Clinical Nursing: The Specialist - The Generalist*

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During the past few years the increasing nursing shortage has received much public scrutiny. Treatment of this subject has varied from alarmist accounts in the popular press to elaborate statistical treatment in the professional journals. No matter how the counting process is managed, the end results are the same. All projections are bleak and dismaying. However, most seem to have one common theme. Most of the various projections seem fixated on maintaining the status quo form of nursing far into the future. The widely circulated report of the Surgeon General's Consultant Group on Nursing (1963) is an example of this type of thinking. There are few refreshing suggestions for change.

It might be helpful and productive to examine the present structure of the nursing profession in an attempt to seek points of departure that might make the future assurance of patient care more tenable. The present means of preparation of nurses and methods of giving care seem to becoming increasingly inadequate to cope with the enormous demand for care. In the face of this demand, the nursing profession has the appearance of being immobilized by its own dilemma. Needed innovations and change are slow to materialize.

The present state of nursing seems to be the result of a series of accidents of history. In order to fully appreciate the scope of the problem, a brief historical analysis may have some utility. No attempt will be made

to order the priority of importance of the following items in this short analysis. Nursing has remained as highly female as the two powerful groups, with whom the profession interacts, has been predominately male. The cultural pattern of male ascendancy tends to dominate this interaction. Instead of asserting their own professional destiny, nurses have demonstrated a predilection to accede to the decision making of hospital administrators and physicians. An analysis of the work delegated to them by these two major groups tells a story in itself. Nurses have become inundated with many activities which greatly distract from the main task of clinical nursing. In response to this "overload," there has been very little organized resistance from nurses.

A second influence is the great reluctance on the part of nurses of professionalize the profession. Membership in the American Nurses' Association remains relatively low to the potential. Nursing is the only profession which does not prepare all its practitioners in university and collegiate settings. Even more important, it is the only clinical profession in which the membership is not prepared at the post-baccalaureate level. As a consequence, nurses have been without the benefit of the power of knowledge when collaborating with other health professionals. Compared with the other health disciplines, nurses have been unable to speak and to write with authority.

A third influence is the lack of organized continuing education programs. As a result of clinging to hospital schools as the primary training ground, continuing education has been discouraged. Hospital schools end their responsibility to their students upon graduation. There is little or no organized means by which graduates from diploma programs can continue their education through these facilities. Nurses who seek further education must do so through
some other educational means. When nurses attempt to do this they become rudely aware of how little academic merit is attached to their previous hard work. Disenchantment with the whole system of education and disillusionment with the profession are further by-products. A form of anti-intellectualism seems to pervade the profession and to further hamper innovation and change. The means of translating available new knowledge to its application in clinical practice becomes tenuous at best. Nurses learned "how" instead of "why." A continuation of this pattern can be a sure method of guaranteeing mediocrity.

A fourth important influence was the decision made by nurses to attempt to give nursing care through "others." No other major profession has so willingly given up its central concern. With this decision, nursing sold its birthright for the proverbial mess of porridge. Nurses became managers of care rather than providers of nursing care. The supervision of large numbers of untrained, poorly trained, and half-trained workers became such a major preoccupation that patient care frequently had the appearance of a lesser consideration. Prestige and status became attached to managerial roles and abilities rather than to competence with patients. All the economic rewards were centered on these roles. This economic support added strong reinforcement to this movement. Graduate degree programs emphasized role training rather than clinical nursing. The gap between competent nurses and patients widened.

It may be said in some defense of nurses that they may not have been the prime makers of this decision. The Hill-Burton Act provided a substantial reservoir of funds for a rapid expansion of hospital beds. Community hospitals tended to over expand. Not only did every community want its own hospital but it also wanted each type of service. Physicians exerted great pressure to have
beds and other facilities to serve their patients. Harassed hospital administrators in turn placed great pressure on directors of nursing to staff expanded and unopened units. Nurses felt this sustained squeeze. Having never formulated any official clinical standards of care, they seemed at a loss to resolve the complexities of the problem. The most expedient way out was to water down the quality of nursing care by employing non-professional personnel. This apparently was preferable to taking a strong professional stand against superordinate persons such as employers and physicians. By this decision nurses became "neither fish nor fowl"—neither fully committed clinicians nor fully recognized managers.* The managerial type of nursing took on a more concrete form when the so-called functional method of nursing care was introduced. Under the rubric of assigning nursing personnel according to competency, it became a euphemism for entrenching the managerial system. Nurses became task specialized. The gulf between professional nurses and patients was almost complete.

Concurrently with these developments nursing educators adopted a "purist" format. Nursing educators and students were no longer to become contaminated by service to patients. Educators, for the most part, retreated from direct responsibility for patient care. The National League for Nursing, as an accrediting agency, tended to frown upon educators having any service responsibility. The best prepared persons in the profession became disengaged from clinical care. Patient care units became to be viewed almost as sterile laboratories rather than scenes of professional investment and excitement. By being removed from direct service responsibility, nursing education became more

* I am indebted to Dr. William Form, Head, Department of Sociology, Michigan State University, for this observation.
academic than clinical. It is no wonder that the most common complaint of nursing students is that education and practice are worlds apart.

The last of the historical events to be touched upon was the collapsing of the six national nursing organizations into two. Unlike many clinical and professional associations which are organized around central specialty areas such as psychiatry and surgery in medicine or clinical and experimental interests in psychology, the American Nurses' Association is organized under such rubrics as a Nursing Service Administrators' Section, a Head Nurses' Section, and a General Duty Nurse Section. Other similar sections are delineated. Functions, standards, and qualifications are defined for professional positions. Thus the structure of the professional association appears to reinforce a managerial orientation to nursing care. The clinical conference groups occupy a relatively impotent position in the organizational structure. Role concerns take official precedence over clinical concerns. Organization position becomes more important than professional competence. The difficulty of buttressing clinical practice is increased.

Where has this review led us? What, if anything, has it contributed to our discussion of the day? If the nurse generalist is defined as a clinician who attempts planned nursing intervention to assist in reversing or arresting the pathology of patients and if the nurse specialist is one who does this same activity with greater expertness and creativity, what are the implications of the foregoing analysis for nurse practitioners. One deduction could be that most nurses are neither generalists nor specialists but rather just managers of care. This conclusion may seem unduly harsh or perhaps wholly incorrect. However, if one examines the process of nursing care in many hospitals, one is hard put to find a significant amount of professional time and professional
nurse accountability for direct clinical care. Nursing often seems to have the form rather than the substance of clinical care. If nurses make the decision to return to direct clinical practice, the question of the generalist vis a vis the specialist will be able to be examined more definitively.

Suppose, for a moment, what the present state of the profession would be now if the following events had replaced the historical trends and occurrences cited above. (1) A substantial number of men had been recruited whose uninterrupted career patterns matched those of hospital administrators and physicians. (2) The professional education of nurses had been moved, at an early date, to colleges and universities. (3) Graduate education emphasizing clinical training had been developed. (4) The economic rewards for nurses had been placed on clinical competency. (5) Nurses had not allowed hospital administrative functions to have been assigned to them. (6) Finally, if instead of surrendering their investment in nursing care, nurse educators had allocated part of their time to direct patient care and to nursing service. Probably, if these events had come to pass, there would be no need for this paper. In all likelihood, the issue of specialization would have been decided years ago. The problems of the profession would be of a different nature.

However speculation, about what might have been, will not resolve today's quandaries. Two major considerations loom as guidelines that are basic to posing the notion of specialization. The first of these considerations pertains to the level of the quality of nursing care. The general hospital is divided into many specialized subunits. Is it feasible to expect that high quality care can be obtained consistently by putting nurses trained as generalists only into this wide variety of specialty units? Is it conceivable that
generalists can continue to be used as staff, in any sort of indiscriminate fashion, on these specialized units and still maintain high standards of nursing care? As medicine and the other health disciplines become increasingly specialized, can generalists from the nursing profession articulate effectively with them? Is it a sound principle to carry on the practice of the interchangeability of nurses on the various specialty units? Under an organizational pattern that emphasizes discrete, special units, will nurses become prone to turning into task specialists rather than to become generalists in the process of clinical care? These are a few of the many questions which must be tested before the nursing profession can settle for a predominately generalist orientation.

The second major consideration is the problem of how to successfully manage new knowledge. A popular theme of the day is the so-called explosion of knowledge. New information is being created at a much faster rate than it can be translated into practice. Professions need a linkage system between sources of new information and the practitioners in the field. Practically all the professions have attempted to manage knowledge by the process of specialization. The persons with specialist training act as linkage systems between the new knowledge being created in their specific area and the profession in general. By this mechanism, inputs of new knowledge are being fed continually into the profession. As a result, the entire profession is being constantly upgraded.

A profession which does not have this linkage system is likely to be dependent on others for knowledge and innovation. A "dependent" profession is not likely to be accorded great social worth or to be intensively sought after
as a team partner. It appears reasonable to expect that, without specialization, the information gap between specialists in the medical profession and generalists in the nursing profession will become greater. The inter-professional strain between both may increase further. It also seems safe to predict that increasing amounts of specialist technicians will be invented to handle this knowledge deficit. Society cannot afford to wait for any one profession to decide whether knowledge will be utilized. Specialization in nursing will not stop this trend but it may reduce the necessity for much of it. The more that new technical specialists are introduced, the greater becomes the problem of the coordination of patient care, and the more likely is the generalist to find another worker between the patient and himself.

Given the present state of affairs within nursing, what alternative paths of action are available? In the next few paragraphs, one possible plan will be suggested, mainly because parts of the plan are being developed in various settings. This plan calls for the surrendering of most of the coordinative functions, now being done by nurses, to unit managers and other departments. The single criterion by which nursing would retain an activity would depend on whether or not it was a clinical activity. For many years, nurses have attempted to coordinate patient care without the authority to do so. Much nursing time and energy are invested in this dilemma of coordination. It is the chief distraction from clinical practice. With this suggested plan, the only coordination assigned to nursing would be that of coordinating clinical nursing care.

The hospital nursing services would be divided into specialty services. Each patient unit would be staffed by nursing teams and supervised by a nurse
specialist. The nurse specialist would report directly to the director of nursing. All other layers of supervision would be eliminated. The director of nursing (or chief of nursing practice) would not be responsible for any administrative or bureaucratic tasks excepting those directly related to supervising a clinical nursing program. The director of nursing would be a clinician and serve as a consultant on nursing care to the staff.

The nurse specialists supervising each patient unit would be responsible primarily for programming the clinical care for the twenty-four hours on the units that they supervise. In addition, they would set the nursing standards, coordinate activities within shifts, and across shifts. They would be responsible for the in-service education program peculiar to that service only. Another prime function of the specialists would be that of facilitating the articulation of medical programs with the nursing care programs so that the level of patient care could be raised. This plan does not preclude the use of other nurse specialists either as team leaders or as members of the nursing team.

The nurse specialists would not be confined by time scheduling to any one shift. They would have the freedom to structure time spent in the patient unit according to service demands. This will permit the specialists the freedom and fluidity to move with the demands of the situation as determined by that moment in time.

Many nurse generalists still would be necessary for the effective management of patients. It is a common present practice for generalists, who are working in a specialty unit, to call themselves medical, psychiatric, or surgical nurses without the preparation to go with this specialty designation. If nurses with specialty training were working on these specific units, the generalists
would have the opportunity to work with them side by side, obtain frequent consultation from them, and observe their performance. By having this highly visible "role model" for daily interaction, the generalists would have a rich opportunity for upgrading their skills and the whole process of nursing care would be improved. There would be an increased likelihood of job satisfaction and a greater zeal for and commitment to the profession would probably ensue.

It is not suggested that hospital nursing services attempt a massive change in this or similar directions. Pilot units should be set up to test the workability of the design, to solve the initial problems, and to provide a working model.

There are not enough nurse specialists to supply the demand for these kinds of designs. However, many nurses intuitively desire to have close contact with patients. More nurses probably would enroll in graduate programs if they had the opportunity to interact with expert nurses and to experience the satisfaction of acquiring more competence in patient care. The level of nursing practice would be raised by the consultation and demonstrated practice of the nurse specialists. Nursing students would have a different and more professionally stimulating type of behavioral model. With the surrendering of non-clinical activities, it is possible that the nurses aide group could be greatly reduced in numbers or eliminated entirely from the nursing department. Most important of all, professional nurses would be brought into close contact with patients. After many years, patients would begin to receive the kind of nursing care that current nursing knowledge could make available to them.