THE PRACTICAL NURSE: ROLE EXPECTATIONS HELD BY RELEVANT GROUPS

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BY

MARION ELIZABETH HANLEY HILL

AN ABSTRACT OF A THESIS

Submitted to the College of Education,
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ABSTRACT

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The purpose of this study was to identify and clarify the agreement and disagreement of role expectations which the practical nurses, directors of hospitals, medical doctors and three groups of professional nurses: administrators, non-administrators and clinical instructors hold for selected aspects of the duties and responsibilities of the practical nurses. These expectations related to the following areas of practical nursing: general responsibility, bedside, bedside-technical, technical and medical. Intra-analysis of the expected and actual roles of the practical nurses was also included in the study. It was hypothesized that the expected and actual roles of the practical nurses would be defined differently by the different respondent groups.

Practical nurses, directors of hospitals, medical doctors and three groups of registered nurses: administrators, non-administrators and clinical instructors associated with the eight practical nurse centers in Michigan were given a questionnaire dealing with expected and actual role of the licensed practical nurse. Opinions were expressed on a five point scale of intensity varying from "never" to "always." Thirty-three items were selected for intensive analysis. The expected and actual roles of the practical nurse, as seen by the practical nurse, were

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Expected and actual (inter-analysis) role expectations of the respondent groups were compared with those of the practical nurse and agreement and lack of agreement noted.

Significant differences were found between means of certain items pertaining to the expected and actual roles of the practical nurse as seen by the practical nurse. There tended to be more in the area of general responsibility than in the areas of duties.

Significant differences were also found between the means of items pertaining to the expected and actual roles of the practical nurse as seen by the practical nurse and the respondent groups. Following is the order of general disagreement of the perception of the expected role of the practical nurse: registered nurse administrator disagreed on 16 items; registered nurse non-administrator disagreed on 11 items; medical doctors disagreed on 10 items; registered nurse clinical instructors disagreed on nine items and the director of the hospital disagreed on eight items. The order of general disagreement of perception of actual role of the practical nurse was as follows: registered nurse non-administrator disagreed on 21 items; registered nurse administrators disagreed on 16 items; medical doctors disagreed on 12 items; registered nurse clinical instructors disagreed on 12 items and directors of hospitals disagreed on 11 items.

Implications for the reduction of these disagreements in the role expectations of the practical nurse were discussed.

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CHAPTER I

THE PROBLEM

Introduction:

There is much evidence that the practical nurse is fully accepted on the nursing team and that her services and usefulness are in constant demand. The problems faced in this study deal with the role of the practical nurse. In the past she has been defined broadly as a worker who "shares in the care of the sick." (39) Actually, in practice, she has worked independently, often performing her functions with either no on-the-spot supervision or only a minimum amount of it. Her practice has always been recognized as being limited in the range of nursing situations which she could nurse but the boundaries have only been vaguely defined. This study has been designed to better define her role in the hospital setting of working either in a close relationship with the professional nurse in more complex nursing situations or her independent nursing role.

Independent nursing role, as used here, is meant to imply that the nurse is able to assess the needs of the individual patient; to select from understandings and skills learned in a range of nursing situations those she needs in a specific situation; and, in making such selections and carrying out the required nursing measures, to use the judgment that is compatible with her role. As she performs these functions she recognizes the individuality of the person being nursed. In addition, she

understands the nature of his illness and the physician's medical care plan and is able to give the prescribed medications and treatments skillfully and with understanding of their anticipated effects.

In direct connection with the foregoing, the following will help to clarify the functions of the practical nurse according to the Michigan Statutes regulating practical nurses:

1. The practical nurse cannot be permitted to do the specific acts (such as administering anesthetics, hypodermic injections, skin tests, x-ray treatments, etc.) which have been held to be solely within the province of the registered nurse or registered physician.

2. The practical nurse may be permitted to administer medications under the supervision of a registered nurse or physician but only under direct supervision or under direct orders which do not allow her to use her own judgment.

3. The practical nurse cannot be placed in direct charge but must always be under direction and supervision. (16: 315-316)

Results of this study would help to determine the role expectations of the practical nurse as held by the directors of hospitals, medical doctors and three groups of registered nurses as well as the expectations the practical nurse holds of herself. To what extent is the role of the practical nurse that of "assistant to" the professional nurse? How limited are her responsibilities? How complex are the nursing situations? Does she

or does she not need a complete understanding of the rationale of every aspect of the nursing care that is being given?

The following may be used as criteria by which to identify what is meant by "less complex" nursing situations: (1) when the patient's condition is relatively stable and no major change is expected for some time; (2) when the measures of care do not require depth of scientific understanding and are rather constant in nature and (3) when the care required is largely of an assisting character and not of the sort that requires a great deal of instruction of the patient.

Thus it may be said that there are many points of confusion in the current definition of the role of the practical nurse. Of particular interest are the functions or cluster of functions that have come to be expected of this class of workers within positions that they typically occupy in the organizations or social systems of the hospitals in which they work.

Statement of the Problem:

A major purpose of this study was to identify and clarify the divergence and convergence of role expectations which the practical nurses, directors of hospitals, medical doctors, and three groups of professional nurses: administrators, non-administrators, and clinical instructors hold for selected aspects of the practical nurses. These views were related to the following areas of practical nursing: general responsibility, bedside, bedside-technical, technical and medical.

The research was based on the assumption that the foregoing groups hold different expectations and, because of these different expectations, possibilities for role confusion are created.

This study explores at least two of the principal sets of expectations which determine the character of the nurse's role which, according to Benne, stem from the institution, one, through administrative channels from the top of the hierarch down and second, from the peer group in the working situation. (4: 196) The practical nurse needs to understand her proper role and be prepared to fulfill those expectations ascribed her. Some of the reasons for role confusion and conflict in nursing may be due to the practical nurse's lack of knowledge of the expectations or she may hold role expectations not convergent with the expressed expectations held by directors of hospitals, medical doctors and registered nurses. These role parts were contained in a questionnaire to which the different groups responded.

Importance of the Study:

The greatest number of practical nurses are employed in hospitals. Since the relationships in the professional setting of these institutions has become more complex it appears increasingly important that every role acted in it must be perceived clearly and consistently by all groups so that there may be smoothly operating social relationships.

Regardless of what the practical nurse does or does not do, it is unlikely that any given act in a situation will be perceived by all groups in the

same way. However, by defining more clearly areas of various groups, recommendations for the reduction of role conflict can be made.

The successful functioning of any institution is directly proportional to the degree of job satisfaction and subsequent role performance of its members. The practical nurse's nursing role may be satisfying only to the degree that those interacting have perceptions which align themselves in action.

Dr. Bruno Solby, specifically writing on "The Role Concept in Job Adjustment," has shown that every job (role) has three values. These are identified as: (1) social saturation value in meeting emotional needs, (2) role value in financial compensation and experience in the job situation, and (3) integration value in expressing specific talents in productive work. He also states that role conflict decreases role value.

> If the role value is decreased and becomes smaller than the social saturation value, the social saturation value will have to increase proportionately if the degree of integration is to be maintained. If the role value however decreases without any change taking place in the social saturation value, the integration value of the job diminishes too. (38: 222-229)

He based much of his research on J. L. Moreno's development of the role concept described in Who Shall Survive. (28) Solby goes further to state:

> If the role value the individual experiences in his job is so closely related to his social saturation value that in the individual's emotional experience they very nearly become

> identical, the integration value the individual experiences through the job increases proportionately to the increase in the role value. If, for instance, a man in his 'job' of being a physician realizes in his profession all the desirable roles and, at the same time, the saturation of his needs for interpersonal relationships because of his close relationships to his patients or because his family and friends love and admire him because of his being a (good) physician, this individual experiences well-being as the result of the higher integration value of his job. Any increase in the role value accompanied by an increase in the social saturation value will augment his experience of integration. (38: 229)

Knowledge or role, as it is perceived, should lead to increase in role value which would be the first step in helping to accomplish healthy and positive integration. In their writings, Moreno, Solby, and Lewin conclude that acquisition of role concept helps for positive life adjustment. (23: 110)

A hospital is an integrated system of roles organizing the activities of its members toward common goals. Role expectations allow for the prediction of appropriate behavior in a given social system. A knowledge of role and an understanding of potential role conflict is necessary if the incumbents of a particular position, namely the practical nurses, are to function adequately in the internal organization of that system, the hospital. Chapter II describes studies which have investigated the importance of the role in similar situations and that have contributed to a better understanding

of role and role conflict. This research concerning the extent of disagreement between the practical nurses and relevant groups concerning role expectations of the practical nurses should add to these studies.

Scope and Limitations:

The study provided for role expectations to be identified by the directors of hospitals, medical doctors, practical nurses, and three groups of registered nurses, identified as administrators, non-administrators, and clinical instructors. The study measured the convergence and divergence of role expectations and also the degree to which they were held.

Although the practical nurses may interact with all registered nurses in a hospital, the investigation was limited to certain groups of supervisors, head nurses, clinical instructors, and team leaders.

Only those aspects relating to the bedside, technical, medical, and general categories of the role of the practical nurse were studied.

The study utilized an open-ended questionnaire and interviews were administered to consultants, administrators and clinical instructors in both the fields of registered and practical nursing. From these preliminary methods a formalized questionnaire was devised to identify certain facets of the practical nurses role. The data collected in the formal instrument were restricted to the responses to the questionnaire and generalized only to the population. The population from which the selected

sample was taken was limited to eight practical nurse centers in Michigan. These centers were chosen as representative of private, public, small town, city, and metropolitan programs.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction:

The review of literature for this study encompassed two major areas: (1) role theory and analysis of role expectations and (2) authoritative writings related to nursing roles. The normative position was reviewed last.

Role theory and analysis information will be discussed first since it forms the basis for the theoretical point of departure for this research study.

Role Theory:

The concept of role is an integral part of sociological vocabulary although it has a wide variety of meanings. Nieman and Hughes, in their re-survey of the literature from 1900 - 1950, distinguished various definitions and usages of the concept in terms of (1) the dynamics of personality development, (2) functional definitions in terms of society as a whole and (3) definitions in terms of specific groups. They found three elements of similarity.

1. All of the definitions and usages of the concept involve either an individual definition of a specific situation or an individual acceptance of a group's definition of a specific situation.

2. Role behavior involves the assumption of a process of interaction which leads then to further generalization. Namely, that man is the only role-playing animal and that is one of the characteristics that distinguishes man from other animals.

3. Human behavior cannot be explained or described by use of traits or other atomized concepts but must be viewed from the framework of organized and integrated patterns of behavior. (29: 141-149)

Neiman and Hughes pointed out that in the early historical development, in the area of theoretical assumptions and implications, the frame of reference was almost exclusively that of symbolic interactionism and that this trend has continued to modern times as exemplified by those who use the concept as a basic factor in the process of socialization. They indicated the most definitive use of the concept and the one about which there is the most consensus was the trend toward associating the concept of role with that of status.

That many definitions are merely a matter of semantics was discussed in Gross, Mason and McEachern's review of the literature and they stated:

> What Linton and Newcomb define as role, Davis defines as a status; what Davis defines as a role, Newcomb calls role behavior and Sarbin role enactment. (19: 13)

Most authors, McEachern included, conceptualize three basic ideas which may not appear in the definitions of role themselves but consider that

individuals in social locations behave with reference to expectations. They remarked that most of the authors have used the role concept to embrace the normative element of social behavior.

Sarbin's article on role theory covered the development of, and research in, role theory, much of which was related to the concept of role with that of status. (35: 223-258) The article also contained numerous references to work which has been done in this area.

Parsons agreed with Linton, in that role is the dynamic aspect of status, the behavioral counterpart of the "ideal" or expected position defined by status. (31, 24)

Bates departed from Linton, in that he said the social role is a non-behavioral structural sub-unity of norms. (2: 313-321) A social role is normative and structural in character and is part of a social position and not an expression of the position in action. His work attempted to develop a uniform language including definitions of role, position, norms and status.

Charters summarized role theory in the organization of a school. (11) He encouraged studies of internal organization and staff relationships within a school. In his study he proposed the following assumption:

> An individual's behavior is strongly influenced by the expectations which members of the various important groups have of him and his relationship to them. In the context of organizational theory, role has added significance because certain of these expectations become institutionalized and an individual is penalized

> by the organization if his behavior deviates from that which is expected of him. (11: 41-43)

Related Studies:

The studies reviewed dealt with role expectations held by various groups and made use of role theory as was reviewed in the beginning of this chapter.

Getzels and Guba studied role conflict in the teaching situation. They studied three major issues: (1) the nature of expectations attached to the teacher role; (2) the extent of conflict among these expectations; and (3) the differential effect of such conflict on the teachers as a function of certain personal and social characteristics.

The authors concluded that:

1. The teacher is defined both by core expectations common to the teaching situation in general and by significantly varying expectations that are a function of local school and community conditions.

2. Many of the expectations attached to the teacher role are inconsistent with expectations attached to other roles the teacher typically occupies. That is, the teaching situation is in many critical elements characterized by role conflict.

3. The nature of role conflicts is systematically related to certain differences among schools and among communities.

4. The existence of role conflicts may be taken as evidence that the teacher role is imperfectly integrated with other roles. The consequence of role conflict may be frustration for the individual teacher and ineffectiveness for the educational institution.

5. There are differential reactions among teachers in the extent of their ability to recognize role conflict in the teaching situation. These differential reactions are systematically and meaningfully related to certain personal characteristics of the teachers. (18: 30-40)

Washburne represented a type of role research in which the actor's involvement and his self-image were the key concepts. (43) The study examined various factors related to the stress which the actor experienced in the position. The actor may have found conflicting expectations being held by the community, colleges, or organization for his behavior. The impact of these upon the personality of the actor provided the basis for this study.

Bidwell drew conclusions about satisfaction in teaching and administrative roles. (6) He stated that the school administrator and the teachers might be seen as participating in a system of reciprocal role-expectations. From responses to a questionnaire he attempted to measure the perceptions and expectations of the teachers regarding the principal and superintendent and the degree of satisfaction of the respondent in the teaching position.

The author concluded that:

1. Convergence of teachers' role-expectations toward the admistrator and their perceptions of his behavior will be accompanied by an expression by these teachers of satisfaction with the teaching situation.

2. Divergence of teachers' role expectations toward the administrator and their perceptions of his behavior will be accompanied by an expression by these teachers of dissatisfaction with the teaching situation.

3. The level of teaching satisfaction is dependent upon convergence or divergence of expectations and perceptions of their fulfillment and is independent of the nature of the expectations. (6: 1, 41)

Doyle did work in the expectation convergence between teachers' perception of their role and parents', administrators', and school board members' perceptions of that same role. (17) In comparing the beliefs of the teachers with the expressed expectations of administrators, school board members and parents, it was found that teachers held many beliefs which the others did not share. The greatest divergence was that teachers held erroneous beliefs as to what parents expected of them 50 per cent of the time.

Cowan attempted to identify and clarify role expectations held by building directors, principals, adult education coordinators, and teachers regarding the position of the community school building director. (13)

He hypothesized that building directors, principals, adult education coordinators and teachers sometimes hold different role expectations regarding the building directors position. Cowan also hypothesized that certain selected personal variables of building directors were systematically related to role expectations held by building directors. Known personal characteristics of the significant others were assumed to be related to their expressed expectations, too. The analysis of the data supported the hypothesis that building directors and significant others hold different and sometimes conflicting expectations regarding the position of building director.

A comparison of selected personal variables of the relevant groups with regards to the proportion of respondents defining the position and holding affirmative expectations failed to support the assumption that systematic relationships would be discovered.

Hoffman studied the role of the elementary special area teacher and consultant role. (21) Seventeen school districts in Michigan were chosen in which conflicting expectations held by teachers, administrators, special area teachers and consultants, concerning this role were analyzed. Sixty-two items were selected dealing with generalized roles. In these selected items, it was shown that there was inconsistency in role perceptions held for these roles.

An attempt was made by Sweitzer to discover the nature and extent of agreement among role expectations and role perceptions held by

various reference groups concerning the superintendent's role. The extent to which the role expectations were fulfilled was related to teacher morale. Five dimensions of leadership behavior and interaction were identified. The study instrument consisted ot three parts and obtained the role expectations (desirable behavior) of each group, the role perceptions (actual behavior) of each respondent group and a measurement of teacher morale. Sweitzer summarized that:

> Even though relatively common criteria tend to be held by the professional members of a school system, they do not perceive or interpret the superintendent's behavior in the same way. There are greater differences among groups in regard to role perception than there are in regard to role expectation. If a superintendent's behavior in attempting to bring about instructional improvement is perceived as being too different from what others believe is effective and appropriate behavior, the general group's climate may be affected and the teacher morale lowered. (40: 1-4)

Campbell studied teacher satisfaction in relationship to teacher-principal agreement. (10: 1-4) He hypothesized that those teachers whose wants and needs were in agreement with their principal's expectations would express significantly higher job satisfaction than would those teachers whose wants were in conflict with the principal's definition of the teacher's role. The hypothesis was supported by the results obtained from 15 principals and 284 teachers. In summary, the administrators were warned to be aware of two aspects of social behavior. The

one is that of job specification and the other, the wants and needs of the individual. It was recommended that the principal needed to be more effective in communicating his expectations to teachers.

Nonnamaker studied expectations held for the enrollment officer at Michigan State University. (30) A random sampling of seven campus groups was chosen. An instrument concerning various expectations held for the enrollment officer's role was constructed. It was concluded that there is no single set of expectations held for the enrollment officer. Significant differences were found in expectations held for the role of the counselor. The duties and responsibilities of the enrollment officer consequently should be more clearly defined.

Authoritative Literature Regarding the Role of the Nurse:

Most of the literature related to the role of the nurse has been primarily concerned with normative approaches to the role of the professional registered nurse. Very little authoritative writing has been found by this author concerning the role of the practical nurse. This field is new and there is still need for much research to be done.

A handbook on the practical nurse by Clark has suggested that what the practical nurse needs most of all is a stabilization of her role. She has gone on to say:

> Just now, in hospitals in any one city, we may find policies and varying levels of acceptance of what a practical nurse may do, can do, and should do. This variation

> exists in spite of the fact that present training programs prepare the practical nurse in the basic sciences, the nursing arts, rehabilitation techniques, pharmacology and admisistration of medicine.
>
> The true role of the licensed practical nurse must be faced squarely and honestly. It is for bedside nursing that she is being trained; it is her greatest job satisfaction and it is there she is most needed. But we know that in one hospital she is not allowed to assume certain responsibilities, such as catheterization or charting, for which she has been well trained, while at others she may be expected to assume duties for which she has not been prepared. (12: 21-23)

The greatest amount of confusion has arisen in the area of medications. Both responsibility and status have entered into the picture. Clark has also reported that at the Cabell Huntington Hospital, Huntington, West Virginia, the practical nurses and registered nurses worked in close harmony. The registered nurse did the paper work, made the rounds with the doctors and kept everything running smoothly. The licensed practical nurse admitted patients, did routine bedside work and was a respected member of the staff. Interestingly, medications were not mentioned.

Vaillot studied the professional worlds of three types of nurses - collegiate, diploma and practical nurses. (42) She investigated differences and similitudes related to the differences in the pattern of professional distances from younger to older students, to differences of nurses interested in bedside nursing to those not so inclined, to characteristics of good and not so good leaders. A pilot study showed that

there were differences in the patterns of distances and identifications between students in schools of different types and that these distances could be measured.

A scale to determine the assignment of tasks was drawn up and administered to the students of the different types of schools. This instrument was used to probe the students' relationship to others in the students' world such as teachers, physicians, hospital administrators and patients on one dimension and the professional versus the traditional orientation to nursing on the other.

Results of these scales showed that practical nurse students maintain a wide distance with what they believe, in a professional sense, to be the ideals of the teachers, the physicians, the head nurses and the patients. Practical nurse students believe that the teachers, the physicians and the head nurses see in nursing an autonomous profession carrying with it a responsibility and prestige and demanding a thorough preparation. They believe that the patients expect from the nurse a warm and devoted personal service but do not see in nursing a responsible profession that sets its own standards and charts its own course. Whereas professional student nurses identify more with the teachers, physicians and head nurses, practical nurses are found to stay in nursing longer since they usually need to earn a living. The professional nurses are likely to be younger and who work for a year or two and get married thus leaving the profession.

Randall conducted an evaluation study of the Lansing (Michigan) Practical Nurse Center relating curriculum to the needs of the practical prescribed by her role. Findings indicated that the course in nutrition was repetitious, particularly in the areas of meal planning, meal preparation and homemaking. The requests for more time for medical-surgical nursing included the following:

1. Demonstrations on special treatments and dressings.
2. More time on charting.
3. Care of equipment.
4. Consistent isolation technique.
5. Assisting the physician.
6. Preparation as 'team member and leader.'
7. Interpretation of routine laboratory tests. (33: 18-21)

More time was also requested to be allotted the courses in disease conditions, anatomy and obstetrics. It was pointed out that there is a limited time to cover the many subjects required by the state and the needs may have to be taken care of at the post-graduate level. Suggested post-graduate courses were medications, psychology-psychiatric, operating room and obstetrics.

Meyer's study applied a projective technique using pictures to assess preferences in structuring a work situation. (26) The following

value types afforded a basis for the findings. Value Type I (designated "ministering angel") preferred pictures with the patient shown alone with the nurse. Type IV ("efficient professional") preferred pictures with nurses shown alone with colleagues. Types II and III ("modern integrations") on their first choice preferred pictures which share the patient with a fellow worker but, on their second choice, Type II preferred the nurse-patient pictures more often than did Type III.

Findings based largely on Chi-Square analysis indicated that:

1. Type I preferred the older traditional nursing of 20 years ago.
2. Type IV preferred the ways of today. She preferred working with doctors more than other value types did and least preferred relationships with patients. This seemed to be a tautological consequence of the classification procedure.
3. Both Types I and II placed the patient first and the doctor second. Both also expressed preference for children which the author conjectures was evidence of their motherliness.
4. Type IV held the most favorable views towards supervision and administration.

A separate cross-sectional analysis of 313 students showed that collegiate and nursing training programs produce different value types.

The author presented a convincing argument that knowledge about incompatibilities within a set of roles (those of general duty nurses) were as essential as knowledge about conflicts between positions (nurse versus doctor or administrator) in understanding the social structures and changing character of work groups. Herein is a significant theoretical contribution of the study. Also, of immediate value, particularly to students of social change and to hospital and nursing school administrators, was the delineation of the changing value system in nursing.

Argyris, in his case study of a hospital, identified as one of the main characteristics of the nurse the need for indispensability as being predisposed toward informal power rather than formal. (1: 38)

Mauksch conducted a study in role perception which answered the question: What do I think of a nurse? (25: 67-70) Results indicated that besides being deferent to authority the nurse saw herself as preferring ordered and clear-cut situations and as being very desireous of avoiding blame producing involvements. She also saw herself as one who received orders and obeyed, as one who assumed responsibility only in limited areas and within limited scope. The author stated that individuals went into nursing to reduce their need for sexual expression. The need for nurturance was met in nursing without sex ("mother surrogate" - sex removed).

Berkowitz state his major hypothesis to be that nurses liked patients who enabled them to feel that they were acting in a fashion consistent with their role concept more than they did patients who did not afford them this type of gratification. (5: 218-219) The data supported the predictions.

The following were used as criteria for self-evaluation:

1. The nurse may have been evaluating herself on bases which were inappropriate to the situation.
2. The relationship between the patient and the nurse was closely associated with the extent to which she felt, when working with him, that she was performing consistently with her role concept.

It was noted that:

1. Graduates used these criteria less than students.
2. The necessity for alteration of the role concept was probably in part what occurred during the period of "adjusting to the new working setting."

This implied that:

1. Nursing education was to be changed so as to reduce adjustment problems during early days on the job and provide more appropriate dimensions for self-evaluation of nursing performance.
2. Education was to be made more consistent with the situation into which nurses gravitated.
3. Nurses recognized that they may never practice bedside nursing, and
4. Formulated new criteria for judging their own effectiveness in varied nursing situations.

In an examination of role perception in hospital interaction, Kogan and Jackson obtained delineations of role concepts by use of the Suczek and LaForge Interpersonal Check List which consists of 128 adjectives or descriptive statements representative of the scope of a subject's relationship to others. (22: 75-78) Subjects were asked to indicate which of these statements referred to behavior which would ideally be exhibited by a patient in the hospital where the study was conducted. This was followed by a description of the behavior which would ideally be exhibited by a doctor and finally by a description of the ideal nurse. Thus, three descriptions were obtained from each of the following; 11 staff physicians, including three residents, 14 ward nurses and 16 male patients, hospitalized with pulmonary tuberculosis, all of whom had been in the hospital for at least two months.

The data obtained in the study demonstrated that there were measurable amounts of agreement and uniformity in the ways individuals viewed their roles and the roles of the people with whom they interacted in the patient-staff relationships within the tuberculosis hospital. It appeared that stereotypes operated in all groups of subjects though to differing degrees. Patients demonstrated the greatest amount of concordance or commonality in their role concepts throughout. There was consistent evidence that the role of the nurse was seen with greater unanimity by all groups of subjects than either of the other roles subjected to analysis. It also appears important and relevant to note that the nurse occupies a pivotal position in the three-way communication between doctor, nurse and patient.

Patients expected those who cared for them to be loving and permissive authority figures and viewed the ideal patient as being conforming, dependent and ingratiating. Nurses, on the whole, agreed more closely with patient opinions than doctors did. All groups of subjects had more uniform views about the role of the nurse than they had about other roles. The opinions of the medical staff about patient and doctor roles could be subdivided into two contrasting views which were directly related to the rate of discharge against medical advice occurring on the wards under their supervision.

Schulman has written a chapter on "Basic Functional Roles in Nursing: Mother Surrogate and Healer" for the book Patients, Physicians and Illness, edited by E. G. Jaco. (36) The author has chosen to conclude the review of nursing literature with a resume of this chapter.

A patient, like a child, is society's concern. Especially in our culture where the patient's needs have been segmented, such responsible adults were members of health professions, their auxiliaries and allies. One such patient-focused group was nursing.

The modern American professional nurse did many things for patients. Too frequently the nurse felt she was "all things to all people". In a hospital ward she was seen writing charts, giving medication, directing janitors, taking pulses, bathing bodies, fixing flowers, answering telephones, administering parenteral solutions, repairing equipment and teaching students. The nurse did many things. The nurse played many roles.

Role was defined here as a set of behavior expectations closely associated and oriented to the achievement of specific or latent goals.

The writer gave one good example of the mother surrogate. She was the tsukisoi,* a low level sub-professional nurse in Japanese hospitals. Tsuki was derived from the word "to attach" and soi indicated nearness -- the description of an individual who was employed to do simple continuous nursing of a patient while he was hospitalized. The nurse of a half century ago may have resembled the tsukisoi. She gave skilled technical care. The mention of skilled technical care as a component in total patient care introduced the functional role in nursing that the author termed "healer." The healer's relations with the patient were centered about the curative or therapeutic process. The healer "healed" and the mother surrogate "mothered." The two roles were seen as quite distinct from each other, not only contrasting, but possibly antagonistic to each other.

The emotional and attitudinal aspect of these roles were quite disparate. Within situational and societal limitations the mother surrogate

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* The information on tsukisoi was obtained by Schulman from a personal interview with Dr. Tsuneo Nakamura, Fulbright Post-doctorate Fellow at the Medical Branch of the University of Texas and from notes on a lecture delivered by Dr. William Caudill in the Seminar on Health and Illness in Cross-Cultural Perspective, Harvard School of Public Health, February 20, 1957.

was allowed freedom of affect. The nurse as mother surrogate was expected to express herself and to support her patient with words and actions of comfort. She was a friend to the patient and their relationship was informal. The goal of the mother surrogate was to sustain. She met a host of supportive needs to keep her patient alive. Her activities were governed by the situation. The healer, on the other hand, was change-oriented and dynamic. Her words and actions were limited to her vital function in the performance of the therapeutic tasks at hand. The healer's relationship was basically discontinuous and fragmentary. Like any other specialized service functionary she was present when the curative process demanded her specialized ministrations. Though the roles were distinct they were always found in combination among members of the health team.

The professional nurse practitioner displayed the existence of both the role of mother surrogate and healer. She was an agent in keeping here patient alive and relatively need free. She was also a partner to the physician and an agent in the curative process. The areas in which the nurse was faced with a clash in role expectations between mother surrogate and healer serves as a basis for the nurse's psychic or social confusion. Since both roles were of intrinsic importance to the nurse, some conflict took on great magnitude and compromise became difficult to achieve. One important element of conflict lay in the affective character of the

mother surrogate role and the intellectual or dispassionate character of the healer role. Bullock applied the thematic apperception test as an indicator of attitudes related to nursing problems stemming from the conflict just mentioned. The benevolent and protective attitudes of nurses were most frequently mentioned. (9: 7-10) In Benne's nurse study, 200 physicians saw nurses as kind and sympathetic or businesslike and efficient. (3: 59-61) More than eight out of ten preferred the "ministering angel" -- affectionate, cheerful, considerate, generous, human. Unfavorable terms applied to the nurse were brusk, coldly efficient, hardboiled, immune to suffering, masculine, unemotional and unsympathetic.

The changing philosophy of nursing education, routine patient care and insufficient personnel for increasing numbers of patients in hospitals contributed to the dimunition of the mother surrogate role. Pearsall's study of nursing supervisors indicated nurses were obstinate in relinquishing their ideal. (32: 24-25) They complained of each development which took them further from the bedside care of patients. They felt uncomfortable and guilty when they went up in the nursing hierarchy for this same reason. It is interesting that a recent study by Roth showed that nurses have persisted in seeing affective qualities in their present relationships while the patients in the same relationship have seen their nurses as rigid authoritarian types. (34) Another analysis by Thorner described nurses as disinterested, oriented to getting their rather specific tasks done and lacking in affect. (41)

Avenues for effective expression have gradually been closing for the professional nurse. The trend toward greater professionalism was foretold by Brown a decade ago and with it the nurse as "healer" assumed greater and greater importance. (8: 76) Devereaux and Weiner castigated the modern hospital and compared its socially sterile atmosphere to the worst therapeutic environments of the past. (14) A major element in this sterility was the inability of nurses to dispense emotional gratification which the dependent patient most needed.

The affective aspect of the mother-surrogate-healer role conflict was far from being resolved. Surfacely, the healer predominated. Below the surface, the mother surrogate existed as the basic psychological orientation of the nurse. She was torn between values of a traditionally ideal role and role performance of antipodal nature. The professional nurse of today was a "displaced person" being tied by emotion, tradition and education to a way of functioning that no longer exists.

CHAPTER III

PLANNING AND CONDUCTING THE STUDY

Introduction:

The purpose of this study was to elicit and compare the perceived images of the role of the practical nurse as held by the practical nurse, director of hospitals, medical doctors and three groups of registered nurses made up of administrators, non-administrators and clinical instructors. The study was based on the assumption that these different groups would hold different role expectations. The study was aimed at noting the divergence and convergence between practical nurses' beliefs, definitions of expectations held by significant others and the expressed expectations of others and the expressed expectations of others.

Hypotheses to be Tested:

1. It is hypothesized that there will be lack of agreement (as measured by the t-test of differences between means) between the expected perceptions of the role of the practical nurse as seen by the practical nurse and the actual perceived duties and responsibilities of the practical nurse as seen by the practical nurse.
2. It is hypothesized that there will be a lack of agreement between the expected perceptions of the role of the practical nurse as seen by the directors of hospitals, medical

doctors and the three groups of registered nurses mentioned above.

3. It is hypothesized that there will be a lack of agreement between the actual perceived duties and responsibilities of the practical nurse as seen by the directors of the hospitals, medical doctors and the three groups of registered nurses and those held by the practical nurse.

4. It is hypothesized that, as measured by the significant t's, there will be a greater consensus among the expected perceptions of the practical nurse as seen by the directors of hospitals and medical doctors and those as seen by the practical nurse, than there is consensus between the three groups of registered nurses consisting of administrators, non-administrators and clinical instructors and those as seen by the practical nurses.

5. It is hypothesized that, as measured by the significant t's, there will be a greater consensus among the actual perceived duties and responsibilities of the practical nurse as seen by the directors of hospitals and medical doctors and those as seen by the practical nurse, that there is consensus between the three groups of registered nurses, and those as seen by the practical nurse.

Techniques and Procedures Used:

Two areas of literature in research and authoritative writings were reviewed as background material for this study. This was necessary since the study encompassed the roles of the practical nurse, role theory and analysis of role expectations.

In reviewing the literature, little was found in research writings concerning the role of the practical nurse. This was assumed to be because of the newness of the program. Some studies were found concerning the role of the registered nurse and making some reference to the role of the practical nurse especially in the investigation by Vaillot. (42)

Review of the research in analysis of role expectations was therefore directed to the field of education where many more studies of this nature have been done relating to administrators and teachers of education. Studies that related to role theory and the concept of role were also reviewed.

From the above generalized professional roles, a questionnaire of selected aspects was developed related to the general, bedside, technical and medical areas regarding the position of the practical nurse. The steps in the development of the instrument and subsequent research follow.

1. Development of a questionnaire containing an intensity scale of values that relate to role parts performed by the practical nurse in the areas of general responsibility, bedside, technical and medical, based on activities suggested by professional nurses.

2. Submitting this questionnaire to a panel of judges in the practical nurse program for criticism and editing of the statements.

3. Submitting the revised questionnaire to administrators, registered nurses, and practical nurses for further clarification and suggestions concerning completeness and appropriateness in a sample of the population chosen.

4. Submitting the final questionnaire to directors of hospitals, medical doctors, registered nurses (specifically administrators, non-administrators and clinical instructors) and practical nurses. (Note: Due to the nature of this instrument, material related to ethics and legal responsibilities may find the respondents reluctant to answer either accurately or at all.)

5. Compilation of the data and completion of an analysis using the t-test technique to find whether two sets of respondents' data are in the same parent population. In comparing the expected and actual responses of the practical nurse date, it was decided to apply the t_d-test to determine whether there is a correlation between these two sets of responses for the practical nurse group. If there is correlation the t_d-test will show the amount of correlation and allow the actual difference between the two sets of responses to be determined.

The t_d-test is to be applied to a random sample of this population. The t-test is also to be used on a selected sample for each of the respondent groups. Due to the large amount of data, selected remaining responses for each of the respondent groups is to be handled by histograms of the percentages of the responses for each of the intensity values.

6. Interpretation of the data and analysis of the significant relationships of the role expectations held by relevant others and an analysis of significant relationships and differences between the expected and the actual responses of the practical nurses. Use would also be made of the t-test results to identify convergence or divergence of opinion among groups concerning each area role as general, bedside, technical and medical.

7. Summarization of findings and preparation of conclusions and recommendations and indication of areas needing further research.

Development of the Instrument:

The questionnaire used for the study was developed after careful analysis of previous research that had been done in the areas of role analysis and role expectations. Information obtained from the interviews, on-the-job observations and review of pertinent literature was used in

constructing an open-ended questionnaire which was administered to a group of practical nurses who had just been graduated from the Lansing practical nurse program and certain selected registered nurses.

Statements from literature, from tape-recorded comments in the interviews and from the responses to the questionnaire were compiled as a pilot instrument.

This instrument was administered to the next group of practical nurses who had just been graduated from the Lansing practical nurse program.

Statements and responses from the preceding instruments were superimposed upon a questionnaire form and contained an intensity scale of values that related to the general, bedside, technical and medical areas of nursing.

This questionnaire was submitted to a panel of judges in the practical nurse program for criticism and editing. Items relating to general responsibility, bedside, bedside-technical (which related more to touch-task items), technical and medical were numbered from one to five and sorted by the panel. Eighty-two statements concerning the practical nurse's role were included. After several revisions, the content of the questionnaire was judged to be as consistent and as accurate as conditions would permit. Since there had been no research done previously in the area of role expectations held by the practical nurse, there were no criteria set up by which to judge the content of the questionnaire.

Definitions:

Definition of the Practical Nurses' Roles. The two categories of the practical nurses' roles were defined as:

1. Independent nursing role.
2. That of assistant to the professional nurse in more complex nursing situations (less complex nursing situation has previously been defined).

Independent Role. As a practical nurse she is able to:

1. assess the needs of the individual,
2. select from understandings and skills learned in a range of nursing situations those she needs in a specific situation, and
3. in making such selections she is able to use her own judgment in carrying out the required nursing measures.

Dependent Role. As that of assistant to the professional nurse in more complex nursing situations, the practical nurse's contribution is a piece of the total nursing care. In this role, the limitations are largely on the degree of here responsibility. Thus, while she has an awareness of the total design of the nursing care plan she does not need a complete understanding of the rationale of every aspect of the nursing care that is given.

The following definitions of terms for this study relied to a great extent on the language for role analysis developed by Gross, Mason and

McEachern in their studies of expectations held by various members of the school staff in an educational setting. (19) These terms are applied as a matter of consistency in this research except in the description of the works of other authors where their own definitions may vary because of context.

Role. Kimball Young concludes that there are really two aspects of role. (45: 88) The first being that of role expectation which he states:

> Arises from what other people anticipate of us from what in the way of action and is signified by the ideals which are set down in terms of roles and the accompanying status. This is definitely a social product and depends upon how others view us from our potential operations. On the other hand, in relation to this, there is what we call role-taking, or what is sometimes referred to as role enactment or role assumption. This is the particular performance as it is actually carried out. (45: 88)

Hartley defines the term role when he states:

> Accordingly, to include all aspects of role requirements, we must define social role as an organized pattern of expectancies that relate to the tasks, demeanors, values, reciprocal relationships to be maintained by persons occupying specific membership positions and fulfilling desirable functions in any group. (20: 486)

Respondent Groups. The term "respondent group," relative to this study, refers to the directors of hospitals, medical doctors, registered nurses (specifically administrators, non-administrators and clinical instructors) and practical nurses.

Perceive. Webster defines the word "perceive" as: (1) to grasp mentally; take note (of); recognize, observe. (2) to become aware (of) through sight, hearing, touch, taste, or smell. (44: 1085)

Expectations.

1. Members of any group have role expectations of any actor in a broadly defined situation.
2. Members of any group have role expectations of any actor in a particular position or situation.
3. Any group may have expectations of a particular actor in a specific situation.

These conclusions were drawn by Brookover in a study on teacher and administrator roles. (7: 3)

Practical Nurse's Definition of Role Expectations. How the student practical nurse defines or understands the role of the graduate licensed practical nurse to be. How the student practical nurse believes the licensed practical nurse would be expected to behave by others significant to her.

Expressed Expectations of Others. How the significant others in this study, directors of hospitals, medical doctors, supervisor nurses, head nurses in charge of floors, team leaders, and clinical instructors expect the licensed practical nurse should act in the prescribed situation.

Practical Nurse's Definition of Actual Role. How the graduate licensed practical nurse actually finds the role to be in terms of what

behavior in prescribed situations she finds is actually expected of her by others significant to her.

Actual Belief Expressed by Others. How the significant others in the study, directors of hospitals, medical doctors, supervisor nurses, head nurses in charge of floors, team leaders, and clinical instructors actually find the licensed practical nurse does behave in certain prescribed situations.

Director of Hospital. A person who is a member of a board chosen to direct or manage a hospital. (44: 414)

Medical Doctor. A person on whom a university or college has conferred the Doctor of Medicine degree as a physician or surgeon licensed to practice in the field of medicine. (44: 429)

Registered Nurse. Michigan Statutes define a registered nurse as one who has been authorized by the state to perform any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the same, and execution of treatments and medications as prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health. (16: 315-316)

Supervisor Nurse. A registered professional nurse responsible for the administration of the nursing service of two or more units, each of which is under the immediate direction of a head nurse. (27: 3)

Head Nurse. A registered professional nurse responsible for administration of the nursing service of a single unit. (27: 3)

Clinical Instructor. A registered professional nurse who is the head of a clinical area in a school of nursing and does both formal and clinical teaching. (27: 3)

Team Leader. Usually a professional nurse (may be a licensed practical nurse) assigned the responsibility of deciding who on the nursing team -- graduate registered nurse, student professional nurse, licensed practical nurse, student practical nurse, and aide -- does what and at which level of nursing to insure greater quality and quantity of patient care.

Practical Nurse. Under the Michigan Statutes a practical nurse is defined as one who has been authorized by the state to perform such duties as are required in the physical care of a patient and in carrying out the medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as defined above. (In registered licensed nurse.) The term "licensed practical nurse" is further defined as one who is authorized by the state to care for the sub-acute, convalescent and chronic patients requiring service under public health nursing agencies, or in institutions, or in homes, working under the direction of a licensed physician or the supervision of a registered professional nurse as a member of a team caring for acutely ill patients, and who is prepared to give household assistance when it contributes directly to the welfare of the patient. (16: 315-316)

Administrators. The term "administrators" refers to that group of registered nurses which includes supervising nurses and head nurses in charge of floors.

Non-administrators. The term "non-administrators" refers to those registered nurses assigned the position of team leaders at the time the questionnaire was administered.

Selecting the Practical Nurse Centers:

Of primary importance to the interest of this study was that practical nurse centers were chosen which represented the private and public; older and younger; small town, city, and metropolitan programs. These practical nurse centers in Michigan were: Cadillac, Detroit (Board of Education), Detroit - Shapero, Flint, Lansing, Midland, Port Huron, and Traverse City. The student practical nurses from these centers affiliated with specific hospitals as follows:

	Center	Type	Hospitals
1.	Cadillac	Private	Mercy Hospital, Grayling; Cadillac Mercy Hospital; St. Joseph Hospital, Pontiac
2.	Detroit	Board of Education	Memorial Hospital; Harper Hospital; Receiving Hospital; Women's Hospital; Herman Keefer Hospital
3.	Detroit-Shapero	Private	Self-contained
4.	Flint	Board of Education	Hurley Hospital; McLaren General; St. Joseph's Hospital

	Center	Type	Hospitals
5.	Lansing	Board of Education	Sparrow Hospital; St. Lawrence Hospital; Ingham Medical Hospital
6.	Midland	Private	Self-contained
7.	Port Huron	Board of Education	Mercy Hospital; Port Huron General Hospital
8.	Traverse City	Board of Education	James Dekker Munson Hospital; Little Traverse Hospital, Petosky; Alpena General Hospital

Respondent Sample:

The respondent sample included the directors of hospitals, medical doctors, registered nurses, and practical nurses.* A letter of introduction, and subsequently the questionnaires, were mailed to the director of each practical nurse center represented in the study with the instructions for distribution to and collection from those respondent groups mentioned. A follow-up letter was mailed these directors two months after the questionnaires were mailed to them. (See Appendix)

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* It was suggested by Dr. Lloyd Meadows, research consultant for the Shapero Practical Nurse Center, in view of his personal experience, that only one doctor be given a questionnaire in each of the centers. The rationale being that it would be better to get one cooperative doctor to actually fill out the questionnaire than give it to several and not get any back.

CHAPTER IV

PRESENTATION OF THE DATA

Introduction:

The data, upon which this study is based, were drawn from eight practical nurse centers in Michigan. All of the respondent group of medical doctors were male. However, both male and female directors of hospitals, registered nurses and practical nurses were included in this sample. Included in the population of registered nurses were those holding positions as administrators, non-administrators, and clinical instructors. Several methods of analyzing the data were used.

A questionnaire concerning the role of the practical nurse was administered to the group. The questionnaire items were marked on a five-point scale of intensity running from never to always. The mean response of each respondent group could then be compared to the mean response of the practical nurse group. If the difference between the means was found to be significant by use of the t-test it meant that the two groups did not belong in the same parent universe.

In order that the reader may be able to identify the personnel involved in the operation of the eight practical nurse centers in Michigan, each such center reported the types of positions involved such as those of an operational and administrative nature. This information is reflected in Table I.

TABLE I. CLASSIFICATION OF PERSONNEL IN PRACTICAL NURSE CENTERS IN MICHIGAN.

Center	Practical Nurses	Directors of Hospitals	Medical Doctors	Registered Nurses			Total
				Administrators	Non-Administrators	Clinical Instructors	
Cadillac	53	2	2	5	24	5	91
Detroit	42	2	1	54	171	6	276
Detroit-Shapero	36	1	2	22	22	2	85
Flint	43	0	1	14	43	2	103
Lansing	34	3	1	5	21	2	66
Midland	8	1	1	1	0	0	11
Port Huron	17	1	1	6	15	1	41
Traverse City	13	1	3	11	17	1	46
Total	246	11	12	118	313	19	719

TABLE II. NUMBER OF USABLE RETURNS

Center	Number Sent	Returned	Per Cent
Cadillac	150	91	61
Detroit	300	276	92
Detroit-Shapero	85	85	100
Flint	130	103	79
Lansing	203	66	32
Midland	14	11	79
Port Huron	46	41	89
Traverse City	96	46	48
Total	1,024	719 (Average)	70

Of the 1,024 questionnaires sent out, 723 were returned. Of these there were 11 from directors of hospitals, 12 from medical directors and 246 from practical nurses. Those returned by registered nurses were broken down as follows: 118 from administrators, 313 from non-administrators and 19 from clinical instructors. This amounted to a 70 per cent usable return. Questionnaires designated unusable were those returned in which responses to the personal classification at the beginning of the questionnaire had been omitted.

It was to be noted that the number of responses did not remain consistently the same number on the questionnaire items. This was due to the fact that some respondents failed to answer some of the items on the

questionnaire. As an example, Item 185 in the medical area was answered by 241 of the 246 practical nurses who sent in usable returns. On the same item, nine out of 11 directors of hospitals who sent in usable returns responded. It was not clear why some individuals failed to answer all of the questions but it should again be emphasized that, due to the nature of the material which may have held a threat to certain of the respondents, particular questions did remain unanswered. The partially completed questionnaires were included, however, for they did indicate a kind of perception of the role in question.

Certain characteristics of the incumbents of various positions were included in the following charts as it was thought that these particular characteristics may have had some bearing upon the way in which the respondents answered the questionnaire. These refer to Tables III, IV and V.

TABLE III. CLASSIFICATION OF MEDICAL DOCTOR BY PROFESSIONAL TITLE

Professional Title	Number	Per Cent
General Practitioner	1	8
Surgeon	5	42
Internist	4	33
Specialist	2	17
Number in Group	12	

TABLE IV. CLASSIFICATION OF PERSONNEL ACCORDING TO THE TYPE OF HOSPITAL IN WHICH THEY ARE EMPLOYED

Hospital Type	Practical Nurses	Directors of Hospitals	Medical Doctors	Registered Nurses			Total
				Administrators	Non-Administrators	Clinical Instructors	
General	235	9	10	113	258	17	642
Tuberculosis	7	0	1	4	51	0	63
Rehabilitation	0	1	1	1	3	2	8
Geriatrics	4	1	0	0	1	0	6
Total Number	246	11	12	118	313	19	719

TABLE V. CLASSIFICATION OF PERSONNEL ACCORDING TO TYPE OF SERVICE CURRENTLY BEING RENDERED BY THEM (Number of Individuals)

Professional Type Service	Practical Nurses	Directors of Hospitals	Medical Doctors	Registered Nurses			Total
				Administrators	Non-Administrators	Clinical Instructors	
Medical	22	0	4	4	58	0	88
Surgical	26	0	6	5	32	1	70
Medical-Surgical	98	0	0	16	92	0	206
Maternity	20	0	0	5	28	0	53
Newborn-Nursery	8	0	0	2	9	0	19
Pediatrics	18	0	1	7	23	0	49
Operating Room	3	0	0	2	14	0	19
Recovery Room	6	0	0	2	8	0	16
Contagion	8	0	0	2	21	0	31
Unknown or Plural No.*	37	0**	1*	73*	28	18*	157
Total Number	246	0**	12	118	313	19	708

** Directors: Classification does not apply here. 11 Directors + 708 = Total 719 respondents in the sample population used in this study.

Since there were only 12 medical doctors participating in the study, it had to be assumed that the remaining physicians in the same population would hold similar views of the role of the practical nurse.

Table IV portrays the types of hospitals in which a particular number of respondents were currently employed. Table V shows the type of service within the hospital which the incumbents were currently working on.

The greatest number of practical nurses were working in the medical-surgical area at the time of answering this questionnaire as were the greatest number of total respondents.

Analysis of the Data by Use of t-test:

The responses to the questionnaire were analyzed statistically to discover areas of significant agreement or disagreement between the attitudes revealed with regard to the expected and actual roles. In this analysis the practical nurses were compared to themselves using a t_d-test on the differences of the responses in order to eliminate the effect of correlation between the expected and actual responses.* In the remaining cases the expected and actual responses for each group of practical nurses, directors of hospitals, medical doctors, registered nurses, administrators, non-administrators and clinical instructors were compared with the corresponding practical nurse responses using a t-test. (15: 123) These data are presented in Tables VI through XI.

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*A random sample of 60 practical nurses were used here. (37: 13)

Specifically, the t-test was used to test the hypothesis to show that the mean of one group of responses is equal to the mean of a second group of responses when the population's variance is unknown but assumed equal. In order to keep the statistical computations within reason, there being six respondent groups, 33 significant questions were selected to be analyzed by the t-test and another 29 significant questions to be represented by histograms from the total of 107 respondents. Detailed analysis was applied to questions representing the five following areas of nursing indicated as general, bedside, bedside-technical, technical and medical.

Since the total number of respondents for calculating the t-test was used, the breakdown referred to above was necessary. In each case that N was substantially greater than 30, the t value of $\pm$ 1.96 at the five per cent level was taken as a significant level. Thus, if there is no difference in the mean responses that one would get from two of the sample groups involved then, in the samples employed, the probability of getting a t value above 1.96 (or below -1.96) is one in 20 (or .05). Therefore, if a t in absolute value greater than 1.96 is obtained an event has occurred which is highly unlikely. Consequently, the assumption of equal means is not tenable which implies that the significant differences in the mean responses exist. On the other hand, a t in absolute value less than 1.96 indicates essential agreement. The analysis sought to determine the extent to which expectations of the respondents were in agreement or disagreement.

TABLE VI. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES FOR THE PRACTICAL NURSES (This is the t with the correlation taken out.)

Question	Expected and Actual
General	
110	-3.18*
209	-2.81*
218	-2.71*
145	1.42
146	-1.28
149	-2.50*
179	-2.19*
181	-0.61
194	-0.88
Bedside	
109	3.61*
139	2.45*
167	1.41
173	1.22
175	0.87
189	0.00
193	-0.10
Bedside-Technical	
162	0.34
164	-2.86*
165	1.92
176	0.58
201	1.60
Technical	
216	2.49*
220	-2.18*
131	1.21
136	1.57
137	1.93
150	2.92*
151	0.10

TABLE VI. (Continued)

Question	Medical Expected and Actual
221	0.00
- 182	0.20
183	1.00
184	2.82
185	2.19

The asterisk in the tables signifies the responses to be greater or less that 1.96 (1.96 and -1.96), therefore significant differences.

Question pertaining to Part II of the questionnaire is the same stem as Part I. 0.05 level of significance.

Formula in Setting up Calculations:

t formula

$$S_x = \sqrt{\frac{E x^2 f_x - N_x^2}{N_x - 1}} \qquad S_{(\bar{x} - \bar{y})} = \sqrt{S_{\bar{x}}^2 + S_{\bar{y}}^2}$$

$$S_{\bar{x}} = \frac{S_x}{\sqrt{N_x}} \qquad t = \frac{x - y}{S_{(x - y)}}$$

Analysis of Particular Items to Determine Divergence and Convergence:

Over one-half of the t values in the entire groups of questions concerning the general nursing area, related to the amount of responsibility a practical nurse assumed and the status accorded her, were significant. Table VII shows that there was considerable disagreement in the respondent groups for both the expected and actual roles.

TABLE VII. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES OF THE PRACTICAL NURSE AND EACH OF THE OTHER RESPONDENT GROUPS (General)

					Registered Nurses					
	Dir. of Hosp.		Med. Doctors		Administrators		Non-Administrators		Clinical Instrs.	
Question	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.
110	0.92	-0.87	0.25	0.46	-3.32*	-5.15*	-0.44	-4.74*	-0.58	-1.37
209	1.10	-0.74	-0.21	-0.60	-5.74*	-6.38*	-4.60*	-4.52*	-0.66	-2.48*
218	5.24*	0.46	1.59	1.59	-2.48*	0.64	-2.08*	-0.67	-4.24*	-2.80*
145	0.34	-1.16	-0.64	-3.55*	0.80	-1.93	-1.37	-5.85*	-5.25*	-3.00*
146	0.07	1.37	1.12	2.22*	0.97	1.23	1.91	3.39*	-0.52	0.80
149	-0.70	-2.68*	-1.92	-1.76	-4.71*	-4.67*	-4.31*	-4.26*	-3.28*	2.27*
179	-0.45	-2.21*	-0.51	-1.70	-4.48*	-4.79*	-2.45*	-4.15*	-0.62	-1.60
181	-2.78*	-4.21*	-2.68*	-1.74	-3.82*	-2.90*	-4.91*	-5.04*	-1.67	-0.84
194	-2.60*	-1.84	-0.03	-0.84	-2.94*	-5.49*	-2.28*	-3.73*	-2.37*	-3.16*

Question pertaining to Part II of the questionnaire is the same stem as Part I. 0.05 level of significance.

TABLE VIII. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES OF THE PRACTICAL NURSE AND EACH OF THE OTHER RESPONDENT GROUPS (Bedside)

					Registered Nurses					
	Dir. of Hosp.		Med. Doctors		Administrators		Non-Administrators		Clinical Instrs.	
Question	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.
109	1.14	-1.14	1.27	-1.08	2.27*	1.48	-0.70	-3.26*	0.36	0.16
139	-1.55	-0.95	-1.55	-2.69*	1.05	1.57	-0.20	-0.98	1.41	-0.43
167	-2.55*	-3.37*	-2.17*	-2.20*	-1.43	-3.10*	-4.74*	-7.61*	-2.12*	-2.74*
173	-0.35	-0.99	0.80	-0.04	0.35	-1.05	0.96	2.58*	1.22	-0.16
175	-2.74*	-1.27	-2.37*	-0.21	-1.77	-1.57	-1.21	-1.32	0.76	1.03
189	0.68	0	1.66	1.36	-2.23*	-5.00*	-0.91*	-2.09*	-0.58*	-0.88
193	-1.96*	-2.50*	-2.19*	-2.97*	0.24	-2.42*	-1.75	1.19	-1.56	-5.05*

Question pertaining to Part II of the questionnaire is the same stem as Part I. 0.05 level of significance.

TABLE IX. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES OF THE PRACTICAL NURSE AND EACH OF THE OTHER RESPONDENT GROUPS (Bedside-Technical)

					Registered Nurses					
	Dir. of Hosp.		Med. Doctors		Administrators		Non-Administrators		Clinical Instrs.	
Question	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.
162	-3.28*	-4.55*	-4.53*	-3.40*	-1.78	-3.01*	-5.20*	-5.34*	-0.94	0.75
164	-0.06	0.15	1.26	1.30	-2.78*	-4.00*	-2.36*	-3.48*	-0.17	-0.68
165	-1.70	-2.00*	-1.17	-1.69	-0.30	0.10	-1.40	-2.63*	-0.99	-1.21
176	-1.55	1.00	-2.35*	2.75*	-0.60	2.54*	-0.22	4.32*	-0.73	1.25
201	-0.12	-0.53	-0.43	-0.68	0.89	1.28	0.96	0	0.53	-0.84

Question pertaining to Part II of the questionnaire is the same stem as Part I. 0.05 level of significance.

TABLE X. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES OF THE PRACTICAL NURSE AND EACH OF THE OTHER RESPONDENT GROUPS (Technical)

					Registered Nurses					
	Dir. of Hosp.		Med. Doctors		Administrators		Non-Administrators		Clinical Instrs.	
Question	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.
216	0.37	10.93*	0.43	2.09*	4.10*	20.19*	2.69*	23.00*	0.95	7.59*
220	1.82	3.40*	1.73	3.92*	0	1.72	-0.23	5.95*	-0.55	2.35*
131	-0.31	-0.82	-0.59	-2.60*	-0.76	-0.55	0.59	-3.35*	1.49	-0.49
136	0.18	-0.86	3.64*	1.13	-2.16*	-2.29*	0.28	-0.46	-1.14	-1.15
137	1.80	1.13	3.23*	1.71	-4.06*	-1.26	-2.35*	1.93	-3.65*	-1.95
150	1.68	-0.55	0.32	-0.88	0.42	-0.24	0.60	-0.13	-0.68	-1.77
151	1.74	0.94	1.34	2.91*	1.82	1.75	1.33	0.75	2.53*	0.22

Question pertaining to Part II of the questionnaire is the same stem as Part I. 0.05 level of significance.

TABLE XI. T-VALUES FOR THE DIFFERENCES BETWEEN THE MEANS OF EXPECTED AND ACTUAL SCORES OF THE PRACTICAL NURSE AND EACH OF THE OTHER RESPONDENT GROUPS (Medical)

					Registered Nurses					
	Dir. of Hosp.		Med. Doctors		Administrators		Non-Administrators		Clinical Instrs.	
Question	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.	Ex.	Ac.
221	2.02*	2.11*	1.73	4.00	0	0	-0.23	3.51*	-0.55	1.47
182	-0.86	0.03	1.40	0.73	-3.72*	-4.11*	-1.80	-2.14*	-2.09*	-2.87*
183	0.15	-0.52	-1.46	-2.12*	3.23*	2.63*	0.59	1.06	2.24*	2.51*
184	-1.47	-2.68*	-2.07*	-2.05*	2.23*	-0.44	0	-1.52	1.85	3.53*
185	-0.82	-1.73	-1.61	-1.94	0.72	-1.42	0	-1.17	-0.67	-1.97*

Question pertaining to Part II of the Questionnaire is the same stem as Part I. 0.05 level of significance.

(Note: In the following discussion the question number in Part II of the questionnaire will be referred to since it contains the same "stem" as in Part I.)

In examining Question 110, it revealed that the practical nurse did not expect to be treated as a "Glorified Aide" but indicated ($t = 3.18$) she usually was treated in that manner. The registered nurse non-administrator felt that the practical nurse was seldom treated as a "Glorified Aide." The registered nurse administrator was in even more disagreement and reported ($t = -5.15$) that the practical nurse was never treated as such.

Results of Question 209 appeared to support the results obtained in the foregoing question. The practical nurse did not expect to find the status of the practical nurse underestimated. However she asserted that sometimes ($t - -2.81$) her status actually was underestimated. Once again it was the registered nurse administrator who disagreed to the greatest degree ($t = -6.38$) with the practical nurse and insisted that her status was never underestimated. The clinical instructors disagreed to some extent ($t = -2.48$) with the practical nurses' actual response but not as much as did the administrators. The medical doctors and directors of the hospitals did not hold significantly different opinions from those of the practical nurses on these two items.

Questions 145, 146, and 149 ran in this same vein of opinion by these groups.

In examining Question 179, it was noted that the practical nurse responded to the statement "a practical nurse takes on the functions of total patient care originally held by the registered nurse" by indicating that she took on the function of total patient care to a moderate extent more than she had expected to. Significant disagreement was found between both the registered nurse non-administrator, the registered nurse administrator and the practical nurses ($t = -4.15$ and -4.79 respectively, actual value). The directors of the hospitals, likewise, held significantly different viewpoints from the practical nurses. Essentially, these professional groups were in accord in stating that the practical nurse was not by any means taking on the functions of total patient care originally held by the registered nurse. The practical nurses claimed that, to some extent, this was happening. Some insight into this was gained when the medical area was analyzed.

The bedside area of nursing explored in Table VIII did not indicate as much general conflict between the respondents regarding the image of the practical nurse related to her bedside role as there was disagreement over the amount of authority invested in her.

Question 109, which stated that the "practical nurse finds practical nursing to be bedside nursing," was analyzed as follows: The practical nurse had expected to do bedside nursing but found that actually ($t = +3.61$) she seldom did bedside nursing. The degree of conflict was greatest (which supports the original hypothesis of this study) with the

registered nurse non-administrator, who held that the practical nurse expected to do bedside nursing and that was actually ($t = -3.26$) what she usually was doing.

Question 139 was based upon the statement "A practical nurse, as a participant on a nursing team, finds that each person on a team is qualified for a specific job and the group work together and participate as a team." All but the doctors ($t = -2.69$) were in agreement with the practical nurse who indicated that while this was what was expected it was not actually the case.

Question 167 appeared to be a highly significant one since all groups of respondents disagreed significantly in both the expected and actual (except for the expected of the registered nurse administrator -- $t = -1.43$) with the practical nurse, who was in agreement with herself on the expected and actual. The results showed that the practical nurse expected and actually did find in her role the "psychotherapeutic function of the nurse to be a good listner, answer patients' questinns, explain procedures, express empathy, steady unchanging attitude and keep the patient free from fear." All incumbents of the other positions disagreed. (See Table VIII, Question 167) They neither expected this to be nor actually found it to be a part of the role of the practical nurse. This supported the results of the preceding question to some degree.

The part played by the practical nurse in evaluating the progress made by the patient was clarified in Questions 189 and 193. The practical

nurse expected to evaluate the patient's progress independently and then contribute to the evaluation made by the physician and the registered nurse. She contended that this was essentially what she did ($t = 0.0$ and -0.10 respectively). The other respondent groups were almost in accord in claiming that the practical nurse was not expected to evaluate the patient's progress and actually this seldom happened. (See Table VIII, Questions 189 and 193)

Table IX presented the data from five questions which were selected from the bedside-technical part of the study.

An important function in hospital nursing was mentioned in Question 162. "A practical nurse is responsible in nursing diagnosis for observing, recognizing and charting symptoms." The practical nurse answered that she expected to chart some of the time, having observed and recognized some of the symptoms, and that this is what she did. ($t = +0.34$) There were highly significant differences in the actual in all groups except the clinical instructors. (See Table IX, Question 162) The directors of the hospitals, the medical doctors, the registered nurse administrators and the registered nurse non-administrators held that the role of the practical nurse was seldom, or never, to involve observing, recognizing and charting symptoms.

The original hypothesis was again supported in Question 164, "A practical nurse is responsible in nursing diagnosis for making decisions as to how the medical doctor's orders are to be put into effect."

There was conflict within the practical nurse group (t = -2.86) which implied that the practical nurses has not expected to make decisions as to how the doctors' orders were to be put into effect but they actually were making these decisions about one-half of the time. The only two groups who were in disagreement with these results were the registered nurse administrators and the registered nurse non-administrators (actual t = -4.00 and -3.48 respectively). These respondents maintained that the practical nurses seldom, if ever, made decisions on how the medical doctors' orders were to be put into effect.

The directors of the hospitals, clinical instructors and the practical nurses were all in agreement in Question 176. The data supported the contention in the question: "The practical nurse has an unequal role of technical and bedside care depending upon the hospital." The registered nurse non-administrators (actual t = +4.32), the registered nurse administrators (actual t = +2.54) and the medical doctors (actual t = +2.75) were in disagreement which indicated that such was seldom or never actually the case.

Table X dealt with the technical area in nursing. The overall disagreement in this group of questions was significant. The content of Question 216 was that "The practical nurse finds a definite person available to supervise her on all new procedures." There was disagreement within the practical nurse group (t = _2.49) who claimed

to have expected supervision on all new procedures but seldom received it. Also, there was highly significant disagreement with all other groups of respondents (highest disagreement was with the following: registered nurse administrators t = +20.19, registered nurse non-administrators t = +23.00). They claimed that there was always a definite person available to supervise the practical nurse on all new procedures.

The practical nurse indicated in Question 220 that "The practical nurse gives treatments that she is not qualified to give," that she did not expect to give treatments she was now qualified to give, but sometimes this actually happened. All respondents except the registered nurse administrators were in disagreement with this and implied that this was actually never true. (See Table X, Question 220)

Question 136 stated that "The practical nurse finds that clinical supervision is not available at times and does the best she can." There was evidence that the practical nurses expected this to happen and found it acutally to be true on occasion. (t = +1.57) The medical doctors implied that they would expect this to happen only seldom (t = +3.64) but agreed it did sometimes occur. The only other point of conflict was with the registered nurse administrators who indicated this was seldom expected nor happened.

Helping to definitely clarify the role of the practical nurse was Question 150 which stated, "A practical nurse is prepared primarily for

technical functions." Of all the incumbent positions held, the practical nurses themselves were the only ones in disagreement (t = +2.92). They indicated that they did not expect the practical nurse to be primarily prepared for technical functions (certainly seldom) but they were. Each of the respondent groups agreed with them. (See Table X, Question 150)

The remaining questions were in the medical area. (Table XI) The practical nurses showed no significant differences between the expected and the actual responses for any of the questions related to the administering of medications. They did not expect to give medications unless a course in medications was given, nor administer medicine unless approved by law. However, upon breaking down the responses into individual questions, the following disagreement was found between the practical nurses and the various respondent groups. Question 221, "The practical nurse refuses to give medications to patients." The doctors perceived the practical nurse as giving medications always (t = +4.00 actual) which was in complete disagreement with the responses of practical nurses. Likewise, the registered nurse non-administrators (t = +3.51 actual) held the same image of the practical nurse relative to administering medications as did the medical doctors. The registered nurse administrators did not, in this instance, support the hypothesis for the registered nurse administrators were in perfect agreement (t = 0 actual) with the practical nurses.

In Question 184 the statement was: "The practical nurse refuses to give medications unless a course in medications is given." The practical nurse indicated that she expected this to be the case and actually experienced it to be. The clinical instructors held the most significant amount of disagreement ($t = +3.53$) implying that medications were being given by the practical nurses regardless of having had a course in medications.

In the final analysis, Question 185: "The practical nurse refuses to give medications to patients unless approved by law," there were no significant differences of opinion between any of the groups. (See Table XI, Question 185)

Analysis of Data Based on Histograms:

The histograms were used to give a different perspective on the data. (See Appendices) It was obvious from the histograms that there was, in many cases, a vast difference between the frequencies of the actual and expected responses of the different groups of respondents. Since a picture has been said to take the place of a thousand words, it was not thought necessary to write in detail on more than a few of the histograms. These represented questions in the general, bedside, bedside-technical, technical and medical areas of the study. The corresponding questions may be found in the instrument for the study which was placed in the appendices due to its length. The writer has discovered certain advantages in referrring only to the main stem of each

of the questions found in Part II of the questionnaire then placing the word "expected" or the word "actual" in front of this statement, thus allowing for a more rapid analysis of the responses.

The value scale on the histograms was changed from:

1 - always, 2 - usually, 3 - sometimes,
4 - seldom, 5 - never

to:

0 - never, 1 - seldom, 2 - sometimes,
3 - usually, 4 - always

The former scale had been used on both the questionnaire and the t-test data but the latter scale seemed to be more meaningful when used with the per cent of frequency of responses in the histograms. Since the units of value remained the same in both, no problem arose. Items which dealt with the role of the practical nurse will now be mentioned.

In the area of bedside nursing a histogram was selected which had no frequency of response above 47.5 per cent. Question 141 which stated "A practical nurse (would expect - actually finds), as a participant on a nursing team, that the nursing team exists in theory only." presented the following information: 46 per cent of the practical nurse respondents expected that this situation would never occur but 41.5 per cent of them found that actually this seldom did occur. Forty-six per cent of the directors of hospitals indicated that they seldom expected this to be the case and 45.5 per cent of that group responded to both "seldom" and "sometimes" in actually perceiving that this does happen. The medical

doctors had a 25 per cent frequency at each of the never, seldom, sometimes and usually degrees of the expected responses but the per cent of frequency lowered to nine and rose to 41.0 and 33.0 per cent respectively for the actual responses. There was an essential amount of agreement between the expected and actual frequency of responses in the "seldom" and "sometimes" values for the remaining respondents. The registered nurses, clinical instructors and practical nurses all responded at approximately the 35 to 45 per cent of frequency. This histogram has been interpreted to mean that the "nursing team" is not as effective as it might be less than one-half of the time.

The following two questions were taken from the Bedside-Technical area. Question 163 reads "A practical nurse (would expect to be - actually is) responsible in nursing diagnosis for making no diagnosis under any circumstances strictly for medical doctors." This histogram refuted the hypothesis of this study. The practical nurses and the registered nurse administrators were in perfect agreement (65 per cent expected, 67.5 per cent actual) with very little disagreement coming from the other registered nurse groups, that in both expected and actual practice the diagnosis was always left up to the medical doctor. Of interest here was the response from the directors of hospitals who, with a 36 per cent frequency, responded that they expected the medical doctors to make the diagnosis all of the time and that he actually did, was responded to

by even less of the directors of the hospitals (27.5 per cent). The medical doctors themselves checked the "always" value at expected at the 50 per cent frequency and actually at the 40 per cent frequency of response.

Finally, the third question to be discussed in this study showed a "significant" amount of difference in the per cent frequency of response from the different groups. This was Question 200 which stated "A practical nurse (would expect - actually does) patient-centered, not task-centered, activities." (Vaillot referred to the word "task" as "touch.") The percentage of responses to be compared all fell in the value "usually" (value number 3 in this scale). The practical nurse group varied within themselves from an expected 30.5 per cent of frequency to an actual 52.5 per cent frequency. The highest amount of expected frequencies were expressed by the clinical instructors at 75.0 per cent and the lowest by the registered nurse administrators at 35.5 per cent which was in agreement with the practical nurses. The highest number of actual frequencies was expressed by the medical doctors (75.0 per cent and the lowest number was represented by the clinical instructors at 37.0 per cent).

The histograms have presented a very graphic picture supporting the evidence in favor of the hypothesis of this study and helping to clarify the role of the practical nurse.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary:

This study was undertaken to gain insight into the internal role of the practical nurse as she is seen in the modern hospital setting by the director of the hospitals, medical doctors and three groups of registered nurses, namely, administrators, non-administrators and clinical instructors. The study also included the image, expected and perceived, that the practical nurses held of themselves. The generalized working role was investigated with a comparison made of the expected and actual perceptions of the role made by each of the respondent groups with the practical nurse to note divergence or convergence of opinion.

The investigation used a five point scale from "never" to "always" which measured the intensity to which these expectations were held. The investigation was conducted in eight practical nurse centers in Michigan. It should be pointed out that results from this study may be idiosyncratic to the particular sample involved and would not hold true for the population of certain other states.

Interviews, on-the-job observation and the review of pertinent literature was used to determine the practical nurses' position. The

role was related to five generalized areas, namely, general responsibility, bedside, bedside-technical, technical and medical. From these areas a questionnaire was developed relating to the role of the practical nurse.

Mean responses to a selected sample of the data were analyzed statistically by use of the t-test to discover areas of significant agreement and disagreement between the attitudes revealed with regard to the expressed and actual roles. This analysis exhibited the highest proportion of differences between the expected role as held by the registered nurse administrators (7)* and the practical nurses in the general area of nursing which dealt with responsibilities invested in the practical nurses. It exhibited evenly distributed differences between these same groups in the technical and medical areas. The greatest amount of actual difference was held between the registered nurse non-administrators (8) and the practical nurses again in the general area. The registered nurse non-administrators (4) and the medical doctors (4) shared equal opinions in the actual responses with the next greatest amount of difference lying in the bedside and technical areas. The practical nurse group had the greatest amount of internal conflict in the general (5) and the technical (3) areas. Totally, the highest degree of convergence in both the expected and actual was found between the practical nurses and the directors of hospitals (18); next with the clinical instructors (21) and third with the medical

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* The numbers in brackets refer to the number of responses showing significant differences.

doctors (24). The two remaining groups of registered nurses (32 each) shared the greatest amount of divergence. Data in the histograms graphically supported this evidence.

Significant differences (t-test for correlated means) were found between means of certain items pertaining to the expected and actual roles of the practical nurse as seen by the practical nurse. There tended to be more in the area of general responsibility than in the area of duties.

Significant differences (t-test for uncorrelated means) were also found between the means of items pertaining to the expected and actual roles of the practical nurse as seen by the practical nurse and the respondent groups. The order of general disagreement of the perception of the expected role of the practical nurse was registered nurse administrator (16) items on which they disagreed; registered nurse non-administrator (11); medical doctor (10); registered nurse clinical instructor (9) and the director of the hospital (8). The order of general disagreement of perception of actual role of the practical nurse was registered nurse non-administrator (21) items on which they disagreed; registered nurse administrators (16); medical doctors (12); registered nurse clinical instructors (12); and directors of the hospitals (11).

Conclusions:

1. There was lack of agreement (as measured by the t-test of differences between means) between the expected perceptions of the role of the practical nurse as seen by the practical nurse and the

actual perceived duties and responsibilities of the practical nurse as seen by the practical nurse. Hypothesis number one was supported.

2. Hypothesis two was supported. There was lack of agreement between the expected perceptions of the role of the practical nurse as seen by the directors of hospitals, medical doctors and three groups of registered nurses: administrators, non-administrators and clinical instructors, and those held by the practical nurses.

3. Hypothesis number three was also supported. There was a lack of agreement between the actual perceived duties and responsibilities of the practical nurse as seen by the directors of hospitals, medical doctors, and three groups of registered nurses: administrators, non-administrators and clinical instructors, and those held by the practical nurse than there is consensus between the three groups of registered nurses: administrators, non-administrators and clinical instructors and those as seen by the practical nurse.

4. It was hypothesized, that as measured by significant t's, there will be a greater consensus among the expected perceptions of the practical nurse as seen by the directors of hospitals and medical doctors and those as seen by the practical nurse than there is consensus between the three groups of registered nurses: administrators, non-administrators and clinical instructors and those

as seen by the practical nurses. In general, this hypothesis was rejected. It was noted, however, that there was greater disagreement between the expected for the registered nurse administrators, registered nurse non-administrators and the expectations held by the practical nurses than there was between the image held by directors of the hospitals and the medical doctors and the practical nurses than the perception of the practical nurse as held by the practical nurse. The registered nurse clinical instructors' consensus was similar to those held by the medical doctor and directors of the hospitals.

5. It was hypothesized, that as measured by the significant t's, there will be a greater consensus among the actual perceived duties and responsibilities of the practical nurse as seen by the directors of hospitals and medical doctors and those as seen by the practical nurse, than there is consensus between the three groups of registered nurses: administrators, non-administrators and clinical instructors and those as seen by the practical nurse. This hypothesis, in general, was rejected. It was noted, however, that there was greater disagreement between the expected for the registered nurse non-administrators and the registered nurse administrators and the expectations held by the practical nurses than there was between the image held by the directors of the hospitals and the medical doctors and the practical nurses than the

perception of the practical nurse as held by the practical nurse. The registered nurse clinical instructors' consensus was similar to those held by the medical doctor and directors of hospitals.

The existence of conflicting expectations may be taken as evidence that the nurses' position in the hospital is not properly integrated with the other respondent group positions within the hospital system. The consequences of such conflict may be frustration for the practical nurse when interacting with other practical nurses, registered nurses, or members of the administrative staff. It may also mean that significant others may be ineffective in their working relationships with the practical nurses. This could result in more ineffective operation of the hospital and a poorer quality of patient care.

These conflicting role expectations may add up to situations or conditions of continuous stress for the practical nurses. Some practical nurses may be selective in reacting to differential expectations of others and in doing so minimize the chances of role conflict. On the other hand, she may be torn between differential expectations she defines as held by significant reference groups. To the extent that her beliefs, definitions of others' expectations and the expressed expectations of the reference groups are significantly different, the practical nurse is placed in a position of potential role conflict.

Recommendations:

It appears that attempts should be made by continuing research which will better define the functions and responsibilities of the practical

nurse, to help the directors of hospitals, medical doctors, registered nurses and practical nurses themselves reach agreement in defining the role of the practical nurse. Pre-service training programs, in-service training programs for any groups working with the practical nurses and consultant special-area practical nurse meetings can help to spell out definitely what is expected of the practical nurse, bringing about a convergence of expectations.

Suggestions for Further Research:

1. Using this study as groundwork for further research, the question might be posed: Why is there such divergence in the intra-practical nurse group? At what stage(s) in the training does this occur and why? Depth interviews could be conducted before the practical nurse goes into training, during training and a follow-up on the job a year later. From this, one might learn why certain problems occur.
2. A study might be made comparing similarities and differences of those practical nurses who stay in the program and those who drop out.
3. A third study might involve the patient to show that the degree of conflict between the practical nurse and the registered nurse administrator, and the registered nurse non-administrator is in direct proportion to the degree of better or poorer patient care.

4. Further studies toward agreement in areas of disagreement between groups are needed to the end that a definite set of statements may evolve to be placed in the hands of all groups relevant to the duties and functions of the practical nurse.

APPENDICES

APPENDIX A

CONCERNING ADMINISTRATION OF DRUGS BY PRACTICAL NURSES

Dear Doctor:

I regret the delay in replying to your inquiry with respect to the problem involved in the utilization of practical nurses in the administration of drugs and medications. The problem is a difficult one because of some degree of conflict between the legal and practical factors involved.

I have made numerous inquiries as to what others are doing or contemplating in this area and find a great divergence of thought and action. I find that at least one hospital in your community is utilizing practical nurses, under certain limitations, in the administration of medications and that several others are contemplating doing so. In the case of the hospital which presently has such a plan in operation, a training program is being carried out under which selected practical nurses are trained under physicians and registered nurses. This hospital reports that its program is working out satisfactorily.

It must, however, in my opinion, be emphasized that even though there is an area in which the services of the practical nurse can be utilized legally in administering drugs, this area is definitely limited by law regardless of the amount or quality of training. Under the Michigan Statutes regulating and licensing nurses, a registered nurse is defined as one "who has been authorized by the state to perform any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of same, and execution of treatments and medications as prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health."

Under the same Statute a licensed practical nurse is defined as "one who has been authorized by the state to perform such duties as are required in the physical care of a patient and in carrying out the medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as defined above." The term "licensed practical nurse" is further defined as one who is authorized by the state to care for sub-acute, convalescent and chronic patients requiring service under public health nursing agencies, or in institutions, or in homes, working under the direction of a licensed physician

or the supervision of a registered professional nurse, or one who is authorized by the state to assist a registered professional nurse as a member of a team caring for acutely ill patients, and who is prepared to give household assistance when it contributes directly to the welfare of the patient.

Under an opinion of the Attorney General of Michigan, it has been held that the giving of skin tests, x-ray treatments, or hypodermic injections in the diagnosis or treatment of ailments or diseases by a person who is not a registered nurse or licensed medical practitioner is unlawful. (O.A.G. 1937-8, p. 357)

While, admittedly, the foregoing definitions and opinion leave much to be desired by way of clarifying the distinctions between the functions of the two classes of nurses, it seems to me that the situation boils down to this:

1. The practical nurse cannot be permitted to do the specific acts (such as administering anesthetics, hypodermic injections, skin tests, x-ray treatments, etc.) which have been held to be solely within the province of the registered nurse or registered physician.

2. The practical nurse may be permitted to administer medications under the supervision of a registered nurse or registered physician, but only under direct supervision or under direct orders which do not allow her to use her own judgment.

3. The practical nurse cannot be placed in direct charge, but must always be under direction and supervision.

It is only, in my opinion, within these limitations and after adequate training that the services of licensed practical nurses can be safely utilized in the area under discussion. The failure to recognize these lines of demarcation may result in the imposition of legal liability in any of three ways. First, the violating nurse may be subject to revocation of license. Second, the violating nurse may be subject to criminal prosecution, and, Third, civil liability (suits for damages) for her acts may be imposed not only upon her but upon her employers and supervisors.

Very truly yours,

Lester P. Dodd
Legal Counsel, MSMS

(Excerpted from The Journal of the Michigan State Medical Society, February, 1960, Vol. 59, No. 2, Pages 315-316)

APPENDIX B

LETTERS AND INSTRUMENT USED IN THIS STUDY

August 3, 1962

Dear

You may recall a summary presented at the Practical Nursing Education Conference at Kellogg Center, Michigan State University, April 5-6, 1962, of the Practical Nursing area of the Michigan Vocational Education Evaluation Project. This particular phase is on The Perceptions of the Role of the Practical Nurse held by the Practical Nurse; the Director of the Hospital; the Medical Doctor; and the Registered Nurse. It is one part of the greater statewide study concerning vocational education and employment matters in Michigan.

It is our sincere belief that a study of this nature will help nursing educators better evaluate their individual programs, and will help the practical nurse to attain greater job satisfaction.

Very soon you will receive the questionnaire which was mentioned at the conference. It is imperative that we know the number of questionnaires needed to reach the following respondents of your program:

1. All student practical nurses in the immediate graduating class who will be graduated at the time of administering this questionnaire.

2. Number of Directors of the Hospitals with which your program is involved.

3. Those registered nurses holding the following positions in each of the hospitals involved:

    1. Supervisors
    2. Head nurses in charge of the floors
    3. Clinical instructors
    4. Team leaders

4. One attending physician from each hospital involved.

Please write the GRAND TOTAL of this number on the enclosed card and MAIL IMMEDIATELY.

This questionnaire is to be administered during the last week of the clinical period. Further instruction will be sent with the questionnaires.

This is the general plan for administering. PLEASE RETAIN THIS SHEET.

We are requesting that you, (Director of the Center), please be responsible for distributing the questionnaires, and ask that the questionnaires be responded to according to the following directions.

1. The Director of the Center will give to the Clinical Instructors those questionnaires for all student practical nurses who are at present completing their training. This shall be administered during the last week of the clinical period August, 1962.

2. The Director of the Center will give to the Superintendent of Nurses those questionnaires for all registered nurses holding the positions mentioned previously. This shall be administered to all of these R.N.s at a given called meeting. The time for administering this instrument is approximately 1/2 hour. Please have these collected at the end of the period, and not taken from the meeting by the respondent to answer independently.

3. Please ask the superintendent of nurses of each hospital involved, to ask the Director of her hospital, and one Attending Physician, to also complete a questionnaire and return to her.

Finally, it will be greatly appreciated if the Director of the Center will be responsible for collecting ALL of the questionnaires and returning them to me. You will be reimbursed for the postage.

Your assistance and cooperation is greatly appreciated and vitally needed to successfully complete this part of the project. If, for any reason, you feel that you cannot take part in this part of the project, will you please write "NONE" across the enclosed card, and return immediately so that we may find another program to take your place.

May I impress upon you that time is of the essence here, and we will send you the questionnaires just as soon as you give us the count.

Thank you very much for your help.

Sincerely yours,

Lawrence Borosage, Director
Michigan Vocational Education
Evaluation Project

Marion H. Hill, Research
Assistant, Michigan Vocational Evaluation Project

October 11, 1962

Dear

Thank you for your cooperation and assistance in this study. We appreciated your prompt return of the questionnaires related to The Perceptions of the Role of the Practical Nurse Held by the Practical Nurse; the Director of the Hospital; the Medical Doctor; and the Registered Nurse. We have been most appreciative of the fine response so far which has kept us on schedule with the study.

In order that we may get the correct percentage of response on our questionnaire, we have one final request. Will you please fill out in the enclosed card and give us the correct number of respondents whose participation was requested in this study at your center. This will probably differ to some extent from the number of questionnaires you originally asked us to send you.

Thank you again for your help.

Sincerely yours,

Marion Hill, Research Assistant
Michigan Vocational Education Evaluation Project

Enclosure

October 11, 1962

Miss Margaret Loessel, R.N.
Midland Hospital School of Practical Nursing
4005 Orchard Drive
Midland, Michigan

Dear Miss Loessel:

You will recall receiving the questionnaires on the Michigan Vocational Education Evaluation Project related to the Practical Nurse which I sent to you about a month ago. Most of the centers have already returned their completed forms and I hope that you have been making progress with the completion of your questionnaires. If any problems have risen in which I can be of help, please drop me a note.

The practical nurse centers, picked for this study, were chosen for their location, size, and other important factors so that our results will be representative of the total population. Therefore, it is important that we have as many questionnaires completed as soon as possible. We have been most appreciative of the fine response so far which has kept us on schedule with the study. We are anxious to hear from you, so please feel free to return the completed questionnaires C.O.D.

Thank you very much for your cooperation and assistance.

Sincerely yours,

Marion Hill, Research Assistant
Michigan Vocational Education Evaluation Project

MH:jj

November 9, 1963

Miss Margaret Loessel, R.N.
Midland Hospital School of Practical Nursing
4005 Orchard Drive
Midland, Michigan

Dear Miss Loessel:

Thank you so much for your cooperation and assistance on this study. We appreciated your prompt return of the questionnaires related to the Perceptions of the Role of the Practical Nurse Held by the Practical Nurse; the Director of the Hospital; the Medical Doctor; and the Registered Nurse. We have been most appreciative of the fine response so far which has kept us on schedule with the study.

In the particular sample which we have picked to represent all of the Michigan Practical Nurse Centers, you have been chosen to represent the newest and smallest; Detroit with Ford Hospital represents the other end of the continuum. It is imperative that we have a questionnaire filled out by the Director of the hospital and one of the attending physicians on your hospital staff. Our records do not show that we have that data from your center, so I am taking the liberty of enclosing two of the questionnaires for that purpose. I am sure there was a good reason why we did not get the results in the first place. Also, if there is anything which I can do to assist you in this assignment, please let me know. A good deal of money and time is being put into this project and the results will be much less meaningful if they are incomplete.

Thank you again, Miss Loessel, for the time you have taken to help us in our busy schedule.

Sincerely yours,

Marion Hill, Research Assistant
Michigan Vocational Education Evaluation Project

MH:jj

Enclosure

December 6, 1962

Mrs. Alice Drulard, Director
Practical Nursing Center
Medical Care Facility
Traverse City, Michigan

Dear Mrs. Drulard:

We deeply appreciate the prompt and efficient response to our questionnaire which you at Traverse City and Alpena have given us. As yet, we have not heard from Petoskey and since this is the final bit of data which we have to tabulate we are anxious to complete this part of the study. Next week will be the last week for student help here at MSU and it would facilitate matters greatly if we were able to get the material from Petoskey taken care of at that time. Then we will be able to send all of the code sheets to IBM for card punching before Christmas vacation. Next term will then be spent in statistical analysis of the data and the writing of the final report of the Practical Nursing area of the study. We are sure you are as anxious as we are to learn of the final results which your data contributes to the total picture. Rest assured; you will, as you put it, be one of the "counted ones."

We hope that it will be possible for the remainder of your material (Petoskey) to reach us during the coming week. Again, thank you so very much for expediting this material as rapidly as you have.

Sincerely,

Marion H. Hill, Research Assistant
Michigan Vocational Education Evaluation Project

MHH:jj

The Perceptions of the Role of the Practical Nurse
Held by the Practical Nurse, the Director
of the Hospital, the Medical Doctor,
and the Registered Nurse

This questionnaire is divided into two sections. Section A consists of general information. Section B consists of questions asking your opinion about certain matters relating to the Practical Nursing Programs of Michigan. Directions for Part I and Part II of Section B are found at the beginning of the Section.

This questionnaire is anonymous and completely confidential.

Thank you for your cooperation and assistance.

SECTION A

General Information

Please CIRCLE the appropriate number in each classification.

1. Location

   1. Cadillac
   2. Detroit (Ford)
   3. Detroit (Shapero)
   4. Flint
   5. Lansing
   6. Midland
   7. Traverse City
   8. Port Huron

2 Sex

   1. Male
   2. Female

3. Marital Status

   1. Single
   2. Married
   3. Widowed
   4. Divorced
   5. Separated

4. Age

   1. 16-20
   2. 21-25
   3. 26-30
   4. 31-35
   5. 36-40
   6. 41-45
   7. 46-50
   8. over 50

5. Educational Status

   1. Minus 8 years
   2. 8 years grammar school
   3. 9-11 years

4. 12 years - high school
5. 1-2 years past high school (business training, other)
6. 1 year minus - Nurse Aid training
7. 13-15 years - some college training
8. 15 years equivalent to R. N. training
9. 16 years plus - A.B., B.S., M.A., M.S., M.D.

6. Professional Title

1. Practical Nurse
2. Director of Hospital
3. Medical Doctor
4. Registered Nurse

7. Medical Doctor

1. General Practitioner
2. Surgeon
3. Internist
4. Specialist - Please indicate area _____

8. At what type of hospital are you currently employed or do you attend patients?

1. General hospital
2. Tuberculosis hospital
3. Rehabilitation center
4. Osteopathic hospital
5. Other - Please indicate _____

9. You are now working on which type of service

1. Medical
2. Surgical
3. Medical-Surgical
4. Maternity
5. Newborn nursery
6. Pediatrics
7. Operating Room
8. Recovery Room
9. Contagion
10. Other - Please indicate professional title _____

SECTION B Graduated Licensed Practical Nurse Role*

There is no right or wrong answer in this questionnaire. Your name is not required and your thinking will not reflect upon you personnally. The questions will be divided into two groups. In this first group you will answer describing the practical nursing role as you would EXPECT it to be; the second group of questions you will answer describing the practical nursing role as you KNOW it to be.

You are asked to CIRCLE the number in each item on the questionnaire to indicate YOUR PERCEPTION of the role of a PRACTICAL NURSE. Do not linger on each item. Move along freely, but remind yourself frequently of the guide question at the top of each section. DO NOT LEAVE ANY ITEM BLANK. DO NOT REFER BACK TO PREVIOUS QUESTIONS.

In this questionnaire you are asked to CIRCLE the number in each item to indicate its PRIORITY as follows:

1.	always	would be one even if other things had to be put aside.
2.	usually	would rate above most things.
3.	sometimes	average in importance.
4.	seldom	would rate above only a few other things.
5.	never	would not be done under any circumstances.

SAMPLE

PART I

A PRACTICAL NURSE WOULD EXPECT

To make the patient's bed daily

(1) always 2. usually 3. sometimes 4. seldom 5. never

---

* The group of practical nurse respondents are asked to consider the expected role as the student practical nurse understands the role to be. Answer the second part of the questions as the licensed practical nurse actually finds the role to be.

Explanation: You would put a circle around the number 1 as above, if you believe the practical nurse would EXPECT that this would always be done even if other things had to be put aside to do it.

In this questionnaire you are asked to circle the number in each item to indicate its PRIORITY as follows:

1.	always	would be done even if other things had to be put aside.
2.	usually	would rate above most things.
3.	sometimes	average in importance.
4.	seldom	would rate above only a few other things.
5.	never	would not be done under any circumstances.

SAMPLE

PART II

A PRACTICAL NURSE WOULD ACTUALLY

Make the patient's bed daily

1. always 2. usually (3.) sometimes 4. seldom 5. never

Explanation You would put a circle around the number 3 as above, if you believe the practical nurse would ACTUALLY make the patient's bed about half of the time, or find it average in importance.

NOTE: SHE is used in this questionnaire to indicate either male or female. All numbering on this instrument is for the purpose of IBM coding.

PART I

A PRACTICAL NURSE WOULD EXPECT

1. Practical nursing to be bedside nursing

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

2. To be treated as a "Glorified Aid"

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

3. To learn good concrete technical knowledge

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

4. To have more security, less responsibility than the R.N.

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

5. To understand herself better through the practical nursing training.

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

6. To have too heavy (in quantity) assignments

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

7. To have the status of the Practical Nurse underestimated

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

8. To have the P.N. program accepted as an educational experience rather than a program to staff a hospital

   1 - always 2 - usually 3 - sometimes 4 - seldom
   5 - never

9. To have a good understanding between the P.N. Center and the hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

10. To have good coordination between the book and clinical experience

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

11. Qualifications and limitations as a Practical Nurse to be well understood by all hospital personnel

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

12. To have the status of the Practical Nurse overestimated

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

13. A definite person available to supervise her on all new procedures

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

14. To have more things to do than she could handle

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

15. To do treatments or give medications she is not qualified to do

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

16. To be prepared realistically for hospital life while at school

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

17. To be placed in charge of the floor on clinical duty

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO REPORT ANY DIFFICULTIES TO THE

18. Supervisor nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

19. Head nurse in charge of floor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

20. Team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

21. Clinical instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

22. Instructor of AIDS

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO RECEIVE ORDERS FROM

23. Supervisor nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

24. Head nurse in charge of floor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

25. Doctor (M.D.)

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

26. Intern

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

27. Team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

28. Clinical instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

29. Anyone in command: M.D., R.N., P.N., or AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

30. Licensed Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT THE TRAINING PERIOD FOR THE PRACTICAL NURSE

31. To remain as it is - 12 months

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

32. To be changed to less than 12 months

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

33. To be lengthened to 18 months

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

34. To be lengthened to 24 months

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

35. In any case, to be a college accredited program, with the transfer into the professional nursing program being optional

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT IN CLINICAL SUPERVISION

36. To have the instructor observe the way she does Rxs and answer questions for her

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

37. To be shown first by the instructor and then be observed by the instructor whenever needed

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

38. To be observed by the R.N. whenever the instructors are absent

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

39. To be shown to do a procedure by anyone who knows how: M.D., R.N., other P.N. or AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

40. That if clinical supervision isn't available she would do the best she could

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

41. To supervise other P.N.s and AIDS on treatments

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT AS A PARTICIPANT ON A NURSING TEAM THAT

42. Each person on a team would be qualified for a specific job and the group work together, participate as a team

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

43. The nursing team exists in theory only

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

44. There is one weak link on the team

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

45. There appears to be only two on a team, the Practical Nurse and the team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT AS A PARTICIPANT ON A NURSING TEAM THAT

46. That she would take responsibilities to help her team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

47. That there would be better patient care

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO EXERCISE HER OWN JUDGMENT IN NURSING SITUATIONS

48. Only to the extent that the training has qualified her

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

49. To be a good worker, take orders, and not expect to think for herself

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

50. To varying degrees, depending upon the ward, R.N.s and M.D.s in charge

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

51. To varying degrees, depending upon the circumstances

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO EXERCISE HER OWN JUDGMENT IN NURSING SITUATIONS

52. Fully, since the patient expects her to know and use her own judgment

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO BE PREPARED FOR TECHNICAL FUNCTIONS

53. Yes, she would expect to be prepared primarily for technical functions

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

54. More for semi-technical; assist R.N. in complex Rxs

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

55. In a post-graduate course especially designed for specific knowledge in the technical area

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO DO THE FOLLOWING KINDS OF THERAPY

56. Whatever kind of therapy the doctor prescribes

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

57. Physical and occupational therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

58. Medications

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

59. Hydrotherapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

60. Light therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO DO THE FOLLOWING KINDS OF THERAPY

61. Rehabilitation therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

62. Teach the patient to do what he can for himself

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

63. Mental and emotional therapy - understand the patient and help the patient to understand

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO BE RESPONSIBLE IN NURSING DIAGNOSIS FOR

64. Observing, recognizing and charting symptoms

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

65. Making no diagnosis under any circumstances, strictly for M.D.s

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

66. Making decisions as to how the M.D.s orders should be put into effect

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

67. Reporting important symptoms to the head nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

68. Discussing the case with the head nurse or team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT THE PSYCHOTHERAPEUTIC FUNCTION IS

69. To be a good listener, answer the patient's questions and explain procedures, express empathy, steady unchanging attitude, and keep patient free from fear

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

70. Finding, recognizing, and accepting the patient's problems. Discussing them with the doctor and carrying out the suggested program

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

71. To be matter-of-fact about procedures and express empathy, but recognize your limitations and make referrals

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

72. To have enough time to devote to any one patient to meet the emotional needs of the patient

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO BE PREPARED FOR BEDSIDE NURSING

73. Yes, primarily for bedside nursing

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

74. Primarily bedside nursing in some hospitals, but not in others

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

75. To have equal role of technical and bedside care

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

76. To do independent nursing based on the selection of certain kinds of patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

77. To have an unequal role of technical and bedside care depending upon the hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

78. To take on the functions of total patient care originally held by the R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

79. For the R.N. to be the "hub of the wheel" and the P.N. to be "one of the spokes"

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

80. To take on the functions of total patient care originally held by the R.N., except for giving medications

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT

81. To have the role of administering medications to patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

82. To refuse to give medications to patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

83. To refuse to give medications to patients unless a course in medications is given

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

84. To refuse to give medications to patients unless approved by law

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT TO BE TAUGHT AND HAVE PRACTICE ADMINISTERING MEDICATIONS WHERE? BY WHOM?

85. To be taught in classes on medications at the school (center) by a qualified instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

86. To be taught in the hospital while on floor duty by the supervising R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

87. To be taught in classes on medications at the hospital by a qualified instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

88. A course in medications to be an optional, post-graduate course in either institution

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

89. In any case, giving medications would be optional

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

90. If a course in medications is given, narcotics should be included

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE WOULD EXPECT

91. To evaluate the patient's progress independently

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

92. To evaluate the patient's progress in cooperation with the M.D.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

93. The evaluation of the patient's progress to be done only by the M.D. and/or M.D. and R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

94. To have a unique role recognized as being "apart" from R.N.s or AIDS

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

95. Patient-centered, not task-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

96. Both task and patient-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

97. Mainly task-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

98. A personalized program geared to the individual needs of the Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

99. Remedial courses set up in areas for those weak in certain subjects

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

100. Individual counseling related to personal problems of the Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

101. Individual instruction and/or supervision made readily available to those in training

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

102. To waive certain class subjects by passing a special comprehensive examination in the subject - "comp out"

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

103. To receive special transfer credit into the Professional Nursing curriculum for any general or basic liberal arts courses taken in the Practical Nursing Program

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

104. To be able to specialize in certain areas: surgical, pediatrics, etc.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

105. Intensive training in specialized areas to be optional

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

106. This training would be offered at the undergraduate level

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

107. This training would be given at the graduate level in preference to the undergraduate level

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

PART II

(Do not refer back to PART I)

A PRACTICAL NURSE ACTUALLY

108. Does find practical nursing to be what she expected

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

109. Does find parctical nursing to be bedside nursing

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

110. Is treated as a "Glorified Aid"

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

111. Does learn good concrete technical knowledge

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

112. Does have more security, less responsibility than the R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

113. Does understand herself better through taking the practical nursing training

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

114. Does have too heavy (in quantity) assignments

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

115. Finds <u>less</u> time is needed for certain subjects

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

Please indicate subjects _____

_____

116. Finds <u>more</u> time is needed for certain subjects

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

Please indicate subjects _____

_____

117. Finds that practical nursing is an educational experience, not a program to staff a hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY REPORTS HER DIFFICULTIES TO THE

118. Supervisor nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

119. Head nurse in charge of floor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

120. Team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

121. Clinical instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

122. Instructor of AIDS

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE RECEIVES ORDERS FROM

123. Supervisor nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

124.- Head nurse in charge of floor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

125. Doctor (M.D.)

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

126. Intern

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

127. Team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

128. Clincal instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

129. Anyone in command: M.D., R.N., P.N. or AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

130. Licensed Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY IN CLINICAL SUPERVISION

131. Has the instructor observe the way she does Rxs and answer questions for her

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

132. Has the instructor observe the way she does treatments and answers the P.N.s questions only if time permits her

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

133. Is shown treatments first by the instructor and then observed by the instructor whenever needed

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

134. Is observed by the R.N. when the instructors are absent

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

135. Is shown how to do a procedure by anyone who know how: M.D., R.N., other P.N., or AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

136. Finds that clinical observation is not available at times and does the best she can

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

137. Supervises other P.N.s or AIDS on treatments

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

138. Is expected to make a lot of decisions on her own

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY AS A PARTICIPANT ON A NURSING TEAM FINDS THAT

139. Each person on a team is qualified for a specific job and the group work together, participate as a team

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

140. There is one weak link on the team

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

141. The nursing team exists in theory only

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

142. There appear to be only two on a team, the Practical Nurse and the team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

143. The Practical Nurse takes responsibilities to help her team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

144. There is better patient care

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY EXERCISES HER OWN JUDGMENT IN NURSING SITUATIONS

145. Only to the extent to which the training has qualified her

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

146. Is a good worker, takes orders, and does not expect to think for herself

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

147. Finds it varies, depending upon the ward, R.N.s and M.D.s in charge

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

148. Finds it varies, depending on circumstances

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

149. Finds the patient expects her to know and use her own judgment

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY

150. Is prepared primarily for technical functions

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

151. Is prepared for semi-technical. Assist R.N. in complex Rxs

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

152. Finds need for more courses than are now offered during training especially designed for keeping up on specific knowledge in the technical area

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

153. Finds need for a post-graduate course especially designed for specific knowledge in the technical area

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY DOES THE FOLLOWING KINDS OF THERAPY

154. Whatever kind of therapy the doctor (M.D.) prescribes

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

155. Physical and occupational therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

156. Medications

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

157. Hydrotherapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

158. Light therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

159. Rehabilitation therapy

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

160. Teach the patient to do what he can for himself

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

161. Mental and emotional therapy - understand the patient and help the patient to understand

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY IS RESPONSIBLE IN NURSING DIAGNOSIS FOR

162. Observing, recognizing, and charting symptoms

1 - always 2 - usually 3 - sometimes 4 - seldom
5.- never

163. Making no diagnosis under any circumstances, strictly for M.D.s

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

164. Making decisions as to how the M.D.'s orders are to be put into effect

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

165. Reporting important symptoms to the head nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

166. Discussing the case with the head nurse or team leader

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY FINDS THE PSYCHOTHERAPEUTIC FUNCTION IS

167. To be a good listener, answer patient's questions and explain procedures, express empathy, steady unchanging attitude, and keep patient free from fear

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

168. To find, recognize, and accept patient's problems. To discuss them with the doctor and carry out suggested program

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

169. To be matter-of-fact about procedures and express empathy, but recognize her limitations and make (referrals omitted due to typing error)

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

170. To have enough time to devote to any one patient to meet the emotional needs of the patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

171. To meet the patient's emotional needs regardless of the amount of time she spends with them, by having a healthy and reassuring attitude as a Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

A PRACTICAL NURSE ACTUALLY

172. Is prepared primarily for bedside nursing

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

173. Is prepared primarily for bedside nursing in some hospitals, but not in others

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

Please qualify _____

174. Has an equal role of technical and bedside care

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

175. Does independent nursing based on the selection of certain kinds of patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

176. Has un unequal role of technical and bedside care, depending upon the hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

177. In smaller hospitals more technical

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

178. Finds the amount of responsibility that is assigned to the P.N. depends upon the attitude of the charge nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

179. Take on the functions of total patient care originally held by the R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

180. Finds the R.N. to be the "hub of the wheel" and the P.N. to be "one of the spokes"

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

181. Takes on the functions of total patient care originally held by the R.N. except in giving medications

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

182. Have the role of administering medications to patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

183. Refuses to give medications to patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

184. Refuses to administer medications to patients unless a course in medications is given

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

185. Refuses to give medications to patients unless approved by law

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

186. Is taught and has practice administering medications in the hospital by the clinical instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

187. Is taught and has practice administering medications in the school (center) by a qualified instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

188. Is not trained to pass medications in a hospital by anyone

1 - always 2 - usually 3 - sometimes 4 - seldom

189. Evaluates the patient's progress independently

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

190. Evaluates the patient's progress in cooperation with the M.D.

1 - always 2 - usually 3 - sometimes 4 - seldom

191. Evaluates the patient's progress in cooperation with the R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

192. Evaluates the patient's progress in cooperation with the other P.N.s

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

193. Finds evaluation of the patient's progress to be done only by M.D. and/or M.D. and R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

194. Has a unique role recognized as being "apart" from the R.N.s

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

195. Has a unique role recognized as being "apart" from AIDS

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

196. Has more security than an AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

197. Has more responsibility than an AID

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

198. Has less security than the R.N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

199. Has more responsibility than an R. N.

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

200. Does patient-centered, not task-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

201. Does both task-centered and patient-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

202. Does task-centered activities

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

203. Finds the Practical Nursing Program personalized to meet the individual needs of the Practical Nurse

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

204. Gets individual instruction in subject matter where she is weak

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

205. Gets individual supervision whenever needed

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

206. Gets individual counseling related to the Practical Nurses personal problems

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

207. Is able to specialize in certain areas

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

208. Is dispensing narcotics to patients

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

209. Finds the status of the Practical Nurse underestimated

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

210. Is dispensing narcotics to patients only under supervison of clinical instructor

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

211. Does find the Practical Nursing Program accepted as an educational experience, rather than a program to staff a hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

212. Does find good understanding between the Practical Nursing Center and the hospital

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

213. Finds good coordination between the book and clinical experience

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

214. Finds her qualifications and limitations as a practical nurse well understood by all hospital personnel

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

215. Finds the status of the Practical Nurse to be overestimated

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

216. Finds a definite person available to supervise her on all new procedures

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

217. Has more things to do than she can handle

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

218. Is placed in charge of the floor on clinical duty

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

219. Is prepared realistically for hospital life while at school

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

220. Gives treatments she is not qualified to give

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

221. Gives medications which she is not qualified to give

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

222. Gives medications which it is unlawful for her to give

1 - always 2 - usually 3 - sometimes 4 - seldom
5 - never

APPENDIX C

HISTOGRAMS

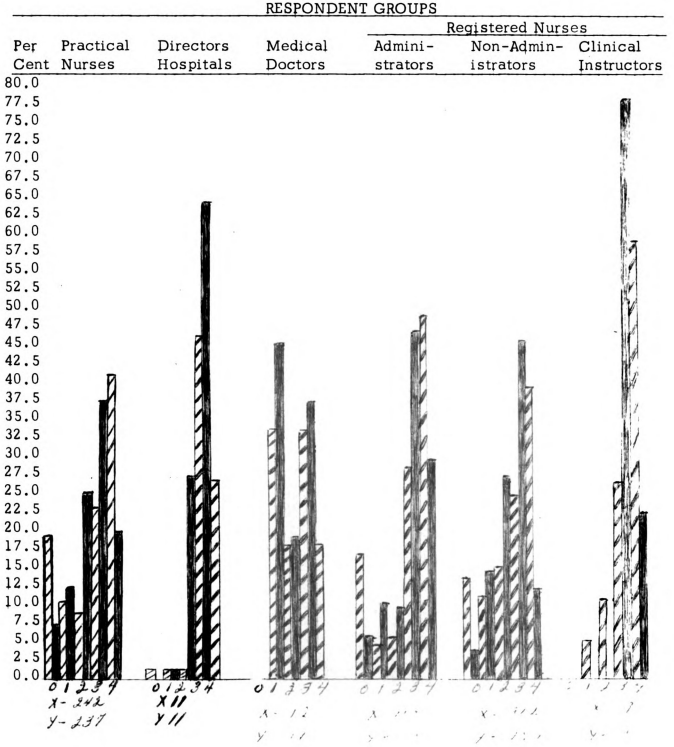
NOTE: The following is the key used in setting the histograms.

 Actually  Expected

Number in sample: x = expected, y = actually

0 - never 1 - seldom 2 - sometimes
3 - usually 4 - always

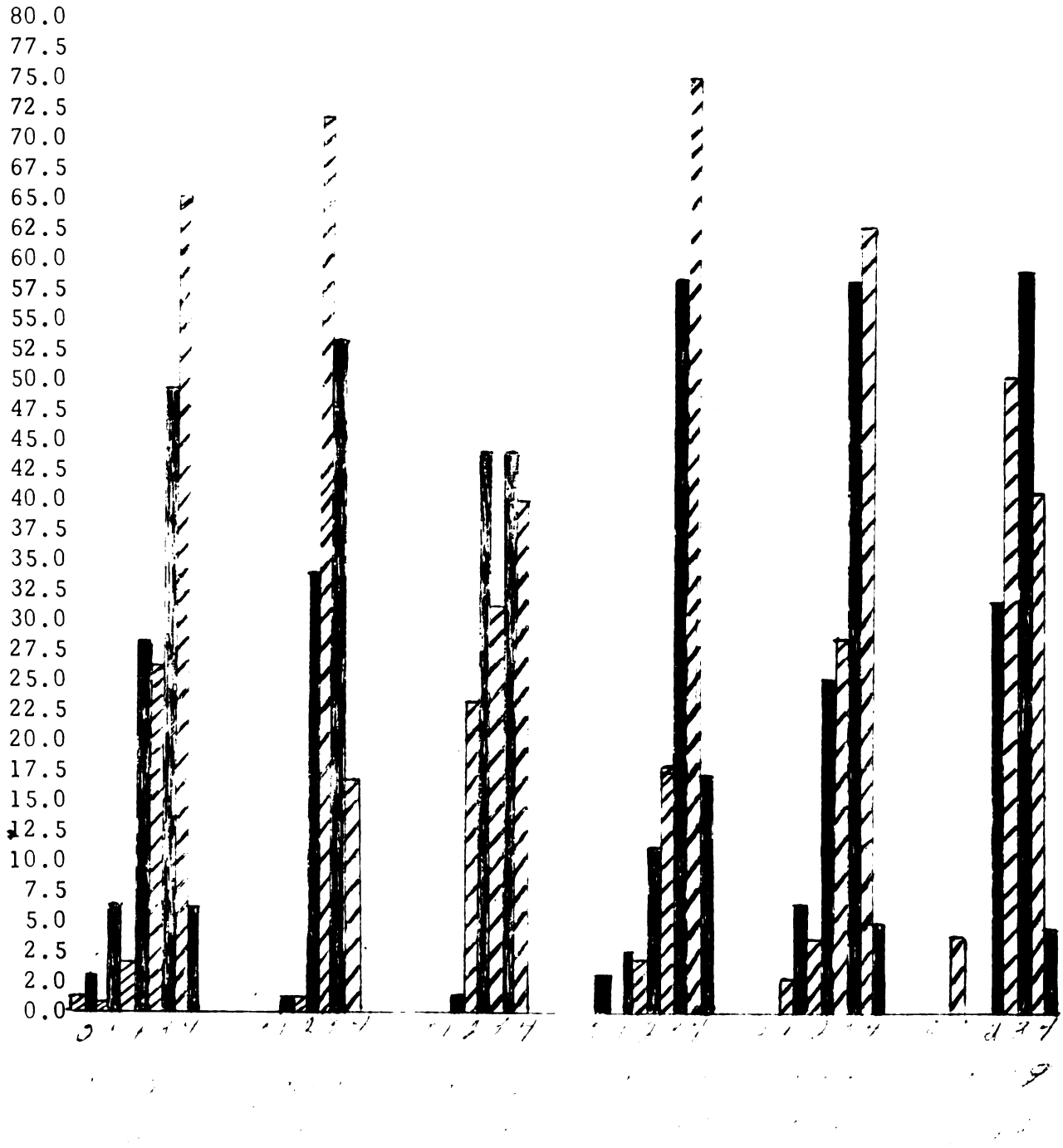
Question Number 8 and 211A



Question number 11 and 214

RESPONDENT GROUPS

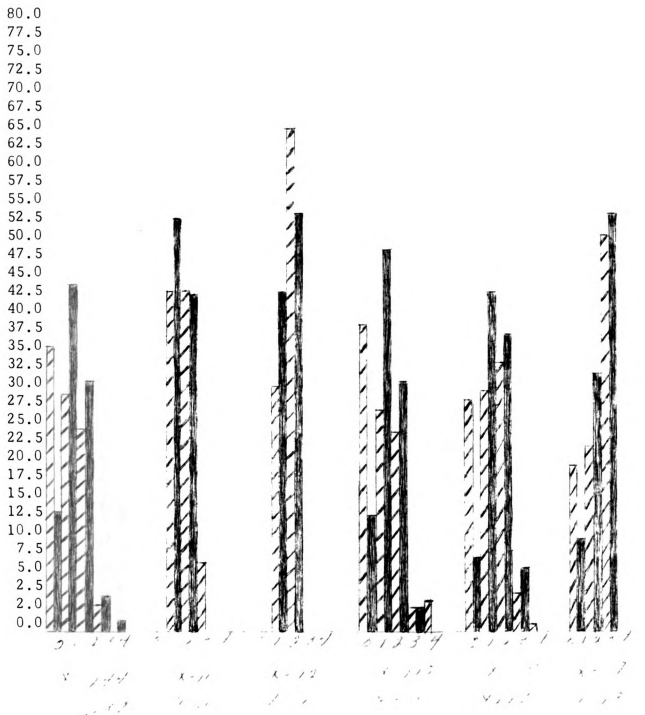
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 12 and 215

RESPONDENT GROUPS

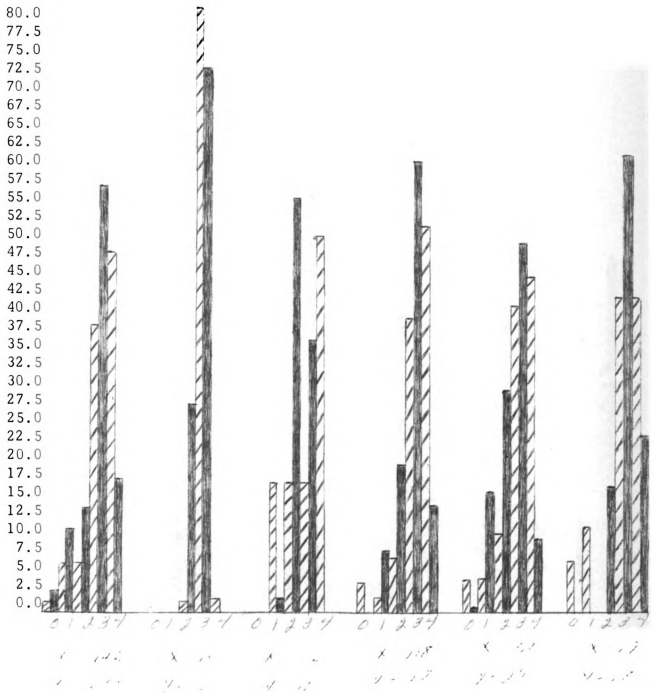
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors
80.0						
77.5						
75.0						
72.5						
70.0						
67.5						
65.0						
62.5						
60.0						
57.5						
55.0						
52.5						
50.0						
47.5						
45.0						
42.5						
40.0						
37.5						
35.0						
32.5						
30.0						
27.5						
25.0						
22.5						
20.0						
17.5						
15.0						
12.5						
10.0						
7.5						
5.0						
2.5						
2.0						
0.0						



Questions Number 16 and 219

RESPONDENT GROUPS

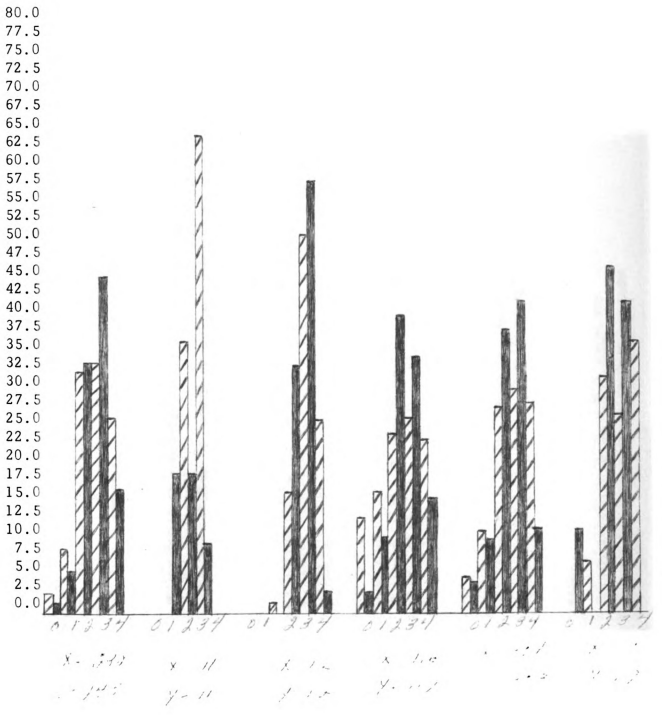
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 50 and 147.

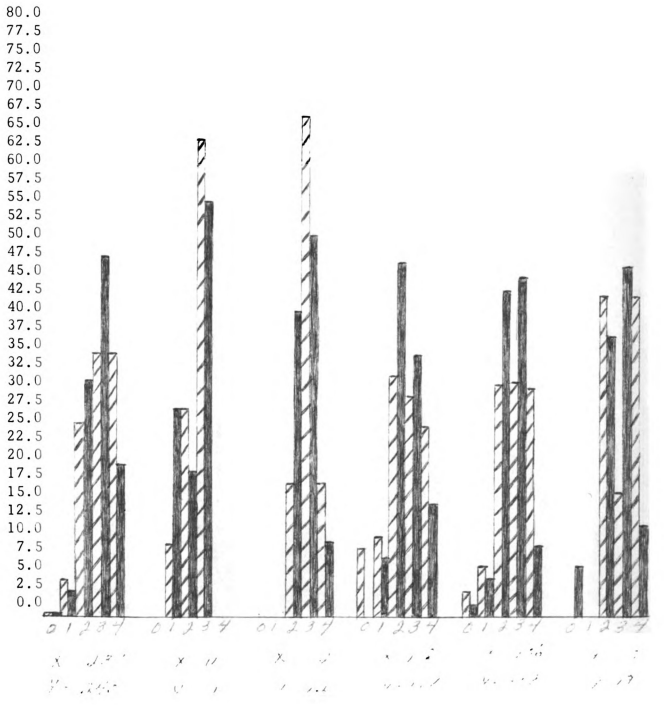
RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 51 and 148.

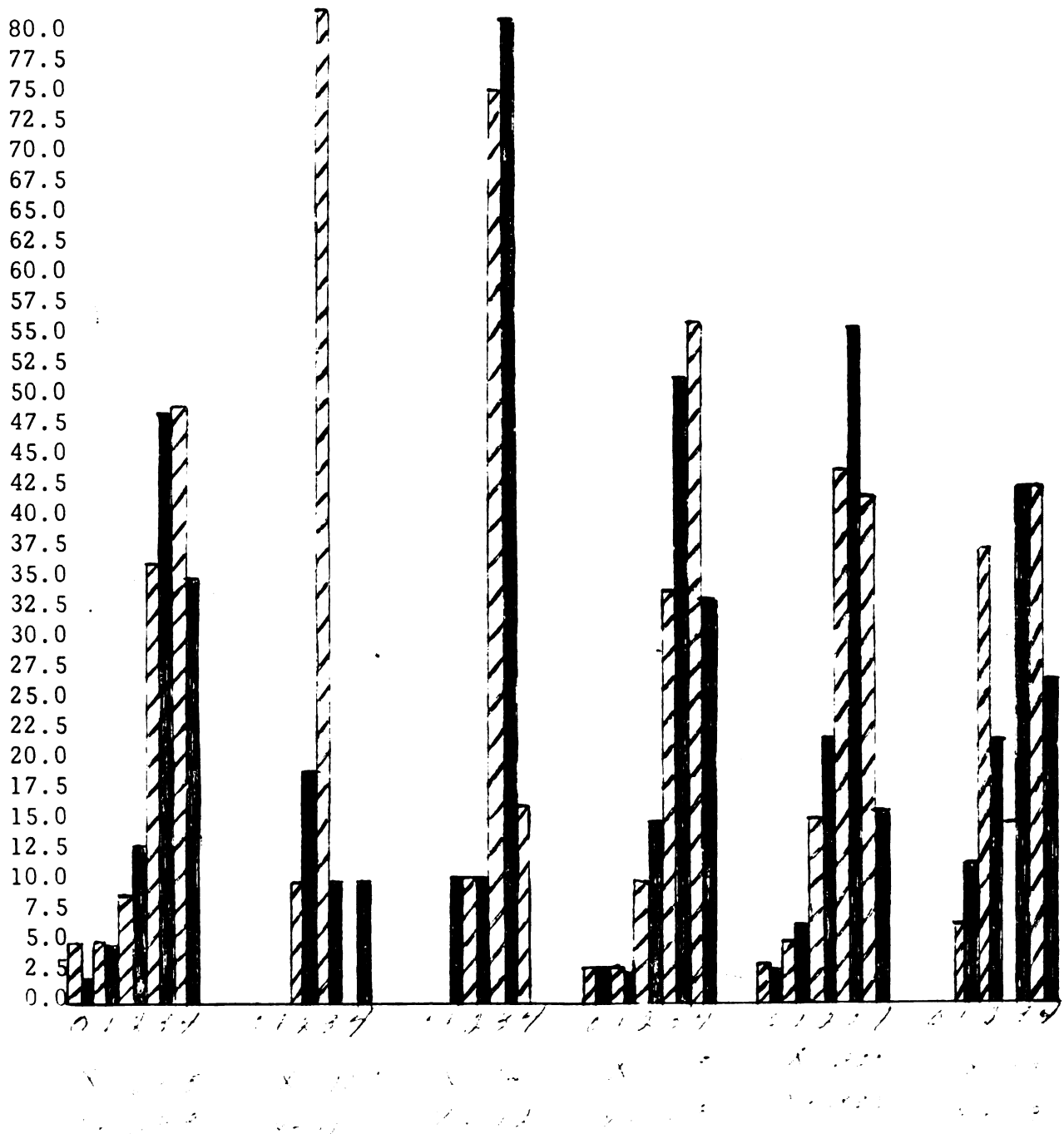
	RESPONDENT GROUPS					
				Registered Nurses		
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Administrators	Non-Administrators	Clinical Instructors



Questions Number 79 and 180.

RESPONDENT GROUPS

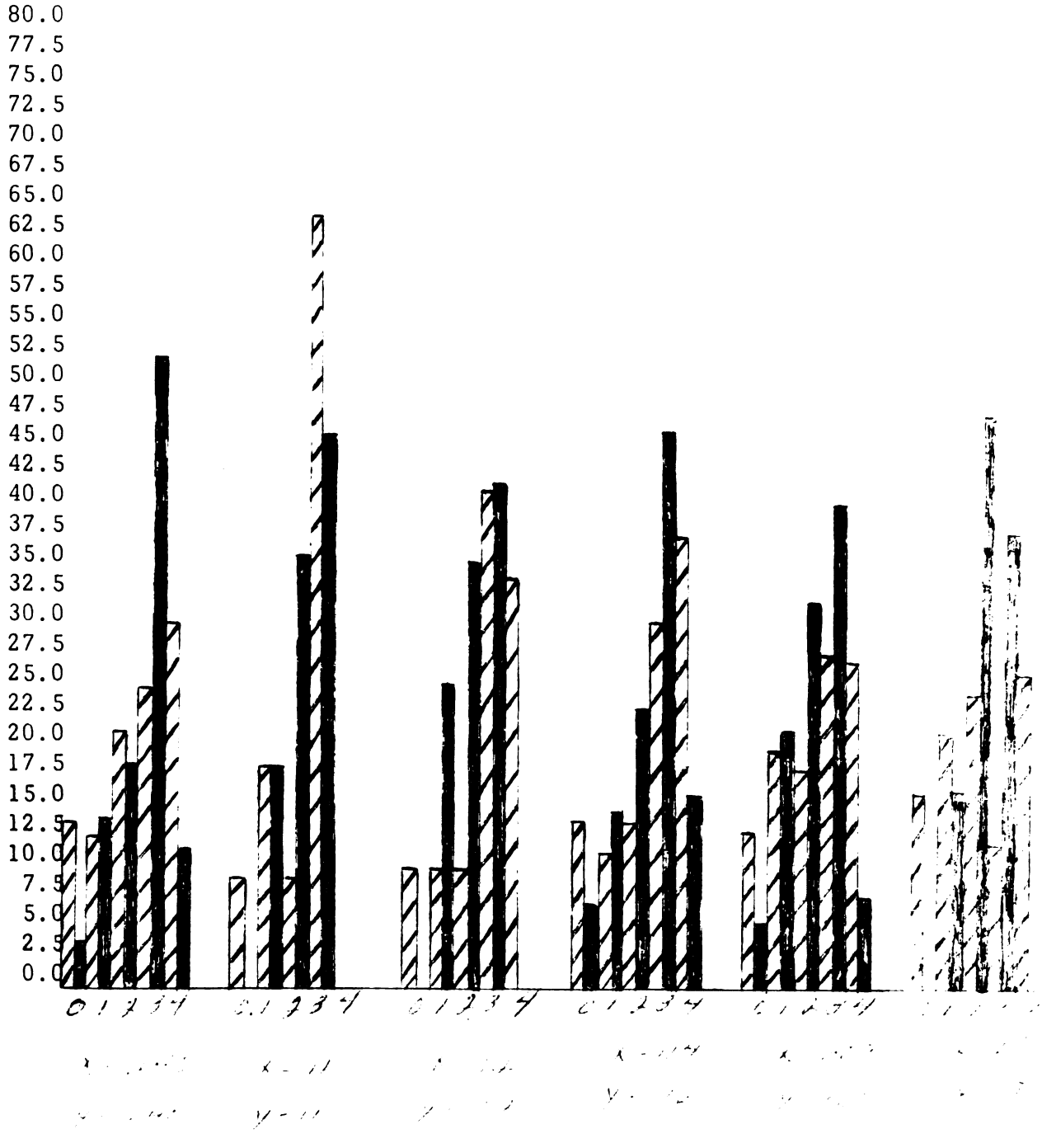
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 98 and 203.

RESPONDENT GROUPS

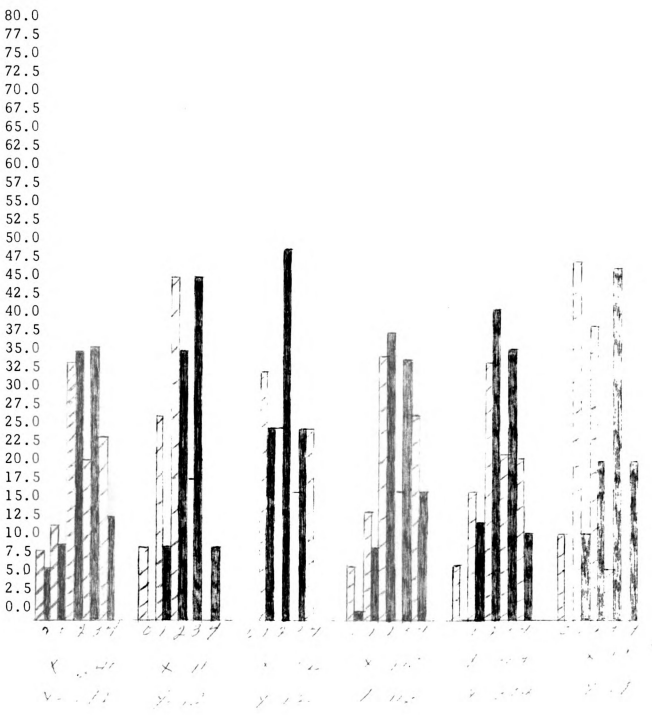
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clincal Instructors



Questions Number 99 and 204.

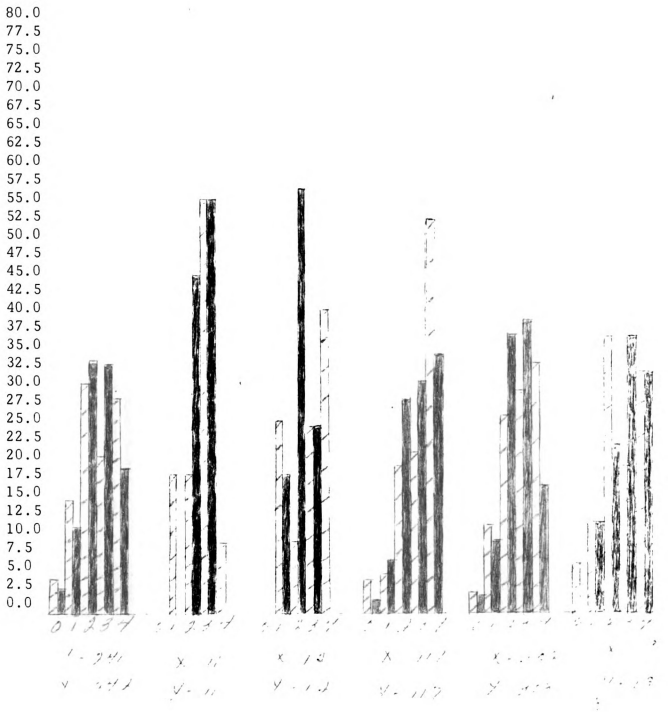
RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 100 and 206.

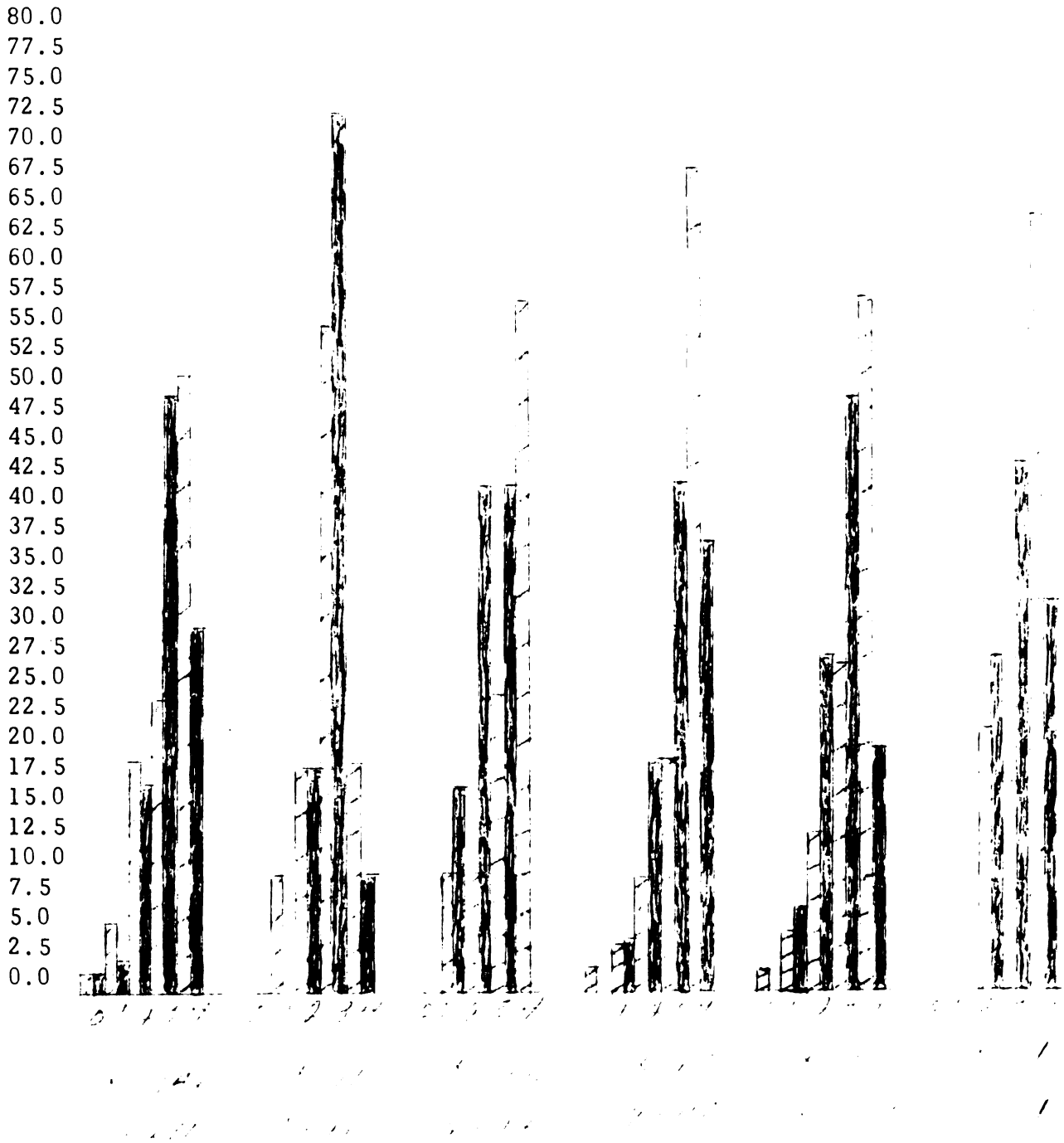
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors
	RESPONDENT GROUPS					



Questions Number 101 and 205.

RESPONDENT GROUPS

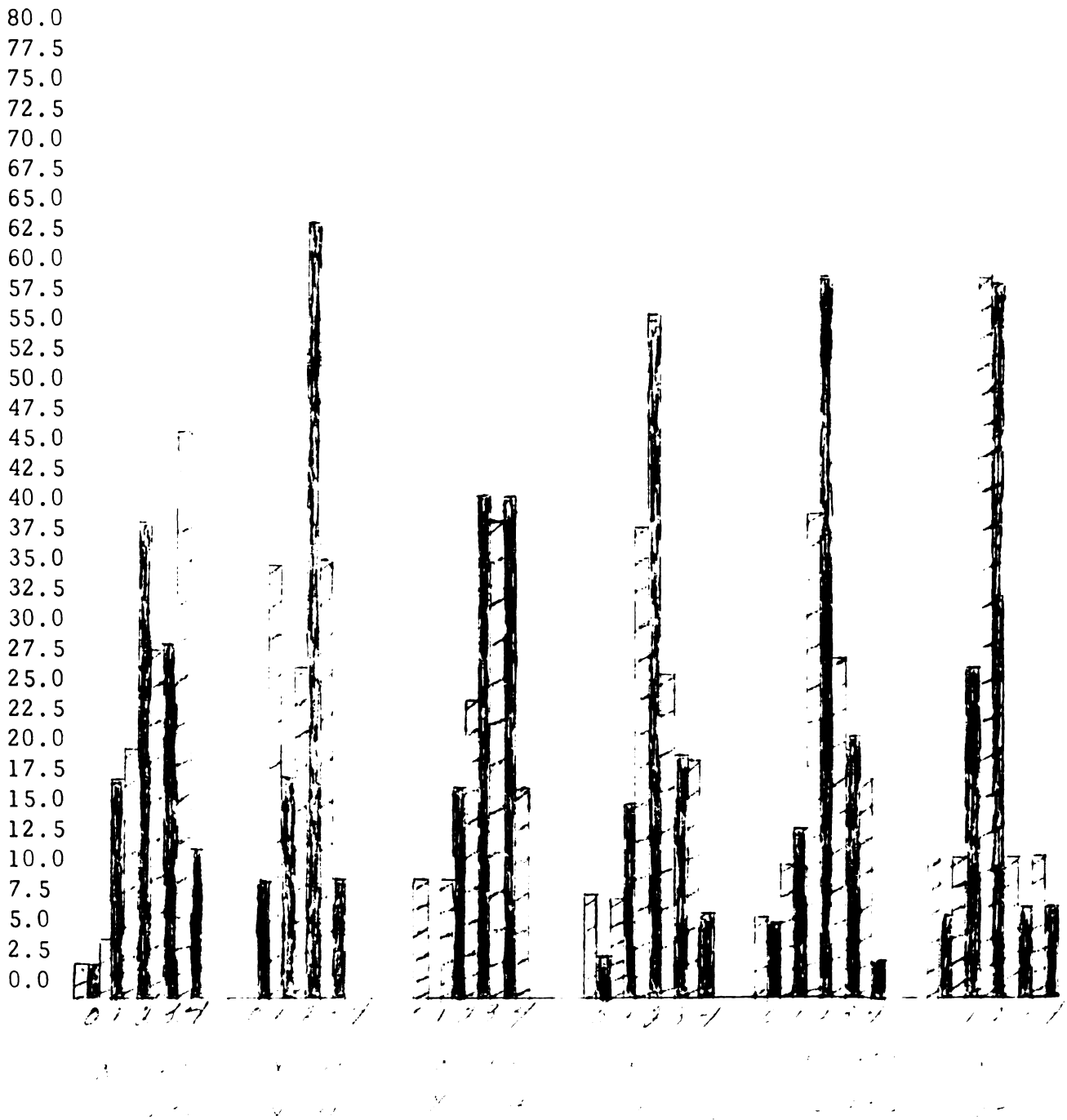
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 104 and 207.

RESPONDENT GROUPS

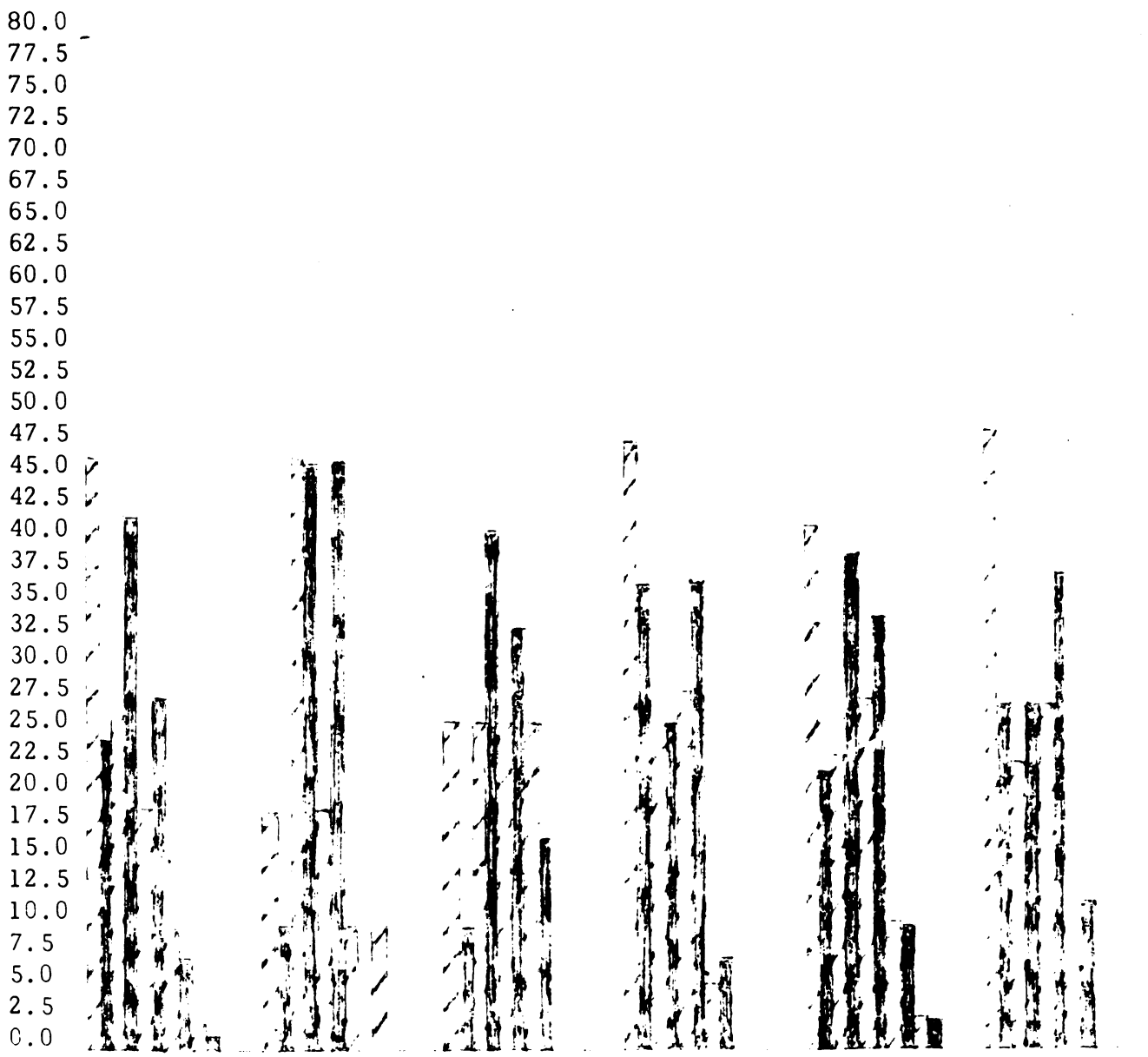
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



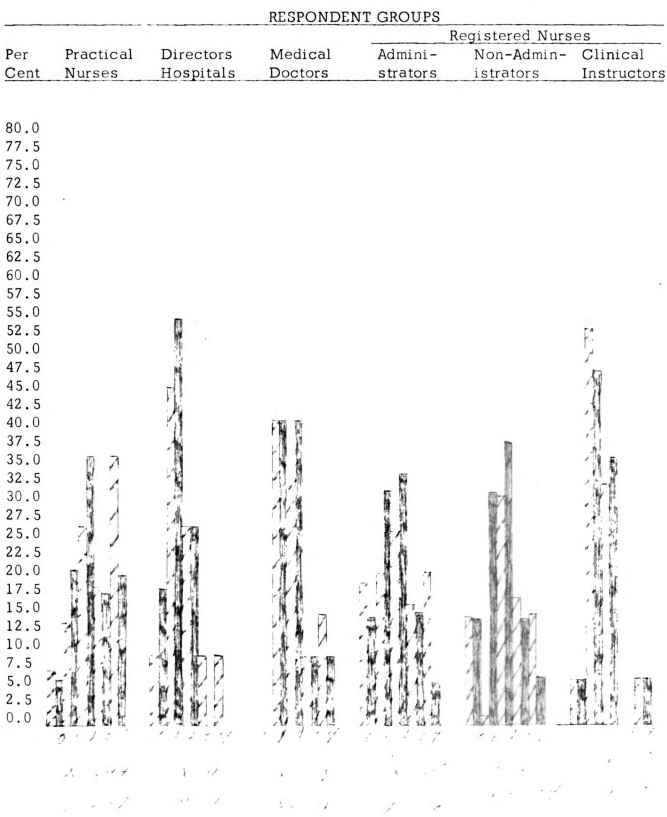
Questions Number 43 and 141.

RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



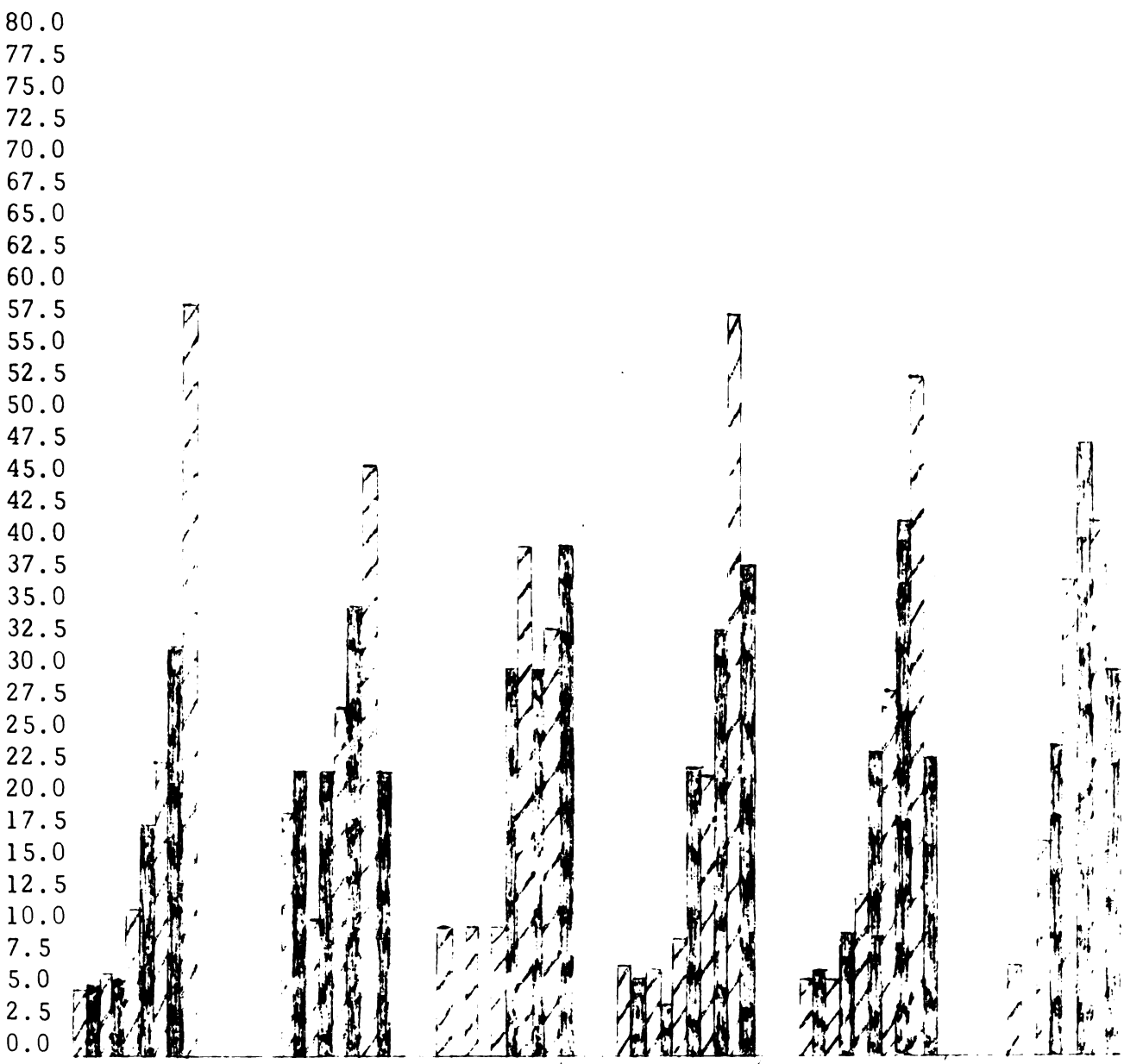
Questions Number 70 and 168.



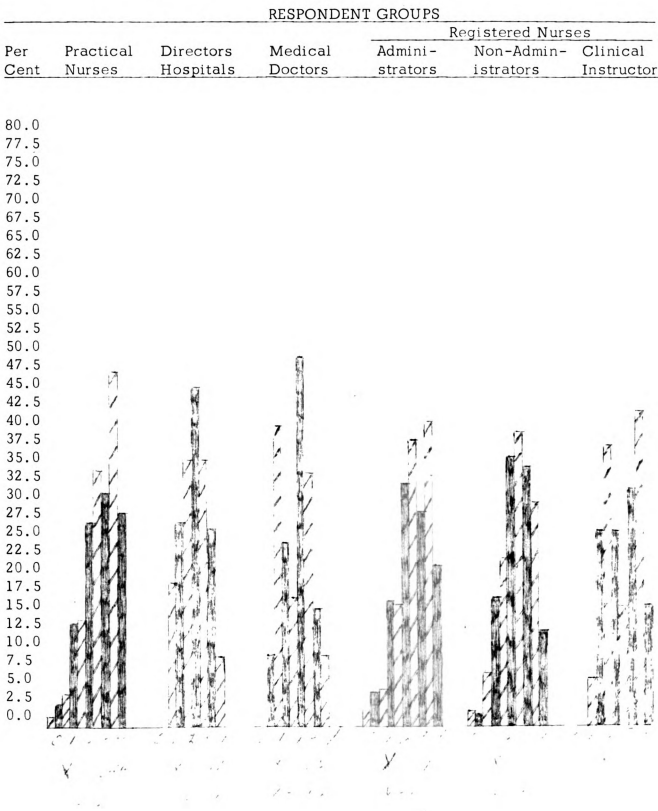
Questions Number 71 and 169.

RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



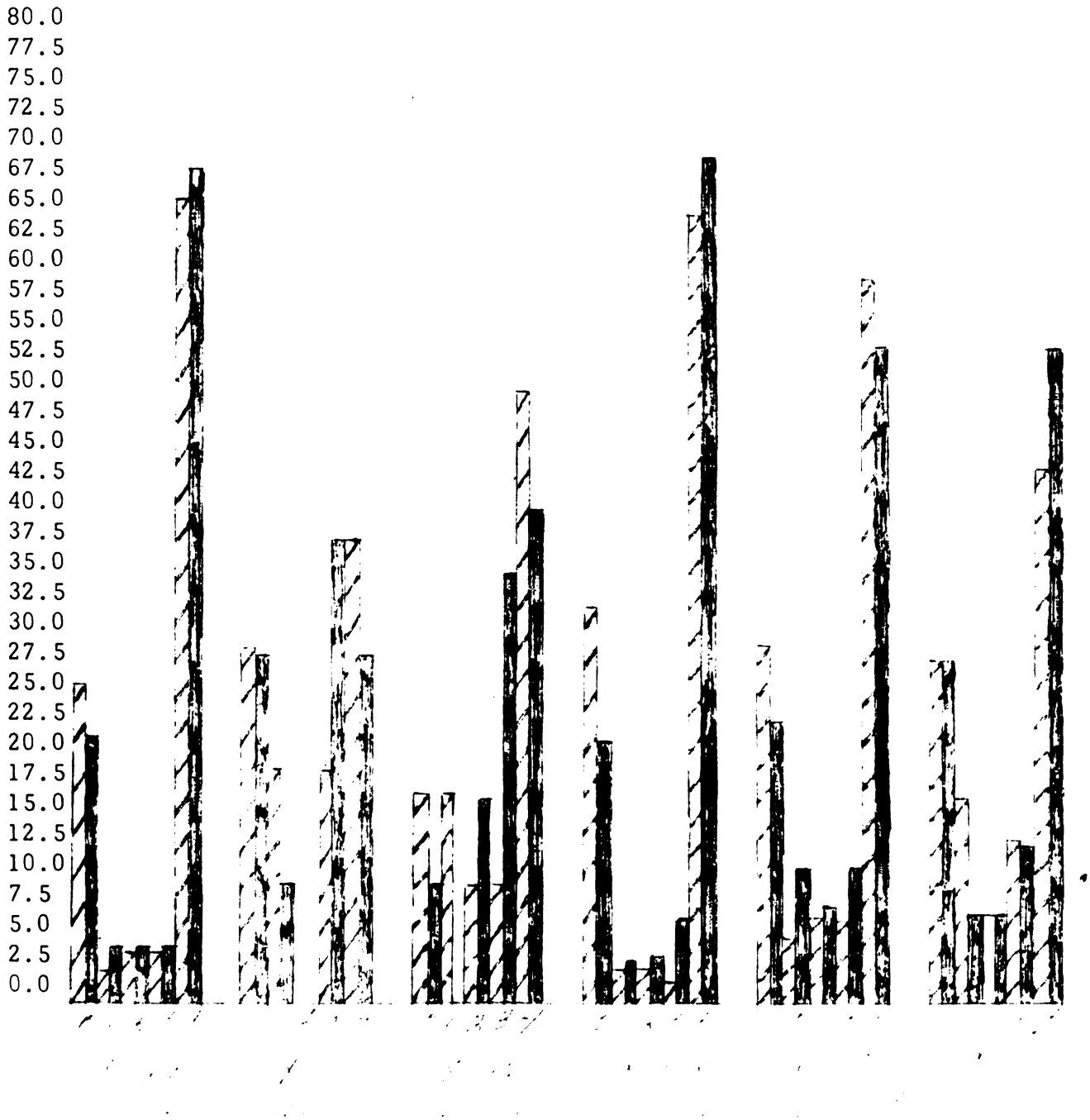
Questions Number 72 and 170. (Bedside)



Questions Number 65 and 163. (Bedside-Technical)

RESPONDENT GROUPS

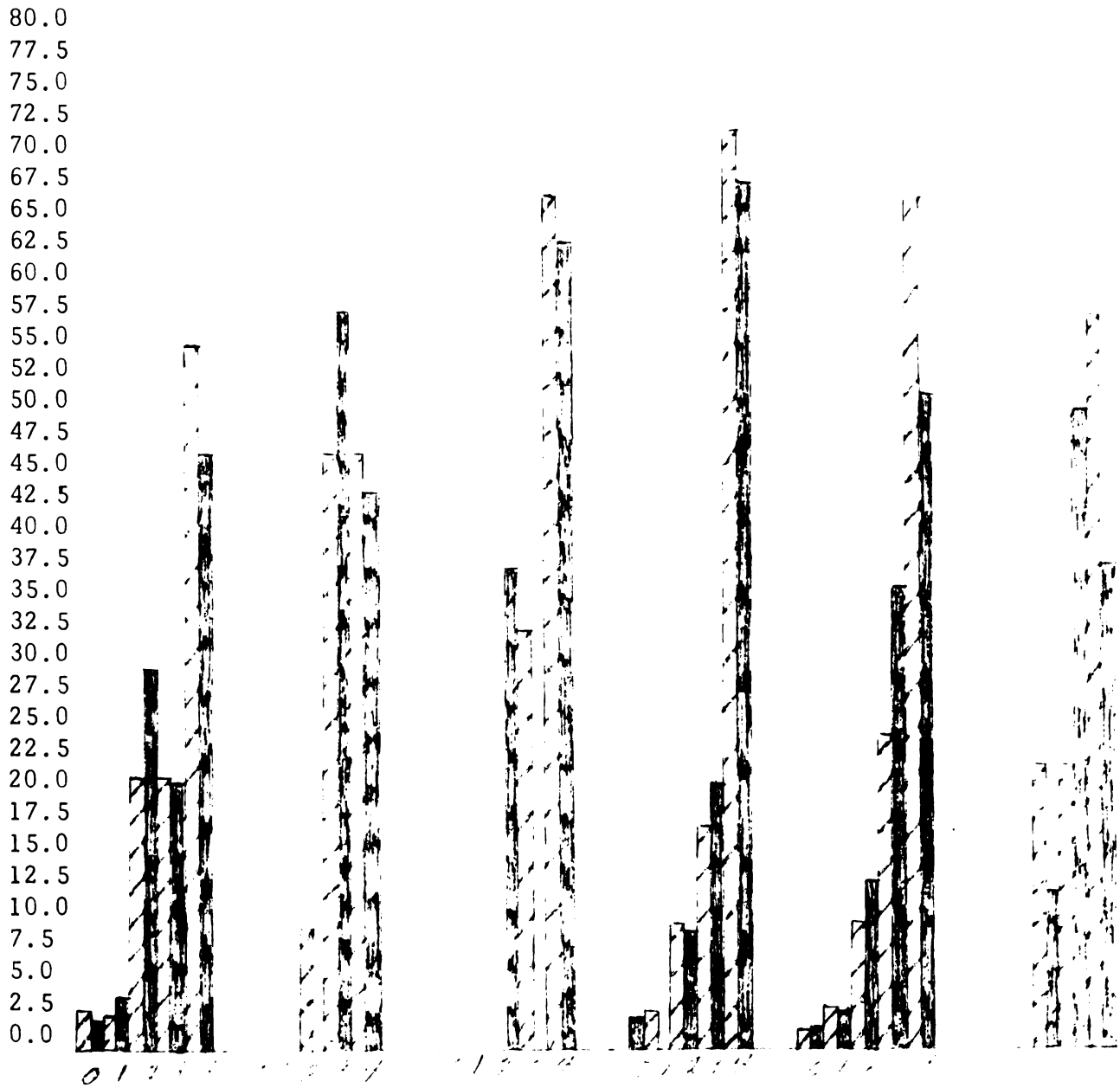
Per Cent	Practical Nurses	Directors Hospitals'	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 68 and 166, (Bedside-Technical)

RESPONDENT GROUPS

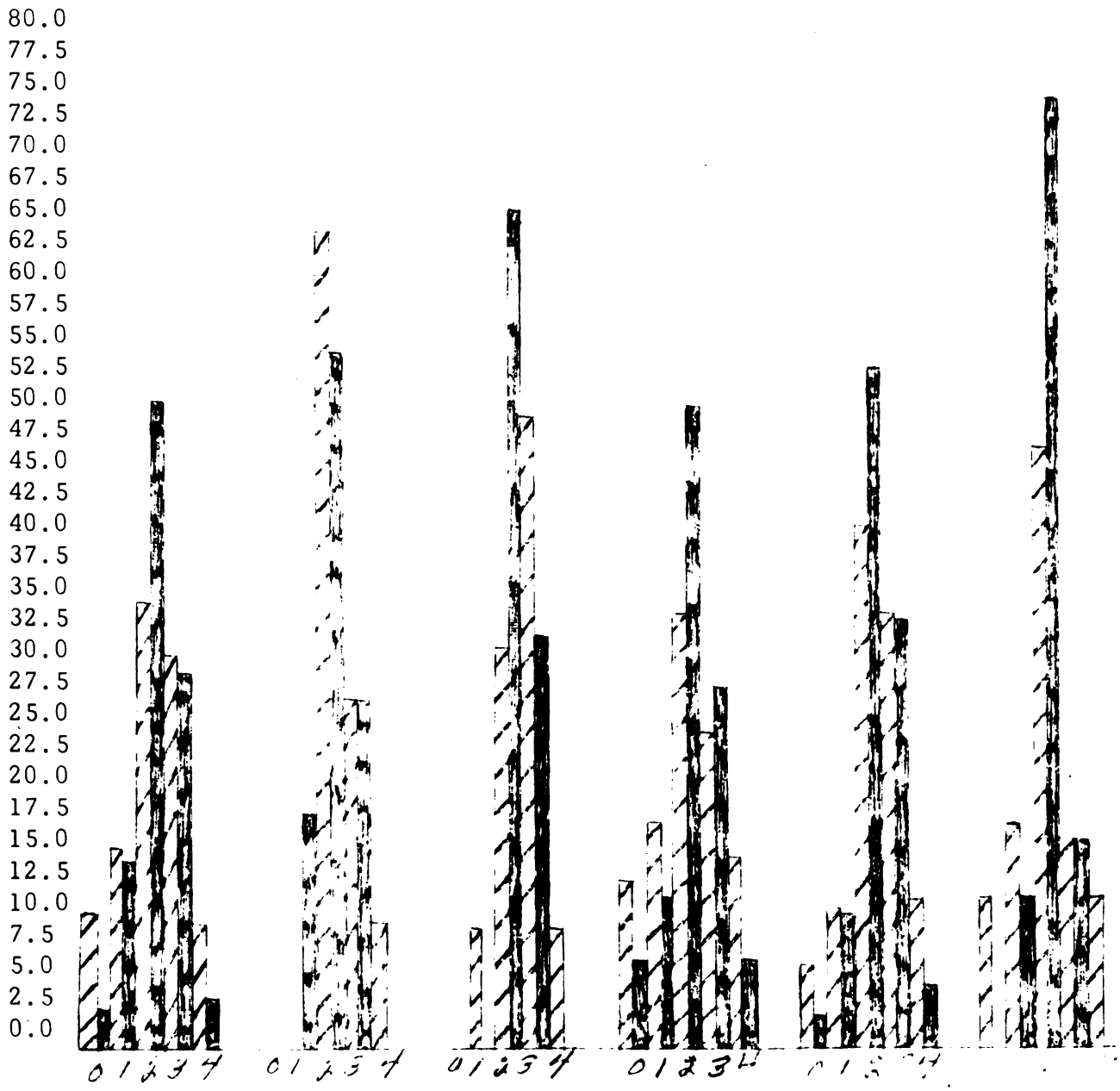
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 77 and 176. (Bedside-Technical)

RESPONDENT GROUPS

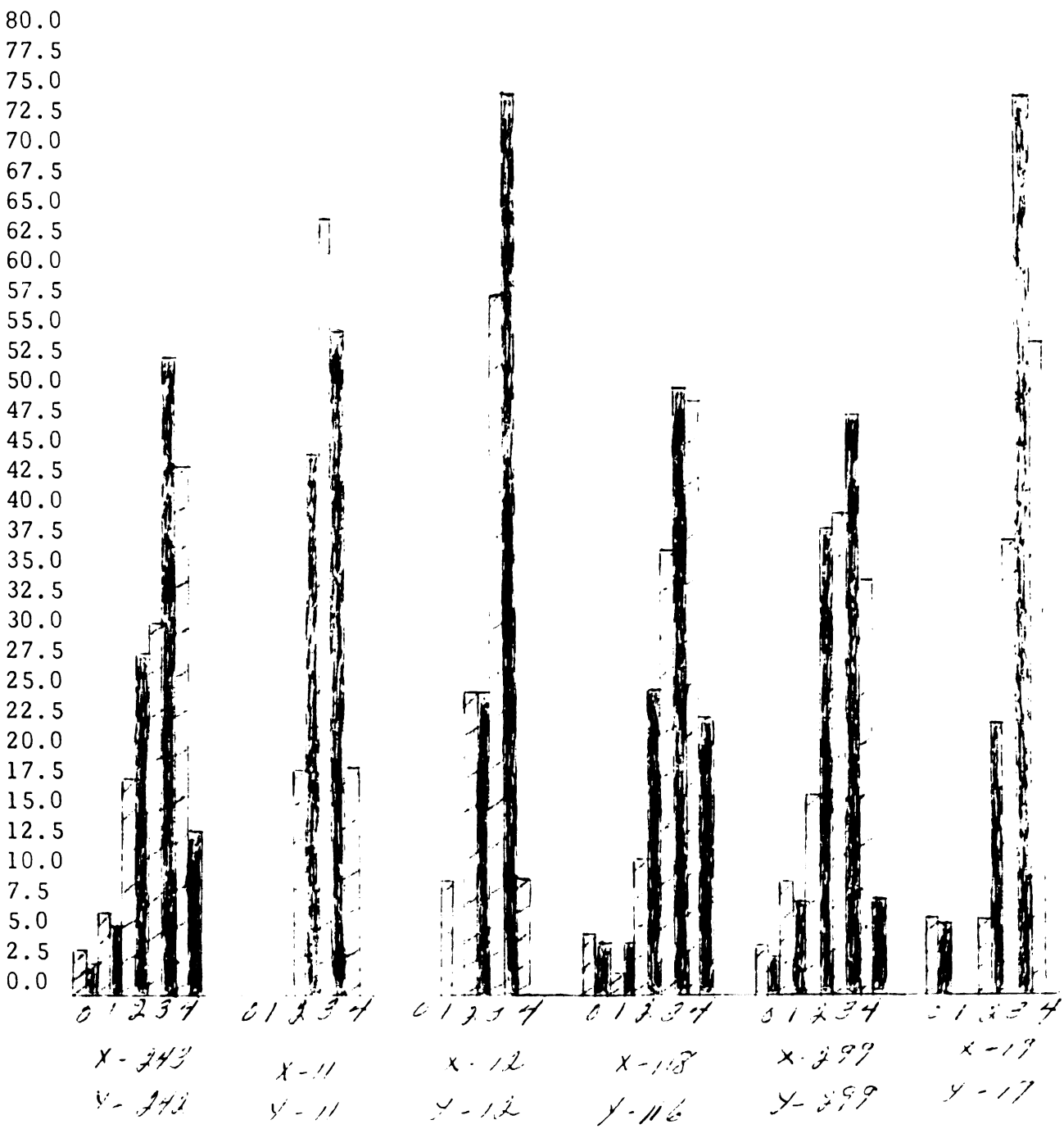
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 95 and 200. (Bedside-Technical)

RESPONDENT GROUPS

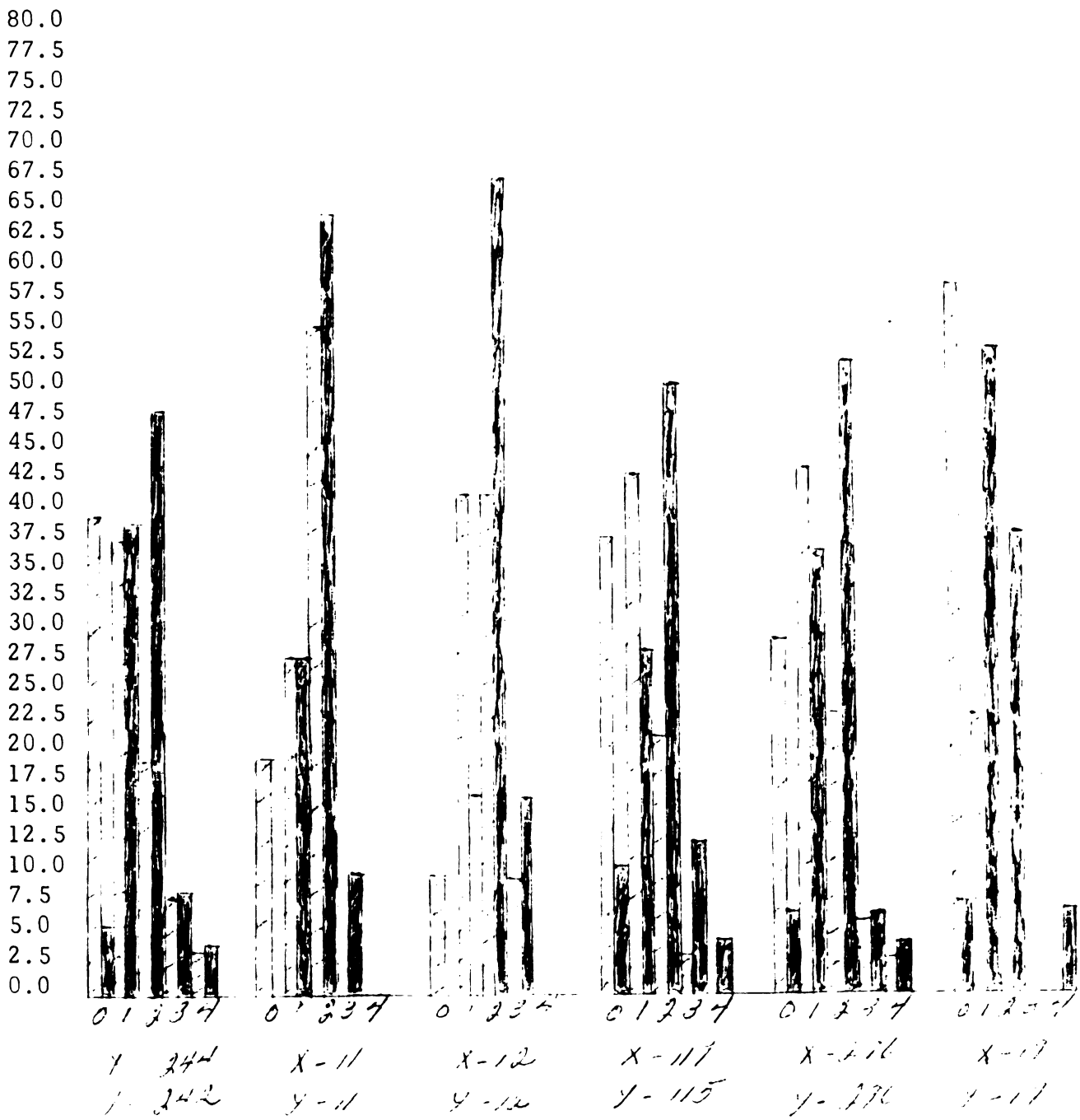
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 97 and 202. (Bedside-Technical)

RESPONDENT GROUPS

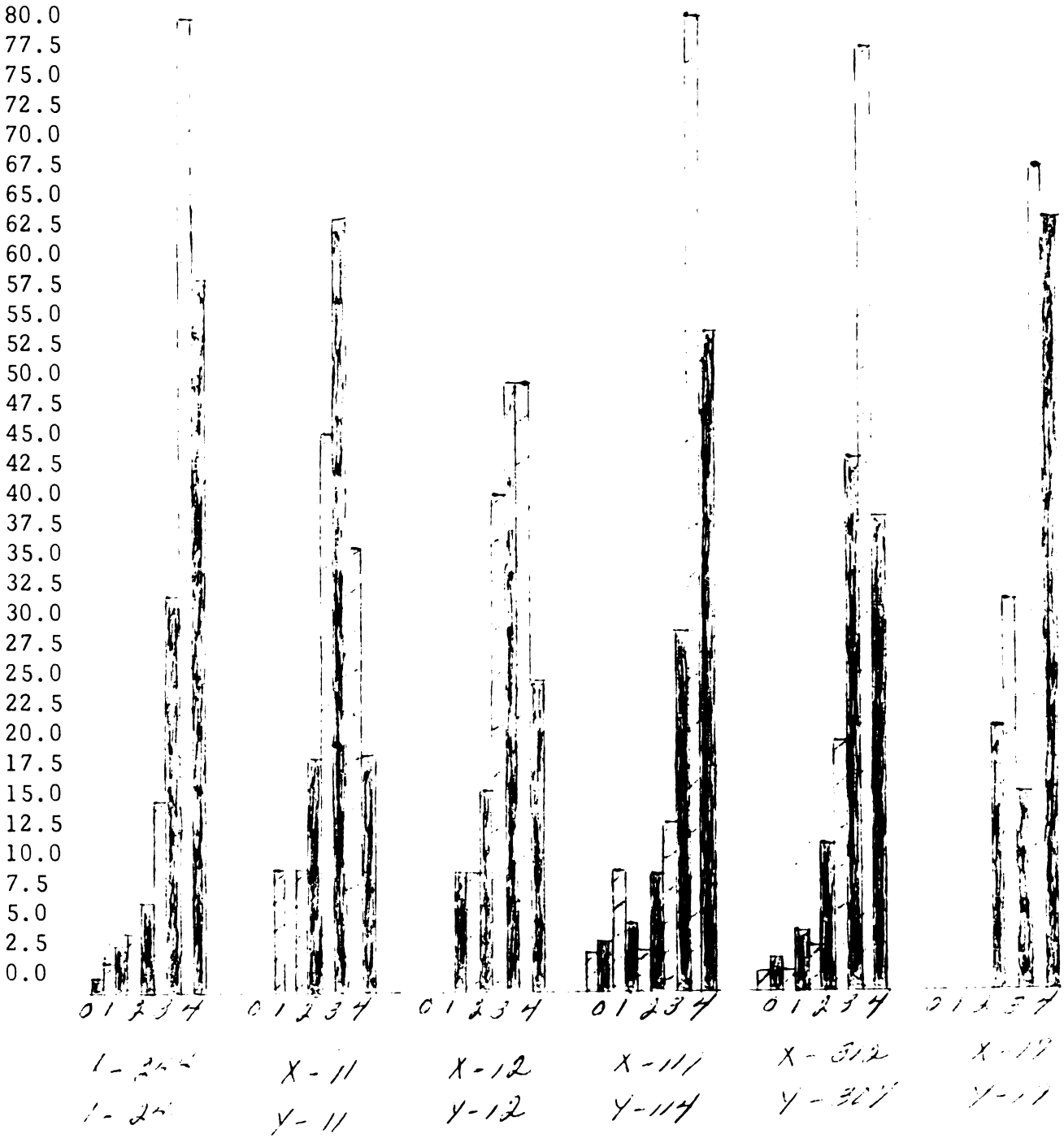
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 37 and 133. (Technical)

RESPONDENT GROUPS

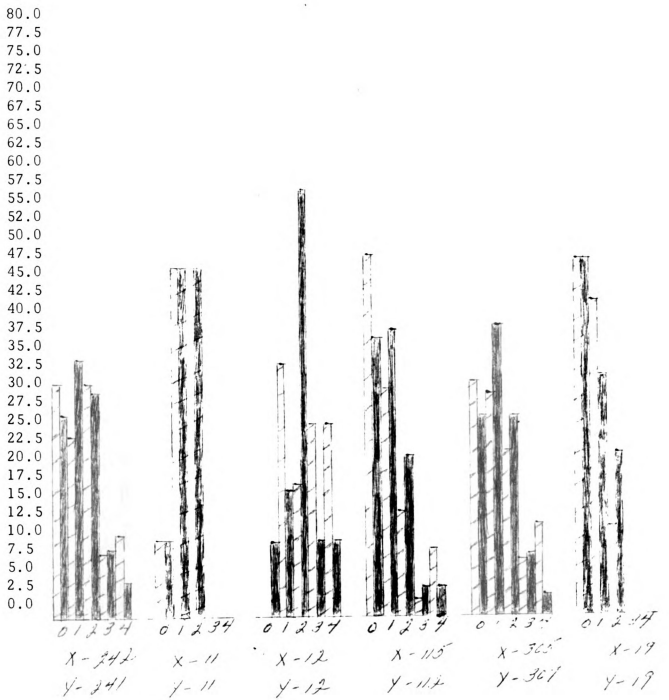
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



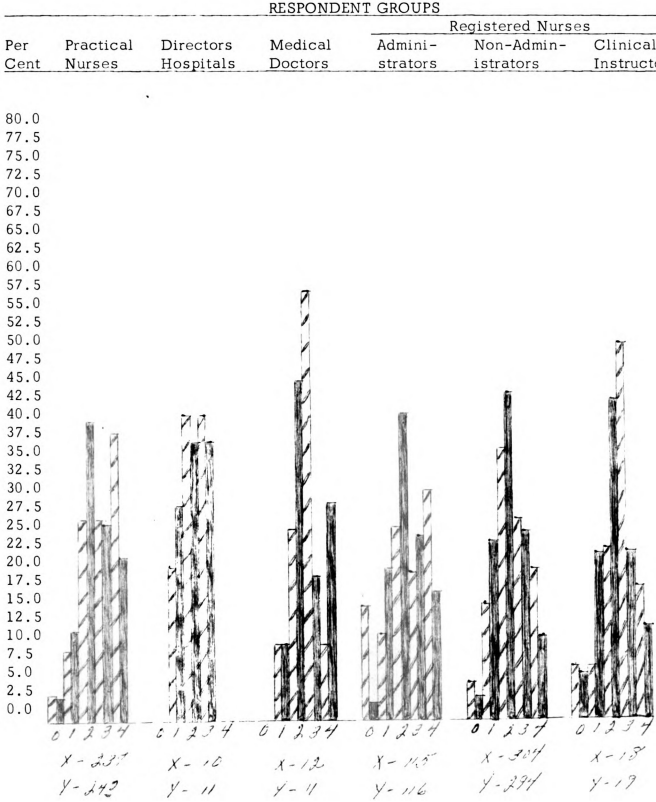
Questions Number 39 and 135. (Technical)

RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 55 and 153. (Technical)



Questions Number 56 and 154. (Technical)

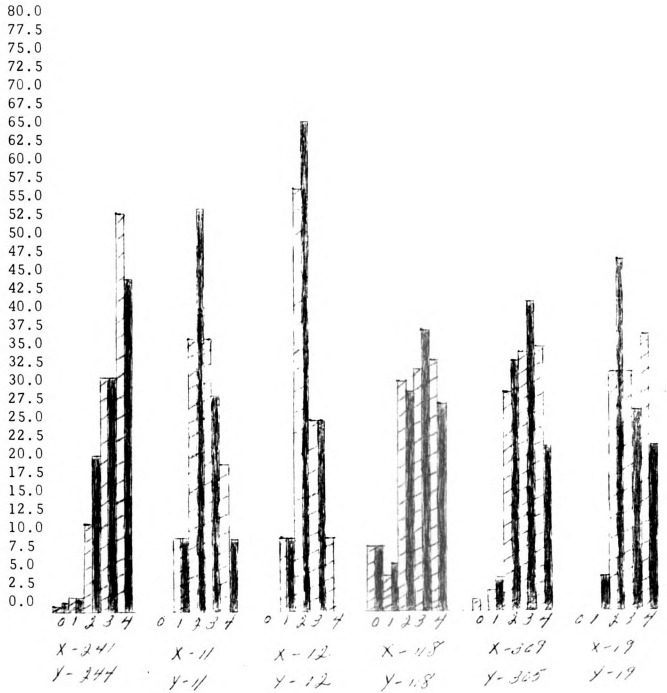
RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clincal Instructors
80.0						
77.5						
75.0						
72.5						
70.0						
67.5						
65.0						
62.5						
60.0						
57.5						
55.0						
52.5						
50.0						
47.5						
45.0						
42.5						
40.0						
37.5						
35.0						
32.5						
30.0						
27.5						
25.0						
22.5						
20.0						
17.5						
15.0						
12.5						
10.0						
7.5						
5.0						
2.5						
0.0	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	X - 2.42	X - 1.1	X - 1.2	X - 1.15	X - .809	X - 1.4
	Y - 2.44	Y - 1.1	Y - 1.2	Y - 1.15	Y - .809	Y - 1.2

Questions Number 62 and 160. (Technical)

RESPONDENT GROUPS

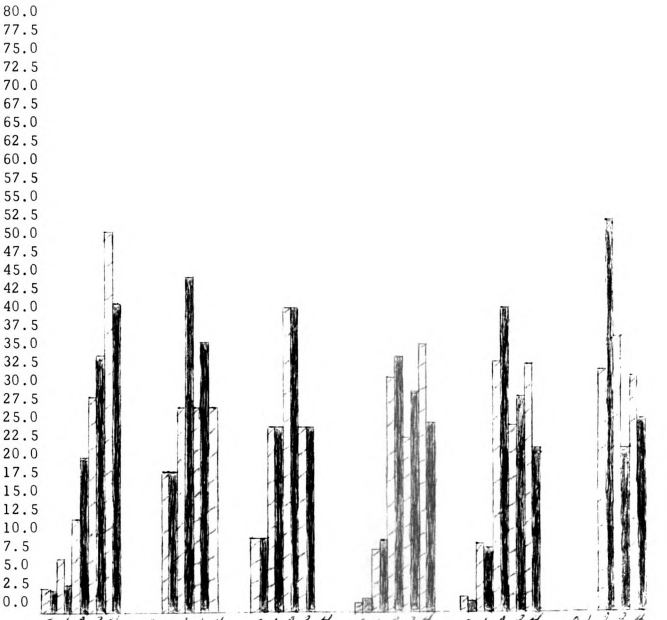
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 63 and 161. (Technical)

RESPONDENT GROUPS

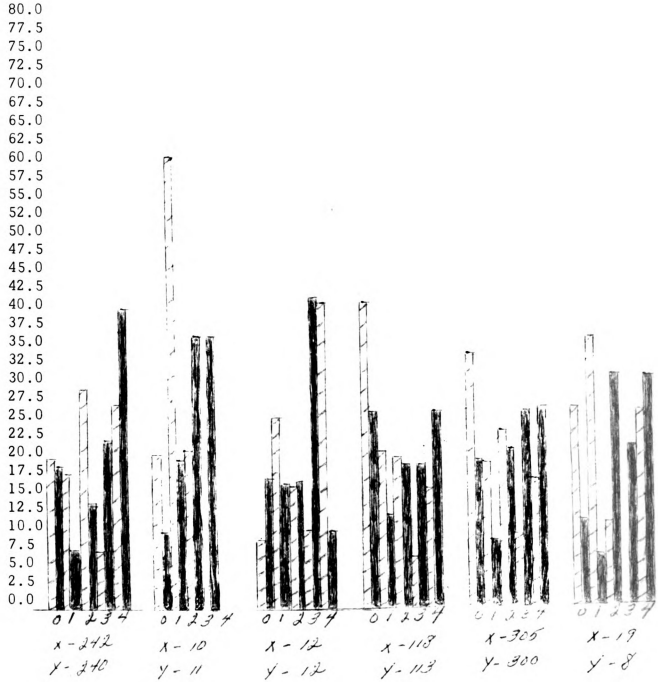
Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 86 and 186. (Medical)

RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Registered Nurses: Clinical Instructors



Questions Number 85 and 187. (Medical)

RESPONDENT GROUPS

Per Cent	Practical Nurses	Directors Hospitals	Medical Doctors	Registered Nurses: Administrators	Registered Nurses: Non-Administrators	Clinical Instructors
80.0						
77.5						
75.0						
72.5						
70.0						
67.5						
65.0						
62.5						
60.0						
57.5						
55.0						
52.5						
50.0						
47.5						
45.0						
42.5						
40.0						
37.5						
35.0						
32.5						
30.0						
27.5						
25.0						
22.5						
20.0						
17.5						
15.0						
12.5						
10.0						
7.5						
5.0						
2.5						
0.0						
	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	x - 245 y - 117	x - 10 y - 5	x - 12 y - 8	x - 116 y - 54	x - 306 y - 114	x - 19 y - 8

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