CONTEMPORARY DEMANDS ON THE COMMUNITY NURSE

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INTRODUCTION

A quarter of a century ago Mr Harold MacMillan delivered his famous *Winds of Change* speech in Cape Town. In 1975 Dr. Wolff Bodenstein, in delivering a paper on primary health care, referred to the *storms of change*. Now, a decade later, John Naisbitt speaks of *megatrends* when elaborating on change on a worldwide scale from an industrial society to an informational society. Alvin Toffler's widely read *The Third Wave* speaks of similar trends on a scale comparable to the agricultural revolution and the industrial revolution.

Change in South Africa in the eighties, in almost all fields of human endeavour, reflects the pattern described by both Naisbitt and Toffler. This pattern can also be discerned in what may be termed the *revolution* in nursing in South Africa today.

It is always difficult to adapt to change. It is perhaps more difficult to direct change in a meaningful and constructive way.

The complexities of the South African scene with all the problems of its first and third world communities, and their frequently contradictory demands, are reflected in the health services and therefore in nursing which strives to meet the needs of the total population.

Contemporary demands on the community nurse are equally complex and likely to increasingly tax her adaptibility; her professional knowledge, skill and assertiveness; her willingness to accept wider responsibilities and her sensitivity to team members and the changing needs of the community.

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SOME IMPORTANT TRENDS IN CONTEMPORARY SOCIETY

Centralisation

Centralisation, one of the characteristics of the industrial era, is particularly reflected in political systems, governmental agencies, the economy, corporations and many others. Together with centralisation, *bigness* became the norm in Western industrial societies.

Decentralisation is a feature of tomorrow's world. It is gathering momentum in South Africa where constitutional change and a national urbanisation strategy, together with the Population Development Programme, have already provided for the development of independent and National states, regionalisation of economic development and greater autonomy for and emphasis on local government with concomitant development of infrastructure and participation in decision-making.

The development of smaller factories and home industry are encouraged, emphasising an opportunistic or entrepreneurial approach and selfhelp.

In the health care field the National Health Care Facilities Plan stresses the importance of basic health care at community level and the provision of health centres and community hospitals — bringing the large, academic hospital, with specialised services, into perspective and blurring the sharp division between institution and community. As regionalisation progresses the division will hopefully disappear altogether so that the hospital becomes part of the community it serves.

The President's Council, in its report on Demographic Trends in South Africa, recommended that basic health care be taken into the community, beyond the hospital and clinic-based pattern with which we are familiar. This implies an expansion of mobile services, which already reaches into sprawling urban developments, also into the furthest corners of our rural areas thus decentralising basic health to the fullest extent.

In the nursing profession we find a similar trend. The S A Nursing Association adopted regionalisation of its structure and functions when the present Constitution came into force in 1982. This has led to greater involvement of professional nurses generally in decision-making about matters concerning the profession. The increase of members in financial standing already indicates amongst others, a greater interest in Association affairs.

In hospitals the functional approach to work allocation, typical of a factory approach, is gradually being replaced by different patterns of patient allocation and the formal application of the scientific method in nursing. The end result of these changes is decentralisation of decision-making about patient care and a move away from the traditional hierarchial nursing structure.

Trends towards decentralisation and deconcentration will increasingly influence our personal lives and challenge concepts which, perhaps, are outmoded and to which professional nurses tend to cling with great conviction.

OPSOMMING

Die eise wat vandag aan die gemeenskapsverpleegkundige gestel word is omvattend van aard en sal in 'n toenemende mate haar aanpassingsvermoë, professionele kennis en vaardigheid, en haar sensitiwiteit vir die veranderende behoeftes van die gemeenskap toets. Wêreldtendense wat tans in verband met gemeenskapsverpleging ons aandag verg is veral die toenemende desentralisasie en die wegbeweeg van spesialisasie na 'n meer algemene benadering.

Specialisation

Closely related to centralisation and decentralisation is the concept of specialisation. Division of labour and the proliferation of professional groups are wellknown phenomena.

The nursing profession itself has not remained unscathed although the concept has not been carried as far as in certain other professions. Toffler suggests that specialisation in health care may have been instrumental in producing an attitude of reliance as opposed to selfhelp and personal responsibility for health.

There is, however, a tendency towards a generalist approach. In nursing this is manifested in the comprehensive basic nursing course now being implemented. Unfortunately — and related to amongst others, the division between hospital and community and therefore perhaps based on a false premise — the post-registration community nursing course has also given rise to several offsprings.

High technology/High touch

Parallel to the increasing use of technology — and this trend will continue — is an emphasis on interpersonal skills and human contact to counteract the dehumanising effect of the factory approach. The phrase *high tech/high touch* has been coined to indicate this trend.

Seeking the company of others outside the individual's work sphere is manifested in many ways, for example, the mall shopping pattern, *rock* concerts and various interest groups. Nurses who work in high technology specialised areas, such as the operating theatre and intensive care units, have established strong, cohesive societies where they share special interests and have personal contact with colleagues.

Education

Education too is moving away from the factory model of rote learning and basic reading, writing and arithmetic. In South Africa the entire educational system is being restructured as a result of constitutional change and the recommendations of the de Lange Commission. Changes in the nursing education system are at the forefront of change in the nursing profession, tending to leave other subsystems of nursing behind.

Other Trends

There are many other trends which will influence nursing in general and community nursing in particular — changes in the family, in disease patterns and the increasing incidence of social pathology in urban areas, to name but a few.

THE COMMUNITY NURSE

Toffler describes the human product of the industrial era as punctual and obedient, preferring repetitive work in a hierarchial structure and believing in standardisation — people with *metallic* personalities.

Although the community nurse has her origins in the industrial revolution she never became part of the industrial system. She tends to be individualistic and unregimented. She experiences a great deal of job satisfaction and is self-motivated. Interpersonal skills and a non-directive approach are part of the tools of her trade.

The focal point of her role has always been maternal and child care in the family context including mothercraft, health education, dealing with social problems and the prevention of communicable diseases, particularly those in which social factors figure prominently. She carries out her functions in the clinic and in the home where she holds a position of particular privilege and trust. Her role does not include a clinical nursing component.

In time, further components were added to her role, the criteria apparently being that these aspects concern community rather than hospital care. Furthermore, most of these aspects fulfil first world or industrial community needs and contain a clinical nursing component. In keeping with these additions the name of her qualification changed from public heath nursing to health visiting to community health nursing (health visiting, school, district and occupational health nursing) and finally, to simply community nursing science. Attempts to generalise her role is clearly reflected in these changes.

An analysis of qualifications held by nurses employed by local authorities in South Africa shows that less than 20% of professional nurses hold the post-registration qualification in community nursing science. In the Department of Health and Welfare this figure is approximately 48%. South African Nursing Council statistics show that in 1978, 4,6% of all registered nurses held the qualification in community nursing science. In 1983 the percentage was 6,2%.

From these figures it can be deduced that community health needs cannot and have not been met by nurses holding the post-registration qualification in community nursing science only. Her role has, in spite of various pressures, remained exclusive and non-clinical. She concentrates on the mother and child in family context — on health and not on disease — and she is found in promotion grades in the community nursing structure. Clinical nursing in community services is rendered by registered nurses not holding post-registration qualifications.

The vast pool of ill-health in rural and urban developing communities has, over a period of time, made great demands on community health services and increased the pressure on the community nurse to become a generalist and to include clinical nursing practice in her role. To meet these needs a post-registration course in clinical nursing science, health assessment, treatment and care was introduced after attempts to include this component in the community nursing science course had failed. Once again there was a clear indication that the community nurse is not a generalist and certainly not a clinical nurse practitioner.

In the late seventies the concept *primary health care* and the objective *health for all by the year 2 000* was introduced by the World Health Organisation.

Neither of the present post-registration courses in Community Nursing Science and Clinical Nursing Science, Health Assessment, Treatment and Care, quite meet the needs of Third World Communities for basic health care, although both courses contain aspects of the essential elements of primary health care.

MEGATRENDS AND CONTEMPORARY DEMANDS ON THE COMMUNITY NURSE

It seems that the two issues in community nursing which need to be addressed most urgently are the demands resulting from decentralisation of health services and a generalist approach versus specialisation — in both first and third world contexts.

Decentralisation of health services, it seems, will ultimately lead to comprehensive health care on a regional basis rendered by a single authority. This type of health care organisation will require dynamic nurse leadership in the community, be it an industrial or a developing community.

The present post-registration course in nursing administration prepares the professional nurse for management at hospital level. This probably explains why only 2% of community nurses practising in local authority services are in possession of this qualification. The management of community nursing services requires expertise in negotiating for resources; resource allocation — including human, financial, material, informational and technical resources; in monitoring vital statistics and the setting and achievement of objectives; in personnel management and labour relations — in short, leadership and vision.

The author believes that urban industrial communities, in spite of medical aid schemes and the concentration of medical manpower in private practice, will continue to need the specialised knowledge and skills unique to the *health visitor*. Her specialised role has been tested and proven to be vital to the health of the South African community — be it in private practice or in local government service — and it is from her ranks that leadership in the management of community nursing services needs to be drawn and developed.

Developing communities, on the other hand, need basic health care services with a strong emphasis on secondary prevention.

The nurse graduating from the comprehensive basic training course may be able to meet these needs. If she can, she will be the generalist of the future.

Morbidity and mortality rates and demographic trends in South Africa are causes for grave concern. The need for midwifery and neonatal care and paediatric nursing with services extending into the community from a base hospital is a possibility in a comprehensive approach. Community nursing alone will not be able to significantly make an impact on current morbidity and mortality figures.

First World communities are ageing at an alarming rate and the plight of old people in any urban area is serious in the extreme. In time, with a generalist approach, this vulnerable group should perhaps receive greater emphasis in the basic course for registration.

CONCLUSION

The cost of health care generally is prohibitive and — as in other fields — it seems that expensive training for specialised fields of practice is something of the past. The graduate of the comprehensive programme will hopefully be versatile, adaptable and willing to function on a wide basis, also in the community.

There does, however, exist a need for the specialised role of *health visitor* and for the development of leadership and management skills in community nursing services.

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Do we all behave like competent, knowledgeable professional practitioners in our collegial relationships with other members of the health team, or do we take a back seat when professional case discussions are held? Do we shrink from the professional limelight and behave as if we are ashamed of our existence as a professional nurse?

If the nurse does not understand the basic legal, ethical, physical, biological, therapeutic, social and psychological elements of safe and considerate nursing care; if she does not understand her own rights as a registered nurse practitioner *viz-a-viz* her employer; if she does not understand or practise the fundamental principles underlying the professional conduct of a registered nurse; if she does not understand, and observe, the nature of her responsibilities as the doctor's colleague; if she does not understand or accept that the patient is her patient as well as being the patient of the doctor; if she does not understand or accept the rights of the patient in the care situation and if she has no confidence in herself as a practitioner, we cannot call her a professional practitioner despite what the law says.

Professional practice is based on knowledge, understanding, acceptance of a role, responsibility and accountability, and if the nurse does not know or observe the facts delineated in the preceding paragraph, there is no professional practice. Under such circumstances practice is an illusion and reality is shrouded in ignorance with negation of professional responsibilities. We may then say — this type of practice is a dream of the kind known as a nightmare! Both the community and the profession are at risk.

CONCLUSION

We know the problems we are facing. The real question is what are we going to do to make nursing practice safe and satisfying for all those who seek our help? What are we going to do to make every nurse practitioner a practitioner in the fullest sense, so that nursing practice may bring real meaning to the life of the practitioner?

If we believe in nursing practice, we have a duty to help our fellow practitioners to be competent and compassionate practitioners. The ball is in our court!

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