Role Change of Public Health Nurses Working with Indigenous Aides

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THE WAR on poverty has sparked the use of indigenous aides in some service agencies (*1*). Increasingly, use of these workers in health services, including public health nursing services, is being tried.

The concept of role, problem of role definition in nursing generally, and role changes and conflicts observed when indigenous health workers were incorporated into a generalized public health nursing program were explored. Ten public health nurses in a large California health department were interviewed for their impressions about role changes and conflict.

New Careers

A book by Pearl and Riessman, "New Careers for the Poor" (*2*), and papers in various professional journals (*3–6*) pertaining to employment of indigenous workers in service fields explain this concept. An indigenous worker is a person from an agency's target population. His ethnic and socioeconomic background is therefore similar to that of the agency's clients.

There are several reasons for this drive to employ the poor in service agencies. The first is that the poor need jobs. Many low status, unskilled jobs for which they have qualified in the past are being eliminated by automation, so that unemployment of the unskilled is increasing at an alarming rate (*7, 8*). New jobs must be created to combat unemployment.

A second reason is that a poor person needs not just a job, but one which will give him a measure of status, satisfaction, pride, and self-respect. He needs to feel that he is contributing to his community, that he is using what special skills he has or can develop, and that his job is dynamic and has a future. The crux of the new careers movement is that jobs should be built on the ladder principle, each position leading to a more responsible one (*9*).

A third reason for employment of indigenous workers is that a meaningful job gives the worker a chance for self-rehabilitation. A fourth is that expanding services to the poor have increased the need for manpower, especially new types of manpower since many needs in the poverty areas have not been met by traditional methods (*10*).

Basic to the new career concept is the theory that residents of these areas have special, vital skills. The indigenous worker may communicate better with those persons labeled "hard to reach" by professionals. His role depends more upon friendship and personal involvement than on the traditional professional-client relationship. He could become a model to members of the community.

Communication between agency and community has often been difficult, and the indigenous worker is a link between the two. Potts and Miller, in describing the use of community

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health aides in a farmworker program, have pointed out this principle (*6a*):

> Because their background is the same as that of the families, they can point out to the nurse some of the attitudes, fears, and resentments, which might be acting as a barrier in her contacts with families. Not only do the aides assist with interpreting cultural or economic views, but they often are able to give the nurse clues to some of the existing family relationships which might be affecting the health of the members.

In discussing the use of auxiliary personnel in social work services, Otis (*11*) provides terminology which could be useful in public health as well. He distinguishes three types of auxiliaries as follows.

> THE NONPROFESSIONAL performs clerical, maintenance, and generally routine tasks. He may do mimeograph work, organize car pools, drive a car, keep the reception and play rooms tidy, etc. He makes it possible for the professional to have more time for professional duties.
>
> THE SUBPROFESSIONAL functions as an assistant and performs tasks that are reallocations of the professional role. He may help the client fill out forms, determine simple eligibility requirements for service, help carry cases supportively, provide simple, well-defined services, etc. Use of the subprofessional thus increases delivery of the simpler functions traditionally assigned to professional staff.
>
> THE NEW CAREER WORKER [carries out] functions which have not been performed or have been poorly performed by the professional staff because of their middle-class background, the established definition of the role and function of the profession, and the traditional function of the agency. The new career centers on a new function which capitalizes on the lower-class status of the individual. . . . The new function may make use of a skill the individual already has, such as homemaking, or special skills developed through inservice training.

The new career theory implies that the new career worker is not to be used merely as a nonprofessional or subprofessional, but agencies are likely to limit his use in this way. This danger has been shown by Pearl and Riessman (*2a*).

> Care must be taken lest the nonprofessional be given only menial tasks which professionals shun. There is no question that such tasks will be performed by nonprofessionals, but nonprofessionals must also be assigned more meaningful tasks, increasing in proportion as they advance in position.

Reiff warns that the nonprofessional may ". . . become a garbage heap where the professional dumps the patients he feels he can do nothing for . . ." or be used as a ". . . menial who performs all the 'dirty work' that the professional resents and wishes he could get rid of . . ." (*3a*).

To avoid misusing the new career worker, I propose an ideal model for his role. This ideal model encompasses role segments from all three categories in Otis' framework.

However, Otis warns of the danger of romanticizing the use of these workers, and Riessman sums it up as follows (*1a*).

> It is easy to be uncritically enthusiastic about them (and many have been) especially in view of the strong chorus of criticism of the professionals who serve the poor. I believe that the achievements of these indigenous nonprofessionals are impressive, their talents unique, and their future in social service and education very bright. However, I think it much more important to consider their best use, their proper training, and the problems they bring, rather than merely to sing their praises.

Riessman points out some special problems indigenous workers may have because of their background, such as keeping a confidence, accepting authority, and overidentifying with the agency. He adds that, "Merely coming from the same class as the client is not, of course, enough to make a good worker. The native nonprofessional must be carefully chosen and trained" (*1b*).

Concept of Role

In considering the functions of nonprofessional and professional personnel in agencies, the concept of role is pertinent. Each person occupies one or more positions in the total network of his society. The term "position" or "status" is used to indicate location within a society, and includes designations such as mother, daughter, nurse, and landlady. Positions usually coexist. One can be a mother and a nurse at the same time.

Each social group defines explicitly or implicitly the behavior expected of an occupant of one of its positions. "Each position carries with it definite prescriptions for behaving toward other persons in related positions" (*12*).

The definition of role includes prescribed behavior, but the concept of role is actually much broader. It includes expected values and attitudes, which give the concept a should or should

not quality, and emphasizes expectancy rather than actuality (*13*).

Benne and Bennis point out that role is neither the description of the actual behavior of a nurse on the job nor the job description, but ". . . the cluster of functions that come to be expected of a given class of workers within positions that they typically occupy in the organizations or social systems in which they work" (*14*). The role for a given position consists of many segments, not all of which are of equal importance. A person's role depends on the role of other persons in that setting.

While the concept of role refers to expectations for a class of people occupying a position, role behavior (sometimes called role performance or role enactment) refers to what a particular person occupying that position actually does or feels or believes (*15*).

> Of central importance . . . is the concept of *role enactment*, which refers to the way in which a role is actually carried out by persons authorized to perform the role. The fact that roles are not always enacted in accordance with any one set of ideal standards may be partially explained by the fact that actors may have different normative expectations of themselves and of other actors in particular circumstances, which is to say that they have different *role conceptions*.

Although Haas does not stress it, personality variables are undoubtedly of central importance in the different ways in which persons behave in a certain role (*16*).

Important in occupational role change is the notion of role conflict. Most texts of social psychology treat this subject in terms of the problem created when one person occupies two or more conflicting positions, interrole conflict. The dilemma of the working mother is an example of this.

Another type of role conflict, which seems to be discussed less frequently in the literature, is the intrarole conflict experienced by occupants of a single role. Brown proposes that it ". . . arises from disagreement on what is proper behavior for role occupants" (*18*). These disagreements are rooted in a changing society where social roles are often only vaguely defined, in constant flux, and highly dependent on the personal views of those who are involved.

Knutson brings out the occupational and practical aspects of changing roles (*19a*).

> Role demands and role conceptions are constantly changing, for no social group remains stable. New requirements may be identified, new situations will arise and require different patterns of role definition and role performance. People grow on the job and it is essential that the job grow with them. Likewise, organizations change their orientations and policies and change in their definitions of purpose and immediate goal.

Another important aspect of role conflict is that it ". . . may occur when roles of different members of the group overlap . . ." (*19b*).

Because of the far-reaching potential for role change and for overlapping of roles with the addition of indigenous workers to a public health nursing program, a certain amount of role conflict on the part of nurses vis-a-vis aides logically can be expected—at least temporarily.

Role of the Nurse

The role of the professional nurse is in great flux (*20*). Because professional role change is a charged topic, debates on the future of nursing are infused with great feeling.

Role change in nursing does not occur in a vacuum. Roles of professional nurses are changing in concert with those of other health personnel. Increasingly, nurses are turning the physical care of patients over to their auxiliaries. At the same time, nurses consider direct patient care the most important and gratifying aspect of their role (*21*). Perhaps the greatest dilemma in nursing is the resulting role deprivation (*22*). Significantly, the newly developed expanded role of the nurse (*23*) returns the nurse to patient care.

This role deprivation may also affect public health nursing, in which the professional nurse has been in control. In the past few years some public health agencies have begun to use indigenous workers in their regular nursing services or in special projects (*24–26*). The role of these new career workers was not formulated by the nursing profession, and until a comfortable consensus of their role in public health nursing is developed on a national and local level, role conflict is likely to occur.

The Interviews

I interviewed 10 public health nurses about how the roles of public health nurses are changing with the addition of indigenous workers

and how nurses feel about this change. Because the interviews were unstructured, only broad impressions emerged. Circumstances did not allow interviewing the indigenous workers as well. The interviews focused on the use of indigenous workers in the general public health nursing program, rather than on home health aides used in the bedside nursing program or on dental aides in a special project. Many of the nurses had experience with more than one type of aide.

The 10 nurses were employed by the Alameda County health department, a large county health department with several district offices and a total complement of about 100 public health nurses. The agency has a generalized public health nursing program as is usually found in metropolitan areas in California.

The major criterion for the selection of indigenous workers was that they meet the definition of poverty as currently formulated. There was no set requirement for level of formal education. The health department selection team placed emphasis on personal qualities, such as ability to communicate and interest in other people.

Each aide is assigned to a public health nurse who supervises her work. Either this nurse or others in a group of nurses may give tasks to her. Formal orientation and inservice education programs for the aides are being developed and implemented by the agency, but until recently most of the responsibility for orienting and teaching the aides has been in the hands of the nurses themselves.

The role of the aide has not yet been spelled out explicitly. Probably their use to date could be considered a pilot phase with a great deal of leeway allowed in role experimentation.

The five nurses in each of two district offices who had an indigenous aide assigned to them at the time were interviewed. The nurses' experience with indigenous aides ranged in time from 1 to 18 months, with an average of approximately 7½ months. This includes the experience two of the nurses had with indigenous workers on a dental project, but excludes their experience with home health aides.

All respondents were staff-level public health nurses aged 23–53 years with bachelor's degrees. Their experience in public health ranged from 13 months to 11 years, with a median of 2¾ years. Seven had had no other jobs in public health; three had spent an average of less than 1 year in another public health job. Because an employing agency substantially prescribes roles for its employees, the agency itself probably has been a potent force in shaping the views the nurses have had of their roles in the past and in reshaping their role expectations relative to the new indigenous workers.

Role of the Aides

I asked the nurses why they thought the aides were being used and how they thought the trend evolved. All answered in terms of the need for jobs for the poor and the manpower shortage in public health nursing. Only one nurse mentioned the need for jobs with hope and meaning. Four nurses mentioned that the workers are being used because they might be able to reach some people the nurses were unable to reach, but their lack of conviction was apparent in the following statements.

—There is one theory that they would be able to communicate better with hard core families.
—The poverty program is hoping for better results.
—They say that the underprivileged have a closer relationship, better rapport, because of their similar background; I don't believe it.

The nurses said in effect that the aides are here because they need work and we need help. Thus, the aides' role seems to be perceived by the nurses in just those terms—work for the aide and aid for the nurse.

The 10 public health nurses seemed reasonably independent in developing the role of the aides relative to their own. Data on the roles they are given have been divided into five broadly defined categories, modeled on Otis' types of auxiliaries.

1. Nonprofessional tasks are the generally routine tasks, largely in clinic work. They include helping with setup, weighing and measuring, PKU testing, pulling records, welcoming mothers, and keeping the flow of the clinic going.

2. Subprofessional tasks are the reallocations of the professional role. Included are casefinding, simple followup related to appointments, followup of simple, well-defined cases after

specific direction by the public health nurse, locating families recorded as not at home or lost, routine immunization followup, simple referrals to community resources and to the public health nurse, getting identifying information for the record at clinics.

3. Nontraditional tasks are house-to-house surveys, interpreting a foreign language, transportation, accompanying patients, babysitting, and child supervision in clinics.

4. Health teaching encompasses teaching simple concepts in many health areas.

5. New career tasks might include interpreting the agency and its services to the community, community liaison, interpreting attitudes and problems of families to professional staff, encouraging health care among community residents, assessing health and other problems, helping families to solve problems, supporting and motivating families, following up families without specific directions from the public health nurse, reaching the hard to reach, supervising other new career workers.

These categories of functions are of course tenuous. More intensive work is needed to delineate the indigenous worker's role.

The nurses were asked what kind of work the aides actually do, and their responses were roughly divided into the same five groups.

Six nurses reported that their aides work in clinics, and four of these nurses specified that their aides perform some nonprofessional tasks; the other two nurses did not indicate what their aides do in the clinic. It is assumed that the other four aides do not work in a clinic because their nurses do not. No particular problem with roles would be expected since the tasks in this group are those which have traditionally been performed by volunteers.

All of the nurses used their aides for some simple subprofessional tasks, as illustrated by the following interview responses.

—She does the footwork for the public health nurse and checks on general health supervision.

—She makes appointments and sees to it that people follow through.

—She goes out to see if the children have started their immunizations, and she goes out on an open family folder if the only important thing is completion of immunizations.

—In families you know, the nurse does the initial teaching, and then the aide follows up.

—She is given information before she goes out about what she can answer, what immunizations are needed, and then she lets the public health nurse know if there are any problems.

Most of the nurses reported that the aides perform some of the nontraditional tasks. These functions have not generally been considered a legitimate part of the role of a public health nurse. Nurse transportation of patients usually has been proscribed, and babysitting has never been considered. Public health nurses, under special circumstances, have conducted surveys, but it is my impression that this has not been very satisfying to them. Apparently role conflict is minimal when roles do not impinge upon each other.

Only four nurses spontaneously and convincingly mentioned teaching as part of the aides' role. Four did not mention it at all, one thought that her aide might take on teaching tasks gradually, and one mentioned it only in relation to dental hygiene. Nevertheless, it seems that many aides should be capable of simple health teaching regarding immunizations, nutrition, dental hygiene, family planning, and so forth.

But traditionally the public health nurse has been a teacher. Furthermore, the norms of our society dictate that a teacher be well qualified and well informed on his subject. However, since the health message has often not come across to patients, especially in poverty areas, professionals must ask themselves whether it is possible that indigenous workers, whose major qualification is that they are from the poverty culture, can successfully share this role.

Only four nurses seemed reasonably committed to turning over some of the new career tasks to their aides. Three of these nurses are among those who indicated that aides were being used because they might perform certain functions better than public health nurses. The following interview responses indicate the nurses' use or nonuse of aides in new career tasks.

—I am working her in to supervise another aide in clinic.

—She is good in well baby visits, finding out what problems they have. She has some innate ability to recognize problems. I don't feel that she should get involved in problems with the pill and the intrauterine device.

—She follows up on lapsed appointments to find out the reasons why.

—Venereal disease has not been stressed, but she brought it up herself. She can go ahead and refer people who have symptoms of venereal disease. Eventually I expect her to do general health supervision, picking up such health needs as feeding and toilet training that she has handled with her own children.

—Sometimes they follow up on hard-to-reach families. They carry the public health message to community groups such as the PTA if they have kids in school.

—I don't send her out on prenatal and venereal disease visits. I feel I should do that myself. Sometimes I send her to see a family I am unable to reach.

—She works with problem families we didn't have time to contact, to motivate them to complete immunizations and so forth.

—Occasionally they give too much of their own advice without checking with the nurse, but my aide hasn't done that.

Change in Nurses' Jobs

The nurses were asked how they thought their jobs had changed and what they thought would happen to public health nursing if the trend to use aides continues.

Eight of the nurses clearly saw their role as changing in the direction of supervision, teaching, consulting, coordinating, and teamleading. The ninth nurse said, "It will be like in the hospital," and the 10th felt that there would be little change in the nurse's role.

It was no surprise that a role change in the direction of supervision, teaching, and the like was not embraced with unanimous joy, even though these roles generally carry higher prestige, status, and remuneration than patient care. Hospital nurses have mixed feelings about losing direct patient contact.

In the interviews, the feelings of the nurses about the new supervisory and teaching functions were sometimes hinted at and sometimes freely expressed.

—It takes all my time to supervise and teach. I'm not accustomed to supervision. It's like having a student, but a student has more medical background. I hate to see public health nurses become just administrators, sitting behind a desk, because I get satisfaction out of patient contact.

—The public health nurse will become a team leader, similar to the nurse in the hospital. I don't feel that the aide program threatens the public health nurse; it just changes her functions.

—Public health nursing will be more supervisory. I like working closely with families. I'm not interested in being just a supervisor.

—We will become more coordinators, supervisors, and consultants. I'm divided on it.

—The nurse develops skills of supervision and teaching of auxiliary personnel.

—We will become more like supervisors and spend less time with patients. We will be bogged down with paperwork. I like to make visits myself. She does what I would like to do.

Role change in the direction of supervision and teaching with the addition of indigenous workers has been noted in the fields other than public health nursing. Riessman refers to this change in social work. "Perhaps the future will find each professional supervising and teaching five to eight nonprofessionals" (*1c*). Reiff forecasts it for the mental health services. ". . . The role of the professional will change. He will need to be more of a consultant, supervisor, and administrator" (*3a*).

Six nurses thought that public health nurses would have less patient contact in the future, and none indicated that she considered this change desirable. Six thought that public health nurses would spend more time with complicated, difficult families, and none indicated that this was undesirable. Concentrating efforts on difficult patients is clearly in line with the role expectation of a public health nurse, and she sees this role segment as remaining in her own hands.

The nurses had mixed responses to the trend of using aides in public health nursing programs. Five thought it saved time and seven thought it was time-consuming. Obviously there is some overlapping of response here. Several of the nurses seemed unsure whether it saved time or not.

At this stage of the aide program, the time-consuming aspects seem not yet balanced out by the time saved, as far as the nurses are concerned. In addition to the time needed for supervision, several of the nurses complained of the clerical work involved in working with aides. While nurses commonly do clerical work, it is considered improper to use their time this way.

Several nurses mentioned that it is difficult to find work for the aides. Since public health nurses are rarely short of work, this difficulty in keeping aides busy might be a symptom of

the nurses' uncertainty about the aides' role and ability, and of some conflict about relinquishing any part of the nursing role to an untrained person.

A few nurses mentioned the positive aspects of the program, but these comments were not numerous.

In their evaluation of the trend to use aides, none of the nurses gave a clearly negative response. However, there were indications of mixed feelings, which some respondents freely admitted. The interview responses indicated that these nurses were making a real effort to see the aides as an asset and that they were attempting to adjust to their new roles.

—Maybe I'm idealistic, but from her own background she can communicate better with families. She is more practical and realistic in seeing what might benefit the family. I expect to learn a great deal from her about what is practical and what is not and how to get information across to families. I expect quality, but I am not sure I'm right. It's frustrating because I expect more quality than the aide will ever be able to achieve. I am caught between ideals and reality.

—Some aides are very able in interpreting needs for immunizations and the importance of dental care and hygiene. I work with her and help her to relate to families, how to be a listener. The aides will be used more and more . . . I have some question about it. There will be limits as to how far they can go. I suppose there are many hidden potentials. New things take getting used to.

—I have mixed emotions. It's good if the aides are good.

—As yet they are not an asset in the caseload. I'm reluctant to give up any case; they might miss something that is important, but some dig up things that you haven't noticed. Some patients tell them things that they haven't told you, so it evens out. You have to do it. Burdens are placed on you all the time, all these new programs, and nothing is ever taken away. But now that we are getting our feet wet, it's easier.

One nurse who spoke highly of her aide and apparently used her very well said that many public health nurses feel that aides get paid for doing nothing. She also thought that they feel threatened that they will lose their jobs to the aides. Another nurse who also seemed to have a positive attitude toward the aide program likewise referred to the threat felt by other nurses, but added that this is silly, because aides could not function independently. Others had the following comments.

—The aide is not always accepted in the home. I have been turned down once at most, but she has had many objections. But then, many others have asked for her.

—They are able to relate to some of the families we haven't been able to. They are less different in personality and education. I don't know just how it works. Some have poor attitudes to routine health care; they have never bothered to go to physicians themselves and find it difficult to see that it is important.

—She has good judgment on when to do the teaching, when the family is receptive. She communicates back to me a lot of the feeling of the people we deal with.

—I'd like to see them organize some kind of community group—social, reciprocal babysitting, educational. They have the ability to approach a member of their neighborhood with more ease, and are more accepted in some situations. They communicate on the same level as the patients and they understand some of their habits and folklore.

—They are good at establishing rapport with people in their own geographical area, and they have very nice relationships. They can get people to do things where we sometimes cannot.

It is essential to point out one theme which consistently ran through the interviews; practically all the nurses felt that the aides could not be evaluated as a group, but that they were individuals with different personalities, capacities, and potential. It is probably impossible to fit all indigenous workers into the mold of the ideal model since the successful filling of this role might well be less dependent on skills that can be taught than on inherent qualities of culture and personality.

As a group the nurses wanted more careful selection of the aides, formal orientation, and inservice education. Aides have been placed in the nursing division to play a role which is not yet clearly defined and for which they are inadequately prepared, so that the burden of role definition and role indoctrination has fallen upon the individual nurse.

There is some question on the part of social engineers regarding the amount and type of training for new career workers. The problem is that the worker's one great asset is her identification with the poor, and it is feared that she will lose this and become professionalized. All the nurses wanted more training for the aides, and several showed their awareness of the possible pitfalls of aide training. However, only

one nurse indicated a need for nurses to be trained regarding their relationships with the aides.

Summary

A small, exploratory study was done in a large county health department in California which had started to use indigenous aides in the public health nursing program. Ten public health nurses were interviewed to elicit their feelings about the function of the aides and about their own changing roles.

In this early stage of the program the role of the aides was not spelled out explicitly and the nurses were free to experiment with the role of their aides.

Functions of aides were classified into five groups: nonprofessional, subprofessional, nontraditional, health teaching, and new career tasks.

Most nurses reported that they used their aides for some of the nonprofessional tasks, as well as for simple subprofessional and nontraditional tasks. However, tasks involving health teaching were infrequently turned over to the aides, and few of the nurses seemed committed to turning new career-type tasks over to their aides.

Almost all the nurses saw their role as changing from one with an emphasis on patient contact to one of supervision and teaching. Their reaction to this change was not favorable, since they liked patient contact. They felt that supervising an aide was time consuming, and they were unhappy about the clerical work involved. They reported some difficulty in finding enough work for the aides to do, possibly because they were uncomfortable about the reallocation of functions.

Generally, their feelings about this new program were mixed, but they were making an effort to adjust to their new roles. All felt that indigenous workers should not be judged as a group, but that they are individuals with different assets. They saw a great need for more careful selection, orientation, and training of indigenous workers.

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