THE IMAGE AND ROLE OF THE NURSE: AN ANALYSIS OF DIFFERING PERCEPTIONS AND THEIR EFFECTS UPON NURSING EDUCATION IN NEW ZEALAND.

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L I S T O F C O N T E N T S

List of Tables and Figures *ii*

1. INTRODUCTION 1

2. A BRIEF HISTORICAL OVERVIEW OF THE FOUNDATION AND DEVELOPMENT OF NURSING IN NEW ZEALAND 5

3. IMAGES OF THE NURSE 11

4. THE ROLE OF THE NURSE

- 4.1 Definition of Nurse 20
- 4.2 Defining the Nature and Content of Nursing Practice 22
- 4.3 Role Theory and its Application to Nursing 34
- 4.4 Some Significant Studies of the Role of the Nurse 38
- 4.5 Change and the Role of the Nurse 49
- 4.6 Role Confusion and Conflict in New Zealand Nursing 53

5. THE EFFECTS OF DIFFERING IMAGE AND ROLE PERCEPTIONS UPON NURSING EDUCATION IN NEW ZEALAND 61

6. CONCLUSION 66

Bibliography 69

LIST OF TABLES AND FIGURES

TABLE I The functions of a Registered Nurse 31

TABLE II Three year programmes of Basic Nursing Education in New Zealand 65

THE IMAGE AND ROLE OF THE NURSE: AN ANALYSIS OF DIFFERING PERCEPTIONS AND THEIR EFFECTS UPON NURSING EDUCATION IN NEW ZEALAND.

1. INTRODUCTION

Virtually all nursing research has as its ultimate aim the improvement of patient care. But, as Anderson (1973) points out, those engaged in such research often find their efforts bedevilled by the problem of establishing acceptable criteria or standards against which to measure the qualitative aspects of nursing care. Most of these difficulties appear to arise from two distinct, but interrelated, historical tendencies: that of researchers to view nursing within a traditional 'medical care' frame of reference with little distinction being made between the services provided by doctors and those provided by nurses, on the one hand; and that of nurses, as an occupational group, to unquestioningly assume responsibility for a diverse and ever-expanding range of health service functions, on the other.

Many factors can be shown to have contributed to this latter tendency. As technological sophistication has increased, new therapeutic techniques have altered not only the classical courses and outcomes of many disease processes but also the kinds of people being admitted to hospitals for in-patient care. Field (1967), for example, has very convincingly demonstrated that while the advent of antibiotic therapy brought about a marked decrease in the number and

length of stay of in-hospital patients being treated for acute infections, it has also been responsible for an increase in the number of older patients with chronic illnesses requiring rehabilitative and social support.

But patients are also changing in other significant respects. Over recent years their expectations of the health services have risen substantially. As Preston (1977) has pointed out, the average New Zealander now demands access, as of right, to a level of medical and related services available only to North American millionaires a generation ago. Thus, over recent decades, the hospital, traditional workplace of the great majority of nurses, has become an increasingly complex organisation of professional specialists, paramedical workers and administrators. But increasing complexity has brought escalating costs and, in New Zealand, a consequent impetus towards the establishment of less expensive alternative methods of providing medical and nursing care.

The studies of Hughes, *et al.* (1958) suggest that of all the factors which have influenced the functions of the nurse, one, the downward movement of procedures from the doctor to the nurse, has been pre-eminent in its significance. Taking vital signs, dressing wounds, removing sutures, testing urine, catheterisation, giving dangerous drugs and attending to intravenous infusions are just a few examples of medical tasks that, over the years, have been absorbed into the range of acknowledged nursing functions. In turn, the nurse has passed to

ancillary staff many of the tasks she once performed; for example, the distribution of meals and drinks, stripping and making beds, bathing and feeding patients, cleaning and dusting. Not only has this process created a need for specialised technical training for nurses, it has also given rise to certain problems of supervision and control. Consequently, there has been a tendency for growing numbers of qualified nurses to be employed in administrative, teaching and supervisory activities, thereby leaving students and domestic staff to cope at the operational level, that is, with patients.

The actual tasks that nurses perform vary a great deal and often depend on the characteristics of particular employment contexts. If a hospital has a housekeeping service, a dietary department and a ward clerical service, it is unlikely that cleaning, food service and clerical tasks will be regarded as nursing duties; if a hospital or community-based health service trains medical students, it is likely that its nursing staff will carry out fewer technical procedures than would nurses employed in a service which does not have medical teaching responsibilities. On the other hand, if there is a shortage of nursing staff, ancillary helpers may be required to perform many of the direct patient care tasks than would normally be the responsibility of the nurse.

Most of the factors already referred to can be described as external factors; that is, they can be shown to have exerted their primary influence on the role and functions of the nurse from outside nursing itself.

There are, however, some significant internal factors at work. In the main, these relate to the development of nursing as a profession. During the course of their examination of current nursing theories, Wooldridge *et al*. (1968) found that, to date, these theories have tended to emphasise areas of practice where the nurse assumes prescriptive authority. Because major responsibility for the biological pathology of patients traditionally rests with the doctor, nurses have deliberately sought to establish a social practitioner role in which the nurse has independent prescriptive authority over the psycho-social aspects of patient needs. It is this function which the nursing profession is stressing through its rapidly growing body of literature.

Given that the preceding statements accurately reflect significant aspects of the present situation, it is not surprising to find that there are major discrepancies in the views held by nurses, doctors and others about the role of the nurse within present day health services, and that these discrepancies frequently create confusion and conflict within the nurse's work situation.

As Anderson (1973) has taken care to emphasise, studies of the nurse's role have practical, as well as theoretical implications. Because the standing of the nursing profession depends largely on the esteem of non-nurses, namely, the public and those with whom nurses work, it is important for nurses to be aware of how these groups view their role. Furthermore, when significant role discrepancies are empirically identified, nursing leaders

have a more valid basis upon which to recommend what direction nursing should take, what changes can reasonably be made for improved relationships, and what consequent adaptation is needed within programmes of nursing education. In the absence of such information, important professional decisions tend to be made either on the basis of affect (the 'I feel' principle), or to be delayed indefinitely in the hope that the problem, if ignored for long enough, will go away of its own accord.

While this paper touches upon many aspects of the problems of role definition in nursing its main concern is with the effects, past, present and potential, of differing perceptions upon nursing education in New Zealand.

2. A BRIEF HISTORICAL OVERVIEW OF THE FOUNDATION AND DEVELOPMENT OF NURSING IN NEW ZEALAND

The history of nursing is inextricably interwoven with the evolution of organised religion and medicine. In early times, nursing was primarily associated with the feeding and care of infants, attending the aged and infirm and the administration of remedies such as herbs, fermentations, poultices and baths. From this tradition nursing became an important part of the charitable work of the Church, a bond that was not weakened until the relatively recent rise of secularism. As secularism grew, responsibility for the organisation and control of health services was gradually transferred from the Church

to state and civil authorities.

However, as Abdellah (1971) points out, religious dedication did not vanish completely, for throughout the nineteenth century the deaconesses at Kaiserwerth Infirmary in Germany were actively involved in educating lay persons for various public services including nursing, teaching and the management of children and convalescents. Possibly the most famous pupil of the Kaiserwerth establishment was Florence Nightingale whose name is prominently identified with the emergence of nursing as a health profession with an orientation more closely allied to medicine than to the charitable work of the church. Not only did her work coincide with a period characterised by dramatic advances in scientific and medical knowledge, but her close contact with scientists, health reformers and politicians greatly assisted her advocacy of nursing as a profession.

Although New Zealand's first hospital was established in Auckland in 1841, it was not until 1846 that Government formally accepted responsibility for meeting the hospital needs of the new colony's Maori and indigenous European residents. Significantly, the colonial hospitals (later renamed provincial hospitals) and their psychiatric equivalent, the provincial lunatic asylums, were provided, conducted and used in accordance with the prevalent notion that hospitalisation was a therapeutic last resort. Small wonder that, when first established, nursing services in New Zealand followed the old English pattern which Miss Nightingale so strongly

deplored. In essence, the staff was untrained and consisted of a master and a matron and such other domestic help as could be obtained. Convalescent patients were also expected to assist with the routine ward work. Remnants of this system were to be found in New Zealand hospitals as late as the 1880s, although by that time some hospitals, notably those in Auckland and Wellington, were moving towards the employment of probation nurses and sisters as in England.

A new era was ushered in by the employment of matrons who had trained under the Nightingale system. In turn, they established hospital training schools which, although having their roots in the English Nightingale tradition, differed from their English counterparts in that they were placed under the direct control of hospitals. Thus, an apprentice-type training was developed, the students being employees of the hospitals, learning as they worked.

Nursing, as an emergent profession in New Zealand, fought strenuously to improve standards of training, but while the passing of the Nurses Registration Act in 1901 was hailed as a real triumph for professionalism, progress generally was limited by the continuing subjection of education to what was euphemistically described in the Board of Health Report (1974) as 'hospital operational efficiency'. Thus, it comes as no surprise to find that, although there have been certain obvious improvements, New Zealand's hospital-based apprenticeship system of nurse training has changed relatively little since its inception in 1883.

Even though the mid 1970s saw the establishment of six technical institute-based programmes of basic nursing education, the apprenticeship system and the organisation required to support it still forms the basis of most hosptial nursing services in this country.

In New Zealand, as in many other countries, the psychiatric and psychopaedic nursing services have developed separately from general nursing services. As 'A Review of Hospital and Related Services in New Zealand' (1969) makes clear, this state of nursing apartheid results largely from the fact that the psychiatric and psychopaedic hospitals developed independently from those providing care for the so-called physically ill. Generally sited away from high density residential areas, these hospitals were planned and conducted to ensure the safe custody of inmates whose prospects of discharge could only be described as negligible. Within all of these hospitals males were cared for by men and females by women. A matron was in charge of the 'female' side of the hospital while a male 'head nurse' was responsible for the running of the 'male' side. The male attendants were divided into two main categories: those who worked outside the hospital operating transport and maintenance services, or undertaking the supervision of inmates assigned to farming, gardening, painting and other work details, on the one hand; and those who worked inside the hospital providing nursing services, on the other.

After the passage of the Mental Defectives Act of 1911 which attempted to establish these institutions upon the

hospital model by providing legal confirmation of a change of nomenclature from 'asylum' and 'lunatic' to 'mental hospital' and 'inmate', there was a gradual trend to substitute the term 'attendant' with that of 'nurse'. However, in spite of the relatively early emergence of this trend, registration for psychiatric and psychopaedic nurses did not become a reality until 1945 and 1961 respectively.

New Zealand's first State-provided community health nursing service, the backblocks district nursing service, was established in 1909 after two private community-based ventures, namely, Nurse Maude's district nursing service which commenced in Christchurch in 1896, and the Plunket Society's extra-mural service founded in 1907, had shown that there was a very real need for specialised nursing expertise to be more directly available to the wider community. This need was given further recognition when, in 1911, the Department of Health, concerned about the high mortality rate among Maori infants and the apparent lack of immunity which older Maori children had to infectious diseases, established a native nursing service, the purpose of which was to deal directly with health and problems at a local community level. The year 1917 saw the advent of the school nurse whose principal function was to assist with the medical examination of school children. Thus, New Zealand's early community health services were pioneered by a variety of types of nurse. By virtue of their professional and geographical isolation, rural district nurses in particular, exercised high degrees of responsibility and authority, their work

often overlapping with that of doctors and dentists. Unfortunately, the basic hospital training programmes provided little in the way of effective preparation for such roles.

Over the years, New Zealand's health services have undergone a dramatic increase in complexity but, in spite of this, the nursing profession has persisted, at least until recently, in retaining the apprentice as the dominant employee unit within the nursing workforce. In addition, it has shown a marked reluctance to part with what can be referred to as its traditionally generalist or 'jack-of-all-trades' role. While nurses have generally accpeted the more complex tasks required of them, they have often been reluctant to surrender non-clinical activities to other groups of workers.

One consequence of this apparent failure of nurses to adapt to changing circumstances is of special significance. In order to relieve the mounting pressures created by the development of more complex clinical services, steadily increasing numbers of qualified nursing staff have been employed within New Zealand hospitals. However, it should be noted that these people have *not* been employed to supplement the clinical nursing workforce, but rather to augment administrative and supervisory hierarchies. As a result, success in New Zealand nursing (as defined in terms of status and financial reward) has come to be measured almost solely in terms of the distance the nurse has moved *away* from involvement in direct patient care.

During the past two decades there have been a number of major investigations into nursing in New Zealand. While the majority of these (Reid, 1965; Department of Health, 1969; Carpenter, 1971; Department of Education, 1972; New Zealand Nurses Association, 1976) have been concerned with specific aspects of nursing education, two significant reports (Board of Health, 1974; Nursing Education and Research Foundation, 1977) have effectively focused attention on the numerous unresolved issues which presently confront nursing service development in this country. While it is difficult to make authoritative predictions about what the future may hold for New Zealand's nursing services, one point at least seems to be worth making - if the moves which followed the publication of the various nursing education reports can be taken as any guide, it seems likely that the nation's nursing services are about to undergo some substantial changes.

3. IMAGES OF THE NURSE

In a paper cited by Anderson (1973), Taves, *et al.* (1963) advanced the suggestion that people tend to be characterised in terms of their vocations. Thus, when one knows that a person is a nurse, one tends to estimate his/her education, income, prestige and possibly cultural interests, in terms of the image one has of nursing.

The fact that an image may frequently bear little resemblance to the reality is effectively illustrated by comparing the widely held image of Florence Nightingale

with the actualities of her existence. While her name is popularly synonomous with the bedside nurse devoting her lifetime to the welfare of her patients, spending day and night soothing fevered brows and making compassionate and comforting utterances, most of her life was, in reality, spent as a semi-invalid in her home writing monumental reports on sanitation, finance, hospital construction and the education of nurses. While the persistence of such a distorted image may appear to be of very little consequence, it is pertinent to point out that because of it, many people, including a substantial number of nurses, still believe that there is no real need for well educated nursing practitioners. In essence, they do not see nursing as an academic discipline and feel that the apprentice-nurses who 'learn their trade' in on-the-job contexts are all the profession requires.

Obviously, the public image of an occupation is of great significance to its membership for the views of those outside the occupation will tend to promote or impede progress not only of individual members but of the occupational groups as a whole.

During the past three decades there have been a number of studies which, by focusing attention on non-nurses' images of nursing and nurses, have added a new dimension to the profession's knowledge and understanding of itself. Congalton (1962), in a study designed to ascertain the public image of nursing and nurses in New South Wales, Australia, found that while people saw nursing as a noble and worthwhile profession, a significant

proportion of those surveyed (one in five) would not recommend it as a career to a girl who seemed interested, mainly because of a belief that the life of a nurse is an undesirable one and that it 'does something' to the personality and character of a girl. In spite of this reservation the public image of the nurse in New South Wales was a very positive one, nurses being characterised as practical, efficient, industrious, feminine, patient, friendly and women of high moral ideals. In Davis' study (1969) which compared role expectations of nursing with social work, it was found that the public tended to connect the nurse's role almost exclusively with the hospital. Nursing was seen as a traditional role for women. It called for one to be industrious, methodical and dependable, while being co-operative, considerate conventional and adaptable. The tendency towards submissive and subordinate roles was regarded by many of the respondents as a limiting factor on the occupational freedom of nurses. Hughes *et al.* (1958) found that women had a more favourable image of the nurse than did men; women saw the nurse as interested in the problems of others and less self-oriented, where as men described the differences between nurses and other women on the basis of training, education and knowledge. Men occasionally expressed hostility and competitive feelings about nurses. The image of the nurse for both sexes was more favourable the lower were the respondents on the socio-economic ladder. When people were asked, 'How do nurses differ from most other women?', those from the upper

socio-economic classes described them as 'unladylike', hardened, cynical, indifferent to human suffering, unrefined etc., suggesting a servant-like relationship. Those from the lower socio-economic classes consistently saw the nurse as a more sympathetic, hygienic, protective, superior figure.

The rapidly changing environment within which New Zealand nursing found itself during the early 1970s prompted George Hines, then Senior Lecturer in the Department of Business Administration, Victoria University of Wellington, to undertake New Zealand's only published study of the public image of the nurse. Concerned at what he considered to be the undue reliance of the nursing profession on subjective feeling about the public's thoughts on nurses and nursing and well aware that negative attitudes could lead to an unsympathetic hearing from the public on issues of great concern to the development of nursing services, Hines (1973) set out to obtain impartial information on the public image of the New Zealand nurse. A representative sample of university students, housewives and male managers were asked to rate 15 pairs of adjectives which could describe nurses. The respondents were told to place an "X" on the position on a scale between two logical opposites that best described the personality of the typical nurse. For comparative purposes, the respondents were also asked to make ratings for primary school teachers and office secretaries. Averages were then computed for the student, housewife and manager groups.

It was clear from Hines' findings that housewives had the most positive image of the New Zealand nurse, while students had the most negative. On the basis of the strongest ratings of the three groups, the nurse emerged as feminine, responsible, patient, unselfish, calm, understanding, and friendly, but also as unimaginative and rigid. Except for the rating of slightly unambitious, all personality factors were positively evaluated by housewives.

The comparison of nurses with school teachers and secretaries revealed clear image differences. Teachers were rated as significantly more intelligent, ambitious, cultured, imaginative, industrious, and less rigid than nurses. Secretaries had an image of being more exciting, flexible, understanding, and friendly than nurses. Nurses were rated as clearly more feminine, responsible, unselfish, and calm than teachers and secretaries but also as more unimaginative and rigid.

While the results of Hines' study were in general agreement with those of Congalton (1962), whose study was conducted within a very similar cultural environment, three points appear to be worthy of special mention:

(1) Although the image of the New Zealand nurse was found to be favourable, there seems to be room to speculate on the implications of being rated as unimaginative and rigid. Could it be, as Hines himself suggests, that the New Zealand public prefers nurses who are seen to 'follow

the doctor's orders' dogmatically and without exception?

(2) Even though most of the assigned personality traits were found to be on the positive side of the scale, the strength of particular perceptions varied substantially among students, housewives and managers. This variance seems to suggest that New Zealanders are likely to be differentially susceptible to the influence of publicity about nurses and nursing. Housewives, for example, could be considered as more likely to believe that nurses deserve higher pay on the basis of being very industrious than are students who tended to see nurses as being slightly lazy. Because managers perceived nurses as being substantially less responsible than did housewives, it seems likely that it would be more difficult to convince the former than the latter that nurses should take on higher levels of responsibility.

(3) On the basis of Hines' findings, school teachers appear to have a more favourable public image than nurses. While the results obtained did not suggest that nurses were not valued or respected, the more favourable teacher ratings must be seen as being at least a potential cause of concern to nurses if only for the reason that it is with this group that nurses must regularly compete for fiscal and administrative support.

The images of nurses and nursing held by those with whom nurses share their work environment, that is, patients, the consumers of nursing care, on the one hand, and health services colleagues, especially doctors, on the other, are also of considerable importance to nurses as an occupational group, for as the 'significant others' in the day-to-day professional life of the majority of nurses, their views exert a strong influence over most aspects of the profession's working relationships.

Coser (1962) found that patients saw the nurse's essential task as one of lending personal reassurance and emotional support to their lives. They described the 'good nurse' as one who had a kind and personal manner. They seldom saw the nurse in the decision-making field, the information-giving field or having a job that involved much professional skill. Mauksch and Tagliocozzo (1962) also found that the patient's evaluation of a good nurse focused on the nurse's mode of dealing with patients; they stressed her personality, wanting her to be friendly, warm, kind and benign. They expected her to give willing and spontaneous service by promptly responding to their call. Supportive care was mentioned by nine out of every ten respondents, whereas expectations involving therapeutic dimensions were mentioned far less frequently.

While both of these studies were undertaken in the United States of America, it is interesting to note that Anderson (1973), in an investigation conducted in Britain some ten years later,

reported very similar findings; patients expected the nurse to be kind, understanding, patient, sympathetic, cheerful and available to the patient. In addition, it was stressed that a good nurse must be courteous, civil and polite. Overall, emotional support was seen as being much more important to the patient than technical care.

Unfortunately, relatively little effort seems to have been made to ascertain the kinds of images which doctors, as a broad occupational group, have of present day nurses and nursing. From time to time the comments of individual doctors are reported in the news media but because these comments, taken overall, tend to reflect a very wide divergence of opinion, they provide no real basis on which to make pronouncements about the views of the medical profession as a whole.

However, the findings of Anderson (1973) do provide at least a little insight especially into the potential for conflict inherent in the drive of nursing towards full professionalization. While just over 80% of the 75 doctors who took part in Anderson's study stated that, in their opinion, nursing was a profession and that nurses should be regarded as professionals, their views did not seem to be related to professionalism as it is associated with education in a university, length of training or level of knowledge, but rather to the belief that the nurse must be dedicated to his/her work. When asked about the type of person who should be recruited into nursing, many of those who apparently supported the concept of nursing as a

profession indicated that the nurse should have common sense rather than intelligence, high moral ideals, should be practical, always willing to help the doctor, have rapport with people and very much want to nurse. About one-fourth of the doctors (27%) suggested that the best type of preparation for nursing was essentially practical. Anderson cites the following comment as typical of this view:

> 'The best type of training for nurses is entirely oriented around the ward; that is, entirely practical with tutorials on the wards for academics, and perhaps ward rounds to explain conditions. I doubt if it is very good to have classroom lectures.' (p. 82)

The remaining 73% favoured a combination of practical and academic training:

> '. . . practical backed up with theory; they should know why they are doing things, not just how.' (p. 83)

When asked by Anderson to answer the question, 'The main thing the doctor expects of a nurse is . . .' the doctors' responses stressed technical competence (71%), efficiency and reliability. Very few mentioned expectations related to the emotions of the patient. There were no major differences between doctors related to age or country of medical education, although surprisingly, the physicians, (i.e. the medical specialists) were more technically oriented than the surgeons.

What sorts of images do nurses have of themselves and of their profession?

Because nurses, in common with others, tend to perceive

their role in accordance with their beliefs about themselves and about their profession, nurses' images of nursing will be discussed in the section entitled 'The Role of the Nurse'. However it is appropriate, in the light of Anderson's findings, to make brief reference to two studies which appear to reinforce the notion that the efforts of nursing to achieve true professionalization are likely to bring nurses into conflict with doctors.

While Burling *et al.* (1956) found evidence that younger nurses tended to see their role as more of a shared task with doctors, with a steadily decreasing social distance, Wessen (1960) considered that the nurse's status could best be described as ambiguous because although the nurse had professional status, upward mobility was blocked by the doctor.

From the foregoing comments it can be seen that, although there has been comparatively little local research into differential aspects of the image of the nurse, there is a great deal of evidence from studies conducted in Britain and North America to suggest that there may be some very significant discrepancies between the views held by various groups within the New Zealand community.

4. THE ROLE OF THE NURSE

4.1 DEFINITION OF NURSE

According to The Concise Oxford Dictionary, a nurse is 'a person, usually a woman, charged with or trained for

care of the sick or decrepit'. The fact that this statement is so broad and therefore potentially open to use by a wide range of occupational groups is probably one of the root causes of the difficulties which members of the nursing profession have encountered in their attempts to achieve acceptable professional role definition.

In order to maximise clarity in the remaining sections of this paper it was necessary to adopt a specific working definition which would effectively exclude not only those occupational groups outside or on the periphery of professional nursing (for example, dental nurses and Karitane nurses), but also students of nursing (irrespective of whether their programme of nursing education was service-based or not) and nursing auxiliaries such as enrolled nurses and nurse aids.

The definition which seemed to meet these criteria most satisfactorily, apart from the implication that the nurse is invariably a woman, was that formulated by the International Council of Nurses in 1965:

> 'The nurse is a person who has completed a programme of basic nursing education and is qualified and authorised in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick.' (p. 6)

Basic nursing education, in turn, was defined as:

> '. . . a planned educational programme that provides a broad and sound foundation for the effective practice of nursing and a basis for advanced nursing education.' (p. 6)

Thus, a nurse, in present-day New Zealand, is a person who, having completed an approved programme of basic nursing education, is *registered* (as distinct from *enrolled*) to practice in accordance with the provisions of the Nurses Act (1977).

4.2 DEFINING THE NATURE AND CONTENT OF NURSING PRACTICE

Few, if any, professional groups have expended so much time and effort trying to define the nature of their practice and the role of their practitioners as the nursing profession.

While it is self-evident that an occupation or profession whose services affect human life must define its function, Florence Nightingale was probably the first and last nurse to be clear in her own mind about 'what nursing is and what it is not'. In her most often quoted work, *Notes on Nursing; What It Is and What It Is Not,* published in 1859, she said:

> 'It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what *nursing* has to do in either case is to put the patient in the best condition for nature to act upon him'.

Although there can be no doubt that Miss Nightingale's views significantly influenced the development of modern

nursing, the advent of nurse registration and practice legislation around the turn of the century made it necessary to describe nursing in such a way as to protect the public and the nurse. Thus began the seemingly endless struggle to define nursing and the nature of nursing practice. The thinkers in the profession have put forth a variety of theories, each one conceived as a scientifically based, conceptual structure from which all nursing activities can logically be derived or into which all nursing activities can be logically fitted. The doers, in contrast, have tended to settle for, 'We're too busy practicing nursing to worry about defining it,' thus subtly putting down the theorists. But, as yet, no one definition of nursing, theoretical or pragmatic, has won universal acceptance.

The persistence of the problem of finding an acceptable definition of the nature of nursing practice can be attributed to a variety of factors; two of the most difficult to counter being the scope and diversity of knowledge required for effective nursing practice on the one hand, and the unorganised state of available nursing knowledge on the other. While the combined effect of these factors is to inhibit the formulation of a well integrated conceptual framework upon which to base nursing practice, they do not, in themselves, preclude the specification of activities appropriate for the nurse to undertake. However, even this approach has proved to be problematical largely because of the extremely fragmented nature of nursing services. This is especially so in New Zealand where King (1977) maintains that fragmentation has been 'legitimated' by four separate, but inter-related,

strategies:

(i) the introduction of a variety of practitioners trained to operate in an institutional setting rather than educated to practice the art of nursing in whatever context that care is required;

(ii) the deliberate provision for differing levels of legally recognised (either by enrolment or by registration) practitioners of nursing - to operate primarily within an institutional setting.

(iii) the perpetuation of a system of basic nursing education which entails the provision of nursing services by students while being prepared to provide such services;

(iv) the employment of an appreciable proportion of other unqualified personnel, ostensibly to undertake non-nursing tasks of a limited nature.

In view of the apparent ambiguity which seems to surround what is and what is not nursing it is hardly surprising to find that many nurses tend to be preoccupied with tasks which are properly the province of others (Reid, 1965; Department of Health, 1969; Carpenter, 1971; Board of Health, 1974). However, as King (1977) points out, sometimes it is indeed difficult to differentiate between nursing and non-nursing activities because it is not necessarily the activity *per se* which is important but the context in which it is carried out. An appreciation of this sometimes subtle difference requires, in King's opinion, not only a high degree of sensitivity, but also a sound understanding of the nature of nursing practice.

The contention that nursing is a unique service in society is one against which there would seem to be little argument. Although many of the nurse's tasks are linked to, and may be the same as, those performed by others in health-care services, the members of the Nursing Development Conference Group (1973) were unanimous in their contention that the uniqueness of nursing lies in the *reasons for* what the nurse does in society as well as in the characteristics of what is done. On the basis of their belief that a description of the why and the what of nursing would embody a general concept of nursing, the members of the National Development Conference Group undertook a very detailed review of the different concepts of nursing encountered in the nursing literature. But, given the nature and purpose of this paper, it is both appropriate and expedient to concentrate on certain key conceptions of nursing; that is those which have significantly influenced the development of current beliefs about the nature and content of nursing as it is practiced in New Zealand.

Throughout the first two decades of this century most attempts to define nursing were made in order to meet the requirements of nurse registration and practice legislation. By and large these definitions reflected the concept of the nurse as a follower of the doctor rather than as a self-directed independent health worker. There can be little doubt that this was also the view of prominent members of the medical profession, many of whom waxed eloquent on the value of the 'new' profession of nursing. Thayer (1919), for example, stated that nursing was ' . . . wholly complementary' to

medicine and without it 'the proper practice of the art of therapy is inconceivable'. It is interesting to note that in 1925 the eminent physician and philosopher William Osler also pronounced in favour of nursing, referring to it as 'an art to be cultivated'. However, Osler, like the majority of his medical contemporaries, clearly envisaged that the 'art' would always be practised under the supervision of the doctor.

Understandably, the idea of the nurse being merely the doctor's assistant has never been satisfying to the profession as a whole. Although Taylor (1934) defined nursing as 'adapting prescribed therapy and preventive treatment to the specific physical and psychic needs of the individual', she also contended that ' the real depths of nursing can only be made known through ideals, love, sympathy, knowledge and culture, expressed through the practice of artistic procedures and relationships.' In these statements, Taylor, a prominent American nurse, anticipated some of the current emphasis on patient-centred, individualised care and on the importance of a liberal, broadly-based education for those who wish to become nurses.

The years which immediately followed the Second World War saw a phenomenal increase in the range and complexity of health-care services and, as a corollary, the emergence of many new categories of health services workers. Not surprisingly, scheduling and co-ordinating what was to be done to and for the patient became a major task. Although a number of health services planners identified the nurse as the most appropriate person for the role of patient care co-ordinator this finding met with a

mixed response from nurses many of whom expressed the view that their direct patient-care functions had already been severely eroded by newcomers, namely physiotherapists, occupational therapists and social workers.

Discontent with the increasingly ambiguous position of nursing resulted in a flurry of research activity culminating in the publication of large numbers of detailed analyses of nursing functions, statements of belief and position papers. Typical of the analytical studies was one undertaken by the California State Nurses Association (1953); the end result of the Association's extensive investigation was the identification of over 450 nursing activities within the general hospital context alone!

Many of the statements of belief and position papers stressed the importance of the emotional support offered to patients by nurses. Because the overwhelming majority of nurses in Europe and North America have been women, nurses have often been regarded as 'professional mothers'. Frances Reiter Kreuter (1957,1966), is one nurse who, over a period of years, has strongly advocated acceptance of the concept of the nurse as a mother surrogate. It is her 'unalterable conviction' that practice, the direct care of patients, is the absolute primary function of the nursing profession. While admitting that administration, teaching and supervision are essential underpinning for good patient care, Reiter Kreuter considers them to be secondary to direct patient care. The nurse is seen by Reiter Kreuter as protecting the patient, teaching him, performing for him those acts of self-care he cannot do himself,

and providing comfort and encouragement.

Johnson (1959a, 1959b) adopted a somewhat more intellectual stance, contending that nursing was a direct service to persons under stress relative to their basic human needs with nursing effort and actions being focused on relieving tension and discomfort so as to restore or maintain internal and interpersonal equilibrium.

Orlando (1961), in an attempt to clarify the independent or self directed aspect of the nurse's work, emphasised the importance of the nurse being able to systematically evaluate aspects of nursing care in terms of their appropriateness and effectiveness. She said:

> ' The purpose of nursing is to supply the help a patient requires in order for his needs to be met. The nurse achieves her purpose by initiating a process which ascertains the patient's immediate need and helps to meet the need directly or indirectly. She meets it directly when the patient is unable to meet his own need; indirectly when she helps him obtain the services of a person, agency or resource by which his need can be met.
> . . . In order for the nurse to develop and maintain the professional character of her work she must know and be able to validate how her actions and reactions help or do not help the patient or know and be able to validate that the patient does not require her help at a given time.'

One of the most influential of the post-War definitions of nursing has been that formulated by Virginia Henderson and first published in 1955. Within three years of its appearance in a book entitled *The Principles and Practice of Nursing* (Harmer and Henderson, 1955) Henderson's definition was adopted by

International Council of Nurses; subsequently it has re-appeared in numerous textbooks, monographs and booklets. Henderson states her definition in the form of a concept, the concept of the unique function of the nurse:

> 'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; of this she is master'.

Henderson also acknowledges that the nurse has other functions:

> 'In addition (the nurse) helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of the medical team, helps other members, as they in turn help her, to plan and carry out the total program whether it be for the improvement of health, or the recovery from illness or support in death.'

While the concept of the nurse as an independent practitioner was not new, Henderson was one of the first nurses to recognise that efforts to return the patient to a state of wellness are not always successful. She realised that unless a nurse is realistic about the probable or possible negative outcome of a patient's illness, he/she will be prone to disappointment and frustration. However, if responsibility for helping the patient to achieve a peaceful death is included in the nurse's role, both nurse and patient will recognise their roles more precisely and be able to co-operate in setting realistic goals.

During the present decade there has been considerable

discussion about the difference between the practice of nursing and the practice of medicine. Rozella Schlotfeldt (1973) has differentiated between the roles of the nurse and the doctor as follows:

> 'The nurse's *primary* concern and functions related thereto, is that of helping each person to attain his highest possible level of general health; the doctor's *primary* concern and functions related thereto is the diagnosis and treatment of illness.
>
> Both doctors and nurses are concerned ultimately with the health of people. The doctor's *practice* focus, however, is on differentially diagnosing and treating pathologies through the selective application of medical science and the discriminating use of available medical strategies. The nurse's *practice* focus is an assessing people's health status, assets and deviations from health, and on helping sick people to attain health through selective application of nursing science and the use of available nursing strategies'.

While Schlotfeldt's statement clearly indicates that medicine and nursing have differing primary concerns and practice foci, it does not elaborate those health care areas or functions in which the nurse can reasonably be expected to display competence and skills.

One of the most detailed statements of the functions of the nurse to be published in recent years is that formulated by Congalton (1977) for the Nurses Education Board of New South Wales (see *TABLE I*). Established in 1973 by the Government of New South Wales, the Board was given the responsibility of providing the Minister of Education with advice concerning all matters pertaining to the education of nurses. While various attempts had been made to establish the functions of the nurse none appeared to be suitable to the Board's purpose. It was decided, therefore, as a matter or urgency, to set about

TABLE I: NURSES EDUCATION BOARD OF NEW SOUTH WALES

THE FUNCTIONS OF A REGISTERED NURSE

(Assuming that those persons the nurse deals with are physically or mentally ill or at risk)

This statement designates the essential elements of professional nursing to be regarded as the goal for attainment by the time of registration as a general certified nurse.

The registered nurse is seen as a person who has the responsibility to plan and give quality of patient care and work as a competent member of a multi-disciplinary health team.

The concept of the nursing process which sums up this professional role is embodied in the following five facets (all other functions being seen as emanating from these):

(i) Identification of individual needs
(ii) Interpretation of individual needs
(iii) Planning care to meet those needs
(iv) Implementation of planned care
(v) Evaluation of care and subsequent needs.

Professional nursing functions, therefore, can be said to be of a preventative, curative, palliative and rehabilitative nature, and embodied in each of these is the essential nursing element of "caring", with the emphasis on total situations rather than procedures and on the individual and not only on the specific condition.

The following tables provide focus for and emphasis on specific functional areas; however it should be stressed that, although arbitrary divisions have been made, several topics are common to several categories, and to avoid repetition they have been placed in categories where the greatest emphasis is thought to exist.

A Professional Responsibility	B Basic Nursing Care	C Specific Nursing Procedures	D Observation and Action	E Human Relations	F Administration	G Education
The awareness of professional self-identification, exemplified by the provision of a specialized contribution to the meeting of the health needs of the individual and the community, by: 1. Being an effective member of the health team, involving: a. Implementation of prescribed policies and treatments b. Skilful and responsible delegation, where appropriate c. Independent decision-making and action *when appropriate* 2. Acting responsibly within a professional code of ethics	Skilled care, or the supervision of such care, relating to the well-being of the individual, concerning: 1. Physical demands: a. Breathing b. Eating and drinking c. Eliminating 2. Physical activities: a. Moving b. Resting and sleeping c. Dressing and changing 3. Physical comfort a. Body temperature b. Body hygiene c. Safe and comfortable environment 4. Psychological needs related to: a. Privacy (when appropriate) b. Communication (two-way process) c. Emotions (e.g., fears, stress, anxiety and happiness) d. Supportive needs (e.g., understanding and sympathy) e. Need to be loved f. Spiritual needs g. Activity (normal and specific) h. Self-actualization	Participation in medical appraisals Care, prior to, during, and after surgery, treatment, or diagnosis Measuring of bodily activity (e.g., T.P.R., fluid balance) Administration of medications Obtaining specimens for pathology Treatment of wounds and malfunctioning areas Care of the dying Care of the body after death Counselling and other therapeutic action Prophylactic action Rehabilitation Providing emergency treatment Application and supervision of the use of medical equipment (e.g., intravenous and monitoring equipment oxygen therapy, respiratory machines, defibrillators, humidicribs, urinary drainage bags, tracheostomy tubes, renal and peritoneal dialysis apparatus)	Observation of the individual and the environment, with the exercise of skills in techniques of assessment and evaluation in the areas of: a. Physical functioning b. Emotional state c. Intellectual functioning Identification of the individual's need for help Taking appropriate action in relation to signs and symptoms and other relevant factors Reporting accurately, meaningfully and *promptly* Liaison and advocacy based on observation and assessment of the individual or the environment Assessment of care provided, and consequent needs	Establishement of confidence in others regarding the professional standards, behaviour and integrity of nurses Effective understanding of and interaction with: a. Patients, their families, relatives and friends b. Nursing personnel c. Medical personnel d. Paramedical personnel e. Clergy f. Non-medical personnel g. Members of the community h. Community *organizations* Ever-present caring for the individual and provision of support Understanding based on knowledge of different ways of life Appropriate action to meet abnormal behaviour Effective crisis intervention Help for the bereaved	Skilled and effective: a. Leadership b. Supervision c. Management d. Interviewing e. Counselling f. Delegating g. Referring h. Assessing, evaluating and decision-making i. General communication, including eliciting and supplying information Knowledge of and compliance with legal requirements Planning organization and utilization of community and *other resources* Instigation of nursing research Responsibility for care and maintenance of medical equipment	Direct and indirect teaching on matters relating to health care, to: a. Nurses (particularly clinical teaching) b. Patients c. Patients' families d. Community members and groups e. Ancillary personnel f. Paramedical personnel and others Continuing self-education, keeping up-to-date with advances in medicine and nursing The promotion of positive health and prevention of disease or infirmity, in the individual and the community

The above functions may be summarized as requiring the following qualities:

1. A keen sensitivity to the individual's needs and the ability to meet them.
2. A knowledge of and competence in procedures and technology relating to patient care, including adequate knowledge of the effects, side-effects and contra-indicators of therapeutic substances used in care.
3. A clear understanding of the behavioural and physical sciences that provide a basis for the nurse's judgement and related action.
4. An understanding of the nature of society and its relevance to understanding the individual, his needs, and the functioning of the health services in the community.
5. An ability to take independently or collaboratively, appropriate skilled remedial or preventive action.

establishing a statement of the functions of a registered nurse which would be as comprehensive as possible, but without the endless detail of all the tasks which a nurse might be expected to do on some occasion or other. It must be pointed out, however, that this statement, by its own admission, relates to the New South Wales context. Furthermore, it is specific to the competencies expected of a general nurse and makes no attempt to incorporate elements of psychiatric or psychopaedic nursing practice.

New Zealand nurses, too, have been preoccupied with the search for an acceptable definition of the nature and content of nursing practice. In general, their efforts have been directed towards determining and stating in fairly precise terms what it is that nurses should do.

The Board of Health Report (1974), for example, contains the following statement:

> ' Broadly speaking, the functions of qualified nurses are three-fold:
> (1) Initiating and supplying specific nursing care. Specific nursing care includes:
> (a) Establishing, maintaining and terminating therapeutic relationships.
> (b) Creating a therapeutic environment.
> (c) Assessing nursing needs on the basis of physical, emotional, and spiritual requirements.
> (d) Planning, giving or directing, and evaluating care, including rehabilitation.
> (e) Functioning as co-ordinators and as participators in the health and welfare team.
> (f) Adapting to changes relevant to the maintenance of optimum health care.
> (g) Performing specific treatments.
> (2) Undertaking health teaching which includes helping healthy people to stay well and assisting others to adapt to changed physical or mental states. Most qualified nurses have a teaching function in regard to people and their relatives. Many also have

responsibility for teaching students and various other categories of staff.

(3) Undertaking delegated medical care. As doctors undertake more complex work they tend to delegate specific tasks to nurses.'

More recently, participants in the New Zealand Nursing Manpower Planning Workshop when asked to consider the functions of nurses working in a variety of health services contexts, 'quickly resolved to prepare a statement on the generic functions of nursing rather than to specify the almost infinite number of activities undertaken by nurses in various settings.' The following list of functions contained in the New Zealand Nursing Manpower Planning Report (1977) was approved by all members of the workshop:

'Observation, assessment and analysis to contribute to diagnosis;

Planning, implementation and evaluation of nursing care;

Case finding;

Health teaching;

Health counselling;

The implementation of treatment prescribed by licensed medical practitioners;

The teaching and guidance of students;

Creating and managing a therapeutic environment;

Planning, evaluating and developing the health service as a member of an interdisciplinary team; and

The ordering and development of nursing knowledge.'

Both of these broad statements of functions are adequate for the purposes of the Reports in which they are contained, but they are essentially future-oriented and, as such, by-pass most of the realities of the contemporary situation in New Zealand. These realities include the variety of legally recognised nursing practitioners in current practice and the employment of almost as many unqualified persons as qualified nurses for the provision of 'nursing' services in New Zealand

hospitals and health care agencies.

While the search for acceptable definitions must go on for practical as well as philosophical reasons, it must always be remembered that while it is relatively easy to suggest what should be, it is exceedingly difficult to transform the abstraction into a specifiable reality.

4.3 ROLE THEORY AND ITS APPLICATION TO NURSING

Because the sociological concept of role is closely allied to the concept of function it follows that anyone wishing to understand human behaviour in social situations must have a clear understanding of the concept of role.

Despite what he described as a plethora of conflicting definitions, Banton (1965) contends that because it is generally agreed that behaviour can be related to a position in a social structure and that actual behaviour can be related either to the individual's own ideas of what is appropriate (role cognitions) , or to other people's ideas about what he *will* do (role expectations), or to other people's ideas about what he *should* do (norms), a role may be understood as ' a set of norms and expectations applied to the incumbent of a particular position'. (p.29)

Because the concept of status is closely associated with that of role it is appropriate to comment briefly on

the relationship between the two. In essence role and status refer to the same basic aspect of social action but define it from different points of view. While status is a positional concept, being defined in terms of the rights which can be claimed and the obligations which must be fulfilled by any person occupying such a position, role is a behavioural concept, the dynamic aspect of status. In exercising his rights and in fulfilling his obligations, the occupant of a status must act; the action appropriate to any status constitutes a role. Thus, the position or status of 'nurse' identifies a particular body of expected behaviour, that is, the role of nurse.

The term role is a relational one; the role of the nurse, for example, is played in reciprocal relation to a number of other roles, including those of patient, doctor, social worker, visitor, etc. Together these roles form a total pattern thereby making up what Merton (1957) has described as a role-set.

In summary, then, the role of the nurse may be defined as the part the nurse plays in relation to the parts played by other members of the medical team in meeting the health care needs of patients or clients.

Not infrequently the way in which a role is enacted may differ significantly from the role demands or prescriptions (expected behaviour). In turn, these expectations may not co-incide with specifications of ideal behaviour (what should be done). Such discrepancies are often the source

of considerable personal stress for those involved.

Role strain is said to occur when the incumbent of a position has difficulty in meeting role expectations. Even when an individual wishes to conform to the expected behaviour for a role (and not every individual wishes to do so) the problem of meeting complex role demands may prevent him from achieving his goal. Such demands usually arise because the role prescriptions are unclear, too numerous or mutually contradictory.

The nurse in charge of a ward, for example, may be responsible not only for the care of patients but also for the supervision of students, the general oversight of clerical and domestic staff working in the ward, the preparation of reports for various sections of the hospital administration service, assistance to medical staff as and when required, etc. Because different members of the hospital staff may place a different emphasis on the importance of the various aspects of the total role, the charge nurse may soon find the demands of the role to be excessive with role strain the inevitable result.

Role strain can be reduced by a variety of techniques such as giving some aspects of the role priority at certain times and in certain places; by arranging to delegate necessary but awkward aspects of the role to special people or groups; and by according some aspects of definitions of the role greater importance than others. Although this will be affected by such features as the attractiveness of various forms of behaviour

to the incumbent and the ability of other members of the role-set to reward, or punish, behaviour. However, if the incumbent perceives the strain to be irreducible, he may choose to remove himself from what he regards as an untenable position.

Role conflict, as defined by Gross *et al* (1957) is said to exist when the incumbent of a position perceives that he is confronted with incompatible expectations. Role conflict may be experienced at two levels: within an individual's own body of roles; or between the individual's own roles and those of others.

While it is clear that there needs to be relative consensus about the allocation of roles and rewards within systems if conflict is to be contained and resolved, some writers suggest that a measure of dissensus is healthy as it pushes the role performer into developing and improving his performance.

No matter how much the actions of the nurse are reduced by the sociologist to the rights and obligations of the role there is also the irreducible personal element. As Downie (1971) has pointed out, one can accept or reject the rights and duties, thereby giving individual expression to the role.

Occasionally individuals may exhibit behaviour appropriate to a particular role without having the feelings or beliefs which go with that role; they therefore play the role 'tongue-in-cheek'.

This phenomenon is called 'role distance' and might occur, for example, in a competent clinical nurse who is required to act as an administrator during an administrative staff shortage.

Clearly some individuals perform their roles more effectively than others. Sabin (1968) terms those characteristics possessed by the individual which result in effective and convincing role enactment 'role skills'. For the nurse, these include not only aptitude but also education and experience. Despite suggestions that good nurses are 'born to the role', there can be little doubt that aptitude can be significantly enhanced with appropriate instruction and practice.

4.4 SOME SIGNIFICANT STUDIES OF THE ROLE OF THE NURSE

There has been an interesting variety of research into the role of the nurse with researchers exploring not only the nurse's perceptions and those of significant others, but also analysing the relationships which exist between the roles of doctor, nurse and patient.

A number of studies have been undertaken to try to explain certain aspects of nurse/patient interaction and to predict future behaviour. Several of these have led to the development of what can be described as nurse typologies.

Habenstein and Christ (1955) identified three types of nurse:

1. The 'traditionalizer' - dedicated to achieving the ideal, this nurse focused on nursing skills as a means of patient healing; did not like to delegate to auxiliaries; valued "tough tasks"; tended to place a higher estimation on "dirty work" than on tasks requiring technical competence and preferred the old on the basis of past experience. This nurse's satisfactions came from perceived improvement in the patient's health and from expressions of gratitude.

2. The 'professionalizer' - this nurse focused on things that would more adequately and intelligently heal the patient. In clinical practice the emphases were on knowledge, the application of rational faculties to experience, the use of judgement and the creation of therapeutic situations. This nurse delegated freely and obtained satisfaction from a job well done technically.

3. The 'utilizer' - this nurse was relatively indifferent to work tasks; had little or no self-involvement in nursing except to meet short-term needs and accepted change for reasons of expediency.

The Reissman and Rohrer (1957) typology of nurses included:

1. The 'dedicated nurse' who chose nursing for positive reasons and hoped to continue nursing. For this nurse patient care was *the* great reward and nothing in nursing was regarded as unsatisfying. Rules were obeyed unquestioningly because the 'dedicated nurse' believed that they were made by people who knew what they were doing.

2. The 'converted nurse' who entered nursing on negative grounds but aspired to continue. While patient care was the outstanding satisfaction it was a joy discovered after entering. The 'converted nurse' tended to blame herself rather than others when things went wrong and to take a middle course in adherence to rules.

3. The 'disenchanted nurse' who came into nursing for positive reasons but did not wish to remain. This nurse found fault with other people and the institution when things went wrong and undertook no more responsibility for making judgements than was necessary for the arrangement of her own work schedule.

4. The 'migrant nurse' who came into nursing for negative reasons and planned to leave. Work was just a job and the institution and everyone in it was blamed when something went wrong. The 'migrant nurse' tended to make her way by manipulating the rules to suit her own needs.

While Navran and Stauffacher (1958) divided nurses into two groups, those who were 'work-oriented' and those who were 'people-oriented' Meyer (1959), who felt that nursing was in transition between patient-centred care and task or technique orientation, classified nurses into three main groups:

1. The 'ministering angels' who placed high value on undivided relationships with their patients;
2. The 'modern nurses' who preferred to share patients with colleagues but also liked individual patient care. These nurses not only showed concern for the psychological aspects of illness but were able to apply the scientific as well as the intuitive method to the problems of supportive emotional care and patient education.
3. The 'efficient professionals' who were efficient, disciplined professionals who most valued their work relationships with colleagues. Their orientation was clearly towards technical and administrative functions.

Corwin (1960) also classified nurses into three groups; two, the 'service oriented' group and the 'professionally oriented' group, coincided closely with Meyer's 'ministering angels' and 'efficient professionals' whereas the third group, the 'bureaucratically oriented' nurses (i.e. those who saw themselves as servants of the organisation, hired to carry out rules and procedures and rewarded for skill in administration) represented the introduction of a new element into nursing typologies. It is the inclusion of the 'bureaucratically oriented' group which makes Corwin's typology particularly relevant to the New Zealand context.

The character of the nurse's role is also determined by the expectations of others, especially medical colleagues. Coser (1962), in a detailed North American study, found that

the doctor sees the nurse as subordinate rather than self-sufficient; the nurse obeys orders and follows routines. These findings were confirmed by Duff and Hollingshead (1968) who found that the doctor assigned to the nurse the role of assistant to carry out his orders. Nurses were seen principally as keeping records and acting as liaison for physicians.

Despite the fact that patients are generally acknowledged by nurses and other health services workers to be an important reference group, most research studies indicate that they see themselves as 'passive observers' rather than 'actors' with a positive role to play. Coser (1962), for example, reported that many patients not only felt obliged to be co-operative, considerate and understanding, but were reluctant to discuss any rights they might have while in hospital.

Because nurses often feel that they are not performing the role for which they were prepared, they develop a condition described as 'role deprivation'. Kramer (1968, 1974) who studied the relationship between role conception, role deprivation and the length of exposure to bureaucratic employment, found that those nurses who had high professional/ low bureaucratic concepts when they completed their basic nurse training had higher deprivation scores than those nurses with high bureaucratic/low professional concepts. Those with high deprivation scores tended to change jobs more frequently or leave nursing for other employment more readily than nurses with low deprivation scores.

Nurses, especially those employed in hospitals, experience a great deal of stress in their work. They face heavy demands for pity, compassion and sympathy; they are often expected to do the impossible in the way of providing comfort or care. Many nursing tasks are, by ordinary standards, disgusting, distasteful and frightening. Physical contact with patients may be over-stimulating and disturbing. Menzies (1960), in her widely quoted study of tension and anxiety among nurses, found that nurses assume roles against anxiety, using defensive techniques in an attempt to alleviate anxiety producing situations. Some of the principal defensive techniques outlined by Menzies are:

- The use of lists of tasks in order to restrict prolonged contact with any one patient;

- de-personalization of the patient by the use of bed number or disease entity instead of the patient's name;

- de-personalization of nurses by the use of uniforms which emphasise role over person and are a symbol of an expected inner and behavioural uniformity;

- detachment and denial of feelings by the use of a brisk manner, and use of reprimand and discipline for errors;

- attempts to eliminate decision-making by ritual task performance;

- reduction of the burden of responsibility in decision-making by the use of checks and counterchecks by senior personnel;

- deliberate obscurity in the formal distribution of responsibility by a failure to clearly define who is responsible for what and to whom;

- avoidance of any change which threatens the existing defences against anxiety.

Unfortunately, as Menzies has demonstrated, the net result of the use of these defence techniques is that secondary anxiety is aroused. Because it cannot be contained, secondary anxiety, in turn, gives rise to high sickness rates, frequent job changes, and ultimate shortcomings in patient care.

One of the most interesting and best-known studies of the role of the nurse was undertaken in the United States of America by Johnson and Martin in 1958. Instead of defining the nurse's role in terms of a list of tasks, Johnson and Martin chose to analyse it in terms of the specific contribution of the nurse role to the doctor-nurse-patient social system.

As Johnson and Martin point out in the introduction to their study, any social system - that is, two or more people interacting with each other - regardless of its specific size or purpose, has certain functional problems which must be solved if the system is to maintain itself. First, the social system must make progress towards realizing the purpose of the group: it must move towards a goal. Second, the social system must maintain internal equilibrium: relationships between the

social system members must be harmonious and integrated and each member must feel good both within himself and towards the other group members. Thus, any social system may be thought of as having an external problem, that of moving towards the group goal, and an internal problem, that of maintaining integrated relationships among the members by managing the tensions of individuals in the group. Using the terminology of Parsons and Bales (1955), Johnson and Martin refer to actions which are directly goal-related as 'instrumental' while those related to maintaining motivational equilibrium are described as 'expressive'. On this basis, they then differentially define two main leadership roles, that of instrumental leader or task specialist on the one hand, and that of expressive leader or tension-manager on the other.

In summary, Johnson and Martin contend that:

- the instrumental problem in the doctor-nurse-patient social system is essentially that of 'getting the patient well'; the expressive problem is that of managing the tensions of the system members that are, at least in part, generated by the activities necessary to restore the patient to health.

- the patient is in no position to assume leadership of the triad - if he could 'cure' himself he would not be in the hospital. Rather, because he is ill, he is thought of by society as a person who needs help, who is obliged to seek help and who co-operates with those qualified to offer it.

- within the system, instrumental and expressive functions are not participated in equally by nurse and doctor; instead there is a clear division of labour in which the nurse assumes the role of expressive specialist and the doctor that of instrumental specialist. Compared to the activities of the doctor, the nurse's activities are not directly related to the 'cure' of the patient. Rather they are ' caring activities' designed to 'establish a therapeutic environment' and include a variety of specific behaviours from creating a comfortable, pleasant physical setting to the more directly nurturant activities of explaining, reassuring, understanding, supporting and accepting the patient. These acts are mainly meaningful as direct gratifications to the patient and serve to lower his tension level. As Johnson and Martin point out, it is crucial to their argument to recognise that many of the nurse's physical acts of care, although they may involve technical procedures, are primarily significant to the patient as reflections of her attitude towards him. By caring *for* the patient the nurse shows that she cares *about* him.

The doctor's activities in examining, diagnosing and treating are not directly gratifying to the patient. While the patient understands these activities are necessary to his recovery, they are, in themselves, often felt by the patient to be embarassing, painful and anxiety provoking. Indeed. it is the doctor's instrumental activities, which according to Johnson and Martin, tend to produce the tensions in the patient which the nurse seeks to reduce. Because of the tension-reducing (and, thereby, directly rewarding) aspect of her activities, the nurse receives from the patient an emotional response perhaps best described as 'appreciation'. Thus,

the nurse tends to judge herself, and her colleagues judge her, in terms of whether the patient likes or 'appreciates' her.

The doctor, in contrast, cannot expect to be 'loved' by the patient in the way the nurse is. He has to judge his effectiveness, not in terms of the patient's attitude towards him, but in terms of whether or not the patient is 'getting better'.

Thus, because the nurse plays an expressive role, she gets a reward of 'appreciation' from the patient; the doctor, the instrumental specialist, gets his reward from his own assessment of whether his medical interventions are defeating the pathological state.

- inasmuch as the doctor is primarily responsible for system goal attainment - 'getting the patient well' - he must be the chief authority in the three way relationship. It is he who must define for the nurse and the patient what must be done in order to get the patient well. While not having the doctor's authority, the nurse is not without power; she controls the patients, too, but not so much by giving 'orders' as by subtle indirection. This indirect use of power is seen by Johnson and Martin to fit with her expressive role; she cannot be the authority figure and, at the same time, the giver of direct gratifications.

- the nurse's principal role in the three-way system is that of system integrator; that is, she serves as a kind of intermediary between the doctor and the patient by interpreting the doctor and his activities to the patient. Although the doctor as team leader is responsible for the major decisions

regarding the patient's treatment, his efforts will be to little avail if the patient does not trust the doctor, or understand his instructions. It is upon the nurse that primary responsibility for establishing and maintaining harmonious relationships rests. Thus, while the doctor, as instrumental specialist, leads the system, the nurse, as expressive specialist, integrates it.

While it is true that nurses perform technical functions and doctors perform expressive functions, the point which Johnson and Martin make is that if one looks at *all* of the things nurses and the doctor do in doctor-nurse-patient system, nurses do far more for the patient of an expressive nature than doctors, whereas doctors are very much the masters of the instrumental functions. In other words, expressive functions are performed primarily by the nurses and secondarily by doctors and instrumental functions are primary for the doctor and secondary for the nurse.

Although Johnson and Martin's analysis has been widely quoted, it has not won universal acceptance. Thorner (1955), maintained that the nurse's role is directly concerned with the instrumental function of 'getting the patient well':

> '. . . the pattern of expectations constituting the nursing role is characterised by disinterest, functional specificity, affective neutrality, universalism, and performance-oriented achievement'.
> (p.532)

According to Thorner, who made his observations while a patient in a large general hospital, the hospital patient is regarded by nurse and doctor alike simply as a *case* to be cured, not as a *person,* and it is *not* within the nurse's role to become involved with the patient's emotional or social concerns. However, it should be pointed out that Thorner's analysis was not intended to apply to all the occupational roles that nurses might hold, but just to the general hospital nurse role in the doctor-nurse-patient social system. Having assumed that the goal of the system was 'full recovery of the patient', Thorner convincingly argues that the aforementioned pattern of expectations is functionally necessary.

Skipper (1965), 'in order to gain at least a cursory empirical view of the nurse's role', gave a self-administered questionnaire to 239 nurses employed at a large, metropolitan hospital in the United States of America. The results led Skipper to conclude that there was no justification for placing primary emphasis on either the expressive or the instrumental function to the relative or total exclusion of the other!

In essence, Skipper's findings support the contention of Schulman (1958) that although the nurse plays many roles, two, that of 'mother surrogate' on the one hand, and that of 'healer' on the other are of particular importance. While the general public has an image of the nurse as a 'mother surrogate', the hospital situation sanctions the 'healer'

role and, as a consequence, the potential exists for the nurse to be caught between the poles of the two roles.

When the role of the nurse is considered in the light of these diverse and sharply contrasting definitions and analyses, it is hardly surprising to find that confusion and conflict are two of the most constant characteristics of modern nursing practice.

4.5 CHANGE AND THE ROLE OF THE NURSE

At this stage it is pertinent to reiterate that the role of the nurse, in common with all other roles, is dynamic and, as such, subject to continuous change.

During the past one hundred and twenty or so years the nurse's role has undergone many modifications reflecting the evolution of nursing from a somewhat diffuse activity carried out almost exclusively in the home of the patient into a highly specific set of functions performed principally within institutional settings.

While these changes have clearly been substantial, there can be little doubt that those which will occur over the next one hundred and twenty years will be even more dramatic.

And herein lies the problem. Although the importance of accurately predicting the future role of the nurse is

widely recognised, giving effect to the dictum is a classical case of 'easier said than done'. However, because past experience has shown that it is possible to identify most of the significant trends in health services development at a comparitively early stage, the task of predicting at least the direction of likely role change is less of a crystal ball gazing activity than it might at first seem to be.

As Shetland (1976) and Preston (1977) have demonstrated, health care delivery systems everywhere are in crisis. At no time in history has so large a proportion of society's resources - financial and human - been allocated to the preparation of health workers and the delivery of health care services. And it is quite safe to say that at no time has there been so great a dissatisfaction, not only among the public but also among those who provide the care. However, as Shetland observes, crisis connotes danger but it also connotes opportunity; in this case the opportunity for nurses to meet long ignored health needs while, at the same time receiving the increased satisfaction and role fulfilment which result from the chance to participate in the provision of direct patient care.

The so-called 'health care crisis' has already begun to influence the scope and nature of current nursing practice both overseas and in New Zealand. While the exponential increase in new technologies for dealing with health and social problems has been accompanied by a dramatic increase in cost to the consumer (direct and indirect), this fact has served as an

impetus rather than as a deterrent to public demands for more and better health services. In order to spread available resources as widely as possible many governments, including that of New Zealand, have opted to move away from their traditional emphasis on hospital-based services towards one in which the community becomes of focus of health services activities. The 1975 New Zealand Government White Paper, 'A Health Service for New Zealand' contained the following statement:

> 'Care ... cannot begin and end at the door of the hospital, but must provide for people in the environment in which they live and work. The community orientation of health services demands a community based service.'
>
> (p 7 - 8)

With the defeat of the Labour Government the White Paper lapsed; however the incoming National Government clearly shared its predecessor's commitment to the development and expansion of community-based health services. Not only did the Report of the Department of Health (1977) stress the need to change the nature and direction of the flow of health care resources away from institutional care and the treatment of illness towards health promotion and the prevention of disease but it also pointed out that the present organisational structures and the people trained to provide traditional health services were not well suited to the requirements of health promotion and disease prevention. The Government's recent publication, 'Planning Perspectives 1978 - 1983' (1978), provides further evidence of its determination to give priority to community-based health services by indicating that the development of future health services should be guided

by the following principles:

> '- that in the delivery of health services increased emphasis should continue to be placed on health education, health promotion, and the prevention of disease and accidents;
>
> - that more emphasis should be placed on the development of public health services, such as occupational health and environmental protection;
>
> - that policy should continue to move towards the provision of community-based services, including voluntary services, and away from hospital-based services.'
>
> (p 66)

The directional implications for the future role of the nurse seem to be very clear; simply stated, the dominance of the hospital as the place of work for the majority of nurses seems likely to be challenged probably within the next one to two decades.

Impetus for nursing role expansion is a good example of another significant factor for change both in New Zealand and overseas. Increasingly, nurses in non-hospital employment are being called upon to take responsibility for tasks which were formerly considered to be the responsibility of the general medical practitioner; such tasks include initial assessment of medical problems for referral, family health counselling, responsibility for preventive and rehabilitative aspects of disease and disability, etc. While some nurses may debate whether or not such functions should become the responsibility of the nurse, the fact remains that as medical technology expands and as public expectations rise, the demand for health services increases. If the nursing profession refuses to accept the challenge of role expansion, health services planners will have no alternative other than to create yet another category of paramedical worker.

While such diverse factors as the dramatic effects of medical technology on disease patterns, improved educational opportunities for women, and the entry into nursing of steadily increasing numbers of men, have shaped, and will continue to shape the role of the nurse, it is interesting to note that while it has taken just over a century for the role of the nurse to evolve from a community-based, somewhat diffuse activity, into a highly specific set of functions performed principally within institutional settings, present indications are that the evolutionary process will come full-circle, probably before the advent of the twenty-first century.

4.6 ROLE CONFUSION AND CONFLICT IN NEW ZEALAND NURSING

As is the case with all other occupational roles, a complex set of expectations converge to shape what is known as the role of the nurse. Sometimes these expectations reinforce each other, sometimes their meanings in combination are unclear and sometimes they are in conflict. When the various expectations reinforce each other and are consistent, role definition is stable, motivation and job satisfaction are high and - all other things being equal - high work productivity results. But role expectations are not always consistent; sometimes the determining forces work in different directions and blurring or confused role definition results while on yet other occasions the expectations may be contradictory thereby giving rise to role conflict.

In the sub-section entitled 'Role Theory and its Application to Nursing', it was stated that role conflict may be experienced at two levels: within an individual's own body of roles or between an individual's own role and the roles of others. In order to keep discussion brief and to the point, attention will be focused almost exclusively, on the second of the two levels.

In essence, four principal sets of expectations influence the character of the nurse's role: the 'official' expectations that stem from the institution or agency in which the nurse works, the expectations of others with whom the nurse shares his/her work environment, the expectations of significant reference groups outside the nurses immediate work environment, and the nurse's own personal expectations of what a nurse should be and do.

In New Zealand, most 'official' expectations seem to have been derived from one (or both) of two main sources - tradition on the one hand and the Department of Health on the other. Traditionally, in New Zealand, the nearer the nurse is to the patient, the lower his/her status in the professional hierarchy. The more skillful and experienced nurses become, and therefore, the more useful to the patient, the further they move from the patient when they seek career development for until very recently, the only promotional avenues open to them were as administrators of nursing services or as teachers in schools of nursing. Thus, success as a nurse in New Zealand, as defined by hospital boards and the like, has tended to be measured solely in terms of the 'distance travelled' from direct clinical involvement.

Despite the fact that until 1977 no avenue for promotion beyond the Charge Nurse level existed for nurses wishing to remain in clinical nursing practice, the Department of Health has, over the years, maintained the view that nurses should 'nurse'.

> '... it is highly unlikely that we have a shortage of qualified nurses in this country. What we do have is a serious shortage of "nursing". Many health agencies have not yet been forced to ensure that *all* nurses are involved in clinical activities... Too many nurses are still involved in too many hotel type activities such as making empty beds, doing flowers etc and in some instances in management activities which do not require nursing judgement.'

So stated Shirley Bohm, the then Director of the Division of Nursing, in 1974 - some nine years after Professor Alma Reid's forthright assertion that there were some fundamental misconceptions in the role of the nurse in New Zealand because:

- 'auxillary help' was seen serving lunch to and feeding sick patients while students of nursing cleaned stainless steel equipment and mopped the utility room;
- ward sisters were observed to interrupt their ward rounds to patients to answer the ward telephone and look after inconsequential messages;
- a number of deputy matrons spent most of their time dealing with questions relating to linen services and other housekeeping functions.

In Reid's opinion there seemed to be a great deal of confusion about what is and what is not nursing especially for

those in what she described as 'top leadership positions'. But this is hardly surprising for until less than two years ago, promotion and the rewards deriving from it could only be gained by moving *away* from what Reid and the Department of Health considered to be the proper role of the nurse.

As a result, many nurses were confronted with a dilemma whether to accept promotion and move away from that which had initially attracted them to nursing, namely clinical contact with patients, or whether to refuse promotion and career advancement in order to remain active in clinical nursing practice. Sadly, for many nurses, it was not until 1977 that the first steps were taken to create a clinical career structure within New Zealand nursing.

Clashes between the role expectations of others with whom nurses share their day-to-day working environment and those of nurses themselves are apparently a most potent resource of role confusion and conflict. Unfortunately there seems to be very little objective evidence of the extent to which the patient's ideas of the nurse's role coincide or conflict with those of the nurse. Although some hospital boards are in the process of undertaking 'consumer satisfaction' surveys few, if any, of the items included in the questionnaires relate to the nursing role *per se*. Similarly, there appears to be a dearth of objective information about the way in which colleagues, including doctors, physiotherapists, social workers etc., perceive the nurse's role. While the statements of individuals cannot be taken as necessarily reflective of any professional group as a whole, a comment included on the 28 April 1971 Notice of Meeting for the

Canterbury Division of the Medical Association of New Zealand is indicative of the Medical view of nursing which tends to invite conflict:

> '... this Association ... must assume a major role in planning any changes in nursing education and administration. ... Nursing is not and never can be an autonomous profession but it is and must remain, one of the mainstays of our medical system. Doctors have let the control of this group slide away and it is high time we resumed a greater measure of responsibility in this field'.

Obviously the number and nature of 'significant' reference groups outside the nurse's immediate employment varies from one individual nurse to another. Even so, it seems pertinent to comment, albeit briefly about three, the nurse's family, school of nursing and professional association.

One of the most powerful forces for myth maintenance in New Zealand nursing today is the mother of a nurse who is herself a nurse, but a non-practising one! Unfortunately, the picture of nursing which all too frequently emerges from the recounting of 'what happened in my day' bears little or no resemblance to nursing as it is currently practised. As a consequence, many young nursing students experience substantial adjustment problems when attempting to reconcile the 'picture' and the reality.

Clearly, the philosophy and concepts of nursing espoused by a nurse's training school play a vital part in shaping his/her subsequent role expectations. If these beliefs and concepts differ markedly from those of the new graduate's first employing body, role confusion and conflict are likely to be

the result. This problem is possibly greater for the graduates from the technical institute nursing programmes where the patient-centred approach to nursing practice forms the basis for both theoretical and clinical teaching. Upon registration, a substantial number of these nurses will be employed in institutions where the approach to the provision of nursing care is almost always task-centred.

As Shetland (1976) pointed out, professional nursing organisations have the responsibility for defining the nursing role by clarifying the functions which describe nursing practice. To what extent has the New Zealand Nurses' Association, the professional association to which the majority of nurses belong, taken up this challenge? During the past two years the Association has published two functionally descriptive statements about the role of the nurse in New Zealand: the first, released in January 1976, was essentially the same definition of nursing published in the Board of Health Report (1974) and cited earlier in this paper; the second statement was formulated in 1975 by the Alberta Association of Registered Nurses and subsequently adopted for publication by the New Zealand Association in its policy statement 'New Directions in Post-basic Education' (1976). In 1977, the latter part of the Alberta nurses' statement was also used as the approved definition of the generic functions of the New Zealand nurse by the participants in the Nursing Manpower Planning Workshop.

Both statements are very similar in terms of the behaviours they specify as appropriate for the New Zealand nurse however as has already been mentioned, both definitions are future-

oriented and, as such take little account of present day realities. While it can be argued that future-oriented definitions at least indicate the directions and goals thought to be desirable, it can also be said that such definitions, in themselves, create confusion and conflict since present circumstances serve not only to frustrate their immediate implementations but also to stimulate a measure of professional cynicism about the prospects of future implementation.

Despite the recent publication of two functionally descriptive statements within one year, there is some evidence to suggest that many members of the Association are still somewhat confused about the role of the nurse in New Zealand.

At the Association's Annual Conference in April 1977, the following remit was passed with a substantial majority:

> ' That the New Zealand Nurses' Association involve itself in an attempt to define the content of nursing practice in relation to the work of other health professionals.'

Obviously it is a truism to say that each nurse has his/her individual conception of the role of the nurse. However, such a statement highlights the fact that the nurse role may be played in an infinite variety of ways with each interpretation being reflective of an individual perception and level of role skills.

Although some may still argue that the proper role of the nurse within the New Zealand health services is managerial,

that is not to nurse, but to see that the patient is nursed, the overwhelming majority of nurses would agree with the contention of Hutchison (1975) that the nurse's primary function is patient care while his/her primary role is clinical.

This being so, an increasing number of New Zealand nurses are experiencing conflict between their realistic role and their idealistic role. Whereas a growing proportion are now convinced that direct patient care is their legitimate function, in reality they have to organise, teach and undertake administrative functions. It is worth commenting at this point that while many nurses often express their dislike of administration, progress up the status ladder takes them, almost invariably, to just such a set of tasks.

Although confusion and conflict, if permitted to persist without relief, will levy a heavy toll on the motivation, job satisfaction and productivity of the nurse, Benne and Bennis (1959) have made the point that growth will only occur when confusion and conflict are accepted and resolved creatively. To deny conflict or the reasons for it 'usually leads to adjustments quite other than those of growth' according to Benne and Bennis.

Thus the confusion and conflict which characterise New Zealand nursing must be acknowledged for only when it is acknowledged can its nature be explored and possible solutions devised.

5. THE EFFECT OF DIFFERING IMAGE AND ROLE PERCEPTIONS UPON NURSING EDUCATION IN NEW ZEALAND.

The beginning of formal nursing education in New Zealand dates back to 1884. The embryo system, although having its roots in the English Nightingale tradition, differed in one highly significant respect; unlike the school established by Florence Nightingale, each early New Zealand school was placed under the direct control of a hospital. Within these schools an apprentice-type training was developed, the students being employees of the hospitals, learning as they worked. Although certain improvements were made, the system remained relatively unchanged until the introduction of the first of the technical institute-based nursing programmes in 1973.

During the ninety or so years since the advent of New Zealand's first schools of nursing, the nation's health services have undergone a dramatic increase in extent and complexity yet, in spite of this, the nursing services have persisted in retaining the hospital-based apprentice as the dominant employee unit. Several fairly predictable consequences can be seen to have been the result.

First, qualified nurses in New Zealand have tended to see themselves more as supervisors and controllers of students rather than as practicing clinicians. Regrettably,

there are still a vociferous minority of nurses and others who believe that active clinical practice should virtually cease upon the attainment of basic registration.

Second, the practice of nursing in New Zealand until recently has been dominated by what can best be described as an illness oriented, hospital-based concept of care. This is hardly surprising, for, until the advent of the technical institute based nursing programmes in 1973, *all* New Zealand nurses received their basic education within hospital based schools of nursing where they were prepared essentially for a hospital based nursing role.

Third, as overseas nurses began to explore concepts of the role of the nurse, many New Zealand nurses, feeling their isolation from the mainstream of international professional activity, tended to become extremely defensive and inward-looking, often resisting change on the grounds that because everyone knew that New Zealand nurses were among the best in the world, the status quo should be preserved at all costs.

In his book, 'Educating New Zealanders' (1967), Jack Shallcrass makes the point that one of the main problems about formal education is its conservative nature; students almost always being educated for the world their teachers knew or know now, regardless of the fact that this is not the world the students will inhabit during the greater part of their lives.

This observation is of particular relevance to nurse educators who, as a group, have long had a reputation for extreme educational conservatism. It is indeed sobering to reflect on the fact that the majority of today's student nurses will be under 45 years of age in the year 2000. Furthermore, it is likely that they will be living and working in a world so different from that of today's as to be almost like science fiction. Clearly it is essential for the link between nursing service and nursing education to be a very close and mutually beneficial one for neither, as part of the profession, is independent of the other. Nursing service relies on nursing education to produce the competent practitioners to meet service needs; nursing education relies on nursing service to specify what those needs are not just in the numerical sense but also in terms of the roles the graduates will be required to play within the present and future nursing services.

Without such specifications, nurse educators are faced with having to make their own decisions about future nursing service roles. In so doing, they inevitably risk the accusation that they are 'dictating' to nursing service by deciding for it what sorts of nursing practitioners will ultimately be employed by it.

One of the most difficult problems at present facing nurse educators in New Zealand is that of reconciling ideal and reality in respect of present nursing roles. While there seems to be general agreement that the statements or

definitions of the nurse's role which emphasise the clinical aspect of nursing are those to which the profession aspires, the reality is that most of the registered nurses in current nursing practice *do not* have any direct clinical responsibilities although many, of course, are involved in providing clinical supervision and guidance for students of nursing.

The establishment in 1973 of technical institute based comprehensive nursing programmes was, in effect, the first active step towards the acceptance of a clinical role for the qualified nurse in New Zealand. However, the total replacement of hospital based programmes with institute based programmes is far from complete, (see *TABLE II*). While it is not intended to replace all hospital based programmes on a one-for-one basis, the six institute schools now in operation still play a relatively minor role in terms of the overall production of qualified nurses within New Zealand. The fact that there is still no formal plan for the orderly phasing out of hospital based nursing programmes not only creates planning difficulties for hospitals and technical institutes but also serves to aggravate the already substantial demand by hospital based graduates for bridging programmes, particularly in community health nursing.

The concept of the nurse as a practicing clinician received further official support in July 1978, when it was announced that one year post-basic diploma programmes in

TABLE II: THREE YEAR PROGRAMMES OF BASIC NURSING EDUCATION IN NEW ZEALAND

BASIC THREE-YEAR NURSING PROGRAMMES

	HOSPITAL BASED			INSTITUTE BASED
	REGISTERED GENERAL AND OBSTETRIC NURSE	REGISTERED PSYCHIATRIC NURSE	REGISTERED PSYCHOPAEDIC NURSE	REGISTERED COMPREHENSIVE NURSE
	MAY PRACTICE AS A FIRST LEVEL PRACTITIONER (STAFF NURSE) IN MEDICAL/ SURGICAL OR OBSTETRIC AREAS	MAY PRACTICE AS A FIRST LEVEL PRACTITIONER (STAFF NURSE) IN PSYCHIATRIC AREAS	MAY PRACTICE AS A FIRST LEVEL PRACTITIONER (STAFF NURSE) IN PSYCHOPAEDIC AREAS.	MAY PRACTICE AS A FIRST LEVEL PRACTITIONER (STAFF NURSE) IN ANY BRANCH OF NURSING IN NEW ZEALAND *I.E.* IN MEDICAL, SURGICAL, OBSTETRIC, PSYCHIATRIC, PSYCHOPAEDIC OR COMMUNITY HEALTH NURSING.
Number of schools at 31 March 1977:	22	6	3	4
Number of Students for the year ending 31 March 1977:	4,952	647	284	465

ALL PROGRAMMES ARE OPEN TO MALE AND FEMALE STUDENTS ON AN EQUAL OPPORTUNITY BASIS.

The above figures have been drawn from *THE STATISTICAL ANALYSIS OF SCHOOLS OF NURSING ANNUAL RETURNS FOR YEAR ENDING 31 MARCH 1977.*

clinical nursing would be established in four technical institute schools of nursing.

The fact that such changes involve the expenditure of large sums of public money raises the issue of the potential effect of differential perceptions of the nursing image on plans for professional development. As the results of Hines' (1973) study indicate, the current image of the nurse may not always be an asset to the profession when it is attempting to win support for new, and necessarily costly, educational developments such as, the establishment of basic degree programmes in nursing in one or more of the country's universities.

Obviously plans to extend or expand the role of the nurse will have, as a corollary, the pre-requisite of an extended or expanded professional education.

Thus it can be seen that perceptions of the image and role of the nurse have considerable practical significance for those responsible for the planning and providing of nursing education, both at basic and post-basic levels.

6. CONCLUSION

It has been claimed by Shetland (1976) that one of the most exciting developments in nursing today is the

progress that is being made in clarifying and defining nursing's functions, scope and standards for practice and in designing new ways of organising services with clinical practice as a focus. There are few nursing leaders who would not agree that this decade is indeed an exciting one for the nursing profession both overseas and in New Zealand. There are however, some issues which must, as a matter of urgency, be the subject of careful scrutiny and thought by members of the nursing profession.

Possibly the most significant of these is the future direction of nursing practice. Since the end of the Second World War - many highly educated and able nurses have applied themselves to the task of building up a body of professional knowledge specific to nursing practice. These nurses, in their search for prescriptive authority, have tended to draw heavily on the social sciences and as a result the theory and practice of professional nursing, has begun to move even closer to the sphere of the social worker. It would seem to be only a matter of time before some real conflict of interest begins to become apparent. This same process has, it seems, moved the theory and practice of nursing away from its traditional medical orientation. Not surprisingly there are those who feel that there is a gap opening up between medicine and nursing which can only be filled in one of two ways; the deliberate technological expansion or extension of the nurse's role on the one hand, or the creation of yet another category of health worker

(the physician's assistant, for example), on the other.

While New Zealand nursing is by no means immune from this present dilemma, it seems that there is a dearth of much needed information about aspects of the present and possible future roles of the New Zealand nurse. Without a clear understanding of what nurses, especially young nurses, want for themselves and their profession, it is difficult for those involved in the planning and management of nursing education to effectively meet their professional obligations and responsibilities.

As a baseline from which to start the information gathering process, an assessment of the professional values and aspirations of those about to graduate from the programmes of basic nursing education would seem to have much to recommend it. This is especially so at the present time when New Zealand has two parallel systems of basic nursing education currently in operation.

Do the products of the technical institute programmes have significantly different views of nursing than those of their hospital based colleagues? If so, are there any significant consequences for clinical nursing as it is subsequently practiced? The questions are legion, but as yet few have actually been posed.

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