geared to such preparation. As models are developed in service, it is necessary, I believe, that they be opened up for field experience to students in management courses. This should overcome to a large extent the double problems of limited managerial skill in home health services and the schools' disregard of home health services as a critical area of need.

Staffing and Administrative Structure

In our setting, the key service in home health care is nursing. No-one other than a nurse admits or discharges a patient or family. Other members of the staff may be called in by the nurse, but she or he remains the 'anchor' even though nursing may be a relatively inactive service in some situations for a period. A relatively high turnover of staff nurses (about one-third per year) means that supervisors must provide the nurses with a great deal of back-up in decision-making.

It is important, from a managerial standpoint, that the demographic, cultural and economic description be available for each area in order to create an appropriate staffing pattern. For example, the most problematic areas will need more social workers, whereas more home health aides seem to be required in the higher economic areas where families have moved away from their more elderly members. Each of our ten district centres has completed a staffing pattern which is considered appropriate to the needs of its population, and this pattern is used by the personnel office in hiring and assigning staff. The classifications of staff in district centres include

district director
one supervisor to eight or ten nurses
staff nurses
home health aides
social workers
speech and physical therapists (shared by two or more centres)
clerical staff.

There are about twelve family nurse practitioners assigned among several of the centres. One full time physician is now employed to make home visits for direct medical care upon request by the nurses to serve as a medical preceptor for our family nurse practitioners. For several months before he was appointed, we had a physician half time whom the staff could consult about medical problems, and who assisted us in interpreting the medical care plans of the visiting nurse service to the medical community. The physician carries the title of Director of Medical Services and will act as coordinator when we add to our medical staff.

With so varied and decentralised an operation we have given a great deal of thought to our administrative structure. We moved away from borough assignments for assistant directors and now operate on a programme basis. Each of the four assistant directors, however, wanted to maintain a direct line of responsibility for some district centres and these were chosen to coincide, in part at least, with the programme emphasis of the different centres. For instance, the assistant director responsible for home health aide service is assigned the centres with the most home health aides (see Figure 4).

The assistant directors have regular meetings in which the areas of responsibility and plans of each member are discussed, particularly in relation to changes and improvements. These may be modified by the group. The assistant directors also meet the director of social work, director of medical service and others as appropriate. They have regular meetings with the executive director and associate executive director to review plans and progress. Often final decisions about the programme are made at these sessions if they involve significant changes. In general, the associate executive director assumes senior administrative responsibility for district centre programmes and operation, and the executive director collaborates on these when necessary. The executive director assumes senior administrative responsibility for other areas of the agency, that is board and committee relationships, fund-raising, finance, data-processing, public relations, and statistics and studies.

Our largest problem in the administrative structure is that our programme is changing – and promises to change much more if national health insurance is enacted. It is difficult to say whether our present structure is flexible enough to accommodate to all the changes that may arise.

Professional Relationships

It is, after all, only about ten years ago when, for direct services, our agency employed only nurses and a few physical therapists. Even the physical therapists worked from the beginning more as consultants to the nurses than in a direct capacity. Enlarging the variety of people going into the home

FIGURE 4 VISITING NURSE SERVICE OF NEW YORK: ASSISTANT DIRECTORS' ASSIGNMENTS

RESPONSIBILITY	Miss T	Mrs G	Mr N	Mrs S
	maternal-child health and day care centers	home visits — care of sick	home care program	residence facilities
	home health aides/ housekeepers	coordination of inservice education and orientation	hospital and ambulatory care programs	medical services
SERVICE AREAS	coordination with social workers	supervisors' coordination and development	special services unit	family nurse practitioners and clinical specialists
	business staff coordination and development		district directors coordination and development	therapists
				records
LIAISON	public relations department	personnel department		data processing department
COMMITTEES	public relations	personnel education	field practice professional advisory	medical advisory
DISTRICT CENTERS	Lower Manhattan East Manhattan South Bronx	Northwest Manhattan Corona-Flushing	Astoria Jamaica Richmond Hill	Northwest Bronx East Bronx

requires caution on two counts. First, families must be protected from fragmentation of service; and second, the various workers must confer and agree upon a plan of care and then each must fit his role into that plan. It is understandable that this is not always a smooth process. When there are signs of difficulty we have had quite good success from the use of task forces or committees, made up of representatives of the services involved, to clarify policy, for example, with nurses and social workers, with family nurse practitioners and assistant directors, and with staff nurses of two different levels (baccalaureate and diploma graduates). Because of the consistently high motivation of the staff toward serving families well, we are fortunate that relatively few interprofessional misunderstandings occur. The nursing staff have on the whole been enthusiastic about the addition of each new service, and this had made for a smoother introduction of new workers than might have been expected.

As services continue to be added, it will be more difficult for the nurse to function effectively as the 'anchor' who initiates and coordinates services. We have thus set up a special services unit to handle all requests from the nursing staff for home health aide placements of four hours or more, and also the requests for laboratory, x-ray, transportation, equipment and supplies, and pharmaceuticals. All these, except home health aide service, are available to a very limited number of our patients, but we believe the system is capable of satisfactory expansion. The nurse simply calls the special services unit with her requests, and the unit places the order for service through agencies with whom we contract. The nurse in the home checks for satisfactory compliance on her next visit and calls the unit if there is a problem. When the service is no longer needed, the nurse tells the unit, and the unit takes care of the billing forms.

We expect to handle billing for medical care through the unit, because several district centres may be involved in the services of one physician, and centralised billing will be more efficient.

It may be necessary to develop other ways of relieving field staff of detail work and to provide more direct clerical assistance if service is to remain of high quality. It is certain that skilled professionals must concentrate on their service to families if they are to find satisfaction in their work and avoid unwise shifting of responsibility from one worker to another in response to undue pressure.

Staff Development

At the beginning of employment a good deal of time must be spent with all recruits in orientation to the programme, purposes and policies of the agency. Beyond this are separate ongoing education programmes for each group. These are not evenly developed yet, and our education staff is upgrading

or revising many of them. Because of staff turnover, the easy thing to do is concentrate on new people, but we are making a conscious effort to provide continuing education opportunities for staff who stay with us.

Family nurse practitioners have used their skills to teach other nurses during joint home visits or in group discussions in district centres. They, in turn, need medical preceptors to develop and sharpen their effectiveness in physical assessment and patient-care management. These preceptors have been available in various hospital clinics and we will in future use our own staff physicians as well. The family nurse practitioners have been quite wary of assignments that involve them in teaching others at the expense of carrying out direct patient care. Compromises have been made, and our education staff is careful not to make too heavy demands on them for teaching.

A very real need in our agency is for the development of a more effective management programme for district directors and supervisors. Work is underway to accomplish this; it is crucial to the success of a multifaceted service programme.

The issue of proper apportionment of time for education in a service agency is forever with us. There is now some agreement that education programmes need to provide more practical experience and a better basis for the nurse entering the 'real world' as a professional. I hope improvements will occur in this direction, but it will always be incumbent on the employing agency to invest a considerable amount in inservice education, if for no other reason than that technical and scientific advances alter our work and its setting. We can only meet this challenge through constant review of our inservice programme with revision or abrupt change as indicated.

Costs

Home health services have historically been touted as a cheaper solution – cheaper, that is, than institutional care. It is indeed cheaper to send a patient home from hospital with few or no services, but if an adequate array of service is brought to bear, we do not really know if home care *is* cheaper. Every indication is that when home health services are used judiciously and with proper surveillance, the cost will be less over a period for a fair sample of people. If all patients were to require 24-hour care and all the available services, cost would soar.

Our gaps in cost data are largely due to the limited availability of services that are needed for home care and the lack of full data on expenses. No complete study has been done which includes optimum use of services and full cost data that encompass home maintenance, food, clothing, and so on.

With a government grant recently approved, we propose to provide the full range of services to 200 families in one of our areas, regardless of ability to pay, and patients may be any age over 20 years. The plan is to gather complete data of the cost of maintaining this sample of patients at home. We believe this will be important to legislators in their considerations for coverage under national health insurance, and it will be useful in operating agencies as well.

15 The Relevance of Multidisciplinary Education in the Health Care Team

by Margaret Scott Wright
professor of nursing studies
University of Edinburgh

Written in consultation with Lisbeth Hockey, director, nursing studies research unit, Winifred Logan, senior lecturer, and Agnes Jarvis, lecturer, of the department of nursing studies, University of Edinburgh.

The term 'multidisciplinary education' is used in this paper to embrace all the major health service disciplines, and is concerned with the concept of medical, nursing, social work and other paramedical students being able to learn together at the basic and post-basic levels. Emphasis is also placed on the position of nurses in this complex situation, as participation in the multidisciplinary process is especially difficult for them.

Although multidisciplinary education is becoming necessary to the delivery of health care, little more than lip service has been paid to it so far. Undoubtedly the reason for this has been the reluctance of the professions to put the patient or client into the middle of the arena rather than on the periphery. Sometimes he appears even at the bottom of the hierarchical charts illustrating the functioning of the health services. To centralise his position as a vital part of the health care process would necessitate nothing less than a revolution in the thinking and attitudes of the professions.

It is becoming clear that no one health service discipline can provide all the knowledge or resources required. The input of the different professions involved in each case varies considerably and often fluctuates during the provision of care for the individual client.

Thus the need for students of the various professions to participate in some common learning processes in order to appreciate the specific contribution which can be made by each of them, and to avoid wasteful overlap of expertise, is irrefutable.

Commenting on experience with students at the Medical Center of San Francisco University, who participated in multidisciplinary clinical learning, Hester Kenneth says

> 'As they explored and developed the dimensions of their independent, dependent and interdependent roles with student physicians, the nursing students identified areas in which they could contribute to the quality of patient care and approaches to working collaboratively with the medical students. They learned to improve the effectiveness of their communication patterns, to share their ideas and to plan for patient and family care, and to present data in a way that was meaningful and useful to the physician. Of critical importance, each group of students was exposed in some depth to the professional perspectives of the other.'[106]

Another important argument for multidisciplinary education seems to be that, in the long run, it would ensure better use of human and natural resources which will become more rather than less costly. On many campuses there must be a great waste of effort and time by faculty teaching similar material to separate groups of health service students; and many laboratory and clinical facilities must likewise be misused. The teachers in these programmes must, of necessity, be highly qualified and their preparation costly. It also seems to follow that, if involved in multidisciplinary education the staff of one profession would learn to think about the work and contribution being made by the others. A feeling of 'togetherness' rather than of 'separateness' should be engendered amongst them which would be transferred to the students.

Leininger has stated

> 'In some educational settings there are signs of growing interprofessional competition, stresses and "one-upmanship" tendencies among

professional groups. Some of this behaviour shows a lack of understanding and respect for different health disciplines, and often reflects a threat in power relationships of some disciplines trying to control another.'[120]

In many western countries there is vigorous argument about the need to create new health team professions, such as physicians' assistants; and in some countries such new groups of personnel are already in post. Some cogent arguments are made by the medical profession for these new personnel; but it is most probable that such developments would lead to further fragmentation of patient care and waste of human resources.

Leininger also said

'I actually question if there is a shortage of health manpower. Rather I would attribute the health crisis to the inadequate utilization and distribution of available health talent. This explanation of our health dilemma has not been faced squarely by health leaders. Instead they tend to focus on preparing an increased number of new kinds of health personnel with new labels and new role descriptions that are not entirely new or highly innovative, once one realised the full role capabilities and potentials of health disciplines.'

Moreover, if multidisciplinary education is to progress, it must be seen as a cooperative venture by all concerned. But cooperation means more than the contribution of people, money and facilities.

It means the acceptance of the new interdisciplinary relationships in the health care team. This point is made by Yeaworth and Mims.

'In our society the various health disciplines typically have not had a collegial relationship. Medicine has served as the model of the professionalization which the other vocations and semi-professions are attempting to attain.

'Medicine can claim a body of knowledge and theory which is generally accepted as the crucial distinction between a profession and a non-profession . . . It is not surprising, therefore, that a study of psychiatrists, clinical psychologists and social workers revealed that members of adjunct professions who are in low power are eager for more contacts with psychiatrists. On the other hand persons who have high prestige within their own professions, and whose professions have high prestige, are drawn into closer association with their own groups and wish to have few contacts with persons in other relevant professions.'[189]

So, although the multidisciplinary approach may appear advantageous for some of the health team professions, it is by no means certain that it will be attractive to them all. Hildegard Peplau's comments on the disadvantageous position of the nursing profession spring to mind.

'There is a tendency today in almost all literature on health affairs – professional and public reports alike – to see medical care as synonymous with patient or health care. This is the older "pyramid" concept in which medicine sits at the apex and all other disciplines in the health field are distributed towards the base of the pyramid. Nursing being the largest group . . . is usually placed at the bottom of the base in a status orientated rank-ordering within the pyramid.'[150]

If multidisciplinary education is to become an effective factor in preparing health service workers it pre-supposes the existence of an identifiable body of knowledge for each of the disciplines involved. And so if nurses aspire to some involvement in this learning process, they must have the assurance that they can make a specific contribution to patient care related to their own particular expertise.

It is not the purpose of this paper to examine in detail the sensitive matter of how far nursing role and function have been precisely established, or the pros and cons of all that has been written on this issue. That there is some activity, entitled 'nursing', undertaken by one group of health workers which does not seem to be the concern of any of the others, cannot be disputed. One of the clearest and most precise definitions of the nursing function is the one offered by Virginia Henderson.[96] Implied in her writings is the thesis that nursing in its wide spectrum of activity and levels of funtion, must depend on its own use of various behavioural, physiological and biological sciences, to evolve as an applied science. Thus the practice of nursing, like that of other health service professions, is related to some identifiable and unique knowledge, even if that knowledge remains less developed than it should be. Nurses, like doctors, must be confident of their role and take it for granted.

Multidisciplinary education in the health professions is not only dependent upon a viable, applied science for each discipline involved. This form of education, if it is to be effective, must also come to grips with the inevitability of some overlapping between the groups concerned.

As scientific knowledge increases, demographic changes occur, and socio-economic policies evolve, so must the health professions individually and collectively alter their own functions to meet new demands placed upon them by society. But such developments can only take place if each profession is aware of the role of its own practitioners and the knowledge they require to work effectively. A

pertinent comment is made on this by June Rothberg.

> 'The physician's assistant is the symptom of both medicine's and nursing's inability to define their individual roles, to respect each other's competencies, or to deliver an acceptable level of care.'[159]

The Present Position

One or two factors which seem to have encouraged the development of multidisciplinary courses can be identified. Firstly, when a profession such as nursing has become established in institutions of higher education over the years, there is some evidence of development of multidisciplinary activities. Secondly, it also seems that such programmes are likely to be established in those countries where universities and similar educational institutions are being newly set up. Thirdly, it is noticeable that, even in a country where various attempts have been made to provide multidisciplinary programmes, so far no one particular way of doing so has been evolved. Some programmes are provided at undergraduate level, others for personnel qualified in a specialty. There also seems to be a growing consensus that multidisciplinary courses are likely to be of value for the staff of primary care teams.[18,70]

A major difficulty in assessing the present situation is that probably much more action and discussion are going on than those officially documented, and it is quite likely that some of the most advanced ideas are not yet known. So far most multidisciplinary courses have been established in North America. They include the programmes begun at the Medical Center of San Francisco University (1966), at Laval University, Quebec (1967), University of Cincinnati (1972), School of Public Health and Tropical Medicine, Tulane University, Texas (1973), and McMaster University, Ontario.

Some progress is also being made in societies where facilities for higher education are being set up. The Hebrew University in Jerusalem has facilities for undergraduates of several health service disciplines to study and work together. In Ife University, Nigeria, the dean of the life sciences faculty is planning multidisciplinary courses for undergraduates of the health service professions. A programme of university education for nurses has been approved by the National Council of Universities in Venezuela, in which the schools of nursing will function in the faculties of health sciences of the national universities.

In Europe there is not much activity, presumably because many of the academic institutions training doctors are not available for nursing education, and there are few opportunities to establish new ones where interdisciplinary boundaries have not been precisely defined. In the United Kingdom, however, despite difficulties inherent in the educational system, interest has been shown in the multidisciplinary idea for a number of years. In 1967 the Malleson report was published on the work of a working party of doctors, educators and a nurse member, which was set up,

> 'To consider to what extent new patterns of medical education could encompass the education and training of health service personnel other than doctors; in particular to consider the education of scientists in fields related to medicine and the training of laboratory workers, nurses, social workers, hospital and health service administrators and counsellors of different types.'[101]

One of its main conclusions was that the 'greater medical profession' would provide a more efficient service if the 'initial and continuing education' of health service personnel was organised in a more 'common framework' than existed at that time.

Another major recommendation was that a 'common core' two-year course in human biology should be available to students of the various health service professions before they specialised. This idea has been put into effect in the human biology course provided on a multidisciplinary basis at the University of Surrey. One or two opportunities for postgraduate study for doctors, nurses and certain other health service workers with adequate academic qualifications are being provided in new courses for specialists in epidemiology and health education at Manchester and Glasgow universities. At Liverpool University, a new school of community health studies has been established in the faculty of medicine. Courses have included doctors, nurses, laboratory workers, public health officials and others preparing for the certificate in tropical community medicine.

> 'The exchange of news, sharing of experience and development of understanding each others' roles have produced a quite remarkable new level of practical attainment, knowledge and enthusiasm which can only lead to better services in the worldwide areas where these graduates have gone to practise.'[91]

Arrangements are now being made to convert this course into a master's degree programme in community health which will continue to be available to students of various health service professions.

At the informal level there is also increasing opportunity in Britain for students of medicine, nursing and other related disciplines to attend certain clinic sessions where they observe and participate in some aspects of patient care in a multidisciplinary setting. This experience is giving them an awareness

of the functions of other health team members; it is new and full of hope for the future. In primary care, one or two experimental courses have been organised to bring together all the members of the team – doctors, nurses and social workers – for at least a few days to discuss their changing roles as health centres are being opened, and attachment schemes are being launched.

Some details about the organisation, objectives and evaluation of a course provided for a primary care team are given in *The Work of the Nursing Team in General Practice.*[70]

Another multidisciplinary group of health team personnel in various academic departments, together with divinity and law students, at the University of Edinburgh, have been discussing contemporary professional identities, their responsibility to clients and society, and their role as agents in social change. This is a notable development in an institution which has a wide range of faculties and departments representing all the major caring professions, but where, in the setting of an ancient academic institution, it is far from easy to envisage ways of crossing traditional and carefully defined disciplinary boundaries.

In the past year or two, the National Association of Health Students became vocal on the need for closer cooperation amongst students.* The association's main function was to bring together students who will have to work closely as professional members of the health team. This movement also indicates the students' desire for a common policy for their education and welfare.

Problems to Overcome

The major problems are not difficult to define. The first is the great difference between size and educational homogeneity of the medical profession and the wide variations of talent and ability in the nursing profession which prevail in most countries of the world.

Unless the two principal professions in the care team are going to develop some form of learning together, the concept of multidisciplinary education can be forgotten. There is no need here to compare in detail the privileged position of medical education and the various forms of on-the-job or apprenticeship training which are still considered desirable and satisfactory for nearly all entrants into nursing. How is this wide gap in educational privilege and facilities to be overcome so that multidisciplinary education can develop? For this method of education implies not only the need for students of similar ability and quality, but also for staff and faculty who are able to work together in full partnership. It is difficult to comprehend how the latter is to be achieved when, in most countries, nursing remains educationally isolated from the main stream of general and higher education.

The second major problem, contingent on the first, is that people in all societies regard nurses as ancillary helpers of the medical profession. In any broadcast or public debate about health care and services, reference is almost invariably made to *medical* services and opinion. The development of a multidisciplinary approach to health service education would necessitate greater recognition of nursing and the paramedical professions. And, since it will mean spending a great deal of money, until there is such a change in attitudes, financial assistance from the public is not likely to be forthcoming.

Thirdly, and most important of all, any formally organised multidisciplinary education for medical students and small numbers of students from the other health service disciplines would require the full approval and agreement of doctors. Is there any good reason why the medical profession, enjoying its present privileged status, should wish to alter the situation? Yeaworth and Mims in their paper *Interdisciplinary Education as an Influence System*[189], and Rothburg, in *Nurse and Physician's Assistant: Issues and Relationships*[159], make this point.

Not all doctors would agree that no changes are needed in the working relationships of the health professions. Some, by both words and deeds, realise that changes must be made in the interprofessional partnership and learning required to provide the best patient care. These doctors include the members of the working party which reported in 1967[101], and the medical members of the discussion group on interprofessional cooperation amongst primary care team workers in 1972.[18] But it is safe to predict that a considerable change in medical attitudes will be needed before any real progress can be achieved; and attitudinal change is the most difficult of all to achieve.

Another identifiable range of questions would emerge if multidisciplinary education were to become a serious proposition.

What depth and breadth of knowledge can profitably be shared?

When, and at what stage in the learning process should it be taught (undergraduate, professional and/or postgraduate or all)?

Who should teach what?

Where would the resources and facilities come from?

*The association has now merged with the health student sector of the National Union of Students.

So far, the only direct information in answer to these questions comes from the few experiments in various countries and among various categories of students.

An additional complicating factor emerges periodically to confuse the main principles of multidisciplinary education. There is considerable discussion about, and support for, the establishment of multidisciplinary education among nurses and the paramedical professions. But too little is known so far about the detailed contribution made to such courses or the costing of them by the professions involved. The Briggs report on nursing supported the idea.[83] The new University Hospital of Wales provides multidisciplinary teaching for a wide range of paramedical professions, including nursing and occupational therapy.[126] Other similar experiments are being undertaken elsewhere in Britain. These experiments in making greater use of scarce staff and resources, and bringing students together at the formative stage in their careers, are certain to offer many advantages. They should not be equated, however, with multidisciplinary education in the complete sense which must always imply the inclusion of medical students. Indeed, it is conceivable that the exclusion of medical students from interdisciplinary education could ultimately be of considerable disadvantage to the principal objective, the improvement of patient care. Any sharp division which could thus develop between medical and paramedical education would be potentially more dangerous than the present situation.

Possible Solutions

A crucial requirement for progress is the belief by the participants – teachers and students of all professions – in the equality of their positions and the importance of their contribution to the care of patients. For nurses involved in multidisciplinary care, even if so far relatively few in number, it will be essential to be confident about the validity of the professional position and practice. As Mussallem has said,

> 'Surely we can safely assume that our professional status is now secure.'[141]

The medical profession certainly does not waste time arguing its *raison d'être*. Doctors persistently and diligently expound the activities they have appropriated to themselves – diagnosis and prescription – which they have justified by the continuous use of research. Moreover, as much of their research is biomedically based, it is directed to the immediate improvement of patient care, and so the process of implementing findings is immediate and the impact clear to both the profession and the public.

The lesson to be learned from the medical model is for nurses to maintain, augment and implement similar research procedures applicable to their profession, and to ensure that, if they are to have direct impact on better patient care, the findings are acted upon. It seems unlikely that such investigations undertaken separately by the professions can remain separate for long, because of the interrelatedness of their functions. Logically, it would seem that there must be multidisciplinary research as well as multidisciplinary education. This has been recognised at the highest official level in the UK by the establishment of the new machinery of the Chief Scientist Committees for England and Wales and for Scotland. Major decisions on priorities, and on findings of both biomedical and health services research, are being taken by medical and nursing personnel together with biological and behavioural scientists.

Nevertheless, despite these happenings in research, the establishment of multidisciplinary education will only be brought about by the solution of some of the major problems identified above. Bearing these in mind and taking a pragmatic approach, it seems most likely that progress will best be achieved by what might be called the 'oblique' or 'indirect' approach; that is, by bringing about changes in attitudes and by a system of gradualness. The mechanism of change must be invoked, and in such complex and untrodden paths it is never successful if suddenly or precipitately imposed from above and outside.

Those experts in the phenomenon of change, Benne, Bennis and Chin, indicate certain principles which must be employed to achieve it successfully. Firstly, all concerned in the change operation must be involved. Secondly, those to be affected by the change should appreciate the benefits to be achieved by it. Thirdly, those responsible for the change should ensure that the burdens borne by participants will not be pointlessly increased.[17]

These principles have immediate relevance to this discussion. One particular aspect merits comment. If the multidisciplinary participants in the process of change are to appreciate the benefits accruing from it, there is no doubt that the impact will be of a functional rather than a theoretical nature. In other words, the only way to proceed is by making plans for a new method of delivering patient care with the commonly-perceived objective of bringing about some improvement in it. As in other spheres of operation, not least the political, pragmatic functional programmes usually have to precede the more formal theoretical advances. There are many historical precedents for such development, but two approximate examples are the establishment of the Tennessee Valley Authority and the European Economic Community.

To come back to the health professions, it follows

that the need for multidisciplinary education will become most apparent where the various professions find themselves working together to achieve a common objective for patients. They will then become aware of the need to share knowledge, and also of their distinctive areas of expertise. As Hall-Turner has said,

> 'Perhaps the greater influence on changing attitudes is the inevitable infiltration into practice of young doctors, new nurses and others who have learned about or experienced the team approach, whose ideals have not yet been crushed, whose attitudes have not been hardened into rigid channels parallel to but never quite touching . . .'[91]

For instance, the recent *ad hoc* establishment of multidisciplinary primary and other health care teams has highlighted the need for the various professions to learn together and to learn about each other.[70] In intensive therapy units, the proximity of the professional workers with common goals provides another example in which shared learning takes place effortlessly because the professions concerned are interdependent in achieving their goals.

Similarly, the reorganised British health service, which leaves the major responsibility for decision-making in the hands of executive multidisciplinary teams of doctors, nurses, administrators, treasurers, dentists and pharmacists, highlights another vital area for multidisciplinary preparation. There is already quite a number of courses which members of these various professions can attend together. In all these instances, qualified personnel who are working together, and are responsible for initiating health care plans, seem to find little difficulty in adjusting to these new educational processes. But these groups are only a minority, usually an enlightened one, of each profession involved. These beginnings are small, but they are based on a firm functional basis. They are thus one certain growth point for the multidisciplinary approach to health service education.

Another recent development is the appointment of nurse educators and others to the academic staff of universities on the same basis as their medical colleagues. Although it does not automatically follow that multidisciplinary educational programmes or projects will be undertaken in all these situations, the possibility of such progress is inevitably much greater and more likely. In the older established institutions, change from single to multidisciplinary education can be difficult and laborious because of the inevitable institutional rigidity. However, even in these circumstances, there have been some examples of shared learning on a limited basis. Many undergraduate programmes for nurses, both in this country and abroad, have been established within medical faculties and with the positive support of medical staff.

Not surprisingly, on new campuses where the academic structure remains flexible, the establishment of so-called 'life and health science' faculties is a notable development. Despite many problems in this complex area of activity, which still have to be overcome, the multidisciplinary approach to learning is felt to be desirable to meet present day needs.

There are also signs, especially in Britain, that health team students themselves, both inside and outside the universities, increasingly favour a new relationship amongst themselves which, if achieved, would cut right across the entrenched status consciousness of the various professions.

> 'No comprehensive health service can be provided until all health students are prepared to discard their professional positions and form a united movement of equals which will protect the interests of all health students and meet the country's demands for a better system of health care.'[135]

With such views, multidisciplinary education becomes inevitable.

All these examples have common ingredients for achieving positive change. As more nurses and others are prepared to work as equal partners in the health team, as more students of nursing are able to enjoy education institutions of higher education, so will the optimum use be made of all the talents of the team. Because the objective is sophisticated and complex, there will be some disappointing results and perhaps failures along the way, but in the long run multidisciplinary education must succeed in providing better and more economical care of patients. The economic factor has become of greater importance to both developing and developed societies.

Another important principle upon which evolution towards the multidisciplinary approach will depend is 'gradualness'. The nature of the process, the involvement of different professions at varying levels of education, the entrenched hierarchical positions already assumed within and between them, mean that development cannot be forced at too great a pace. Nor can a specific method be prescribed. In fact the impetus to move towards multidisciplinary education may come from different professions at different times, according to local circumstances and the people available.

It is certain, however, that the most privileged group in the health care team has not only the most to give but the most to lose in any such experience. The doctors will need greater persuasion than any of the other members to cooperate and share their rich educational heritage; and it can be predicted

with reasonable sureness that they will only be convinced of the need for change if they see it as useful to patients and themselves. It is imperative, therefore, to take every opportunity to provide short or longer courses for the multidisciplinary team whenever there is medical involvement in joint planning and execution of care.

As yet there is no specific evidence to indicate the most advantageous timing or length of multidisciplinary courses for health service personnel. Nevertheless, it would seem important to provide opportunities at undergraduate level when minds and attitudes are likely to be most flexible. The argument is also strong for using the multidisciplinary approach after the professionals have qualified, when they have experience to draw upon and feel some weight of responsibility for their actions. The other necessity is the inclusion of medical personnel or students, however difficult it may be to achieve.

At all levels in all settings, progress towards multidisciplinary education must be evolutionary and not be forced at a pace which cannot be absorbed. Any multidisciplinary educational experiments, whether successful or not, should cover a long enough period for the effect on the quality and quantity of care to be assessed, and any report of such experiments should be withheld until then. It is at this stage that the patient himself may be involved in evaluating the support and care he has received. Although it is unlikely that an experimental control situation could be devised, undoubtedly some estimate of client-satisfaction could be attempted. When this indicator becomes even slightly positive, the advantages of multidisciplinary education for the health team professionals will be apparent and its acceptance a *fait accompli.*

16 The Status of Continuing Education Programmes for Nurses in the United States

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The Need for Continuing Education

It is alarming to think that the knowledge one gains during formal education becomes obsolete within five to eight years; that the total body of human knowledge now doubles every 15 years.[71]

Such an explosion of information demands continual updating of an individual's knowledge and skills. Fortunately, innovation in teaching techniques and technological advances now make it possible to extend educational opportunities to more individuals. The extended university concept, for example, provides continuing education in areas removed from the educational setting. Moreover, technology has brought programmes via communication satellites, closed-circuit television, videotapes and individual instruction, to people in areas which lack local resources to develop such activities. Finally, the sheer increase in the level of education and the extent to which young adults have continued their education have created an inherent pressure toward more participation in adult learning activities. One recent estimate of the number of Americans involved in adult and continuing education each year was 25 million.

In health care, technology and science have advanced so rapidly that continued competence in the delivery of health care can only be assured through commitment to continued learning. It is estimated that within the past 15 years there have been more advances in methods of diagnosing and treating physical illnesses than had been made in the preceding 1500 years. The drugs, equipment and therapeutic procedures of the 1950s now seem old-fashioned. Cardiac surgery, coronary intensive care, kidney dialysis and similar activities were still in the research stage a few short years ago. Surgical transplants are becoming commonplace. Advances in the treatment of chronic, long-term illnesses are proceeding rapidly. Finally, as new knowledge about causes of illnesses has become widespread and people have been motivated to improve and maintain their personal health, preventive care has become increasingly important.[123] Greater awareness of the need for continuing education for all health professions is evident from the impetus given to such activities by professional associations, government agencies and various groups investigating educational and/or health related issues.

Coupled with technological and scientific advances has been the realisation of a crisis in the present health care system. Today we are plagued by rising costs of health care, maldistribution of health manpower, and inaccessibility of comprehensive health care services. New techniques for improving the effectiveness and efficiency of health personnel are essential if people's health needs are to be met. Continuing education as a means of maintaining professional competency is necessary for developing innovative approaches to health care.

If nurses are to assume an expanded role in the delivery of health care - rehabilitative, restorative and health maintenance services - they must actively seek ways to integrate new knowledge and skills in their practice. Not only is it important to alert nurses to the need to maintain continued competence, it is essential that the profession research and cultivate the most effective means of pursuing continuing education activities.

Continuing Education - Then and Now

Early efforts in continuing education in nursing were being made before the turn of the century,

more than 20 years after the first schools of nursing were founded in the United States in 1873. Yet development of such opportunities is still in an embryonic stage. As Signe Cooper pointed out

> 'The idea of continuing education in nursing is as old as organized nursing, but the concept of lifelong learning for the practitioner has developed slowly.'[53]

In the last three years, increased interest has been expressed in requiring evidence of continuing education for licensure renewal. Areas now enacting legislation of this nature, California for example, have uncovered several shortcomings

no accepted standard definition for continuing education

a need to prepare faculty to teach in organised continuing education programmes

lack of adequate physical and financial resources for continuing education

a problem of accrediting or approving suitable continuing education offerings

no effective means of evaluating continuing education activities

an urgent need for continuing education research.

Such practical problems have led many health professionals to attack any policy of mandatory continuing education on the grounds that such legislation would be premature and ill advised.

In addition to practical problems, certain philosophical considerations weaken the case for mandatory continuing education. As Signe Cooper says, 'It is not possible to legislate learning'.[50] Required participation in certain kinds of educational offerings will not assure learning, nor will it necessarily improve nursing practice. Rigid legal requirements do not allow for individual differences in learning. Learning must be relevant to the individual's need and readiness to learn. Furthermore, to require evidence of continuing education does not perpetuate the concept of learning as a continuous process. Once the requirements for licensure have been met, a tendency to discontinue learning activities until the next relicensure period could develop.

The American Nurses' Association neither encourages nor supports legislation to require evidence of continuing education as a condition for renewal of a licence to practice nursing. The ANA *does* encourage and support efforts to promote continued learning opportunities and to establish voluntary systems of recognition for individual nurses who participate.

ANA's position on continuing education for nurses is based on four premises of professional practice.

1 Continuing education is essential to continued competence.

2 Continued competence in practice is an individual responsibility.

3 The public holds the profession accountable for the competence of its practitioners.

4 The profession has the responsibility for establishing standards for continuing education activities and the climate and mechanism to facilitate continued learning by practitioners.

Early in 1974, ANA developed standards for continuing education in nursing in order to develop the proper climate and mechanisms to facilitate continued learning by nurse practitioners.[4] The association also issued continuing education guidelines in an effort to establish consistency in the approach to recognition of continuing education.[3] These standards and guidelines provide direction for the effective development of programme content, resources (faculty, financing, facilities), evaluation procedures and recognition of participation.

Content

Continuing education in nursing consists of planned learning experiences beyond a basic nursing educational programme. These experiences are designed to promote the development of knowledge, skills, and attitude for the enhancement of nursing practice. In planning any type of educational activity, certain steps must be followed.

1 Establish goals.

2 Decide upon specific objectives consistent with these goals.

3 Determine a plan of action to meet the specific objectives.

4 Assess available resources.

5 Establish a workable budget.

6 Evaluate the results.

7 Reassess the goals.[53]

A programme should be relevant to both the educational needs of nurse practitioners and the health needs of consumers. A programme planner must collaborate with other health professionals, nursing personnel, community agencies, and consumers, in identifying these needs.

When appropriate, an interdisciplinary approach to sponsoring, planning and implementing continuing education activities should be encouraged. Activities should be broader than merely those related to a specific job. They should include content of significance to the entire nursing profession and the health care field in general. An interdisciplinary approach explores ways in which nursing practice and the development of new nursing knowledge are related to other health groups and to consumers of health care, to improve the delivery of health care services.

Continuing education offerings should include more than organised formal courses. The Carnegie Commission on Higher Education in its report, *Toward a Learning Society*, observed that education is too often perceived as an activity that occurs only at certain times in people's lives, in certain few accepted formats, in certain institutional settings, and at certain times of the day.[39] Many non-traditional patterns of education are emerging. Continuing education activities should be implemented through a variety of formats and teaching methodologies.

There are various categories of continuing education programming, such as long and short courses, refresher courses, inservice education and self-directed learning. In addition to the more traditional teaching-learning assignments (case study, patient assessment, and so on), long and short courses may involve special telephone or radio hook-ups, simulation learning (role playing), correspondence instruction, computer-assisted instruction as well as conference and workshop participation.

The terms 'continuing education' and 'inservice education' are often used interchangeably. However, inservice education is only one aspect of continuing education. Inservice education is provided for personnel by the health care agency to enable the agency to fulfil its contractual agreement with the client. Or, as Marjorie Dunlap pointed out in her article, *Continuing Education Programs in Nursing: An Exploration*,

> 'Inservice training is viewed as being work orientated, whereas continuing education is related to the exploration of new ideas and new dimensions to improve the individual's professional competency, which ultimately will affect his professional field.'[62]

Employers of nurses must assume responsibility for facilitating participation of nurses in continuing education activities and programmes. Such participation should be viewed as extending beyond provision for inservice education programmes within the health care agency.[130]

In April this year, a federal administrative law judge ruled against the American Federation of Government Employees Union, thus setting a precedent benefiting the facilitation of continuing education in health care. The AFGE alleged that the action of the Veterans Administration Hospital in Salisbury, North Carolina, in permitting its nurses to attend a state nurses' association clinical workshop in VA time, amounted to an unfair labour practice under an executive order which became law during the Kennedy administration. The judge, in his final report on the case, stated that it was clear that the hospital was simply following a longstanding policy of permitting its nurses to attend worthwhile educational programmes when they could be spared, in an effort to enhance their ability to deliver patient care.[8]

The effectiveness of programming is also dependent upon the practitioners' planning for their own continuing education work. Individual nurses must learn how to select those activities most likely to meet their individual learning needs.

Resources — Faculty, Financing and Facilities

Characteristically, continuing education has been a part time activity for an overloaded faculty. Continuing education faculties are small compared with degree-oriented faculties. Support has been largely dependent upon registration fees and project grants. This type of funding tends to support isolated courses but does not provide for comprehensive programme development.

ANA has resolved to communicate the expectation that all schools of nursing develop innovative approaches to continuing education; that funds be sought from the widest variety of public and private sectors; that regional planning be encouraged to provide a broad spectrum of opportunities; and that graduate programmes be encouraged to develop new and innovative ways to assist faculties to continue their educational preparation.

All individuals with leadership responsibilities for continuing education programmes should be prepared at the graduate level and have expertise in adult education. Moreover, continuing education programmes for nurses should be developed under the direction of, and in collaboration with, nurses skilled in designing and implementing appropriate learning experiences.

The sponsoring agency should make provision for adequate funds to plan, conduct and evaluate the programme as well as provide facilities and resources appropriate to its content.

Evaluation

To date, evaluation is probably the weakest part

of many programmes. Yet it is an educational process which should be an integral part of the programme format, and an ongoing part of the administrative process of every continuing education activity. Plans for evaluation should begin during the initial stages so that it becomes a significant part of curriculum development rather than an afterthought. There are many reasons for evaluation; for example, to determine the degree to which programme objectives were met, to identify reasons for success or failure of the programme, and to improve future programmes.

Sponsoring agencies, learners and consumers of health services should collaborate in evaluating the effectiveness of the continuing education programme. Since continuing education is not oriented to levels of individual achievement, but rather to individual educational needs, the methods used to evaluate preparatory programmes have limited usefulness. There is an urgent need to research the most efficient methods of evaluating the effectiveness of continuing education programmes.

Recognition of Participation

Records should be maintained in a systematic manner, and be available upon request to the individual and accrediting body. The lack of any cumulative record of continuing education activities results in most programmes being built upon narrowly-defined educational objectives and the establishment of short term goals.

The ANA board of directors has adopted the recommendations of the National Task Force to Study the Feasibility and Implementation of a Uniform Unit for the Measurement of Non-Credit Continuing Education Programs to use the continuing education unit (CEU) as a unit of measurement for organised continuing education offerings.[145]

The CEU provides a uniform system for measuring, recording, reporting, accumulating, transferring and recognising participation in non-academic credit offerings. The CEU is defined as ten hours of participation in an organised continuing education experience under responsible sponsorship, capable direction and qualified instruction.

Utilisation of the CEU is not limited to the nursing profession. It provides producers and consumers of all types of continuing education programmes with a nationally-accepted means of recognition and reward for participation in non-credit activities. It applies equally well to all continuing education formats as long as there are a legitimate sponsor and a knowledgeable and responsible person associated with the organisation and implementation of the learning experience. Informal education carried on outside organised channels, and without recognisable sponsorship of instruction, does not lend itself to uniform measurement and CEUs must not be awarded. Such education, useful though it may be to the learner, includes selected and general reading, travel films, discussion groups, attendance at meetings, job entry orientation, work experience, organisational and committee membership, committee and social activities.[4]

Suggested applications of the CEU include

- continuing education offerings in technical and professional areas
- inservice education programmes to improve nursing competence
- courses or classes which may be used as a partial fulfilment of certification of licensing requirements
- programmes sponsored by health care institutions, professional organisations, voluntary agencies, and so on, which are designed to upgrade the performance of nurses in professional or technical aspects of practice
- appropriate liberal education courses.

CEU records can be hand tabulated. However, the mechanics lend themselves to already established computer storage and retrieval systems. Small institutions and organisations have access to computer-based operations in nearly every community served by an industry or college and university. Arrangements can be made, through contractual agreements, for storage and retrieval of CEU records.

Recognition Programmes

Signe Cooper has pointed out

> 'Unquestionably, the concept of continuing education in nursing is growing, but, in the future, this must be planned growth; such planning needs to be done on local, state and regional levels. Otherwise continuing education in nursing will continue to be uncoordinated, fragmented and with duplication of efforts and unmet needs.'[54]

In the ANA's continuing education guidelines for state nurses' associations, programmes are referred to as 'Continuing Education Recognition Programs'.[3] These are financially self-sustained through fees. Each SNA has the responsibility to apply the national standards, and to develop a recognition programme which meets its unique needs and is compatible with those of other states. SNAs also have the responsibility to work with individuals, organisations and institutions to

- assess the needs for, the availability of and accessibility of, continuing education opportunities

encourage the development of quality continuing education activities throughout the state

assist in the planning and provision of offerings

participate in evaluation of programmes

disseminate information about continuing education offerings.

The SNA establishes a minimum 30 contact hours per year of continuing education for its recognition programme. A statewide committee appointed by the SNA approves offerings following standards set forth in the ANA's statement, including offerings in continuing education of an interdisciplinary nature.

The several advantages of establishing consistency in approach to recognition of continuing education between and among various parts of the country include

an insurance that credentials of a mobile nurse population are transferrable

a facilitating of the flow of information that may influence development of additional programmes

a fostering of evaluation criteria and standards for continuing education.

Alvin Toffler, in his book *Future Shock*, writes of a greatly accelerated rate of change which has brought about a premature arrival of the future. In today's society, everyone, particularly people in health care, is faced with the problem of maintaining continuing competence in line with the ever increasing rate of new knowledge.[172]

The quality of health care depends to a large degree on the knowledge, skills and attitudes of practising nurses. With the emergence of new knowledge, technologies and continuing social change, it seems urgent that the nursing profession provide more continuing education opportunities for nurses, prepare faculty for positions in continuing education, and devise methods for determining the effectiveness of continuing education activities.

17 The Open Curriculum in Nursing Education

by Margaret E Walsh
executive director
National League for Nursing

In recent years, more than before, practising nurses from various types of basic programmes in the United States have been seeking additional education to increase their potential for advancement. The open curriculum movement in nursing education appeared to be a response to pressures to provide programmes which would meet the needs of nurses for higher education without the frustration of encountering repetitious course content, and which would recognise professional knowledge and skills already gained.

Recognising this situation, the National League for Nursing responded with a position statement encouraging the development and implementation of the open curriculum in nursing education. The statement, approved by the board of directors in February 1970, defined 'open curriculum' and 'career mobility' and outlined the beliefs of the league about these two concepts.

> 'An open curriculum in nursing education is a system which takes into account the different purposes of the various types of programs but recognizes common areas of achievement. Such a system permits student mobility in the light of ability, changing career goals, and changing aspirations. It also requires clear delineation of the achievement expectations of nursing programs, from practical nursing through graduate education. It recognizes the possibility of mobility from other health related fields. It is an interrelated system of achievement in nursing education with open doors rather than quantitative serial steps.
>
> 'The National League for Nursing believes that
>
> Individuals who wish to change career goals should have the opportunity to do so.
>
> Educational opportunities should be provided for those who are interested in upward mobility without lowering standards.
>
> In any type of nursing program opportunity should be provided to validate previous education and experience.
>
> Sound educational plans must be developed to avoid unsound projects and programs.
>
> More effective guidance is urgently needed at all stages of student development.
>
> If projects and endeavours in this area are to be successful, nursing must accept the above concept of the open curriculum.'[144]

This statement set the stage for exploring new designs to meet both the needs of students and those of the public to be served. One of the first steps toward implementing this statement was the appointment of an advisory committee to study the open curriculum in nursing, composed of national leaders concerned with nursing, education and health care. The committee made a number of recommendations, some short range and others with long range implications. It asked for an immediate accumulation of information about open curriculum opportunities, directed work to begin identifying testing instruments and stimulating the development of new instruments for granting credit and advanced placement, and urged the prompt development of guidelines for schools of nursing interested in establishing open curriculum practices.[103] On the basis of the committee's recommendations, a proposal was developed for

the establishment of the NLN open curriculum project in 1971. The purpose of the project is to influence the open curriculum movement in two ways, through study and action. Major objectives are to survey the open curriculum movement, to provide information about current programmes, and to keep a statistical account of the characteristics of the movement. Another objective of the study is to make a systematic and objective assessment of the movement to ascertain whether current practices are achieving various objectives, especially facilitation of career mobility goals.

Long range objectives and the action component include the preparation of a design for systematic and comprehensive evaluation of the open curriculum, from which guidelines could be developed, and an assessment of the need for NLN to conduct pilot projects to develop the guidelines.

The project was funded for a two-year period, commencing in August 1972, by the Exxon Education Foundation, and additional funds were received from the Educational Foundation of America. However, a significant shift in the sequence of objectives occurred before the Exxon funds became available. In March 1972, the advisory committee recommended that the NLN project take a direct role in designing one or more pilot projects at several schools of nursing. The committee suggested that a small task force of committee members and others with appropriate qualifications be invited to work with NLN staff to carry out this recommendation. The task force was appointed a month later, and together with staff, they gave increasing time and attention to the direct action aspects of the programme.

The reversal of priorities came about mainly because of the responses to two surveys conducted by NLN's division of research. The first, conducted in October 1970, consisted of a brief questionnaire. On the basis of the findings a second, more extensive survey was conducted in January 1972. Questionnaires were mailed to all practical, diploma, associate degree, and baccalaureate nursing programmes in the United States – a total of roughly 2700 programmes. A response of 85 per cent was received, in approximately equal distribution by geographic region and type of programme.

At that time, data indicated that

> 'baccalaureate programs probably are more willing to grant advanced placement to those who have completed both education and licensure as registered nurses, while diploma and associate degree programs are more amenable to advanced placement for nongraduates of registered nurse programs'.[121]

Data also showed that 33 per cent of the programmes admitted students with previous education and/or experience without examination, and 60 per cent admitted students with some form of examination procedure for advanced standing. Approximately 6300 students with previous education and/or experience were enrolled in baccalaureate programmes, and over 3800 were enrolled in associate degree programmes.

The problems of advanced placement that hindered some schools from shortening their programmes for students with prior education and/or experience were rigid course sequences and a lack of appropriate and reliable examinations to be used for evaluation. The most commonly used examinations were teacher-made tests. College level education programme (CLEP) tests were the second most commonly used for non-nursing subjects; and National League for Nursing tests, or a combination of NLN and teacher made tests, were the next most commonly used for nursing subjects.

The task force, or pilot project planning committee decided, as a result of a review of data coming in from surveys done in January 1972 and Fall 1972, that the development of model programmes was no longer appropriate. Since so much was already happening, it appeared more appropriate to select programmes already underway and study their development and progress as examples in forming guidelines for the assistance of schools developing new programmes.

In the latter part of 1972, the committee developed criteria for the selection of pilot programmes to participate in the project. Schools of nursing were invited to indicate their interest in participating in the action/study project, which would involve meeting together, sharing information, and collecting data for the purposes of developing the proposed guidelines and solving some of the difficult evaluation problems. Of approximately 200 schools that responded, a total of 51 (27 individual programmes and 5 consortia) were selected for participation on the basis of the committee's criteria. These included items relating to

- administrative support and procedures
- policies of state regulatory agencies
- faculty preparation and philosophy
- flexibility of the curriculum and the philosophy and theoretical framework guiding it, as well as the use of innovative teaching strategies
- policies governing student admissions, advanced placement, the assessment of student progress and the use of standards of competence based on stated objectives
- adequacy of resources

evidence of plans for periodic evaluation.

NLN, in the spring of 1973, published the *Directory of Career Mobility Opportunities in Nursing Education.*[143] This directory, the first of its kind, was based on two 1972 surveys and lists nearly 1500 open curriculum programmes (55 per cent of the 2687 nursing programmes in existence in the United States in 1972). It provides information about types of programmes, kinds of students admitted, methods used for advanced placement, and maximum time or effort which can be saved. The programmes can be classified generally under four distinct curriculum patterns.

Type 1 programmes that accept only licensed personnel

Type 2 programmes that provide advanced placement opportunities, usually through testing procedures

Type 3 programmes that allow multiple exit options

Type 4 programmes that award degrees on the basis of examinations alone, without required attendance or course sequences

Three conferences of the project schools have been held, the first in the Fall of 1973. Before the conference, each school was asked to submit an abstract describing its programme, the various open curriculum practices in effect, and the barriers or problems faced, for distribution to participants.

Programmes of participating schools differed considerably; some were in the initial planning stages, others were in various stages of development, including a few relatively well established programmes involved in developing or carrying out research on teaching strategies and/or advanced placement examinations. A variety of interesting teaching strategies was reported, including self-pacing, individualised independent study modules, audio-visual materials, and innovative methods of providing clinical experience. The programmes ranged from those accepting aides and corpsmen into licensed practical nurse or associate degree programmes with advanced placement, to those providing advanced placement in traditional baccalaureate programmes and those providing placement into an upper division two-year baccalaureate programme. A few were moving toward a '2+2' programme in nursing, with a core curriculum in the earliest years preparing for the associate degree option at the end of two years (four quarters) or the option to go on to complete the baccalaureate degree. Multiple exit and re-entry options were common to a number of the programmes. One consortium includes an imaginative programme in which articulation among eight schools provides for advancement from aide through graduate work. One of the two schools in this consortium will offer an experimental two-year upper division programme. This consortium will also include one school offering graduate programmes at the master's and doctoral levels. Major problems reported include recruitment of faculty, development of testing programmes (particularly in clinical areas and in performance evaluation), and difficulties posed by the regulatory agencies. Other problems include measuring change in role attitudes in students and methods of changing attitudes of faculty toward non-traditional teaching strategies. According to some schools, the latter require considerable inservice education.

General support by their administration was reported by the project schools, and some have obtained funds for the development and evaluation of their open curriculum projects.

The first conference was devoted primarily to an exchange of ideas. Successes as well as problems were exchanged, and there seemed to be a genuine feeling of progress being made on a frontier of great importance to nursing. The prevailing atmosphere was one of sincere desire to participate in the development of sound practices. Many of the schools commented on the relation of their programmes to community needs, and the pressures from society to do something to provide opportunities for educational advancement in nursing.

The second conference in the spring of 1974, attended by the same study project representatives, focused upon the frameworks or external constraints within which open curriculum projects are developed. It was recognised that the movement toward non-traditional curricula in nursing was operating within the framework of the larger movement in higher education. While no predictions for the distant future were made, one might easily visualise changes in education as a result of the changing teaching strategies and curriculum practices revealed by these conferences.

The first conference identified problems and barriers resulting from constraints posed by regulatory agencies. The various frameworks within which new programmes must operate were discussed at the second conference and included the university or institutional setting, state education department, state board of nursing, and accreditation. The focus was on planning sound practices and working closely with the regulatory agencies involved. Open curriculum programmes that are not built on sound educational principles will defeat their purpose of increasing the educational opportunities for nurses and improving the quality of nursing care and health care services.

NLN and the participating schools should achieve from this project a number of mutually compatible

goals. The schools want to improve their practices and programmes and will benefit from having early access to research findings and testing instruments to make comparisons. The schools will also assist NLN in developing guidelines by contributing the wisdom of their experience.

The participating schools have agreed to have their programmes studied by NLN over several years if necessary. The study will spearhead a broad and systematic evaluation of the entire open curriculum movement in nursing.

Since this paper was given at the King's Fund seminar, a third conference, was held in the Fall of 1974, focused on assessment procedures, both cognitive and clinical, for advanced placement and for assessment of progress. Overall programme evaluation was also examined. Experimentation in the development of nursing assessment tools and evaluation models is one of our critical needs, and a major goal of the NLN project will be to stimulate this experimentation and the development of more adequate tools.

A framework is now being established for the collection of data by schools that will allow further evaluation. In addition to general statistics about enrolment, we hope to be able to compare data on enrolment, attrition, and the product of the various types of open curriculum programmes with data from the more traditional programmes.

The results of such a systematic study will provide a foundation for the achievement of certain ultimate objectives. Two of these are to learn more about evaluation methods and to stimulate the development of examinations which meet the needs of different kinds and levels of students and programmes. A concomitant objective is to learn more about curriculum designs and multiple approaches that can be used to prepare students of diverse backgrounds.

A critical objective that is expected to be satisfied by this project is the development of guidelines for nurse educators in planning and implementing an open curriculum programme at their institutions. Potentially, these guidelines will be the most significant contribution NLN can make to further the implementation of open curriculum practices in nursing. In so doing, it will have moved a long way toward fulfilling the spirit of the statement endorsed by the NLN board of directors in 1970.

There are many exciting programmes and ideas in our country. The open curriculum project will benefit the educators, the nursing students, and the consumers of nursing care.

18 Basic Education of Nurses in Canada

by Helen K Mussellem
executive director
Canadian Nurses Association

In considering a topic as broad as basic nursing education one is tempted simply to describe the present situation with its many complexities, and to trace the forces that led to the more dramatic changes in its evolution. However, for the seminar we were asked to focus on the future and to consider our topic in relation to four questions: Where are we now? What is projected? What problems or issues remain? What are the proposed solutions? Therefore, this brief consideration of basic education of nurses in Canada has been divided into these four headings.

Where Are We Now?

As in other countries of the western industrialised nations, the educational process and programmes of health personnel in Canada have undergone some striking changes in recent years. The most dramatic have occurred in the education of nurses at the basic diploma level.

The forces influencing nursing education are so numerous that any attempt to analyse them leads to the study of the whole Canadian society. To understand the apparent complexities of various systems of basic nursing education in Canada, a brief description of the system of government is needed. Broadly speaking, this system is a blend of features found in the United Kingdom and the United States. All educational matters and all health programmes – except for a small segment relating to national health matters – are subject to the jurisdiction of the ten provincial governments. Thus, there is neither one national system of education nor one national plan for health care; instead, there are ten educational systems and ten provincial health plans. Indeed, many people declare that Canada is a federation of ten separate countries, although the ten separate systems and plans together form a pattern that is uniquely Canadian. Due recognition should, however, be given to the role of the federal government in health matters. The role is circumscribed by its powers but the health side of the Department of Health and Welfare, after 30 years of operation, is involved with numerous, varied and important activities which have been developed over time, in collaboration with the provinces, to cope with the evolving changes in the Canadian health milieu.

How has the pattern of basic nursing education evolved? There are, across Canada, three main types; university schools of nursing, diploma schools of nursing, and nursing assistant programmes.

University Schools of Nursing There are 22 basic programmes, varying from four to five years, and leading to a baccalaureate degree in nursing. They have 3393 students enrolled.

Diploma Schools of Nursing These vary from two to three years. Before 1964, all diploma programmes were offered in hospital-controlled schools. The shift to schools within the provincial systems of education took place in two ways; the development of basic nursing education programmes within existing post-secondary educational programmes (junior/community college type), and the development of a new system under the provincial departments of education that led to the phasing out of the hospital schools.

The development of basic diploma programmes within the educational system is now less of a goal to be pursued than a process that is rapidly becoming a reality. In 1966, only one of 173

initial diploma programmes was within the general educational system. In that year, 21 students were admitted to it, less than one per cent of the total admissions to diploma programmes in the country. In 1973, 8248 students were admitted to diploma programmes within the educational system, 77 per cent of the total number of diploma students. Between 1964 and 1973 the total enrolment in educational institutions increased by approximately 824 per cent!

Nursing Assistant Programmes Eight of the ten provinces have these. Although the Canadian Nurses Association adopted the term 'nursing assistant' for this category of nurse, other nomenclature is used in two of the ten provinces. Programmes vary in length from 10 to 18 months. At present approximately 60,000 nursing assistants are licensed to practice.

Psychiatric Nurses Only the four western provinces (British Columbia, Alberta, Saskatchewan and Manitoba) have courses to prepare the psychiatric nurse, that is 'one who has completed the prescribed course in psychiatric nursing at an approved school; who holds a current licence issued by the licensing body in the respective province; and who is prepared to nurse psychiatric and mentally retarded individuals'.[29]

Although the organised nursing profession provided the original impetus for the development of nursing education within the general educational systems, this phenomenon could not have taken place without other developments in the social and economic scene. These include

a general trend towards placing *all* post-secondary education under educational auspices

rising costs of prepaid hospital insurance that financed support of basic diploma nursing education programmes

pursuit by increasing numbers of high school graduates of programmes in institutions of 'higher status' such as junior colleges and universities

rapid development, in most provinces, of post-secondary educational institutions that could accommodate nursing education programmes

changes resulting from the introduction of prepaid health insurance schemes in all provinces

increasing ability of more families to provide funds to support their children's higher education

provision by post-secondary institutions for more flexibility in requirements of age, educational background, sex, choice of residence and a shorter programme

improved collaboration between health-related organisations (especially the Canadian Medical Association and Canadian Hospital Association), the influence of nurse educators prepared in US universities, and of the 'Community Junior College Movement' for nursing education in USA.

In essence, that is where we are now, in the *basic education* of nurses. Where we are now in the *preparation* of nurses is a more complex question.

For the most part, the development of Canadian nursing education can be traced to influences from UK, USA, and, to a much lesser degree, France. With some modification, the present basic system of nursing education closely resembles that of the USA. This phenomenon is not unique to nursing education; it is seen to some degree in all aspects of the social, cultural and economic development of Canadian society. However, in the health field some unique features have influenced the education of nurses – most notably the early introduction of prepaid hospital insurance and more recently the advent of 'Medicare'.

A New Perspective on the Health of Canadians, published by the Department of National Health and Welfare, gives comparative statistics in health care provision (see Table) and comments

> 'In hospital and medical insurance coverage Canada equals the best of the five countries chosen for comparison; it leads in respect of physicians, is in the middle rank in respect of hospital beds, and is second only to Australia in nurses. Since the countries chosen are among those with the best health care services in the world, there is no doubt that, by the four measures used in the table, Canada is among the world leaders.'[115]

Canada's national health expenditures, including personal care, were 7.1 per cent of GNP, 9.0 per cent of personal income, and $306.11 per capita annual expenditure.

What are the implications of these data for the preparation of nurses? Is the present mix of nurses and other kinds of health workers appropriate to health goals and financial resources? Current information from provincial sources reveals no plans being implemented to change the categories of nursing personnel being prepared, but modification of curricula continues unevenly between and within provinces.

Some may argue that the introduction of the 'nurse practitioner' and other specialised groups represents creation of a new category of nurse, but this is at the post-basic level and not included here. As noted in papers by Canadian delegates, nurse practitioner and primary care nurse

programmes have increased in an attempt to close a gap in the health services. Before the marked increase in these programmes some four years ago, government officials were interested in training a new health worker – the 'physician's assistant'. These workers were increasing in number in the USA. However, concerted action by the organised nursing profession, in close collaboration with the organised medical profession and the hospital association, stopped this proposed development.

Presently, in some provinces, attempts are being made to increase the enrolment in nursing programmes to alleviate the seasonal 'nurse shortage' – this stop-gap, superficial proposal is being made despite the phenomenon of unemployment among nurses in major cities across Canada two years ago. This is under study by the health and welfare manpower division of the federal government, but provincial governments will have to decide on the action to be taken.

The education of nurses cannot be considered separately. It must be put in the context of all those who serve the citizen's health needs. Presently, role diffusion and role blurring are becoming increasingly common not only in the isolated communities but also in urbanised highly sophisticated settings. In some settings the relationship between health professionals is becoming more flexible but, if a generalisation is permitted, a power struggle is apparent.

What is Projected?

There are only a few identifiable projections in the basic education of nurses. Although there are no national projections, some speculations will be made on the basis of current specific and non-specific data. (There are, of course, variations depending on the province.) These changes include

> completion of the shift from hospital-based diploma schools to schools within the post-secondary educational system
>
> shift of all nursing assistant programmes into the educational systems of the provinces
>
> development of national optimum standards for basic nursing education, as a preliminary step in considering a possible programme of national voluntary accreditation.

In addition, although evidence is mounting to suggest that the overall level of the state of health of Canadians does not improve by expanding health services and increasing numbers of health personnel, some provinces project a greater increase in numbers enrolled in basic diploma programmes. *A New Perspective on the Health of Canadians* states

> '. . . there can be no doubt that the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate. Marvellous though health care services are in Canada in comparison with many other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating the self-imposed risks and adding to our knowledge of human biology'.

Curriculum changes, furthermore, are projected for all categories of health workers. These will assist students in developing skills as a 'health' rather than an 'illness' oriented worker. There will also be changes in, or modification of, the education of nurses to promote greater role flexibility in various

TABLE: COMPARATIVE STATISTICS OF HEALTH CARE PROVISION

	percentage covered by medical and hospital insurance	number of hospital beds per 10,000 population	number of physicians per 10,000 population	number of nurses per 10,000 population
Australia	79 (hospital) 75 (medical)	117.4	11.8	66.6
Canada	almost 100	102.3	15.7	57.3
Denmark	96.7	89.4	14.5	53.4
Sweden	almost 100	145.8	12.4	43.7
United Kingdom	almost 100	111.4	12.5	35.1
United States	85 (hospital) 65 (Reg medical) 35 (Maj medical)	82.7	15.3	49.2

Source: *A New Perspective on the Health of Canadians,* by M Lalonde, Information Canada, April 1974.[115]

settings. Many examples already exist; for example, the role of nurses in the isolated nursing stations in Canada's north.

What Problems or Issues Remain?

A serious and persistent problem is the shortage of qualified faculty. With more than 75 per cent of students now enrolled in educational institutions, this shortage is becoming more obvious. In 1972, only slightly more than half (54.4 per cent) of all those employed in Canadian schools of nursing had a baccalaureate degree, and 10.7 per cent had a master's or higher degree. The rest had no special preparation beyond a diploma in nursing (22.2 per cent), or had some post-basic credits toward a baccalaureate degree (12.6 per cent).

In relation to the qualifications of those employed in the clinical area, statistics reveal that less than one per cent (.7) had a master's or higher degree, and only 6.4 per cent of all directors or assistant directors had a master's or higher degree.

Although not specifically an educational issue, the two most critical problems affecting the Canadian health services are availability and accessibility. Despite rising costs of these services – the annual rate of escalation being 12 to 16 per cent in recent years, which is far in excess of the economic growth – there is growing evidence that in urban, as well as in remote areas, people are unable either to 'get into the system' or to receive the services they need or desire. This problem has educational implications.

We need to assist students in developing an interest in the value of research. Many problems in nursing require research by nurses – or with a nurse as a team member – and there is a paucity of nurses prepared in research.

We lack a clear concept of the total nursing role within the health field and of the types of nursing educational programmes required. No data are available to suggest that the present categories of nursing personnel are appropriate for the present, or for the future. In addition, there continues to be a lack of differentiation of use of graduates of the three main categories.

An intangible two-fold problem is the nurse's perception of her ability to function in the milieu of changing role relationships and the value she places on her own role. These attitudes and values are frequently developed in the formative or beginning educational programmes in nursing.

What are the Proposed Solutions?

There is great difficulty in proposing solutions to the multifaceted problems in education. There is also danger in looking at educational solutions in isolation. At present, there are no nationally formalised plans. However, some problems will be resolved more readily than others; for example, the preparation of teachers in schools of nursing will respond to a well conceived and well planned programme supported by sufficient funds.

The need for more research orientation in nursing is more complex and will require efforts of faculty in curriculum development. With the present small numbers of nurses prepared for research new ways must be explored for utilising other disciplines such as economists, social scientists and systems analysts.

A proposed solution for a clear identification of the nursing role, the types of educational programmes required, and differentiation of use of graduates, challenges the initiative of the organised nursing profession. It requires an in-depth study of the roles and functions of people needed within the occupation of nursing, and the development of a curriculum to prepare nurses for competent practice to fulfil these roles and functions.

In addition, solutions must be found to determine the economic value of nursing services. What share of the 'health dollar' should be allocated to nursing services? This has implications for the numbers and categories of nurses that should be prepared in the educational system.

Although the federal government is not involved with educational matters, assistance in promoting new programmes may come indirectly from the commitment of Health and Welfare Canada to the health field concept; that is, recognition that some problems in health care services are national in character – particularly those relating to environment, life style and human biology.

Closing Address

Edited transcript

by Jessie M Scott
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The purpose of this seminar was to explore together the ramifications of re-alignment of the roles of health professionals, especially of nurses in primary care and in the clinical specialties. We explored also the impact of technical and scientific advances on nursing, and the changes in management of institutions and services. We looked at the relationship between nursing education and practice and the preparation needed to develop the competencies required in new and enlarged functionings.

We were exploring these ramifications and impacts in the context of a movement throughout the health care field from episodic care to health maintenance and health protection. It is a move from the medical model – one focused on pathology – to a model focused on health – a health model which includes early detection of disease and the prevention of crises and which ministers to the health needs of the community and subpopulation groups within the community as well as to the family and the individual.

Our discussions were also set in the context of a strategy assuring equal access to health care regardless of socio-economic conditions or geographical locations; a strategy that seeks to balance supply and demand, to build upon the strengths in the present system, and to encourage efficiency and effectiveness in health care planning and delivery. We saw interrelated forces at work; the health care worker, the people and the health care system in which they mutually participate. We talked about participatory management instead of the old-style administration – a very difficult concept to deal with and perhaps even to agree with.

Overlaying all of this was a nagging concern about rising costs, about environmental problems and hazards, the need to establish and adhere to priorities in the distribution of resources and services, and the constraints placed upon us as the population grows, as our world shrinks, as we use up more and more of our resources. Our commitment as health professionals must perhaps first be to the distribution of resources before we can get around to our practice. We were reminded of the problems of measuring cost-effectiveness in health delivery systems, of the consumer's rising interest in and altered attitude to health care and the providers.

Helen Mussallem spoke to us about the measures to estimate the status of a society, and described a model incorporating economic as well as social indicators. We were all pleased to know that social indicators had been added to economic ones. If the economists make decisions for us by themselves in relation to health care, we could get into a position of having 'two for one' which is less expensive than the quality we are looking for. For example, in my Division we project the numbers of nurses we think we shall need to provide quality care. We reached our objective for 1975, but in terms of numbers of people not of the expertise needed. It came about, I think, because we began to produce two for one. So it is extremely important to have social as well as economic indicators in our forecasting model, and to look at long term as well as short term effects on society. These social indicators concern human biology, the environment and life style. We were told that, of the present monetary allocation, 95 per cent is used for the biological and 5 per cent for the environmental and life style. We need a different balance from that allocation.

Recurring themes underscored all our subsequent discussions. First, we talked of nursing practice

moving into the community and away from the institution or hospital. But the movement is not yet congruent with our nursing education systems. We have more people presently being prepared to practice in hospital. We were also concerned with the movement to provide group services, and this again is not congruent with our education. The educational systems prepare you to take care of one patient and to deal with his problems. The systems will have to reflect the movement more carefully and to be more congruent with what is happening. Our consumers are changing, so are the costs of care, and as we move from the medical to the health model, we have to have an accompanying way of assessing the health field. The Canadian experience had difficulties in the beginning because there was no agreed-upon concept of what a 'health field' really is. We were talking about the need to assess the health status of subpopulation groups and to forecast their needs, and the shift in subpopulation groups within a community from time to time, and the attendant shift in needs and demand.

Three examples of present projects in the United States may help to show what we mean.

In a study of school nurses and their role in the State of Delaware, we found that 40 per cent of school absences were accounted for by 14 per cent of the children. They came from families who were at high risk. If the school nurses, by looking at the families and their constellations and chronic problems, had known these facts, they would have dealt with this subpopulation group in a different way from just dealing with the individual child absent from school.

In another interesting experiment, nurses from the school of nursing of the University of Washington have keys to the apartments of frail but ambulatory elderly people who live alone so that they may visit them. They also bring them together in clinics where their health status and the kinds of services they need can be assessed. The faculty and nurses are now beginning to provide the services. They are called 'turnkey nurses' and as a result have gotten a lot of publicity they might not have had if they had been called something else.

The third example is a project at the University of Texas to teach community nurses the concept of assessment of population needs and working with the community in terms of what its actual needs are. This project perhaps ties in with the role envisaged for the community health councils in Britain and the advisory health councils in Canada. It is hoped to replicate the curriculum in the school of public health at the University of Illinois, and to find out if this turn in curriculum development for community nursing will function.

The health team concept came into our deliberations. It is different from and broader than the nurse-doctor team, with changing members in rotating positions. The physician is not always at the apex; he takes his turn in the rotation. And we looked at the place of the consumer in this health team.

As we talked about the nurse in primary care and the clinical nurse specialist, we got around to the problems of role identification, particularly in the face of technological advances. Christine Brown showed how we are at the mercy of pressures of numbers, pressures of time, pressures of new inventions and techniques, and pressures of sociological generalisations. This led us to the ethical problems of life-saving technology, the 'living will' and changing the life style of individuals. Huguette Labelle pointed out the ethical considerations in changing the life style of someone in a way he may or may not find acceptable, and in the ways we talk to him about it. I am reminded of a study a while back of nurses and physicians working in an intensive care unit. When they dealt with a patient in crisis they worked very well together; but if the patient was going along well and was 'flattening out' his problem and then 'goes sour', as we say, the nurses and physicians tended to feel hurt with each other because the physician wanted to do more in terms of technology while the nurse wanted to institute her caring role. There are times when nursing and medicine go together and other times when they separate.

We moved to a rethinking of nursing practice as a discipline, particularly in the advent of the clinical specialist, the concept of the nurse in therapy rather than the nurse therapist, and the need for definition of the scope of nursing practice.

Underscoring much of this was the whole question of accountability – the legality of practice, the legal problems arising from omissions and commissions of care, the question of malpractice and how to ensure against it. We extended the concept of accountability to include the nurse's responsibility for the effects of decisions brought about by the system. These decisions are not always in the interest of the person in your care. And you are just as accountable for interfering with these decisions when they are not in the interest of the person for whom you are responsible as you are for giving the right medication. Certainly, we are now being held responsible for political and social decisions affecting health care as well as those affecting nursing practice. So accountability is extended to the social role and the more effective use of the system as well as practice. This led us to look at the legitimisation of the nursing role, questions of certification, credentialling, standard setting, and the monitoring and testing of standards by peer review.

Lastly, we dealt with education, and the question of sharing learning experiences with other professions. We saw a move away from job-specific preparation towards the preparation of people to enter the profession, and we discussed the sequences of learning needed to reach whatever the terminal objectives are. We talked about the numbers and types of educational programmes, the different levels of competencies coming out of these, and how well or badly they mesh in our health care delivery systems. Margaret Walsh brought to our attention the shift in our educational responsibility in relation to advanced understanding for indivuals, self-case learning, independent study, and the simulation models now being developed for learning. You can place in the computer whatever problem it is you want to think about and select alternative solutions; so you can learn from the computer and you are not dealing with the realities of life. There are programmes now developed around this concept. If we are moving to that kind of learning, the socialisation process for the learner will be different.

We talked of the mix of people now coming into the profession and the need for nurses to be more representative of the population. Many areas, in the United States anyway, are under-served because the nurses working there do not have the preparation needed by the population they are serving, nor are their origins and backgrounds compatible. We talked of evaluation of the quality of care and its three dimensions; structure, process and outcomes.

Throughout all our discussions came the question of leadership – the paucity of leaders, the concept of leadership in concert with others and not just within our own profession. We were conscious of the image of our profession and of public expectation compared with the reality.

So the time came for ideas and suggestions for action based on the recurring themes of our seminar. One of the first things we could do would be to identify rather carefully the nursing components of a national health programme – the nursing components for the service, for education, for practice and for research. Secondly, we need to construct a nursing delivery system to fit the structure of a health delivery system. This goes along with the first suggestion because, before identifying the nursing components of a national programme, you have to know what that programme is about.

Thirdly, we could interlock the nursing delivery system with the educational system at all levels of expertise and sophistication. We need to, and if we do we shall develop a pattern of nursing education that has relevance to the time in which we now live, as well as to the future. Very often we forget that the people who come into nursing today will influence the system 30 years from now. They are not going to influence it tomorrow – we are doing that.

Then, we could identify critical problems in nursing practice to develop a national programme of practice research, and to establish priorities for this. We need to study nursing performance with nursing productivity. We certainly need to investigate the scientific basis of nursing practice. I would like to see someone investigate examples of nursing practice in specific settings with specific populations to find out what it is we are talking about.

A particular interest of mine is the study of the decision-making capabilities of nurses relative to their basic nursing education. In the past we educated nurses to make decisions in relation to the care of an individual patient or the group of patients in the service they were responsible for. But we are now talking not about that old system of episodic care; we are talking about a health delivery system focused on health protection.

All these ideas for action point to the need to develop leadership capabilities on a continuing basis. We have to examine the leadership role now and to forecast this role for future requirements. Why have I selected leadership as my last point? Because changes in health care institutions and agencies, and thus in nursing, will be effected as an outgrowth of leadership and not as an outgrowth of external pressures. At least I would hope so.

This is why leadership and the development of leadership capabilities are so essential now. Leadership has a future orientation in terms of what *can* be, what *ought* to be, and how to get from here to there. Programmes to prepare leaders are essential if action for change is to be performed adequately by those of us who are responsible for nursing. The future is not a matter of inevitability but of choice. If the leaders are to guide the choice they must be appropriately prepared.

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Index

Alaska, nurses in 18

American Academy of Pediatrics 19

American Federation of Government Employees Union 86

American Medical Association
Committee on Nursing 15

American Nurses' Association 19 44 52 85 86 87

Augenstein L 34

Austin C J 32 100

Automation, effects of 33–34

Aydelotte M 40

Belloc N B 32 100

Benne K 81 100

Bethlem Royal Hospital 60 61

Boivin M 31 32 100

Boroughcourt Hospital 61

Borough of Scarborough Health Department 68

Boudreau report 26 101

Briggs report 44 61 72 81

British Association for Behavioural Psychotherapy 60

Canada northland, nursing in 35 95

Canadian Hospital Association 94

Canadian Medical Association 94

Canadian Nurses Association 94

Carnegie Commission on Higher Education 86 101

Carpenter H M 26*fn* 101

'Challenge examinations' 28

Clinical nurse specialist 43 44 47 54–55 66 98

Collective bargaining 65

College level education programmes (CLEP) 90

College of Nurses of Ontario 27

Committee on Costs of Medical Care (USA) 54

Committee on Nurse Practitioners (Ontario) 25

Committee on Senior Nursing Staff Structure (UK) 43 44 *see also* Salmon report

'Common core' course 79

Community
health centre 46 68
health departments in hospital 47 67
-hospital liaison 68
see also Local health unit
nurse practitioner 18
nursing
costs of 76
education 18 61 75–76
management 73–74
range of services 73–75
staffiing 74
see also Primary care
psychiatric nursing 61

Comprehensive Health Manpower Training Act (USA) 13

Computer-assisted learning 34

Continuing education unit (CEU) 87
see also Education, continuing

Cooper S S 85 87 101 102

Co-practitioner 26
see also Group practice *and* Team care

Counselling 17 33 44 53 58 66

'Credentialling' 20 98

Department of Health and Social Security (UK) 69

Department of Health, Education and Welfare (USA) 15 17 53 54 55*fn*

Department of National Health and Welfare (Canada) 30 31 35 93 94

District nurses 23

Dunlap M S 86 102

Economic Council of Canada 11

Educational Foundation of America 90

Education
  baccalaureate programmes 17 26 93 95
  basic programmes 17 25 26 35 93
  changes due to science 36
  college programmes 17
  community nursing 18 75–79
  continuing 16 35 84–87
  costs 27
  diploma courses 93
  family nursing 18
  inservice 41
  master's degree programmes 56 95
    in primary care 18–19
  multidisciplinary 77–83
  nursing assistants 94
  paediatric nursing 19
  post-basic 26
  primary care 17 18 25–26
  psychiatric 94

Evalution studies
  conference (USA) 54
  continuing education 86–87
  family nurse practitioners 19
  nursing practice 21
  open curriculum 91–92

Expanded practice 13 18
  see also Extended roles

Extended roles
  community nursing 23
  primary care 15 17 28
  school nursing 19

Exxon Education Foundation 90

Family nurse practitioners 16 18 24 76
  evaluation of 19

Family practice 13
  units in hospital 48

Free clinic 15

Glasgow Royal Infirmary 62

Good Samaritan Hospital 41 42 45

Group practice 16
  nursing in 26 62 67 68

Hall J E 58 103

Hall-Turner A 82 103

Hastings report 68

Health care
  costs 16 97
    in Canada 12 27 30 94 95
    in UK 72
    in USA 54
    of community services 76
  delivery systems 46 49
  field concept 12 30 96
    implications for nursing 32
    use in planning 31
  promotion 32
    nurses' role in 23–24 33 53
    use of television 35
  visitors 23–24

Hebrew University 79

'HMO' (Health Maintenance Organization) 16 17

Henderson V 78 103

Institute of Mental Subnormality 61

Joint appointments 65

Joint Board of Clinical Nursing Studies 39 45

Kenneth H Y 77 104

King's Fund 61
  seminar objectives 9–10

Laval University 79

Leadership 55 56 99

Lea Hospital 61

LeBow M D 58 104

Leininger M 77 78 104

Licensure renewal 85

Liverpool University 79

Local health unit 64
management of 65 68–69
study of 65–66
see also Community health centre
Loeb Center for Nursing and Rehabilitation 18

MacFarlane J 43*fn*
MacKenzie N 36 39 104
McKeown T 12 104
McMaster University 27 28 66 68 79
Malleson report 79
Manchester Royal Infirmary 37
Manchester University 43*fn*
Martin R 43*fn*
Maudsley Hospital 60 61
Mayston report 44 69
Mead M 20
Medical
advances 35 36–38
attitudes 28 81
research, nurses' role in 38
'Medicare' 12 44 94
'Medline' 13
Middlesex-London District Health Unit 60–68
Midwifery 54 62
Milton Keynes 24
Mims F 78 80 107
Ministry of Social Affairs (Quebec Province) 47
Montefiore Hospital (New York) 17
Mottram E M 24 106
Mussallem H K 81 105

National Association of Health Students 80
National Council of Universities, Venezuela 79
National health insurance 17
National Health Service (UK)
cost of 72
reorganisation 10 69–72 82
National League for Nursing 89 90 91 92
National Library of Medicine (USA) 13
Neurosurgical nursing 43 44
New York City Mission 54
New York State Nurses' Association 55*fn*
Nurse-clinician 44 50
Nurse-practitioner 44 66
Nurse-therapist 57–59 60–62
Nurses
accountability of 13-15 17 27 98
attitudes to work 41
distribution of 17
extended role 15 17 19 23 28
returning to practice 16
school 19 47
Nursing
adult neurotics 60
child psychiatry 60
community 18 61 73–76
empathy 58
general 52 62
in time of crisis 57–58
long-term care 60
management 68 69 73–76
mental handicap 61
neurosurgical 43–44
operating room 54
orthopaedic 43–44
paediatric 18 19
primary care 17–18 53 63
psychiatric 43 44 49–50 57 60 94
public health 54 66
research *see* Research studies
role changes 16 35–37 39 40 42
specialists 43 47 54
specialities 36–37 47 54 55
statutes 16
teachers 38–39 *see also* Education

O'Neill E 43*fn*
Ontario College of Physicians 27
Ontario Health Insurance Program 27
Ontario Ministry of Health 27
Ontario Provincial Ministry 68
Open curriculum 89–91
Open University 38
Operating room nurses 54
'Orbital organisation' 41
Organisation change 41–42 44
Orlando I J 58 105
Orthopaedic nursing 43–44

Paediatric nurse practitioner 18 19

Peplau H 78 105
Performance indicator framework 11–12
Practice models 20 24
Presbyterian Hospital, Philadelphia 18
Primary care
  definitions 13–14 25–26 66
  education 17 25 30 82 94–95
  planning 24 47
  practice settings 26–27
  practitioners 17–18 20 53 63
  research 24 63 67 98
  restrictions 27–28
  role models 66
Professional standards review office 17
Programmed investigation unit 37
Psychiatric nursing 43 44 48 49 60-62
  consultation team 49
  education in Canada 94
Public attitudes 15–16 21 40 80
Public health nursing 54 66

Queen Mary's Hospital for Children 61
Queen's University, Ontario 27

Research studies *see also* Evaluation studies
  ambulatory care 18
  attachment schemes 67–68
  intensive care 18
  local health unit 65–66
  nurse interviews 18
  open curriculum 90
  paediatric nursing 18
  primary care 24 63 67 98
  school nursing 98
Role models 66
Rothberg J S 79 80 105

St. Joseph's Hospital Family Medical Center 67
Salmon report 69
San Francisco University 77 79
Satellite communications 35
School nurses 19 47
School health care 47 65
Selye H 35 106
Smith J 24 106
Snow C P 22 106
Social
  accounting 11
  change 15
  indicators 11–12 97
Sorokin P A 34 106
Stanley Royd Hospital 61

Teaching, clinical 44
Team care 20 23 68
  education for 22
  in psychiatry 49
  relationships in 78
Toffler A 88 106
Transportation 34–35
Travelbee J 57 106
Tulane University 79
'Turnkey nurses' 98
Tushingham E 43*fn*

University Hospital of Wales 81
University of British Columbia 27
  Cincinnati 79
  Edinburgh 80
  Illinois 98
  Surrey 79
  Texas 98
  Toronto 66
  Washington 98
  Western Ontario 65 67

Veterans Administration Hospital, Salisbury (NC) 86
Victoria Family Medical Center 67
Victorian Order of Nurses 63 68

Weaver B R 58 103
White House Conference 1930 54

Yale University 18
Yeaworth R 78 80 107

APPENDIX to An Overview of Primary Care in the United States, by Jessie M. Scott + Mary Elizabeth Dunn. in Nurses and Health Care [Edward Lucas: Ed) KEHFL 197

Estimated Numbers of Persons Employed in Selected Health Occupations, January 1971

Health Professional	Number	Percent
Total	1,356,120	100.0
Registered nurse	750,000	55.3
Physician	323,200	23.8
Pharmacist	129,300	9.5
Dentist	102,220	7.5
Veterinarian	25,900	1.9
Optometrist	18,400	1.4
Podiatrist	7,100	.5
Allied Health Occupation		
Total	2,743,000	100.0
Nursing Allied	1,270,000	46.3
Licensed practical nurse	(400,000)	
Aide, Orderly, Attendant	(870,000)	
Medical Allied	1,073,000	39.1
Medical laboratory	(140,000)	
Radiologic technologist	(100,000)	
Medical record personnel	(53,000)	
Dietitian and nutritionist	(47,000)	
Physical and occupational therapist	(40,000)	
Other personnel 1/	(684,000)	
Environmental allied	242,000	8.8
Aide	(101,000)	
Technician	(69,000)	
Engineer and Scientist	(60,000)	
Sanitarian	(12,000)	
Dental Allied	158,000	5.8
Assistant	(112,000)	
Hygienist and technicians	(46,000)	
Health Professional and Allied Health Personnel		
Total	4,099,120	100.0
RN, LPN, and nursing aide	2,020,000	49.3
Physician and medical allied 1/	1,396,200	34.1
Dentist and dental allied	260,220	6.4
Environmental allied	242,000	5.9
Pharmacist	129,300	3.1
Veterinarian	25,900	.6
Optometrist	18,400	.4
Podiatrist	7,100	.2

1/Includes medical library personnel, medical assistants, inhalation therapy technicians, health educators, and other allied health workers.

Sources: BHRD, Project SOAR, November 1973.
DN and Interagency Conference on Nursing Statistics, 1974.

NUMBER AND TYPE OF PROGRAMS TO PREPARE REGISTERED NURSES FOR EXPANDED ROLES*

I. CERTIFICATE PROGRAMS

Range of time in length of course - 0.75 months to 1 year

Type Program/Number	83
Pediatric Nurse Practitioner	42
Family Health Nurse	16
Nurse Midwife	7
Medical Health Nurse	3
Adult Health Nurse	3
Primary Care Nurse Practitioner	2
School Nurse Practitioner	2
Child Health Associate	1
Maternal Health Associate	1
OB - GYN Associate	1
Rural Health Nurse	1
Ambulatory Child Health Care Nurse	1
Nurse Midwife/Family Nurse Practitioner	1
Clinical Thermal Injury Specialist	1

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* Compiled from A Directory of Programs Preparing Registered Nurses for Expanded Roles, 1973-74 DHEW Publication No. (NIH) 73-31

II. GRADUATE PROGRAMS/MASTER's DEGREE

Range of time in length of course - 3 quarters to 2 years

Type Program/Number		143
Community Health		26
Community Health Nurse	10	
Family Health Nurse	8	
Public Health Nurse	6	
Rural Health Nurse	1	
School Nurse	1	
Maternal - Child		47
Child Health	6	
Maternal	21	
Nurse Midwife	6	
Obstetrical	2	
Parent/Child	1	
Pediatric Nurse Practitioner	11	
Medical/Surgical		31
Adult	6	
Aging Specialist	1	
Bio-pathology	1	
Cardiac and Respiratory	1	
Cardiovascular	3	
Gerontology	1	
Medical/Surgical	17	
Physiological	1	
Psychiatric/Mental Health		33
Adult	2	
Child	3	
Community Mental Health	2	
Psychiatric	25	
Psycho-social	1	
Rehabilitation		4

APPENDIX

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A1 + A4

NURSES PREPARED FOR ADVANCED PRACTICE

In recent years there has been a decided increase in registered nurses preparing for advanced practice in nursing specialties. There were 11,121 graduations from masters programs in the academic years 1966-67 through 1971-72. One-third of these, 3,750, were from programs whose functional purpose was preparation for advanced practice rather than administration, supervision, or teaching. The proportion of total graduates preparing for specialty practice increased over this six year period from 21 percent to 45 percent.

GRADUATIONS FROM MASTER'S PROGRAMS IN NURSING,
ACADEMIC YEARS 1966-67 TO 1971-72

Academic Year	Total Graduations from Master's Programs	Graduations from Master's Programs Preparing for Advanced Practice	
		Number	Percent of Total Graduations
1966-67	1,534	323	21.0
1967-68	1,615	367	22.7
1968-69	1,766	438	24.8
1969-70	1,988	771	38.8
1970-71	2,083	885	42.5
1971-72	2,135	966	45.2

Source: Some Statistics on Baccalaureate and Higher Degree Programs in Nursing, National League for Nursing, Annual Editions.

REGISTERED NURSE GRADUATIONS FROM MASTER'S PROGRAMS PREPARING FOR ADVANCED PRACTICE, BY NURSING SPECIALTY, ACADEMIC YEARS 1966-67 TO 1971-72

Nursing Specialty	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72
Total	323	367	438	771	885	966
Medical-surgical	92	131	111	236	293	313
Medical-surgical	81	117	87	200	260	288
Specialties	11	14	24	36	33	25
Maternal-child	48	92	80	154	180	187
Maternal-child	15	30	57	71	85	111
Maternity	14	23	6	28	34	13
Pediatrics	19	39	17	55	61	63
Psychiatric-mental health	145	121	214	265	306	331
Public Health	36	23	32	76	98	98
Public Health	18	16	24	61	90	89
School nursing	18	7	8	15	8	9
Other	...	...	...	16	6	11
None or not designated	2	...	1	24	2	26

Source: Some Statistics on Baccalaureate and Higher Degree Programs in Nursing, National League for Nursing, Annual Editions.

Adjusted Estimates of Employed Registered Nurses - Biennial Distribution by Field of Employment, January 1968 - 1972
50 States and D.C.

Field of Employment	1972[1] Number	1972[1] Percent	1970 Number	1970 Percent	1968 Number	1968 Percent
TOTALS.....	780,000	100.0	722,000	100.0	667,000	100.0
ospital, nursing home, and other institution.....	578,000	74.1	519,000	71.9	463,700	69.5
ublic Health and school.....	54,800	7.0	51,600	7.1	47,100	7.1
rsing education.....	28,400	3.6	25,400	3.5	24,600	3.7
ccupational health.....	20,000	2.6	20,000	2.8	19,600	2.9
ivate duty, office nurse, and other fields.....	98,800	12.7	106,000	14.7	112,000	16.8

[1] Interagency Conference on Nursing Statistics January 11, 1974 - figures rounded.

Nurses and Health Care

Collected papers from the second
King's Fund Transatlantic Seminar of Nurses

Edited by **Elizabeth Lucas**

In a foreword, Geoffrey Phalp, secretary of the King's Fund, writes 'Far-reaching changes in the techniques of medical and surgical practice; an increasing contribution to patient care by those who are not, in the traditional sense, nurses; the demands upon nurses participating in management; the involvement of nurses in new professional procedures: these and other concerns seem nowadays to require a fresh approach and a re-appraisal of what was once regarded as a clearly recognised pattern of duty and service'.

Twenty-one senior nurses from Britain, Canada and the United States demonstrate this 'fresh approach and re-appraisal' in their papers on nursing practice, management and education, in relation to changing patterns of health care, changing circumstances, and the new expectations of other professionals, of patients and of nurses themselves.