The Nurse-Clinician

Because this term is being discussed so widely today, the Journal asked the nurse who coined it to explore its meaning. Her beliefs about what a nurse-clinician could mean to the profession, based on the philosophy of nursing she has developed in her 35 years of experience, seem to us to hold one answer to that age-old question: "What is nursing?"

FRANCES REITER

Some 23 years ago in a speech I was giving, I used the term "nurse-clinician" to describe a kind of nurse that I thought was needed by both patients and the profession. So far as I know, the term had not been used before. Today, however, as so many of us struggle to identify nursing's nature, its practice, and its directions, we hear the term "nurse-clinician" being used with increasing frequency.

Of course, not everyone means the same thing by it. I'm not even sure that I mean quite the same thing today by nurse-clinician as I did in 1943. For me, it is a concept that has been gradually evolving during my almost 40 years of nursing experience: a distillate of my ideas as they have been added to, enriched, tempered, and altered by those of others.

I cannot present my concept of the nurse-clinician, without also presenting some of the nursing philosophy that underlies it. I believe the time has come—may, indeed, be overdue—for us to reexamine our total value system. So this discussion will necessarily include some of my own personal and philosophic nursing values.

Paramount among these—and integrally associated with my concept of the nurse-clinician—is my unalterable conviction that practice is the absolute primary function of our profession. In recent years, however, I have found to my distress that it is necessary for me to identify what I mean by "practice." To me, it simply means the direct care of patients, but I find "practice" being more and more used to include administration and teaching and supervision.

Now I admit that these three functions are essential underpinning for good patient care and for total health services. But I consider them as secondary to patient care, and I deplore the tendency to use the word "practice" as encompassing these secondary functions. To me this is a devaluation of nursing's primary function: patient care. But, since this is the way the word is now used, I will alter my terminology accordingly and distinguish what I mean by referring to it as "clinical practice."

By clinical practice, I mean those personal services carried out at the patient's side—in contact with him and in behalf of him and his family. There are some indirect services in this category, too: those activities carried out in conjunction with other nurses or with other professions—away from the patient but still directly in his behalf.

In our present complex hospital situation, direct nursing care is—or should be—the one area over which nursing has complete control. And it seems to me that, depending upon what we do in this area, we write our own destiny and that of the future of nursing. Hence, my conviction that the nurse-clinician, and the profession of nursing itself, must always remain closely identified with nursing practice.

CLINICAL COMPETENCE

Clinical competence, as I see it, has three dimensions—I call them ranges of function, depth of understanding, and breadth of services. Some of the personnel caring for patients will be prepared and proficient in one or more aspects of these several dimensions, but the nurse-clinician must be competent in all three.

Let's look at the ranges of function first. These I see as care, cure, and counseling. First, care: the fundamental things that we do to make a patient comfortable, the things that he is temporarily unable to do for himself. Early in my student days at Johns Hopkins, I became convinced that personal care of the patient is the heart of nursing practice. This care may be of a physical, palliative, protective, or rehabilitative nature, but it need never be less than personal. Nor need it be less than professional if we use and involve ourselves as we change the patient's position, give him mouth care, or support him as he coughs.

A little later in my career, when I studied at Teachers College, I realized more fully the importance of a second dimension to care—that of the use of basic sciences underlying this care and I gained a deeper unde-

FRANCES REITER is an educator but she went into teaching with a rich background of nursing practice. She earned her nursing diploma at Johns Hopkins and her bachelor's and master's degrees at Teachers College, Columbia University. She spent the first 10 years of her career in nursing service in various staff positions and in private practice. Her next 20 years were spent in nursing education, first at Boston University and then at her alma mater, Teachers College. Five years ago she assumed her present post, that of dean of the Graduate School of Nursing, New York Medical College. She is chairman of the Committee on Education of the American Nurses' Association.
derstanding of the rationale that governed what I was doing for my patients. I believe now that there is a body of knowledge underlying care and that we have hardly scratched the surface of it.

My basic nursing, as I had learned it, had of course included the specific treatments that nurses carried out: in those days, the irrigations, the compresses, the medications. But not until I became supervisor of ward teaching and staff education at the Massachusetts General Hospital did my concept of this second range of clinical practice—curative nursing—become crystallized.

By curative nursing I mean much more than mere technical expertness in carrying out treatments and pouring medications. I refer, rather, to a much broader group of restorative and rehabilitative activities: to a sound knowledge of the principles on which they are based and of the goals to which they are directed. Curative nursing, as I see it, calls for a special approach—a perception of the medical and therapeutic goals so that nursing care can be tailored accordingly. If this curative range of nursing is to be practiced in close collaboration with the physician, it requires still more depth in the second dimension—understanding of clinical data and medical science.

Why did I become aware of this at MGH? Because I encountered there a kind of nurse, a kind of atmosphere, that I had not perceived before. I was not a peer of those MGH nurse supervisors, so far as cure was concerned. They had something I didn't; a clinical knowledge, competence, and approach that enabled them to function as professional colleagues of the medical staff.
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Take the neurologic supervisor, for instance. She not only knew neurologic nursing practice, she knew a great deal about neurology and neurologic medical practice. She worked closely with the chief of staff on patient management and care. She attended the departmental meetings. She was part of the group that planned each new therapy. Every door of knowledge was open to her.

Many of these doors she opened herself, as did the other clinical nursing supervisors there. They read the medical literature, they went on rounds, they sought out knowledge; they had to keep themselves informed about medical-surgical practice so that nursing practice could be integrated with it. Much of their study was self-impelled and self-disciplined. It derived from their own expectations of themselves, from the expectations of their medical colleagues, from this atmosphere of interdisciplinary exchange, research, and practice.

This kind of knowledge, this kind of nursing, I felt, was exceedingly important so far as full-dimensioned clinical practice was concerned. I was secure in the “care” range of practice and I had thought I was secure in the “cure” range, but here I perceived a much greater span of curative influence. Combine depth of basic science with care and depth of clinical science with cure, I said to myself at the time, and you have a nurse-clinician.

However, as I turned this over in my mind during the next few years—years in which my own insight and understanding were being enriched by psychoanalysis—it became clear to me that there was still a third range to clinical practice. I call this range counseling and I know that it too must be based on a deep level of understanding—of perceptiveness and wisdom about the dynamics of human behavior.

By counseling I refer to the kind of emotional, intellectual, and psychological support that sometimes borders on the realm of social work but is still a part of professional nursing practice. Within this range, too, I see such nursing responsibilities as health promotion, preventive teaching, working with families, and the full therapeutic use of one’s self in relationships with patients.

THE MOTHER ROLE

As the nurse cares for her patient throughout these three ranges—care, cure, and counseling—it seems to me that she is essentially acting as a mother substitute. She is trying to protect him from harm, teaching him to avoid it; she is comforting him and making him comfortable when he is hurt or ailing; and she is encouraging him in doing the things that will help to grow. This may be oversimplified—but I believe that these mother-like ministrations represent the nucleus of nursing practice and are professional only when the second dimension, that of knowledge, plumbs the wisdom of human motivation.

Now, in the days when nursing was largely a matter of one nurse “specializing” one patient—often, even around the clock—competence in care, cure, and counseling, based on a relatively shallow dimension of nursing knowledge, may have been all the nurse needed in order to serve her patient well. Today, though, with so many separate disciplines involved in the patient’s therapy, with so many kinds of personnel providing patient care, and with a complete turnover of these personnel every eight hours, I see a third dimension to clinical competence: the breadth of the services rendered.

Here, too, the services fall into a “three-C” division: coordination, continuity, and collaboration—all in relation to the kinds of programs and persons with whom nurses associate, and all in behalf of the patient.

Thus, it is my concept that nursing—perhaps, in the form of the nurse-clinician—is responsible for coordinating all the various professional services relating directly to the patient’s welfare. I see the nurse-clinician, too, as responsible for continuity of care: from one shift, one group of personnel, to another; continuity of care from the hospital to the home; and continuity of nursing care after patients have reached the point of maximum medical benefit—longterm nursing care and treatment.

Collaboration—the third of this group of C’s—is, to my mind, the most significant of these services, so far as professional maturity and the development of the nurse-clinician are concerned. In fact, I would consider evidence of the ability to collaborate with medicine the most discriminating index of having attained the stature of nurse-clinician. By this I don’t mean simply a capacity to “get along” well with the physician. I mean having the necessary knowledge, attitudes, and perceptions that will enable nursing to work in a collaborative relationship with medicine to achieve the therapeutic, restorative, and rehabilitative goals set for the patient.

Let me illustrate what I mean, and the illustration will cover all of the last three C’s—coordination, continuity, and collaboration.

There is, in practically all situations, one physician responsible for the medical management of the patient. He may be the patient’s personal physician, the resident in charge of the service, or the chief of staff. Whoever he is, he is the one who determines the diagnosis and the tests that lead up to it, the therapies, the ultimate medical decisions. Essentially, he is responsible for all of the patient’s professional services.

But, when we come to nursing, it is a group of nurses and ancillary personnel who are responsible for a patient’s care around the clock and through the week. If a nursing decision must be made, there is no one nurse responsible for making it, as there is one doctor. Instead, it will in all likelihood be made by the nurse in charge on the shift when the need for the decision arises. It may not be the best decision, nor made by the best qualified nurse, nor necessarily followed through on successive shifts and days.

But suppose, on the other hand, that there was one nurse with authorized responsibility for nursing
nursing's primary function is patient care... administration and education are essential underpinnings but they are secondary... to call them nursing practice is a devaluation of it.

practice within a given area. Like the physician, she, too, might be on 24-hour call—for consultation and decision-making whenever nursing practice problems occur. (This idea has been tried at the University of Florida at Gainesville and found workable.) Obviously, she will have to be a very well-qualified nurse—a nurse-clinician.

I like to think of this nurse as a member of the school of nursing faculty. (Here, too, I think I reflect the philosophy of Dorothy Smith, dean of the College of Nursing and chief of nursing practice at the University of Florida College of Nursing; her title exemplifies what I am talking about.) To me, it is highly appropriate that the faculty member combine these two responsibilities—for practice and for teaching—for I do not believe you can do one without the other.

Let's look a little further at the possible relationships that might exist between the physician and the nurse-clinician. These are based on another of my concepts: that the nature of nursing service is implementation of the total therapeutic regimen. I would like to think of the nurse-clinician as having the abilities to serve as what might be called "clinical nurse associate" to a physician or group of physicians, being on call the same way the physician is and responsible for many decisions concerning the patient's welfare.

Actually, I believe that the nature of the relationship between the doctor and the nurse is different from that obtaining between the doctor and the member of any other professional discipline—social worker or diet therapist, for instance. The social worker has little or no responsibility for helping the diet therapist carry out her objectives, nor does the speech therapist have much to do with supporting the objectives of the social worker. Both doctor and nurse, on the other hand, share responsibility for the patient's total well-being, and this includes the need to coordinate and assess the specific contributions of these other specialties in the patient's best interest.

THE DOCTOR-NURSE RELATIONSHIP

I have already indicated that I think the essence of nursing is its motherlike ministrations. Now I would remind you that the doctor has always been thought of as the good "father" figure. Put these two concepts together and you will see that the relationship between doctor and nurse is—or might be—akin to a parental one: one wherein they share a mutual responsibility for the welfare of patients, just as actual parents do for their children.

This parental relationship between doctor and nurse, it seems to me, is something quite different from the relationship of either one with other members of the professional health family. It is a relationship which—if recognized, cultivated, and utilized—should provide the patient with care that is continuously evaluated and modified to meet his changing needs.

Not too many nurses are prepared to work in this type of interdisciplinary relationship, nor will all doctors welcome or make full use of the nurse-clinician who does have this capacity. But I maintain that only through such a collaborative working together can the patient be best served and nursing achieve its greatest potential.

Finally—and returning again to the breadth of the nurse-clinician's practice—it is not enough for her to be fully proficient in the care of the acutely ill patient, not even enough for her to enjoy the best kind of collaborative relationships in the acute setting. An additional criterion is that the nurse-clinician be competent in practice in all the stages of illness or wellness represented in the various settings in which we find patients today: not just the acute general hospital, but the home, the community, and the long-term facility, to mention the major ones.

It is on this latter setting—the care of the infirm, the aged, the disabled, the chronically ill—that I would place greatest emphasis. Here is the area with the greatest number of patients; here is the area with the smallest
number of nurses, relatively and absolutely. Medicine may have done all it can do for these patients. Yet there is so much more to be done with them, so much that falls into the domain of independent nursing functions. I cannot conceive of a nurse-clinician as less than expert in assessing the needs of, and providing care for, patients within this category.

Now let me see if I can describe the nurse-clinician against this background of the dimensions of clinical practice. First, let me emphasize that nurse-clinician is a generic title, not a functional one. It describes a "state of being"—an accumulation of a depth of knowledge and experience that might be put to work in any number of positions—provided, of course, that the holder of these qualifications remains actively engaged in nursing practice.

The nurse-clinician, as I see her, is a master practitioner throughout all the dimensions of nursing practice. She is able to provide basic and technical care based on perceptive understanding of the patient's psychobiologic needs. Additionally, she brings to patient care a high degree of discriminating judgment in assessing nursing problems, in determining priorities of care, and in identifying the nursing measures necessary to achieve both immediate therapeutic objectives and long-term rehabilitative goals.

COMMITMENT TO EXCELLENCE

But, even more fundamental than the intellectual qualifications of the nurse-clinician is her feeling of commitment to the provision of the highest quality of nursing care. In addition, I feel that she has a professional responsibility for extending her judgment and standards of care to larger and larger groups of patients. Obviously, there is never going to be a nurse-clinician available for total care of each patient. Therefore, it is all the more important that the nurse-clinician, in one way or another, insures that truly professional nursing care—the full-dimensioned kind that she knows how to give—reaches every patient within her area of responsibility.

Let me explain what I mean. In our present system of patient services, nursing care is provided by what I call a "pyramid of personnel." The broad base of this pyramid is represented by the ever-growing numbers of ancillary personnel, the narrow apex by the relatively smaller number of professional nurse practitioners. It is the ancillary personnel who provide the bulk of direct care to patients. The contact of professional nurses with the patient today is, I submit, typically brief and intermittent: limited to such therapeutic tasks as giving medications or performing technical procedures, or to such administrative tasks as assigning, directing, and supervising the work of others.

This system, in my opinion, has resulted in a relative—and sometimes absolute—lack of professional nursing care for patients. It is almost literally impossible for patients to purchase professional nursing care at their bedside. The best they can get is the services of a "team" led by a professional nurse.

Depending on the team leader, the care the patient receives may or may not be of a professional quality. All too often, the team leader is at least one step removed from the patient; she is not involved in his direct care. Like the head nurse, she is a victim of our system that places emphasis on spreading available nursing service to all patients. She must be concerned with the amount of care. The nurse-clinician, by contrast, is concerned with the kind of care.

If I seem to be laboring this point, it is because I see it as a vital one. Nursing's gradual withdrawal or removal from direct nursing care has created a vacuum around the patient—one which is rapidly being filled by a variety of less well-prepared personnel. I can even visualize the day when we may be actually ruled out from giving direct nursing care. This is our job, not yours. I can hear the organized ancillary personnel saying to us, just as they said it to the nurses at Fairview, as reported in the January 1966 American Journal of Nursing. It seems to me that if we continue our present patterns of nursing service, we may end up by giving away our very birthright.

Therefore, I see the nurse-clinician as a person with the abilities, the motivation, and the commitment to "hacking" her way down through the personnel pyramid so that her professional knowledge and judgment are exerted in behalf of every patient. Inevitably the question: just how is she going to do this? will be asked, and I will have more to say about this later on. For the moment, though, let me describe a pilot study we carried out at the New York Medical College, Flower-Fifth Avenue Hospital—one intended to explore ways to improve nursing care and to see how the competencies of the nurse-clinician could be utilized within the reality situation of a hospital unit.

Several nurse-clinicians—all members of our nursing school faculty—served as integral members of the nursing staff of a 61-bed medical-surgical unit for a 14-month period. They did not represent additional personnel; they served as clinical staff on the unit. We made sure that they were free of administrative and managerial responsibilities, functioning only in patient care and free to develop their own patterns.

Let me describe, for instance, how the nurse-clinician on the 3 to 11 shift functioned. First came the report from the nurse responsible for patient care during the previous shift. Under the leadership of the nurse-clinician, this report—rather than the usual flip through the Kardex to check doctors' orders, preps, and the like—evolved into a major device for teaching, supervising, and insuring continuity of care. Questions asked by the nurse-clinician provided guidance to the other nursing personnel, improved their perceptions of patient needs, and helped them establish priorities.

Then the nurse-clinician made nursing rounds. This permitted her to evaluate the patients' status, de-

determine their needs for medical attention, and make judgments as to needed nursing measures. As she made her rounds, the nurse-clinician provided nursing care and services as indicated: she might adjust the traction, instruct a patient in deep breathing, or get him a bedpan.

Now, these rounds served several purposes. First, the nurse-clinician was actually at each patient's side as a practitioner, using her informed judgment to determine his nursing needs. Some of these she met herself; otherwise, she worked closely with the person giving the care. Second, these rounds communicated to the patients a sense of caring and of safety; the nurse-clinician's services were always available to them and they knew it. In fact, they soon came to feel that nursing personnel cared not only for them but about them.

A final purpose—one that was served not only by the initial rounds but by the nurse-clinician's continuing involvement in patient care—was that, by observing the level of care being given, the nurse-clinician could evaluate the nursing staff's need for instruction and supervision. This she was able to provide on the spot—by demonstration and by serving as model. On the completion of this demonstration, we were able to say something like this:

The nurse-clinician's motivation, judgment, and visible and expert nursing care skills benefited both patients and staff, directly and indirectly. Patients benefited not only from the direct care the nurse-clinician gave, but from her informed perception of the care they needed as she passed this on to others. Her methods of giving care provided other nursing personnel with moral leadership and instruction by demonstration. And her own participation in giving care, coupled with the obviously high value she placed on this, gave real status to the provision of direct nursing care. Aides took more pride in their work, and other nurses no longer referred to bedside care as "aides' work."

This demonstration by a faculty of nursing represents only one possible pattern of utilization of nurse-clini-
cians. If we agree that this is a kind of nurse-practitioner we need, I am sure that many patterns of involvement will await her in the future.

I do not envision all future nurses as nurse-clinicians. To my mind, these will be the select members of our profession—the ones who will form the membership, perhaps, of our projected Academy of Nursing. We have not yet spelled out the criteria for admission to this body. When we do, I hope that among them will be the stipulation that members be those with responsibility for, and engagement in, practice—practice based on the extensive knowledge and clinical experience that should characterize the nurse-clinician.

QUALIFICATION

How should the nurse-clinician be prepared? Actually, I believe that at the present time in nursing education, there is no single avenue to becoming a nurse-clinician. Her background, though, should reflect a relatively long period of preparation in nursing, through a variety of formal and informal learning experiences: formal education, professional nursing education, familiarity with both medical and nursing principles and goals, and extensive clinical practice in a wide range of settings.

I do not believe that a degree alone, master's or doctoral, automatically makes a nurse-clinician. I have had on my own faculty, for instance, a person whom I considered fully qualified as a nurse-clinician in cardiac nursing—but she had no degree and had arrived at her point of clinical excellence through her own extensive study and practice.

Other things being equal, the nurse-clinician of the future will probably have at least a master's degree. But I don't want to run the risk, as we have in the past, of placing all our values on a degree without some substantive knowledge of what went into it. No matter how skilled a nurse may be in the teaching arts, for instance, I would not consider her a nurse-clinician unless she couples her teaching activities with continuing clinical practice. Nor can clinical specialization, in all of its various stages, be considered adequate preparation for the nurse clinician unless it encompasses all the dimensions on which patient care is built.

I believe that it is possible to prepare a beginning nurse-clinician in a basic baccalaureate program, but there are three strings attached to this belief. The first is the emphasis on "beginning": breadth and depth of both knowledge and experience are essential for the nurse-clinician—more knowledge and more practice than she will have in her generic program. So, while the young graduate may be on her way toward becoming a nurse-clinician, she hasn't arrived there yet.

The second string concerns the nature of the generic program itself. This program, I believe, must be
embedded in and radiate out from a medical teaching center—a center for multiprofessional education, practice, and research. Both faculty members and students must feel closely identified with the medical and nursing practice in that center, feel part and take part in the interdisciplinary exchange that goes on there. Only when the student’s home base for practice is such a center can she gain the professional maturity which is marked by the ability to establish collaborative relationships with other disciplines, to speak the same language, to share the same perceptions, approaches, and values. To achieve this, she must learn, practice, and evaluate with others on the professional health team who are doing the same thing.

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I do not believe she will be prepared, even as a beginning nurse-clinician, if her clinical practice experience as a student is offered in a variety of community settings, with no real identification with any one of them. In this kind of setup the student does not have the opportunity to become a part of the total therapeutic team, to develop what might be called the collaborative attitude. Similarly, her instructor—functioning in the patient care setting only as a member of the university faculty—has no responsibility for, no involvement in, the practice there, and therefore cannot pass this subtle value on to her students.

Patient management today—diagnosis, care, treatment, and rehabilitation—is an interdisciplinary affair. The student must learn this from the very beginning; the faculty member must continue to be an active partner in it. Many nurses in baccalaureate programs today receive a fine type of higher education, but it is not professional education. The two are not the same thing, but I think nursing has often failed to recognize the distinction.

Finally, I believe that the student’s spectrum of learning experiences must include all of the settings in which patient care is given: the home, the clinic, the ambulatory services, and the long-term care institutions. Without these experiences, especially the latter, the student’s basic professional education is not complete. It is in the long-term area that the greatest numbers of patients needing care are concentrated. And it is also in this area, where so many ancillary personnel are employed, that the student can begin to learn how to extend her services and judgment down through the pyramid of personnel.

Some day in our hospitals I hope to see what might be called a “clinical nursing staff”—one with no responsibility for anything but patient care. Within such a staff I can visualize nurses with varying degrees of clinical knowledge and practice experience—some on their way to becoming nurse-clinicians, others satisfied to practice on the level they have already achieved.

Take, for instance, the nurse who is deeply interested in the care of sick children: she wants to know more about the medical and nursing practice in this field, to be expert in its care techniques, to learn all she can in this area. She is not a pediatric nurse-clinician, however, unless she is equally expert and knowledgeable throughout all the dimensions of pediatric nursing practice: the child with a chronic disease at home or in an institution, the one needing open heart surgery, the emotionally disturbed child, the adolescent.

Similarly, there may be nurses who are intrigued by the intricate medical-technical responsibilities that nurses carry today: operation of the artificial kidney, the cardiac monitoring devices, the various mechanical respiratory aids. This, to my mind, is curative nursing care carried to a high degree. Here we have another kind of nurse—what we might call the technical expert. This is fine, we need her, but she is not a nurse-clinician.

To recapitulate: I think there is more than one way to become a nurse-clinician. Some nurses, through self-impelled study and practice, may get there on their own. By and large, however, I believe that the most economic way to rapidly prepare a corps of beginning nurse-clinicians is through organized programs of graduate study in professional education. The student would enter such a program having had a liberal education culminating in a bachelor’s degree. Her professional education could then concentrate on two things that would receive equal emphasis: (1) the necessary body of theory and clinical knowledge, and (2) the application of this in repeated, continuing practice which encompasses the full range of function and the full breadth of services.

All very fine, you may be saying. But how are we going to implement all these concepts? What about the changes in our patterns of nursing education, practice, and service that will be necessary to prepare this nurse-clinician, to enable her to practice in the way she is prepared to?

Unquestionably, changes will be necessary, especially within the organization of our present system of nursing services. But I think that we must first decide upon our ends before we worry about the means for achieving them. We need to take a look at where our present patterns have brought us—considerably removed from the practice of nursing—and decide whether this is where we want to remain.

THE ALTERNATIVES

The beginning of change and the beginning of wisdom must start with an idea, a value—in this instance, what is best for the welfare of those who are served by nursing. If others feel, as I do, that the nursing profession has to a shocking degree failed the public, has submitted to—or helped to create—a situation wherein professional nursing care and judgment are not available to those who need it, then we can set about in a concerted way to change things.

If we do not change, if we choose to maintain the status quo, then I think we are in danger of committing professional suicide: that nursing as a personal and professional service to patients may cease to exist. △