Specialization in Professional Nursing*

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One of the most important developments in professional nursing is the preparation of clinical specialists. The title dates from 1938, when it was first used, but it is only in the last two decades that there has been viable effort to back up the title with graduate programs that prepare such clinical experts.

Several trends at work in a society tend to lead toward specialization in a field:

1. Any large increase in knowledge about phenomena germane to a particular field tends to lead toward specialization. In the professions, such increased knowledge places a new and major burden on the generic programs which cannot teach all that is new, nor can they *quickly* revise curricula so as to exclude the outmoded in order to provide time for consideration of larger portions of available new knowledge. In the basic sciences, increased new knowledge opens up more possibilities of relations between different basic sciences. Since not all the basic scientists in a particular field are or can become interested in these relations, nor can curricula in science departments be revised radically, *quickly* enough, so that oncoming scientists can tend to these relations, one result is specialization across sciences—biochemistry is one example.
2. New knowledge in the basic and applied sciences (i.e., in the professions) leads inevitably to new technology, which in turn calls for more complex technological skills and intellectual competencies among the practitioners. New professional practice must first be acquired by a few entrepreneurs—who devise and test them out for effectiveness and who help perfect such practices which ultimately, then, are taught to general practitioners in the profession. However, not all of the practices are or can be taught to general practitioners; as a result, specialization is often maintained around particular professional practices.
3. When the attention of the public focuses on areas of public need which hitherto have received scant attention from the available professions, new areas of specialization tend to be formulated. These new fields usually have a great shortage of professional personnel who have both the interest and some know-how specific to the phenomena relating to these problems. Rehabilitation, mental retardation, and the like, are examples. From this standpoint, new specialists tend to be developed in response to public need and interest.

Specialization within a profession (an applied science) or in a basic science tends to be a division of the generic field or some recombination of aspects of different fields, which occur along some logical lines. The logic is not necessarily apparent to all in a par-

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ticular field at first. With specialization the focus tends to become narrowed upon a piece of the field, which allows greater development of depth of such a piece or the focus is a recombination of a piece of one field with a piece of another field—so that relations among specific phenomena can be studied and formulated (e.g. biophysics).

Initially, the patterning of specialization is determined by avant garde workers in the particular field who see or sense a great need to move—in depth—in a particular direction. With regard to the profession of nursing, at first particular nurses move in a direction that interests them or toward which they have an immediate opportunity. Over a period of time some of these directions survive and some of them don't. Survival of a particular direction is dependent upon many things, no the least of which—in the case of nursing—is the necessity of interesting masses of nurses to accept and support such new directions. (For a group with three-fourth of its members uneducated in academic institutions the task constitutes an heroic feat!) The work of the "pioneer," however, must be subjected to the survival test—if it is to become either a part of generic nursing or a specialized aspect of nursing. Masses of nurses must become aware of individual efforts, learn enough about them to debate their merits, and give them sufficient support so that creative and constructive innovations can continuously be flowing into professional nursing. Ultimately, the profession of nursing—that is, representative workers speaking for and through the professional organization (i.e., The American Nurses Association)—must decide the lines along with specialization will develop or be revised. At the 1964 ANA convention the House of Delegates voted to consider the feasibility of "academics"—a very first step in this decision-making process.

The practical efforts of particular innovators in nursing is no the only initial stimuli in the development of specialization. Governmental funds and other sources of financial support not only aid and abet such practical efforts but serve also as stimuli to the development of particular directions in specialization. Such funds are generally made available to stimulate preparation of experts who can give direction to the profession so that particular health problems of the public can be solved. Some examples are funds for the tuberculosis, heart, and cancer; governmental funds such as the Children's Bureau, Mental Health, Mental Retardation, and Rehabilitation. Universities are urged to seek and use such funds to prepare experts who are needed. Universities turn to individual nurses who have initially been involved in these developing fields and/or have some ideas about what should be done and some bases to help nurse graduate students develop expertise beyond the generic level along some particular line.

Public demand and such grant support, therefore, sometime becloud the problem of the profession's choice of the direction that should be taken in developing or naming specialization in nursing. (For example, the phrase "mental health," which actually preserves the mind-body split, had more sales value in 1945 than did the word "psychiatric"—it was a cleaner less stigmatized word—hence the phrase "Mental Health Act." Most nurses believed that "rehabilitation" was not a specialty, but an aspect of all nursing; but funds available aided and abetted some specialization this direction.) Ultimately, however, it is the nursing profession that must choose; in considering the feasibility of "academics," the Committee of the American Nurses Association will have to decide that X effort should continue and merits inclusion in the academy and that Y effort should not.

The profession has a wide range of choice among already available specialty practice areas, and it has several models used in other professional fields to use as a basis for making a decision. I'd like to discuss these choices and models with you and then focus upon the clinical specialist as one such direction. Some of these choices suggest immediate rejection, while others will require careful deliberative thought by you and by the professional nurses who will have the privilege of representing the reset of us hen responding to the ANA's directive in studying the feasibility of academics in nursing. I have given headings to ten of these choices and will point out the models from other disciplines.

THE AREA OF PRACTICE

Public health nursing immediately raises the question of whether specialization should occur according to the area of practice. If this route is followed then, it is conceivable that specialists would be prepared for general hospitals, psychiatric hospitals, tuberculosis hospitalize, mental retardation centers, industry, and the like. School nursing, similarly, raises the question of whether this requires a "specialist" or whether the general practitioner would specialize according to some other scheme but then have the option of practicing in schools and other types of facilities.

ORGANS AND BODILY SYSTEMS

Medical technology has led to complicated cardiac and renal procedures and to extraordinarily complex cardiac surgery. Similarly, monitoring devices being used to gain new knowledge about cardiac disease has the active participation of several professional nurses. However, I think the profession would reject the development of specialists in renal nursing, cardiac nursing, metabolic nursing, mental nursing, and the like. There might be in time limited development of a few such experts and get feedback into graduate education. There is also the question, however, whether some of these might—at some future date—be considered subspecialties of whatever routes of specialization are decided upon.

AGE OF THE CLIENT

The increasing population of aged persons has given rise to the suggestion that nurses are needed for "geriatric nursing." Similarly, I believe a doctoral thesis here at Teachers College had to do with "Adult Nursing." Following this trend would lead to the development of specialties in "premature, " "infant," "child," "juvenile," "adolescent," then adult and geriatric nursing. The logic is that the phenomena for which nursing services are required are more indigenous than not to the age of the patient.

DEGREES OF ILLNESS

Hospitals have increasingly been developing "progressive care" units. The exploding population together with

advances in medical science has increased chances of survival but given rise to large numbers of patients who have "chronic diseases" for which continuing nursing services (care or supervision) are indicated. Following this possibility would mean developing specialization such as "nurses for acute illness," "nurses for convalescent care," "nurses for chronic illness services," and the like.

LENGTH OF ILLNESS

Similarly, there have been suggestions that the length of illness makes a difference in the knowledge that the nurse must have and in the procedures for application of such knowledge. It is said that with "short term" cases—who are ambulatory in a very short time—a very different kind of depth knowledge is needed than in the are of "intermediate" and "long term" cases. It is said, for example, that more health teaching and counseling can be done with the latter cases and that practically none can be done with the "short term" cases.

NURSE ACTIVITIES

In the last decade or two, nurses have witnessed a considerable fragmentation of nursing services to the particular patient. Articles in the American Journal of Nursing have described some of these. If pursued toward specialization, the profession would develop exerts as "medication nurse," "insulin coma nurses, " "blood nurses" and the like.

FIELDS OF KNOWLEDGE

Sometimes a new field of knowledge gives rise to new terminology that, in turn, could lead to specialization by nurses. Hence such terms appear as "nuclear nursing," "interpersonal nursing," "electronics nursing," and "space nursing."

SUBROLES OF THE WORKROLE OF STAFF NURSE

I have described these subroles in detail elsewhere in the literature but there have been some suggestions that specialization should occur along these lines. If so, we would have the "mother-surrogate nurse," "expert technical nurse," "health teacher," and "nurse counselor" (or "nurse therapist").

PROFESSIONAL GOAL

There has already been some development of "rehabilitation nurse" experts. If we follow this trend, then there should develop specialization of nurses for "prevention nursing," "curative nursing," "ameliorative nursing" and "rehabilitative nursing."

CLINICAL SERVICES

This focus for specialization follows the medical model. Currently there are graduate programs in medical-surgical, maternal-child health nursing, and psychiatric-mental health nursing. It is conceivable that if this model is followed, some consideration must be given to whether the clinical specialization should be broadened by further division of some of the foregoing areas into medical, surgical, pediatric, maternal, and psychiatric nursing. It would also be necessary to consider suitable subspecialties; for example, in psychiatric nursing subspecialties are now available in child psychiatric nursing and mental retardation nursing.

The social work model provides another basis for considering the direction of specialization in nursing. Social work at first followed and since has discarded the medical model. You perhaps know that in the second year (or earlier) of the two-year, Master's level generic social-work educational program, the student elects to major either in "casework," "group work," or "community organization." Similarly, using this pattern, nursing could decide to pattern its specialization upon "dyadic nursing" (i.e., the one-to-one relationship), "group nursing" (including group psychotherapy which is developing), and community nursing (which could take in community mental health centers and public health nursing).

Another major trend that must also be taken into account seems to be at work in the nursing situation. A literature survey by Fern Kumler in June 1964, with respect to articles written by psychiatric nurses in the last decade, indicated that about 40% of these articles has to do with *direct care of patients by nurses* and 40% had to do with *coordination of nursing and patient care* by professional nurses. I was surprised that there were this many articles on coordination; I had, of course, hoped that nurses would have written more about direct nursing practices. Nevertheless, this finding suggests a need at least to consider specialists who are "clinical specialists"—i.e., direct-care practitioners at the expert level—and "clinical coordinators" who are expertly prepared in a clinical area with respect to coordination of car that is given.

If expert "clinical coordinators" are prepared, they need, somewhere along the way, to get some clear differentiation of the significant differences between *patient care* and *nursing care*, and on whether they are coordinating one of the other of these. Nurses and doctors tend to use these two phrases as if they were synonymous with each other, which they are not.

> Hospitals, and health facilities of other types, offer patients or clients a large complex of services called *patient care*. Nursing care is one important component—among others—in this patient care complex. Medical services, nursing services, social work services, psychological services, laboratory services, and many other types of hospital services make up this complex called patient care. Patient care is more than the sum of these separate segments. Interaction and interdependence of personnel and interlocking of their knowledge and know-how, characterize relations among separate services. Professional nurses must sit down with workers in all of the health disciplines, taking the initiative in doing so if necessary, to clarify when, how, and for what purpose nursing does inter-relate with services rendered by other disciplines. Nurses need to pinpoint intersecting, overlapping, and identical functions and activities which they share with other professional disciplines. And nurses must identify their unique nursing functions.†

†Hildegarde Peplau: Keynote address, Michigan Nurses Association, 1964, p. 2, mimeographed (available from Luther Christman, University of Michigan, Ann Arbor).

If "specialist coordinators" are prepared, much thought must be given to their need for clinical expertise and knowledge of personal relationships, administrations, interdisciplinary problems, procedures, and prospects. One thing is certain: nurses now coordinate *patient care*. As the patient care becomes more complex, experts will be needed. Should these experts be nurses?

Need of Clinical Specialists

Clinical practice is the center of nursing. The primary commitment to society of the profession of nursing is the practice of nursing; all other functions are secondary. The profession evolved to serve patients—which means to deal effectively with the clinical nursing problems that these patients present. The clinical specialist serves as a model of expertness representing advanced or newly developing practices to the general staff nurse. Theoretically, the clinical specialist not only works with the most complex problems in nursing but through such work provides a literature which helps constantly to revise the general practice of nursing. The clinical specialist is a model to "beat tradition." The substantive content of nursing has to do with the practice problems and theories that explain and help nurses to resolve these problems. It is precisely because we are short on clinical specialists that we are also short on substantive content.

The clinical specialist is also needed to develop new innovations in practice based upon emerging new knowledge. Theoretically, such specialists have greater freedom in their practice and can effect clinical trials of new ways to approach nursing problems. From such trials should come a feedback of effective practices to general nursing through basic curricula and staff development programs in nursing service situations.

Expert clinical practice in one aspect or slice of generic nursing is also a prerequisite for teaching. I think that it is unfortunate that nurses had their only opportunity, initially, for graduate level study in a teacher-training institution. This slanted the emphasis toward the preparation of teachers—and nurses for other types of functional positions—and it de-emphasized the substantive clinical base beyond what is learned in the basic program that must underlie graduate preparation of teaching. Without additional clinical knowledge, the teacher—despite holding a Master's degree —has nothing new to teach students. The feedback of new knowledge to this extent is limited, and the undergraduate program becomes "stable;" that is, its clinical content changes, albeit too slowly. I think it also has accounted for the fact that the teachers of clinical nursing tend not to keep their hand in clinical work by continuing practice. This tendency has enlarged the dichotomy between classroom and clinical service. In fact, the only glue that should hold nursing service and nursing education together is clinical interest in nursing problems. Also, any nurse teacher who does not work with at lease one patient on some regular and continuing basis becomes rusty in her own clinical competence; this increases her felt inadequacy, which, in turn, interferes with teaching and with maintaining stimulation professional discussions with nurse and other professional colleagues.

What doctors want mostly to talk with nurses about is clinical problems. The clinical specialist makes a good interdisciplinary colleague precisely because she is a sensitive nurse observer, has substantive knowledge, and can talk intelligently with other professionals to share observations and inferences.

Clinical specialization is also a basis for clinical nursing research—of which there is very little. It is expected that eventually all nurses will become sensitized to the problems coming to their attention in the work situation for which nursing as yet has no definitive answers. But the clinical specialist brings a broader matrix of theory that can be used to note problems meriting investigation as clinical nursing research. As the numbers of clinical specialists increase, the clinical nursing research will also increase.

Knowledge Essential for the Clinical Expert

The expert clinician must be a theoretician. She must have some answers to such questions as: What is theory? What different kinds and levels of theory are there? What intellectual and interpersonal procedures for application of theory are useful in nursing practice? How is new theory derived from empirical observations? How are empirical data formulated into testable research hypotheses? And so on. The expert like the general nurse practitioner uses three main steps in her work: (1) observations, (2) interpretation, (3) intervention. The difference is that the expert has more and *more recent* knowledge in her head to use, to explain what she observes and to decide interventions.

The expert clinician must also have a much broader context of scientific knowledge than does the general practitioner; that is, she has depth in knowledge. With the explosion of knowledge in all of the basic sciences—and it is expected this burgeoning of knowledge will continue—it can be assumed that the expert clinical nurse could not encompass all new knowledge. She would focus in one area. For example, in graduate level psychiatric nursing programs, there is a tendency to focus on the behavioral sciences. This does not mean that conceptual knowledge is overlooked. For example, at Rutgers, the students have a seminar in neuroanatomy that goes well beyond any basic program in nursing.

Problem of Title

It would be helpful if a title could be conceived that would convey the idea of clinical expertise in a field. Currently, there are many different title preferences: Clinical Specialist, Expert Clinician, Clinical Associate, Clinical Nurse Scientist, and so on. I think if the profession went the clinical service route of specialization, the title "psychiatric nurse" would be sufficient to designate the expert practitioner who has had graduate education and the title "staff nurse" or "general duty nurse" could be used to designate other less well prepared nurse practitioners.

Education

Advanced clinical education is a knotty problem. Currently, most psychiatric nursing problems—all of which since 1952 are at the Master's level—require about 17 to 19 months of graduate level education. The Rutgers program requires 19 months. I would like to have more time. In fact, I think there will be development in two directions: the Doctor of Nursing Science, as at Boston University, will

no doubt be the professional degree for the nurse who wants exclusively to be the expert practitioner in a field; the Ph.D., for the nurse who wants both to be the expert clinician and clinical nurse researcher. I think this development is slow in coming, but it is on the way.

It takes a lot of time to prepare an expert psychiatric nurse—clinically—for a number of useful reasons. First, the generic programs do not spend sufficient time in bringing into awareness of the nurse the nature of theory and what a nurse practitioner can do with it. Secondly, because nurses tend to be women—mostly in search of a mate—there tends to be considerable reluctance (if not outright resistance) to recognize and use the intellectual capacities that the nurse has. Nurses as women tend to believe the myth of the "feminine mystique" that the woman who is beautiful and dumb is more desirable. Thirdly, the educational program is very often a method of personality reorganization by academic means. The nurse must become an investigator—ready to question and critique everything that she reads—and this runs counter to the approval-disapproval needs of the student. The nurse must become an innovator—ready to imagine, formulate, and try out new ways to approach an emergent nursing problem—and this runs head on into the fear of making a mistake which (magically) may b considered fatal to the patient. The nurse must begin to think operationally, sequentially, and be able to formulate dynamic patterns as well as concepts—which is no small task—and this runs counter to the tendency to swallow what authorities say, to play is safe, to be easily impressed by published ideas, and to think in one dimensional concepts if not in terms of clichés. There are many drastic personal changes that should derive from the graduate level overhaul. As I said previously, I am talking about expert clinicians who can serve as models to beat tradition; that is, to make of the general practitioner a more independent thinker who can make individual judgments and defend them in colleague discussion. To evolve such models takes time.

What Can the Clinical Specialist Do?

Let me say at the outset that we have a long way to go to decide what it is that products of Master's programs, who have had advanced clinical education, can do. In psychiatric nursing, all the thirty some graduate programs are different. I am in favor of this diversity at the moment, for out of it will come a sounder synthesis in due time. Meanwhile, it is possible to say some of the things that the psychiatric nurse specialist can do and some of the things clinical specialists in general can do.

PSYCHIATRIC NURSE SPECIALISTS

There seems to be two main lines of development in the country. One has to do with the social milieu—milieu therapy, it is called; the other has to do with more direct psychotherapeutic work. There is very little that nurses have published on the milieu operations. In a general way, these psychiatric nurses promote a psychotherapeutic ward atmosphere, intervene in day-to-day interactions among patients in a psychotherapeutic way, utilize the daily program structure to promote favorable improvement in the patient, and so on. There is also the development of psychiatric nurses as psychotherapists—Rutgers is a case in point. The nurses are being prepared for individual interviewing (nurse therapy) of patients, for group psychotherapy and for family group psychotherapy. In addition, they learn how to do small systematic samplings of ward situations, home situations, and other types of problems, how to consult with a staff nurse who is working with patients, and how to conduct short-term clinical retraining workshops. The students also complete a study of a clinical problem. The best ones are encouraged to complete study at the Ph.D. level in a basic science.

CLINICAL SPECIALISTS

The clinical specialist is first of all a generalist—so she can do what is expected of a staff nurse. For this reason most of the programs require that the undergraduate experience of the applicant has included basic psychiatric and basic public health nursing.

The clinical specialist is a sensitive observer and knows how to use a specific theoretical matrix for observations and or formulating clinical hunches to be pursued in further clinical work or in research. The clinical specialist has a mastery of methods to analyze problems—knows how to use various interpersonal maneuvers in this process, and how to apply theory to and use resources in the solution of problems. Because she has a wide base of theory, she also has a respect for the tenacity of psychiatric problems and has patients to persist toward their solution.

The clinical specialist has and is aware of using a broad base of intellectual competencies. She is able to say: "Now I am generalizing from inadequate data—but this is my hunch;" or, "From the data at hand, my inference would be—based upon the following cues;" or, "My observation of such-and-such behavior suggested the use of a concept; and when I pursued that, this is what happened."

The clinical specialist has many modes of assessment of situations and behavior, including theory and other evaluatory systems, and she knows how to use technical reports from other experts in this regard.

Most of all, the clinical specialist has a theoretical and first-hand clinical understanding of the pathology with which she is concerned, in the patients she is working with; she keeps abreast of new knowledge that explains the pathology and purposes it serves; and checks this knowledge against her own observations.

The clinical specialist can write clinical papers and has an interest in keeping track of data in particular situations and in reporting her findings to professional colleagues through clinical papers that are published.

The clinical specialist disciplines herself to a professional use of her time and is able to function as an independent practitioner. She has the courage of her convictions and can defend her practices on rationale grounds, taking into account the fact that while most professional people profess that the needs of patients are the focus of their work, the actual fact is that personal prestige and status more often come first.

Employment of the Specialist

The state of Michigan now has a position title of "clinical specialist." However, before this position is crystallized, I

hope that there will be much concern among professional nurses that this nurse be allowed considerable freedom of movement within agencies in selection of patients with whom she works, in scheduling her time, and the like. There is also the need to consider her relation to the Director of Nurses and also to whom she will turn for validation (discussion and review) of her work. It goes without saying that she ought to be paid a suitable salary; most get $8,000 now.

Some Problems

The development of the clinical specialist has a long way to go. I believe Rutgers is the only program in the country that focuses exclusively on the preparation of expert clinical psychiatric nurses, and it is ten years old. There is really been very little discussion within the profession as to this trend—What it is? How should it develop? And so on. Because of this, there is some "suspicion" about the whole movement. And, like any other major change that has been attempted within the profession, the "status quo" is threatened by the forward look of "experts"—clinical or any other kind. However, the ANA clinical sessions of 1962 and 1964 have demonstrated in a significant way that the nurses in this country can become extremely interested in clinical problems. (Though I must say it was not easy to get the papers for these sessions). I consider these sessions as a very good omen that some kind of clinical renaissance is in the making within the profession. But it is not without problems—and the development of he clinical specialist also has prompted its own set of problems.

In 1955 I did a very small opinion study on the role of the clinical specialist as seen by psychiatric nurses and others. She was in effect expected to be a super-duper everything: expert practitioner, supervisor, teacher, administrator, consultant, in-service educator, aide trainer, and the like. There is a major problem in getting nurses to conceptualize the expert clinician as just that—a person who works with patients, who studies and reports her practices through publications. Clinicians must be taught to say "no," and other nurses must not expect that the nurse clinician—single-handed, among a large staff of general practitioners—will solve once and for all, all of the long-standing nursing problems. Let her be an independent clinician.

The expert clinician works with other disciplines. In psychiatric nursing (and no doubt in other fields) this means that she will work with a variety of doctors, all of them with a different theoretical orientation. This raises the problem of whether the nurse can develop depth in a theoretical way or whether she must forever be eclectic in her approach—knowing a smattering about a lot. There, of course, has not yet been the development of "schools of thought" about clinical nursing in various clinical nursing services. So the depth of the nurse would come from other sources—the behavioral sciences and psychiatry. And so the psychiatric nursing graduate programs must choose.

A drastic change in basic programs would help the clinical specialist movement in a number of important ways. There is still too much stifling of curiosity and initiative; the student who raises questions is more often than not penalized, while the "good girls" get A's—A's that do not necessarily hold up when rigorous graduate education is undertaken. The conformity and regimentation in basic schools does not aid the development of "thinkers," "innovators," "contributors" in nursing—which is the stuff of which is made a clinical specialist. Moreover, basic programs tend to look at liberal arts courses mainly in terms of how much knowledge can be "used" in nursing, rather than as liberalizing, humanizing influences that stretch the minds and thought of some of the students. Since more basic students now come from middle-class homes—which they have largely been protected against the raw elements of life (disease, death, poverty, and the like)—they also tend to be far more naive about human behavior. The liberal arts courses could be just sheer "eye opening" courses for nurse students. The middle-class values also get committed to finding a husband and far less so to a career in nursing (even with marriage). Consequently, it is not always the very young student who is willing to commit herself to a career to the point of a Ph.D.—and the older nurses have all kinds of deficiencies in academic background. Furthermore, as I said previously, women seem more reluctant to stretch their minds; I am constantly impressed by the number of very intelligent nurses whom I get to talk with who depreciate and derogate or belittle their capacities. As one result, many nurses are unwilling to continue education in those basic sciences that now require the most rigorous discipline—mathematics, physics, and chemistry—and yet nursing needs expert clinicians with these kinds of backgrounds as interpreters of what is new that nursing should use. Many times if nurses do go on for Ph.D.'s in any discipline (including the much younger social science), they are lost subsequently to these disciplines because the profession of nursing has a very low tolerance for deviance and independence.

It has been predicted in a remarkably large number of sources that there will be a drastic shift to the community of professional practice within the next decade or two. This poses a very real problem for the nursing profession. In light of the previous discussion of routes for deciding specialization titles and foci, I expect that public health nursing will indeed be loath to have its title lost to posterity and replaced by terms such as "staff nurse" and some sort of "clinical specialist." What does this shift to the community mean in terms of clinical specialization—or the whole question of specialization, for that matter?

Another problem is that the standards of clinical practice. Currently, these tend to be controlled by nurses who are and for along time have been non-practitioners. Perhaps the ANA academies will remedy this. Clinical specialists ought to be the ones to define practices of nursing in a clinical area. There is, however, a long history of letting the situation define nursing rather than for nursing to take a strong hand in defining its own practices.

Practices in a particular field are always related to the available knowledge about the pathology—the phenomena to which that field relates its practices and for which they are intended to be beneficial or curative. In psychiatric work the nature of the pathology is indeed poorly understood, and this is hampering in designing nursing practices. It puts the clinical specialist in the situation of being a "basic" researcher, for as she works with patients she is also collecting data in an attempt to refine definitions of the pathology. Nurses should do this, but not everyone understands that nurses are capable.

The more knowledge the professional nurse gets about any given field, the more she is in a position to criticize the work of another discipline. A need seems to be arising for not only professional ethics but interdisciplinary ethics and means for fair interdisciplinary discipline of various professional workers who are unethical.

A drastic change is occurring in nursing. Students are entering graduate programs directly from undergraduate programs. I think this is a good thing. I do wish, however, that there were demonstration programs to show the nursing profession what a good nursing service clinical supervisory program should be like for new graduates taking a first staff nurse position. If such were available, it would be better to require one year of staff work in such a setting.

The cooperation of current nursing service staff is absolutely essential to the development of the clinical specialist movement. These experts must be allowed independent practice, an opportunity to experiment, and they must have administrative support in the process of trial and error. However, most administrators are not only not clinicians, but many haven't seen a patient for years and merely want a problem-free service—so they are grossly threatened by the "upstarts" the pioneers in nursing—and they slow up progress.

Good progress has been made since 1940 in promoting the idea; now we must get on with the task and give the clinical specialist idea far more substance and support.