EDUCATION FOR NURSING CARE OF AIDS PATIENTS: A STUDY OF LIFELONG LEARNING AND MID-CAREER PROFESSIONAL ATTITUDES

By

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ABSTRACT

EDUCATION FOR NURSING CARE OF AIDS PATIENTS: A STUDY OF LIFELONG LEARNING AND MID-CAREER PROFESSIONAL ATTITUDES

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Health care has become extremely complex. With a world wide epidemic like AIDS and its threat to mankind, this battle knows no borders or national boundaries. As the epidemic progresses, mid-career professionals will be frequently called upon to care for People With AIDS (PWAs). Mid-career professionals must therefore become more knowledgeable about AIDS and AIDS care. One cannot expect to be fully prepared for a life-time career by an initial academic program alone. Further growth and lifelong learning are demanded in the highly dynamic environment of health care today and in the future.

In this study of AIDS and mid-career professionals, an attempt was made to provide a foundation for further discussion on attitudes towards lifelong learning, AIDS, and AIDS care by utilizing the perceptions of mid-career professionals concerning AIDS and AIDS care. Since attitudes often influence behavior, a questionnaire was developed and distributed to two hundred and fifty (250) mid-career nurses working in the Province of Ontario, Canada, to determine the personal and professional factors that were associated with attitudes towards

lifelong learning, AIDS, and AIDS care. The data provided an indication of current problems for mid-career nurses concerning their knowledge and skills about AIDS and AIDS care. The data indicated too, the perceptions of mid-career nurses about the skills and knowledge that are needed for improved nursing practice for PWAs. The results of the study indicated what the lifelong learning needs are for mid-career nurses about AIDS and AIDS care.

The identified knowledge that is needed is to change attitudes in order to decrease the fear of AIDS, to eliminate the social stigma attached to AIDS and PWAs, and to prevent the transmission of the disease from AIDS patients to others. The data showed that knowledge about AIDS and skills were needed to care for AIDS patients and could be obtained from courses offered at the worksite by a joint, co-operative effort between employers and educational institutions.

The focus of the study was "Education for Nursing Care of AIDS Patients: A Study of Lifelong Learning and Mid-Career Professionals' Attitudes." Health care organizations are currently "re-organizing" and "downsizing" in an effort to cope with decreased funding while, at the same time, trying to satisfy the needs and expectations of the clients. All of this activity has caused the health care environment to be in a state of constant change. Identification of the issues faced by mid-career professionals in their pursuit of lifelong learning about AIDS and AIDS care will provide improved nursing care for PWAs in the future.

DEDICATION

I dedicate this dissertation to all those who share the pioneering spirit of lifelong learning through all the stages of life.

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Special recognition goes to my dissertation committee, Dr. Howard Hickey, Dr. Jim Snoddy, and Dr. John Dyrkx. Also special thanks goes to Jo Colby for her superb administrative assistance.

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My sincere thanks also goes to my husband Hans Skornschek and to my parents Florence and Bruce Patton.

Finally, thanks also goes to all my friends and colleagues who helped me to achieve a lifelong goal.

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CHAPTER 1

INTRODUCTION

AIDS AND HEALTH CARE

The focus of this study is EDUCATION FOR NURSING CARE OF AIDS PATIENTS: A STUDY OF LIFELONG LEARNING AND MID-CAREER PROFESSIONAL ATTITUDES. Since we can no longer deny that Acquired Immune Deficiency Syndrome (AIDS) is a life-threatening illness that will involve millions of people, it is our choice to grow and learn from it, to either help those people with this dread disease using current knowledge and skills, or abandon them.

No single virus in history has provoked such concentrated scientific attention as the AIDS virus. Medical experts agree that no human illness or other infectious disease has ever been as complex as AIDS. The complexity is that it is not just one illness but a web of diverse infections and symptoms.

> *"Not even the devil could have designed a virus as fiendish as HIV/AIDS . Clear it out of the bloodstream and it hides in the lymph nodes. Bannish it from the lymph nodes and it lurks in the brain. And even if it could be eradicated from the brain, it can still be found cradled among the chromosomes of a few quiescent immune cells, ready to pounce again when the hunters have gone away."*
>
> Wulf, 1996

The AIDS epidemic, both nationwide and worldwide, has called attention to the scope of problems related to Human Immunodeficiency Virus (HIV) infection. Complicating the already devastating physiological aspects of AIDS is society's reaction to the life-styles of vulnerable populations and peoples' fear of this deadly disease. AIDS has been labelled the public health problem of the century. There is no cure in sight. Central to all of this is the nursing profession which is being increasingly called upon to provide direct patient care, family and community counseling, AIDS education and preventative strategies (Larson and Ropka, 1991).

Officials at the Centre for Disease Control and Prevention (CDC) in Atlanta, Georgia, as of June 1996, estimated that 946,170 Americans had AIDS and that at least one million more Americans are infected with human immunodeficiency virus (HIV), the virus that causes AIDS. In the United States of America in 1996, the medical costs of AIDS and AIDS care alone was 23.4 billion dollars! Costs vary greatly and are dependent on a variety of factors, including geographical location; the lifetime medical costs for each individual person with AIDS in 1996 was estimated to be $225,000 and rising rapidly. Successful treatment for some opportunistic infections associated with AIDS has prolonged the lifespan of People with AIDS (PWAs).

The hidden faces of the AIDS epidemic are women and children. Although the majority of the population with AIDS are men, women and children have also been infected, with the numbers rapidly increasing. Women constitute the

fastest growing group of people with AIDS. The gender difference in incidence of newly infected individuals is expected to disappear soon (Jemmott and Jemmott, 1991). Women with AIDS tend to be younger than men with AIDS indicating that many were infected as adolescents (Bradley-Springer, 1994). Until recently, symptoms typical of HIV infection in women were not included in diagnostic criteria for AIDS that were established by the Centers for Disease Control and Prevention. These omissions led to failures in diagnosis and treatment of HIV infection in women. Over 70% of HIV infected women are persons of color, according to the CDC. They tend to be poor and over 50% have contracted the disease through a personal history of injected drug use or having had sexual relations with drug users. About 30% of infected women who are pregnant transmit HIV to their infants (Bradley-Springer, 1994). In the future, it will become the number one concern of adolescents and teenagers. Given current trends, it is estimated that by the year 2000 over 80,000 American children, ages seventeen and younger, will be left motherless because of AIDS.

In Canada, natives are dying twice as fast as non-natives and live an average of only three years after being diagnosed HIV positive, which is half the survival rate of patients from the general population (Sanderson, 1996).

The epidemic of AIDS means a crisis for health care and nursing. From 1993 to 1994, AIDS increased 9.1% in rural areas and 3.1% in urban areas in the United States. In rural areas a threefold increase in AIDS has occurred as compared to urban areas. This creates more problems due to the lack of

information, geographical and financial barriers to health care, a shortage of nurses, technological deficits, conservative values, and lack of anonymity (Preston and Romeo, 1994).

An estimated twenty-two (22) million people are infected with HIV/AIDS worldwide and most live outside the industrialized countries (CDC, 1996). Many of them cannot afford basic health care let alone high-tech treatments, and most are infected with a different subtype of HIV than those most commonly studied in the United States, Europe, and Canada. The Centre for Disease Control (CDC), 1996, reports that every eleven (11) minutes someone in the United States dies of AIDS.

AIDS and Nursing

Since 1981 when the first AIDS cases were diagnosed in the United States, considerable changes in knowledge and behavior have occurred in the general population. By mid-1987 nearly every adult had heard of AIDS and only a few were unaware of the major means of transmission. The changes in knowledge have been attributed to the mass media, primarily television. Despite widespread awareness however, misconceptions about transmission have occurred in the general population as well as in the nursing profession. Studies of nurses were of two types: (1) surveys of hospital workers which included nurses, physicians, and technicians and (2) surveys of nurses exclusively.

Findings of these studies done on nursing groups in hospitals in the U.S.A. using mass surveys, including knowledge of HIV infection and AIDS, found that most nurses had a working knowledge of HIV/AIDS. In spite of this, gaps were also identified. It was found that many nurses had trouble identifying "at risk" groups, knowing the correct means of transmission, distinguishing the symptoms of AIDS, and being aware of and using infection control procedures. Since the main source of information about AIDS was often through the mass media, fear of AIDS transmission persisted despite the use of the recommended Universal Precautions, and many nurses reported spending less time with people suffering from HIV/AIDS than other patients. Some nurses refused to care for PWAs and felt that they should have the choice to do so, while others stated that they would question their career intentions if faced with an increased workload of PWAs (Swanson et al, 1990).

In order to respond to the challenge of the AIDS epidemic, nurses, the largest body of health care professionals, must have current and accurate information about HIV infection and AIDS to make appropriate intervention possible. Nurses' needs for knowledge are very great, not only because they care for HIV-infected people and PWAs in a wide range of settings, but also because nurses are involved in AIDS education and prevention which are the only measures currently effective against the disease. Nurses need information about transmission of HIV, precautions for preventing transmission, and the related psychosocial, ethical, and legal issues and concerns. All nurses, regardless of

their location or professional background, need to be prepared to deal with AIDS either through direct patient care or educational channels.

Nurses also need to be able to recognize the uniqueness of each person's experience with grief and loss. Although grief is a universal human experience, each person ascribes her/his own meaning to a loss. Education of nurses concerning bereavement must recognize the dynamic process involved in grieving.

The situation of nurses in AIDS care is unique in several respects. As the largest group of health care providers, nurses usually have more contact with persons living with HIV/AIDS. Much of the care given by nurses involves physical contact, some of which exposes them to blood and bodily fluids. Nurses can often experience fatigue and burnout, not only because of the heavy care demands, but also because of the frequent need to work with patients who are often young and dying. Nurses frequently face situations where counselling is urgently needed but time is lacking. Coupled with improved crisis care for PWAs has come increased patient admissions to critical care units where nurses are heavily involved in aggressive invasive therapies and resuscitation procedures necessary to restore these patients to optimal functioning. Since HIV infection is a chronic condition, health promotion interventions are needed to encourage a pattern of living that enables a patient to enjoy the fullest physical and psychosocial capacity with due allowance for disabilities. Healthier lifestyles can only be encouraged by knowledgeable nurses. Nurses can

function more as patient managers than technical deliverers of treatment protocols. Nurses' efforts to help PWAs develop consistency in their management strategies may encourage them to be cared for at home. This is becoming more important as AIDS becomes a chronic condition. Nurses are in a unique position to provide education concerning unsafe behaviors and lifestyles, holistic care approaches, information concerning counseling services, and the co-ordination of all services needed by these individuals. They are also in a perfect position to conduct and disseminate research information, and provide advocacy leadership for HIV/AIDS patients through professional and political action. By taking an active role in community organizations and speaking out against discrimination towards PWAs, nurses can help to decrease public stigma against AIDS and advocate for improved public health policies and education programs.

The rapid growth of the AIDS epidemic and the continuing changes of the health care system demand that mid-career nurses take an active role in lifelong learning in order to keep their knowledge about AIDS and AIDS care current and accurate. Learning opportunities must be made available to mid-career nurses on an ongoing basis and need to include psychosocial support and education for positive attitude development towards AIDS and AIDS care.

The fear of contagion has been characterized by four types of behavior. These behaviors are avoidance, attempting extreme precautions, lack of regard for PWAs, and verbal expressions about their fear of AIDS (Meisenhelder,

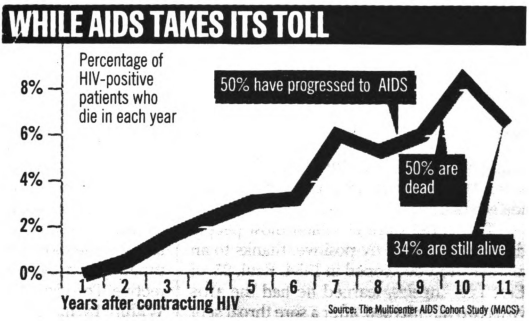
1993). The benefits of lifelong learning for mid-career nurses are numerous. Current, accurate knowledge about AIDS and PWAs will decrease the fear of contacting AIDS, decrease the social stigma attached to AIDS, create more positive attitudes towards AIDS and PWAs, increase willingness to care for PWAs, provide more humanistic nursing care to PWAs, increase consistency in practising Universal Precautions and decrease negative fears and behaviors. Other positive outcomes will be decreased discomfort concerning sexual preferences, different lifestyles, and substance abuse. There should also be less concern about putting family and friends at risk, a reduction in the intense emotional demands of caring for young, dying patients, and an increase in using appropriate coping mechanisms when caring for PWAs generally. Lastly, job stress should be reduced, working conditions improved, and a more positive working environment created. As co-learners, mid-career nurses will be able to build upon each other's strengths and share knowledge and learning experiences. These experiences will help to deepen the understanding and insight into AIDS and AIDS care. Lifelong learning activities will assist mid-career nurses to identify those at risk for AIDS, provide educational programs in their communities, and become advocates for PWAs in the political arena.

> *"AIDS is not simply a disease of high-risk groups. It is a human disease. We are all potentially at risk. No epidemic in history remains confined to one group alone. After all, biologically we are all the same."*
>
> D. Suzuki, 1990

TABLE 1.1.0

AIDS EPIDEMIC STATISTICS

FEBRUARY 1996



CDC, February 1996

History of the AIDS Virus

Until AIDS was discovered, infectious diseases seemed a thing of the past. Viruses are the oldest microbe known to man. They are very patient and can wait years to find a host such as man, animal or plant in order to grow and multiply. Once the virus enters the host, we are always the losers. Viruses have caused plagues such as the Black Plague; epidemics of smallpox and polio; flu, colds, and AIDS just to name a few. Viruses have adapted well to such changes in the environment as over-population.

New viruses are continuing to emerge from the rapid destruction of the rain forests. Mosquitoes from these rain forests have produced forty (40) newly diagnosed viral strains in the United States (CDC, 1996). AIDS continues to shape the history of this century. In Africa, AIDS has always been considered a heterosexual disease. An interesting twist regarding the AIDS virus is that in Kenya there are women who are HIV postive but have never developed full-blown AIDS. There seems to be no logic to the progression of this disease.

In the future, viruses may help to cure genetic diseases such as cystic fibrosis by introducing new genes. As soon as one virus is understood and becomes treatable another one emerges to continue the battle. AIDS, unfortunately, is a very complex virus.

Description of HIV/AIDS Virus

In battling the AIDS virus, the body and virus engage in mortal combat from the beginning. The main battleground is in the hard-to-reach lymph nodes. Scientists have known from the beginning that AIDS is a disease of the immune system, invading and destroying the white blood cells that fight infection. Recently, it has become known that the disease progresses in three distinct and very different stages. The first stage is over so quickly that it can easily be missed. Within days after the virus has penetrated the body, flu-like symptoms occur which last only a few days. The time period between the first stage and the second stage varies considerably. The second stage is the longest. The virus is now trapped in the lymph nodes which become swollen. Other on-going physical symptoms may also appear. This is the stage when most people discover that they are HIV positive due to the antibody test developed in 1984. The third stage of infection is when the T-cells, which comprise part of the white blood infection-fighting cells, drop from an average of 1,000 cells per millimeter of blood to fewer than 500 cells per millimeter. Opportunistic infections such as pneumocystic pneumonia and Kaposi's sarcoma develop (Gorman, 1996).

LIFELONG LEARNING AND THE ROLE OF MID-CAREER PROFESSIONALS IN THE AIDS EPIDEMIC

Why is there a concern/interest regarding the need for lifelong learning for mid-career professionals? For any mid-career professionals working in today's health care system, the environment is very dynamic and the need for currency of knowledge is being demanded. Even without the changes in the health care environment, it can be seen that there are requirements for the development of mid-career nurses. Lifelong learning could be the way to maintain currency.

Lifelong learning can be defined as a process that allows individuals to share ideas, information, and experiences as well as a process by which an individual participates in lifelong learning activities to prepare for current and future changes in practices. Lifelong learning is education beyond the initial preparation that is relevant to the type of patient care delivered in an institution or organization and that provides current knowledge relevant to the individual's field of practice.

The purpose of lifelong learning is to build upon one's educational base for enhancement of knowledge and skills and to decrease the barriers to AIDS by:

- Decreasing the fear of AIDS
- Decreasing the social stigma of AIDS
- Improving nursing practice for PWAs

Three factors are characteristic of present day society that affect what adults want to learn. First, dramatic changes are occurring in the demographic base of our society. Our population as a whole is better educated than ever before and there is more cultural and ethnic diversity. The second and third factors shaping the learning enterprise are economics and technology. The effect of the global economy and technological advances on the nature of adult learning is staggering. Adults are now finding that they must continue to learn well past formal schooling in order to function at work, in the community, and in society. What one wants to learn, what is offered, and the ways in which one learns are determined to a large extent by the nature of the society at any particular point in time. Changing demographics is a social reality shaping the provision of learning in contemporary society.

Technology and the information age are changing the nature of adult learning. Understanding who adults are as learners, why they participate or do not participate in learning, what changes they undergo as they age and how those changes interface with lifelong learning are important considerations in facilitating meaningful learning experiences.

What can/should be done to facilitate opportunities for lifelong learning activities about AIDS for mid-career nurses which are consistent with the needs of the individual, the organizations, institutions, and communities in a changing health care system? It is hoped that this question will be answered in the pursuit of the five areas of interest as outlined in the research questions which can be

found later in this chapter. The full survey instrument is presented in Appendix B.

As long as more than half of the adult population fail to participate in lifelong learning activities, questions about barriers to participation are of legitimate concern. Researchers have identified a number of social and psychological barriers to participation related to a lack of self-confidence, including a fear of failure, a fear of school, and a fear of change. There are good reasons why nurses resist change. Many are richly enmeshed in a fabric of relationships which hold them as they are and many of their peers, friends and relatives do not wish them to change. Change demands a complex kind of renegotiation of relationships with others. Sometimes it is simpler to stay right where they are. The price of change may be too high (Daloz, 1988). Studies have indicated that nurses with negative attitudes about AIDS were more anxious about caring for PWAs; or else they refused outright to care for PWAs. By taking an active role in lifelong learning, mid-career nurses can decrease their fear and stress in caring for PWAs and can gain a better understanding of PWAs and ultimately improve quality of care with a more holistic approach. Failure to combine the elements of knowledge and opportunity for attitudinal examination and modification of behavior may result in a mid-career nurse who, though knowledgeable, is immobilized by personal feelings and is poorly prepared to deliver quality care. The challenge of working with People With AIDS is to provide quality care. As the largest group of health care providers, nurses

usually have more contact with people who are living with HIV/AIDS than any other group of health care workers. Virtually all PWAs at some point in time will be cared for by nurses. Therefore, mid-career nurses need to pursue lifelong learning about AIDS and the AIDS epidemic which is critical for nursing practice in the future.

SIGNIFICANCE OF MID-CAREER PROFESSIONAL ATTITUDES AND AIDS

The purpose of this study is to explore the significance of attitudes of mid-career professionals towards lifelong learning, AIDS and AIDS care. This study will seek to contribute both theorectically and practically to the study of attitudes of mid-career professionals.

What is Attitude? Attitude, as defined by Webster's Collegiate Dictionary, is a "mental position with regard to a fact or a state; feeling or emotion toward a fact or state; a position assumed for a specific purpose." Attitude can be a behavior toward a person, group, thing, or situation representative of conscious or unconscious mental views developed through cumulative experience (Preston, 1994). Attitude is a composite variable that has both cognitive and affective components. Cognitive components are composed of opinions and judgements while affective components are made up of feelings. Attitude is a mental position with regard to a fact or state; a composite variable that has both cognitive and affective components (Schuman and Johnson, 1981). An attitude is usually thought of as having three components (1) an affective component which consists of the individual's feelings about the object (2) a cognitive component which is the individual's beliefs or knowledge about the object (3) a behavioral component which is the individual's predisposition to act toward the object in a particular way.

An attitude always has a focus; it may be a person, a group, or a nation. When the focus is known to many, the corresponding attitude can be used for

the comparative characterization of many persons. The dimension of characterization extends from positive (or favorable) through neutrality to negative (or unfavorable). Persons are thought of as occupying positions on this dimension corresponding to their disposition to behave favorably or unfavorably toward the focus. Behavior predicted but not yet produced is expected to appear when relevant circumstances arise. There is an assumption to exist in a person, a disposition to it or readiness for it. The disposition is the attitude. Attitudes are not directly available to the senses, but the discovery in others must be an inference from their behavior. The right answers are sometimes hard to find especially when the individual's reports of her/his own attitudes are misleading.

An individual's real goals in her/his work and real attitudes towards members of her/his family, another person or group are not necessarily known to her/him. Jung distinguishes two major attitudes or orientations of personality; the attitude of "extraversion" and the attitude of "introversion". The extraverted attitude orients the person toward the external, objective world while the introverted attitude orients the person toward the inner, subjective world. These two opposing attitudes are both present in the personality but, ordinarily, one of them is dominant and conscious while the other is subordinate and unconscious. If the ego is predominately extraverted in its relation to the world, the personal unconscious will be introverted. Changing attitudes refers to the learning necessary for the solution of personal, social, and economic problems of living encountered by individuals, groups, and communities. Positive attitude refers to the positive state of mind of an individual towards a value and can include a

specific emotional or non-emotional disposition such as tolerance, radicalism, or scepticism. It also implies a positive mental position with regard to a fact or a state of mind and includes a tendency to respond, in a positive way, towards certain persons, objects, or situations.

Data from studies show a high percentage of nurses who indicated not only a reluctance to care for PWAs but unwillingness to verbally interact, socially interact, co-work, touch, or maintain friendships with PWAs. Thus the manifestations of fear occur not only in potential risk situations, but also in risk-free situations such as verbal interaction or hand-shaking. These studies suggest ways of decreasing extreme fear through effective and continuing educational programs for nurses (Meisenhelder, 1993). Results from several studies on nurses' attitudes about AIDs have shown that nurses with negative attitudes were more fearful about catching the disease. Additional research has shown that nurses' fear of AIDS has resulted in lack of regard for PWAs, inferior care due to avoidance of carrying out procedures, or attempting extreme precautions. A study by Preston and Romeo (1994) found negative attitudes towards AIDS were related to nurses' lower educational levels and religious beliefs and values. Some areas of human attitudes appear largely to be influenced and shaped by cultural knowledge. Although hidden from view, it is constantly used to generate attitudes and interpret experience. Education, professional experience, personal history, beliefs, values, and religion contribute to the way people in any given society react or behave. Sample and Warland

(1973) state that attitudes, experiences and values have been shaped by the society in which we live and work, as well as by the professional tenets that guide our practice.

Attitude and behavior are highly correlated when treated as multi-item dimensions. There is considerable evidence that human beings are greatly influenced, especially in situations of uncertainty, by the behavior of others and often these "others" are barely known to them. If we discriminate against those with AIDS, we will end up lacking sufficient funds for research and medical treatment when the caseload continues to swell. Not only do people with AIDS have to go through the "stages of dying," they are also faced with issues the world has never had to deal with to this extent, in such massive numbers, and from every direction. AIDS has become our largest sociopolitical issue, a dividing line of religious groups, a battleground for ambitious medical researchers, and a demonstration of man's inhumanity to man.

Determining the relationship of mid-career professionals' attitudes about AIDS and PWAs to the delivery of humanistic nursing care is of paramount importance.

SIGNIFICANCE OF THE STUDY

It is hoped that the information gathered from this group of mid-career professionals about attitudes toward lifelong learning, AIDS and AIDS care will contribute to the body of knowledge concerning their need for and commitment to lifelong learning. Important too, are the questions that will be raised for further research of a theoretical and practical nature. Future research may include a replication of this study with a larger sample and with a focus on speciality areas of health care. In many studies of attitudes, both positive and negative; accepting and rejecting attitudes are identified. The tendency towards discrimination such as quarantine and use of universial precautions for those who are HIV/AIDS positive, may induce HIV/AIDS patients to conceal their condition to avoid social rejection and isolation. The social shame associated with revealing one's diagnosis and being rejected by society thus may cause the epidemic to prevail.

Specific organizations with an interest in the results of the findings will be health care organizations, institutions of nursing education, the Registered Nurses Association of Ontario, the Canadian Nurses Association and the Ministry of Health of Ontario.

The topic of this study has not been extensively researched in Ontario, hence, additional data sources will be less well developed and the research report from this study will make a significant contribution to the related literature

and to those involved in nursing education. Studies of this type cannot be based on "hard" data alone. Attention was paid to the qualitative information which was added to the survey responses by individuals. An effort was made to combine the information gained from these sources with quantitative data to develop the most complete understanding of issues. Data collected from the survey questionnaires was analyzed in terms of the study questions and reported in summary data and narrative information formats.

Research Questions

The research questions which this study addressed were:

1. What knowledge do mid-career nurses have about AIDS and AIDS care?
2. What education and experience do mid-career nurses have about AIDS and AIDS care?
3. What attitudes and opinions are shared by mid-career nurses about the barriers hampering their pursuit of lifelong learning about AIDS and AIDS care?
4. What are the perceived benefits for mid-career nurses in pursuing lifelong learning about AIDS and AIDS care? What are the potential consequences for nursing practice for PWAs?

ASSUMPTIONS

It is assumed that a common form of reference exists for terms and concepts used. It is further assumed that mid-career nurses would provide the time necessary to state their opinions in an honest manner. Another assumption is that many mid-career nurses and institutions, would be interested in the findings. Lastly, is the assumption that mid-career nurses perceive lifelong learning as enhancing their personal and professional knowledge and nursing skills.

The individuals surveyed are mid-career nurses who graduated between 1960-1980 prior to the AIDS epidemic, and who are practicing nursing in Ontario and members of the Registered Nurses Association of Ontario. It is assumed that colleges and universities will be interested in the attitudes towards lifelong learning and knowledge about AIDS and AIDS care of this professional group. This information could also be used to improve the basic nursing education programs as well as the continuing education programs for all nurses in Ontario.

LIMITATIONS

The current economic climate may influence some of the responses and should be taken into consideration when interpreting the data. Budget constraints might have had an effect on institutions providing for continuing education programs and activities for mid-career professionals.

There is always a concern for "interpretation" of certain terms and it could be different for individuals based on many factors. Two possible limitations of this study are low response rate (50% or less) which may mean a biased sample with reduced power; and/or self-reported behavior and opinions may not represent their actual attitudes, opinions and behavior.

The collection of information was dependent on the willingness of individuals to complete the questionnaire. There is no way of knowing if the task had been assigned to someone else. The questionnaire was designed to be self-administered, hence, its validity could be affected by the clarity of the questions and the honesty of the respondents. The biases of the investigator may have influenced the construction of the questionnaire and the interpretation of the qualitative findings. Assessment by other individuals was sought so as to eliminate or, at least, decrease any biases.

The findings of this study can only be generalized to mid-career nurses in Ontario who are members of the Registered Nurses Association of Ontario and who, at the time of the survey, were working in hospitals, colleges, universities

and communities. Not every mid-career nurse in Ontario was polled for her/his opinions, views and comments on AIDS and PWAs and lifelong learning. Mid-career nurses who work in the hospitals and communities of the larger university cities in Ontario may well have different opinions and knowledge about AIDS and PWAs and needs for lifelong learning than their counterparts in different work environments and locations.

DEFINITION OF TERMS

The following terms are defined in the context in which they are used in this study:

AFFECTIVE - refers to a person's feelings and emotions

AIDS - Acquired Immune Deficiency Syndrome - refers to the state of the body at which time life-threatening diseases such as pneumonia or cancer have manifested themselves or are difficult to overcome

ATTITUDE - is a mental position with regard to a fact or state; a composite variable that has both cognitive and affective components

BARRIER - an obstacle or circumstance that keeps people or things apart by barring access or advance

BEHAVIOR - the way a person behaves or acts, their conduct or manners

CDC - Centre for Disease Control and Prevention in Atlanta, Georgia

COGNITIVE - components are composed of opinions and judgements

CONATIVE - to undertake or attempt; expressing endeavor or effort

CONTAGION - the spreading of disease from one individual to another

CONTINUING EDUCATION - is typically viewed in terms of formal programs centered around particular topics and targeted at particular audiences; it is the process by which an individual participates in professional development activities to prepare for current and future changes in practice

EDUCATION - systematic and sustained learning activities for the purpose of bringing about changes in knowledge, attitudes, values, and skills

EPIDEMIC - an outbreak of disease that occurs suddenly, spreads rapidly to a large population, and continues to develop for a period of time

FEELINGS - are responses that are considered to be positive, neutral or negative

HUMAN IMMUNODEFICIENCY VIRUS (HIV) - a virus that weakens the immune system (the body's defense against infection) resulting in life-threatening illnesses such as AIDS being able to overwhelm these defenses. HIV is transmitted only by blood and body fluids. This contact can be via the blood through sharing contaminated needles, via semen through direct sexual contact, or via the placenta of a pregnant woman to her fetus

HOMOPHOBIA - abnormal fear of homosexuals

JUDGEMENT - is an evaluation an individual places on an object or situation as to whether or not it is good or bad, right or wrong

LYMPH NODES - are rounded masses of lymphatic tissue found in a number of areas of the body which act as part of the body's defense system protecting it from bacteria and viruses

MANDATORY - an official command or instruction, compulsory

MENTORING - a trusting relationship between an experienced and a novice employee for the purpose of providing exemplary support, direction, insight, guidance, and advice to the latter with regard to the complexity of their roles

MID-CAREER NURSES - all those registered nurses who graduated between 1960 and 1980 prior to the AIDS epidemic, and who are working in the health care system in Ontario including educational institutions and who are members of the Registered Nurses Association of Ontario

NATIVES (NATIVE CANADIAN TRIBES) - a person born in a certain place or country; natural origin is in a particular region; a person belongs to a locality or country by birth

OPINION - is an idea that an individual holds to be true and is often shared by her/his social group

PWAs - People With AIDS

PWAs - People With AIDS

UNIVERSAL PRECAUTIONS - steps taken to protect oneself from coming into contact with blood and body fluids by the use of gloves, a mask, protective eyewear, and a protective gown

ORGANIZATION OF THE DISSERTATION

Chapter 1 - introduces the dissertation topic and includes discussion about education, health professionals, AIDS and health care, lifelong learning and the role of mid-career professionals in the AIDS epidemic, significance of attitudes of mid-career professionals. It discusses the significance of the study, a listing of research questions, the identification of assumptions, an outline of limitations, the definitions of key terms, and the organization of the dissertation.

Chapter 2 - includes the literature related to the study being explored and analyzed. The chapter is divided into several sections so as to capture the major areas of interest which form the study while providing a backdrop against which lifelong learning and attitudes of mid-career nurses could be understood.

Chapter 3 - provides the design and methodology of the study. It includes a description of the population, survey design, information gathering, and data analysis.

Chapter 4 - contains a presentation and analysis of the findings of the study.

Chapter 5 - summarizes the study, presents the conclusions, examines the implications of the findings, and provides suggestions for further research.

SUMMARY

An examination of mid-career professionals reveals a group needing new knowledge and skills to care for people with AIDS. In order for mid-career professionals to remain current, they must constantly be learning and seeking new knowledge. Due to the number of different routes for the preparation of nurses, there is no common body of knowledge nor equality in skills.

Adult learning theory and practice provides a growing body of knowledge about the characteristics and needs of adults and about how they prefer to learn and how they best can be taught. Developmental theorists have found that when adults return to education at different times in their lives, they do so for different reasons depending, in part, on their developmental stage. Being at a particular developmental level also has implications for how the adult perceives and makes meaning of the situation. Although it has long been known that adults change as they age, not until fairly recently has there been extensive research about the process and the implications for lifelong learning. Development through the lifespan has been addressed both in terms of age-related changes in the way the adult views the world and how she/he makes meaning of experience.

There are many issues facing health care organizations which must be addressed within the context of a changing environment. There is a need for mid-career nurses to possess a solid understanding of AIDS and PWAs, their

needs, and the community needs. Increased knowledge and positive attitudes are necessary for the delivery of care to PWAs in a humanistic and holistic manner.

It is apparent that the knowledge gained about the favorable or unfavorable attitudes held by mid-career nurses concerning AIDS and PWAs will profoundly affect the delivery of humanistic nursing care to PWAs in acute care settings, and in the community. Therefore, a thorough investigation of this issue is extremely important, timely and relevant. A person's health, or a nation's is an almost priceless asset.

CHAPTER 2

RELATED LITERATURE

This study will explore education for nursing care of AIDS patients. It will include lifelong learning and mid-career professionals' attitudes towards AIDS in general and how these attitudes affect nursing practice for PWAs. Although research has supported the relationship berween various attitudes and many non-nursing behaviors, few studies have been conducted on nursing populations. Those that have been attempted are generally atheoretical, theoretical, or descriptive studies which have not employed valid and reliable instruments (Swanson, Chenitz, Zalor, and Stoll, 1990).

The establishment of an empirical basis for effective nursing interventions directed at the prevention, control, and management of HIV infection in the individual and community is crucial (Turner, 1990).

> *"Gaining competence occurs through new learning. Life changes trigger new learning activities and a need to become competent at something new. The drive for competence is lifelong."*
>
> Schlossberg, 1991

> *"Learning rarely occurs in isolation from the world in which the learner lives and it is intimately related to that world and affected by it."*
>
> Jarvis, 1987

COLLABORATIVE LEARNING STRATEGIES

Increasing Understanding

Learning models can range from simply "depositing" materials in an individual's mind to collaborative approaches in which educators and adult learners are active co-learners. Collaborative learning strategies capitalize on an individual's way of learning through self-reflection and interaction with others. Learning is defined as insight. To learn "actively" means "to process" information rather than "to receive" input passively. Personal knowledge evolves throughout our lives (Young, 1995).

Polanyi (1969) argued that all knowledge is personal knowledge. We cannot "know about" anything that is outside our realm of awareness. Furthermore, objectivity is a "false ideal". Polanyi explained that all knowledge is "subjective" in the sense that "it has been perceived" by the person. Consequently, careful examination of perspective is an essential part of learning. Creating personal knowledge means to increase understanding. This does not mean that our personal opinion, values, and beliefs are "right" or that they are to be imposed on others. We will retain unique perspectives as we construct meaning for ourselves, influenced by our view of the past and our vision of future possibilities. Self-reflection and interaction with others are the keys to the learning process. Dialogue with ourselves and with others will expand our realm of awareness and enable us to "see" the broader view (Young, 1995).

Learners construct personal knowledge which has meaning, significance, and relevance for them. We create and cherish our own opinions. However, at the level of understanding reality, "evolving commitments" or "constructed knowledge", we develop our understandings, while respectfully acknowledging other views. When we accept that various perspectives exist, there is no need to compete with others to be "right". Shared meanings and new understandings arise through the interplay of views.

> *"Humanistic orientation to learning is the emphasis on human nature, human potential, human emotions, and affect."*
> Merriam and Caffarella, 1991

Personal understandings evolve as new information is considered. When learners sense a "misfit" between incoming information and their understanding, they may feel discomfort. This phenomenon is described as "cognitive dissonance". We make decisions about new ideas. We reject, partially reject, incorporate, or partly incorporate new ideas. We "choose", we "select", and we "create", meaning for ourselves. Personal understandings are shaped by our perceptions and our choices. Since to learn is to change, effective learning experiences will enable personal understandings to evolve (Young, 1995). Learners are part of an environment. An experience is always what it is because of a transaction taking place between an individual and what, at the time, constitutes the environment. Similarly, cognitive-field learning theorists describe "lifespace" as the sphere of a person's awareness.

Selective Perception

We are never consciously aware of everything in our environment. We are selectively preceptive. However, our understandings can change as our perceptions and perspectives change. We can refocus our attention to "see" what was previously unnoticed. Personally meaningful learning enables you to perceive the world differently--to see things you didn't see before. Everything changes. Many "facts" that are taken for granted in a fact world are a "socially constructed" reality. Although other "realities" are possible, the power of the established order maintains the current state (Young, 1995).

Critical Thinking and Change

Thinking critically about the "way things are" and reflecting on "accepted practice" leads to change. The widely accepted may become "unacceptable." First comes awareness, then comes planning and working to create the desired change. Effective learning experiences encourage active involvement, questionning, and processing of information. Long (1991) identified learners' experiencing, reflecting, and interpreting as distinct and essential parts of the experiential learning cycle. Long (1991) describes adults initiating learning projects as independent, self-directed, and goal-oriented learning experiences. Thinking about what is accepted in our society is part of developing insight.

Self-Directed Learners

Self-directed learning is affected by context. Rather than focusing on society or institutions, the context for learning on one's own is more easily understood in terms of the adult's life situation. Learning on one's own is the way many adults go about acquiring new attitudes, ideas, and skills. Self-directed learning may occur by design, by chance, or by a combination of the two depending on the interests, experiences, and actions of learners and their life circumstances (Merriam and Cafffarella, 1991). Self-directed learning is open to a range of interpretations. At one end of the spectrum, self-directed learning is thought to occur when learners determine goals and objectives, locate appropriate resources, plan their learning strategies, and evaluate the outcomes (Knowles, 1980 and Tough, 1990). At the other end of the spectrum, self-directed learning is thought to incorporate the notion of "critical awareness" (Brookfield, 1986). These approaches to self-directed learning have in common a concern with the psychological growth of the learner (Tennant, 1988). The process of individualization is a hallmark of growth. As individualization proceeds, the person becomes more separate from the world and is more independent and self-generating. Knowles (1975) emphasized that adults learn best when working with content that is relevant, practical, and applicable to their lives. Young (1995) recommended "real-life" problem-solving appproaches and group work to stimulate initiative, participation, and awareness. Learning, in terms of development of insight, occurs not only within formal programs but also over a

lifetime. Collaborative strategies recognize and value the knowledge and past experience of all participants. Collaborative learning strategies are designed to promote active processing of information and creation of new understandings.

Reflection

The potential of reflection, as a learning tool, has been recognized as a way to integrate theory and practice. The importance of reflection as a key learning tool in education has been emphasized by Schon (1991). Nurses, in their everyday practice, face unique and complex situations which are insolvable by technical rationale alone. Two types of reflection are identified: reflection-in-action and reflection-on-action. Reflection-in-action occurs while practising and influences the decisions made and the care given. While a nurse is consciously aware of the knowledge used while reflecting-on-action, this may not be so for reflection-in-action.

Reflection has been defined as a process of internally examining and exploring an issue of concern, triggered by an experience which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective. Schon (1991) identifies three stages of reflection; conscious reflection, criticism, and action. The first stage is triggered by an awareness of uncomfortable feelings and thoughts. This arises from a realization that, in a given situation, the knowledge one was applying was not sufficient in itself to

explain what was happening in that unique situation. This can be an experience of surprise or inner discomfort. The second stage involves a critical analysis of the situation which is constructive and involves an examination of feelings and knowledge. It may be that when an nurse initially analyzes her/his existing knowledge and applies other knowledge, an explanation of that unique situation may be possible. The third stage involves the development of a new perspective on the situation. Therefore, the outcome of reflection is learning.

Open-mindedness and motivation are important skills required to be reflective. While these are not skills in themselves, they are prerequisites to reflection which need to be encouraged. There are certain cognitive and affective skills necessary to engage in reflection. These skills have been identified as self-awareness, description, critical analysis, synthesis, and evaluation. Schon (1991) suggests that it is sometimes possible through a process of reflection-on-action to illuminate the knowledge used. This can be achieved both verbally and in writing. Reflection, therefore, must involve the self and must lead to a changed perspective. Reflection, as a learning tool, is a necessary process in professional education. If learning is to occur from practice, then, reflection is vital (Champion, 1991).

Acknowledging the Experience of Adult Learners

Adult education has its own dynamics which have been shaped by a range of disciplinary inputs such as sociology, history, psychology, economics, and anthropology. The connection between adult learning and psychological growth involves the individual progressing through a sequence of eight stages, the last three of which are autonomous, individualistic and integrated stages. In these last three stages, an adult makes commitments and choices while recognizing the relativity of social perspectives and ambiguities and contradictions in being an adult in a social world. As individualization proceeds, the adult becomes more separate from the world and is more independent and self-generating. Researchers consistently cite experience as a distinguishing characteristic of adult learning (Tennant, 1988).

The idea that the experience of adults is an important resource for learning is axiomatic. One perspective regards learners as passive receivers of attitudes, behaviors, roles, and values that are shaped and maintained by rewards and punishments. A second cognitive perspective on learning attributes is a more active role for learners who are seen as continually trying to understand and make sense of their experiences. In effect, learners reconstruct their experiences to match more closely their existing rules and categories for understanding the world. The relationship between learning and experience is interactive rather than mechanistic. A third perspective, labeled the psychodynamic perspective, draws attention to the emotionally-laden nature of

the relationship between experience and learning (Tennant,1988). Both the psychometric and cognitive structuralist traditions seem to be converging on the view that cognitive growth occurs in the adult years and that this growth is located in the experiences of adults in everyday life (Tennant, 1988). Usually adults experience a range of both positive and negative consequences when participating in lifelong learning. The value that the adult places on these consequences will determine the valence (net force of attraction and repulsion) for the adult to participate.

"Change must not be perceived as an overnight process; it does not happen instantaneously - it is gradual and often painstaking."

W.W. Isaac, 1995

ATTITUDE AND BEHAVIOR CHANGE

Ajzen and Fishbein (1980) assert that an individual's intention to perform any behavior in a given situation is a function of her or his attitude toward that behavior or the object of that behavior and her or his perception of the social norms governing that behavior. Attitude is a composite variable that has both cognitive and affective components. Cognitive components are composed of opinions and judgements while affective components are made up of feelings. An opinion is an idea that an individual holds to be true and is often shared by her or his social group. A judgement is an evaluation an individual places on an object or situation as to whether or not it is good or bad, right or wrong. Feelings are responses that are considered to be positive, neutral, or negative and are expressed by affective words. Behavior or the intention to behave can best be predicted by an individual's subjective opinions, feelings, and judgements about the behavior or the object of the behavior, and by the individual's opinions, feelings, and judgements about the social norms governing this behavior (Schuman and Johnson, 1981).

Although attitude is frequently considered as a predisposition to behavior, periodic reviews have noted the failure of attitude measures to predict behavior. The certainty with which attitude judgements are made may depend upon the degree to which an individual has developed an attitude toward the psychological object. An individual's intention to perform any behavior in a given situation, and eventually the behavior itself, is a function of attitude toward

performing the behavior in that situation, her/his perception of the norms governing the behavior in that situation and compliance with these norms (Sample and Warland, 1973).

Attitude Theory

There is an assumption that attitudes cause, reflect, or, at least, correlate substantially with behavior. Therefore, much research attention has been focused during the past few decades on determining the power of attitudes to predict behaviors. In examining this research, attitudes and behaviors have been found to be related to an extent that ranges from small to moderate in degree in most cases (Schuman and Johnson, 1981). One model, the Ajzen-Fishbein Model of Reasoned Action, has been used frequently to predict the relationship to attitudes of various behaviors. More recently, this model was shown to successfully predict student nurses' intended care behaviors with AIDS patients (Goldenberg and Laschinger, 1991). The Ajzen-Fishbein Model of Reasoned Action asserts that a person's intention to behave in a given situation, and eventually the behavior itself, is a function of attitude about the behavior and the perception of norms governing the behavior (Ajzen and Fishbein, 1980).

In order for attitudes to be better predictors of behavior, there is a need for more precise conceptualization. Attitudes can be conceptualized in numerous ways (Schuman and Johnson, 1981) including:

(a) conceptual congruence--the expectation, based on reason, that a particular attitude and a particular behavior should go together; (b) direction--either positive or negative; (c) intensity--subjective strength of feeling reported by the respondent; (d) centrality--subjective importance of the issue; (e) certainty--differentiation between clearly developed versus poorly developed, weak, ambivalent, or nonexistent attitudes; (f) proximity--the personal versus social focus of the attitudes; (g) specificity--congruence of measured attitudes with specific behavioral act; (h) committed action--actions intended or taken relevant to the issue; and (i) crystallization--attitudes that are firmly imbedded in an individual's belief system are resistant to change. Hence attitudinal measurement instruments are inordinately improved by constructing items that reflect the variety of attitudinal properties described above. Such items should require thoughtful consideration on the part of respondents rather than superficial reaction. Attitudinal measurement instruments need improvement in other ways also. Multi-item indexes must be developed to achieve high reliability. In addition, Likert scaling, which has been shown to be the best type of attitudinal measurement to incorporate an internal measure of strength of feeling, can provide greater differentiation and perhaps more appropriate ordering of respondents.

Swanson et al., (1990) reviewed the literature from 1981 to 1989 regarding nurses' knowledge, attitudes, and practices related to AIDS and the care of PWAs. Thirty-two studies were reviewed. These were largely atheoretical,

descriptive surveys of health professionals in acute care settings, lacking a conceptual framework upon which to base the research design, measurement, and analysis of data. Swanson and colleagues challenged future researchers to move beyond the use of descriptive statistics to more advanced quantitative methods that could explore the relationships among variables more fully and could also be used to test theory.

Conceptual Foundation of Attitudes

The conceptual foundation of mid-career nurses' attitudes about AIDS was based on the idea that nurses' attitudes about AIDS and PWAs could best be measured by exploring their personal and social opinions, feelings, and judgements about these two constructs. Attitudes towards AIDS and PWAs were conceived of as either personal or normative (social). Within each of these are affective (feelings) and cognitive (opinions and judgements) components. These were viewed as influencing nurses' intentions to behave towards AIDS and PWAs and their ultimate behaviors in their nursing practice (Preston, Young, and Koch 1992).

A survey of 731 registered nurses working in rural settings which included acute care settings, hospitals, schools, nursing homes, clinics, community health nurses, and educators. Findings from this study indicated that this sample of rural nurses displayed many negative attitudes towards AIDS. Approximately

twenty percent (20%) also expressed an overall unwillingness to care for PWAs as well as an unwillingness to provide specific nursing care procedures to PWAs. In addition, many reported that their families would be upset if they were to care for PWAs in their nursing practice. In the study of rural nurses, Preston (1994) found that negative attitudes about AIDS were related to nurses' lower educational levels, strong religious beliefs, and lack of experience in caring for PWAs. Several research studies have shown that nurses with negative attitudes towards AIDS were more anxious about caring for PWAs and were more fearful about catching the disease. Additional research has shown that fear of AIDS on the part of nurses has resulted in avoiding the carrying out of procedures, the attempting of extreme precautions, the lack of regard for AIDS patients, and the unwillingness or refusal to care for these patients leading to inferior care (Preston,Young and Koch, 1992).

THE MANY FACES OF AIDS

Children and AIDS

The forecast for the HIV epidemic includes increasing numbers of infected children who will be born to infected mothers. As the epidemic progresses, nurses will be more frequently called on to assist women in making difficult reproductive decisions. The social ostracism is perhaps as tragic to a toddler as are frequent bouts of illness and hospitalization. The hardest part of the disease is fear and rejection. It is hard enough for an adult to cope with; it is impossible to explain to a child. That's why families who have a child with AIDS go underground.

In a society where we have lost all respect and decency in the face of such a fearful disease, is it any wonder that so many parents neither notify the authorities nor any centre for disease control when they discover that their child has AIDS? Children who have been sexually abused are becoming a high-risk group. If we do not change our attitudes towards AIDS patients and children, we will end up with many tragedies. As long as we discriminately ostracize children with AIDS and their families, the families will prevent the sick children from receiving the help they should be getting. As long as fathers fear losing their jobs and mothers are stared at and not wanted at community functions, the sick children will pay the price. The difference with children who suffer from AIDS is that parents don't know what to tell their relatives and their other children. When

they do tell members of the family and friends, they often discover no one wants to have much to do with them. There are many children dying of AIDS who have no love, no hugs, no kisses, no toys, nor loving environment. They are doomed to spend the rest of their lives in very expensive hospitals. They are neglected and rejected often with mothers too ill themselves to take care of them. This is what is happening now to these innocent children.

Recent studies have shown that women are now being blamed for the escalating epidemic in much the same manner as male homosexuals are blamed for the initial epidemic. But for women who risk infecting an infant, the blame becomes more strident. HIV infected women are seen as selfish, irresponsible, or immoral if they choose to initiate or continue a pregnancy. HIV infected women who choose to have an infant are often treated disdainfully (Chenitz, 1992).

Women and AIDS

Women constitute the fastest growing group of people with AIDS. Sexism and stigma are a lethal combination in the HIV epidemic. When women are seen as vectors of disease rather than as individuals with a devastating disease, they become scapegoats (Smeltzer and Whipple, 1991). Women with AIDS have a hard time not only facing the dread disease and all its consequences, but worst of all, the dreadful and almost uniform rejection and isolation that the

diagnosis of AIDS causes. Old friends refuse to have anything to do with them and will stop calling and visiting. The tendency for nurses to protect the privacy of AIDS patients or PWAs, creates formidable barriers for investigators (Larson, and Ropka, 1991). Studies done suggest the need for nurses to provide accurate education and intervention based on specific needs of their female clients. Nurses need to be aware that education, public policy, research, and treatment programs have ignored the special needs of women. This can only be done by nurses who continue to increase their knowledge about AIDS through lifelong learning (Smeltzer and Whipple, 1991). HIV infected women who are mothers have an especially heavy burden to prepare for the care of their children who will be left motherless or orphaned. Hutchinson and Kurth (1991) found that factors influencing HIV infected women about their pregnancy-related decision-making included their desire for a child, their degree of child-centeredness, the influence of family dynamics, religious faith, assessment of risk, attitude toward abortion, degree of optimism, prior experience with pregnancy, death of a child, fears related to childbearing pain, and their ability to care for the child. They also identified a sense of isolation among these women and found that most mothers continued with their pregnancies after HIV diagnosis. Andrews, Williams, and Neil (1992) found that the burden of child-care responsibilities, the guilt associated with exposing a child or children to HIV, the pain associated with sharing the stigma of HIV/AIDS with their children, as well as eventually abandoning their children emerged as important facets of womens' experience of HIV/AIDS. The lifestyles of some women result in their

losing custody of their children. Relationships between mothers coping with their HIV status and the children and others residing with them underscore the need for nurses to approach HIV/AIDS as a disease affecting whole families.

Nurses need to trust that womens' reproductive decisions are based on their personal assessments of what is best. Even if HIV prevention efforts are successful, nurses, through care and knowledge, can be instrumental in assuring that many levels of interventions are appropriately targeted to the goals of preventing HIV infection in women and children (Bradley-Springer, 1994). In a study done by Williams (1991) of women at risk, results showed that women had very little information about new therapies and early interventions for HIV infection. The women perceived themselves as capable of taking action to protect themselves against AIDs in some situations but not in others. An immediate need for drugs was one of the influencing situations. The impact of AIDS heightened the isolation and mistrust which were characteristic of the injection-drug-using community.

Women are often given the responsibility of health care of the family but not the power to make decisions within the family. Only when more is known about womens' roles, their knowledge, attitudes, and beliefs in AIDS prevention, will strategies to empower women to protect themselves from HIV infection be effective. Television was cited as the most common source of information about AIDS by women in several studies. Failure of many women to follow recommendations designed to reduce the risk for HIV infection suggests that

television is ineffective in promoting behaviors that would prevent HIV infection and AIDS (Smeltzer and Whipple, 1991).

Natives and AIDS

Natives in Canada are dying twice as fast as non-natives and are receiving less than half the medical care that other AIDS patients receive. In a study by a Vancouver health care worker named Sanderson (1996), an AIDS co-ordinator at St. Paul's Hospital in Vancouver, Canada, the records show that native AIDS patients enter hospital at a later stage of the disease, have fewer hospital visits, and shorter stays. They also live an average of only three years after being diagnosed HIV-positive which is half that of patients from the general population.

Prisons and AIDS

AIDS patients who are incarcerated in our prisons have no support whatsoever (Kubler-Ross, 1990). They are kept in isolated rooms for months, have no contact with other inmates, are never able to go outside into the fresh air and sunshine, and have no chance to exercise their already physically weakened bodies. Without the use of a radio or TV, they sit all day in their small cells isolated and unattended. They receive no special care and no chance to talk to anyone about the deplorable condition that they are in. With a staff of

caregivers who are negative, vindictive, and revengeful, it is no surprise that prison is the worst place to be if one has AIDS. AIDS patients are shunned by other prisoners and by corrections officers as much as possible. Prisoners are not routinely tested for AIDS when they enter the system. Anyone can be HIV positive and until they become ill and are then transferred to a medical facility, no one will ever know. The grimmest part of all is the ignorance about AIDS, lack of knowledge, understanding, and compassion for those who are terminally ill and receive no treatment. Education of staff is focused on self-protection by being equipped with goggles and rubber gloves in case of an accident or incident involving blood or other body fluids.

Contagion and Homophobia Related to AIDS

AIDS appears more contagious because it combines the powerful symbols of the unknown, punishment and death. Evidence for this proposition appears in research on nurses' attitudes towards AIDS and PWAs. Studies have shown a positive relationship between fear of contagion and homophobia in nurses (Campbell et al., 1991; Martindale and Barrett, 1992). In two different studies, one-third of the nurses in one study and one-half in the other, mistrusted information received about AIDS transmission which is an example of how fear of the unknown makes all information suspect. PWAs can have a certain quality of life, the level of which is often in the hands of nurses.

SUMMARY

Health is multidimensional, therefore, nursing care also should be multidimensional. That is, it should reflect a holistic approach to care. In nursing, quality of life should be viewed as the goal rather than as a variable. Quality of life can result if there is interaction among all members of the health care team during all phases of the health care encounter. For the chronically ill, de Tornyay (1991) suggests that to maintain quality of life the emphasis should be on continuity of care within a community setting.

Studies have documented the existence of fear of HIV in nurses. Although fear of contagion decreases with knowledge of HIV transmission, it is not always eliminated with education about AIDS as demonstrated by several surveys of health care workers (Jemmott and Jemmott, 1991). Fear of HIV contagion appears to be common among nurses despite strong empirical evidence of the low risk of occupational transmission to health care workers (Weiss, 1992). Several independent surveys representing a total of 2,632 nurses, documented that the majority of respondents feared occupational exposure to HIV and greatly overestimated the actual risk (Brenner and Kauffman, 1993). Thus the literature seems to suggest that fear of contagion is more an emotional rather than a cognitive reaction to the threat of AIDS.

Learning is a personal process and is intimately related to the world and affected by it. Three factors are characteristic of present day society that affects

what adults want to learn. The first factor is the dramatic changes occurring in the demographic base of our society. The second and third factors shaping the learning enterprise are economics and technology. Certain learning activities are learner-initiated and others are society-initiated. Learning on one's own is the way most adults go about acquiring new skills and attitudes (Merriam and Caffarella, 1991). Research has shown that adults are often motivated to participate in learning activities by changes in their lives. Learning, so essential to human behavior yet so elusive to understanding, has fascinated thinkers as far back as Plato and Aristotle.

Questions of access to learning and the opportunity to learn have plagued the adult learning enterprise for most of the modern era and have become even more troublesome in recent years. The gap between the better educated who seek out lifelong learning and those who do not continues to widen (Merriam and Cafffarella, 1991). Can an employer require employees to attend educational workshops on AIDS? In a pluralistic society such as ours, the question of who decides what learning opportunities to offer has no single answer. How strongly one believes in a particular position is manifest in the choices one makes when there are conflicting courses of action. Brandt (1990) writes that these beliefs are translated into one's personal value system and it is this system that lies at the heart of ethical practice.

Chapter 3 which follows, provides a description of the design and methodology of the study including a description of the population survey design, information gathering procedures, and the data analysis process.

CHAPTER 3

DESIGN AND METHODOLOGY

The intent of the study was to document the attitudes and opinions of mid-career professionals on specific aspects of lifelong learning; to increase knowledge about AIDS and AIDS care, and assess the potential consequences for nursing practice of PWAs.

This chapter provides detailed information about the research methodology which was used by the researcher in the collection of the data.

Design of the Study

A survey research methodology was used to collect data. The rationale for using survey research to achieve the purpose of the study was that the researcher did not seek to explain relationships, to test hypotheses, or to make predictions. Instead, the intent was to present the attitudes and opinions of mid-career nurses on some very specific aspects of lifelong learning. The plan was to obtain the attitudes and opinions of mid-career nurses regarding their knowledge about AIDS and AIDS care, experience with AIDS and AIDS care, opinions of the barriers to and benefits of lifelong learning about AIDS and AIDS care, and the potential consequences for nursing practice for People with AIDS.

The questions were provided in more detail in Chapter 1, and a copy of the questionnaire was provided as Appendix B.

Study Sample

The study sample was taken from a pool of approximately 7000 mid-career nurses who were members of the Registered Nurses Association of Ontario and were employed in nursing in hospitals, communities, colleges, and universities in Ontario, Canada. As mid-career nurses tend to be members of the Registered Nurses Association of Ontario, individuals were selected from various membership categories offered by the Association. No attempt was made to balance the sample size for male and female proportion or for any particular city or rural area in Ontario. The sample size was two hundred and fifty individuals, both males and females, who graduated from 1960 to 1980 inclusive (pre-AIDS epidemic). The sample was randomly selected. The study sample was not stratified further because the researcher felt enough data was already obtained for the purpose of this study.

A total of 10 surveys were returned as undeliverable making the effective survey sample 240. Please refer to Table 1.1.1 on the following page for more details.

TABLE 1.1.1

QUESTIONNAIRE RECORD

Location (City)	Surveys Sent	Undelivered	Delivered	Usable Returns
	Total	Total	Total	Total
Hamilton	30	0	30	18
Kingston	20	0	20	7
London	30	0	30	6
Ottawa	30	0	30	18
Peterborough	10	2	8	4
Thunder Bay	10	0	10	8
Toronto	100	5	95	69
Windsor	20	3	17	11
TOTALS	250	10	240	141

Fifty-eight percent (58%) of the sample responded to the questionnaire.

SURVEY DESIGN

The primary method for collecting data from the mid-career nurses included in the sample was a questionnaire survey. A copy of the full questionnaire can be found in Appendix B.

The self-administered questionnaire was divided into five sections to facilitate completion, data processing, and analysis. Each section was then sub-divided with items ranging from eight to eighteen. The first four sections of the questionnaire solicited knowledge, experience, attitudes/opinions of barriers to lifelong learning and perceived benefits of lifelong learning while the last section was designed to collect demographic-type information. The rating scale was constant throughout the four sections where knowledge, experience, attitudes/opinions of barriers to lifelong learning and perceived benefits of lifelong learning were solicited.

A Likert scale with values from 1 to 5 was utilized for section one on the knowledge level:

1 = Excellent
2 = Good
3 = Fair
4 = Poor
5 = No instruction on this topic

A Likert scale with values from 1 to 5 was utilized for sections two, three, and four for experience, opinion of barriers and perceived benefits:

1 = Strongly agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree

Participants were encouraged to add comments on the back of the survey questionnaire. The length of the questionnaire allowed for completion of the question in 15 - 20 minutes.

The researcher decided to construct a survey questionnaire after much searching for an appropriate instrument. The investigator did not feel that any of the commercially available or published instruments would have solicited the information needed, especially since this study was not a replication of a previous work. Much effort was put into a literature search by the researcher who gleaned from published articles the common areas of interest, especially those areas which were given much attention in the referenced literature. It is the opinion of the investigator that the instrument, as constructed, was the best tool for the topic under investigation. In the Letter of Introduction (Appendix A) participants were assured of confidentiality.

Pretest of the Survey

The survey instrument was reviewed by a selected panel of mid-career nurses who had a wide range of experience as managers, educators and as researchers. Twelve individuals were involved in this stage. The reviewers were asked to evaluate the survey instrument in relation to understandability of instructions and the clarity and completeness of the questions. The reviewers had the additional task of completing the questionnaire as well as providing

feedback on clarity and understandability of the questions. Based on the reponses and comments of the reviewers, changes were made to the draft questionnaire. The feedback from the selected panel was very helpful in providing suggestions for clarity and some necessary changes which were made to the instrument before it was sent out in the final form. The responses from the reviewers were analyzed for effectiveness of the items.

Data Collection Procedures

The survey was addressed to two hundred and fifty (250) mid-career nurses who were current members of the Registered Nurses Association of Ontario, and who graduated between 1960 and 1980 in the pre-AIDS epidemic. They were also all employed in nursing in hospitals, communities, colleges and universities in Ontario, Canada. Ontario has many large colleges and universities which provide programs and degrees in nursing or other health related fields of study. The researcher, being a member of the Registered Nurses Association of Ontario, had access to a pool of approximately 7000 mid-career nurses from which to obtain the randomly selected individuals.

The questionnaire was sent out in the spring of 1996 to two hundred and fifty (250) randomly selected individuals from the pool with the intent of capturing the attention of potential respondents prior to the summer holiday break. Data was colleced over a three month period. The respondents were asked to return the

completed questionnaire to the researcher in the stamped, self-addressed envelope which was provided with the survey instrument. No one wished to provide additional information by way of a personal interview but some made written comments on the questionnaire. A few individuals commented that they found the survey very interesting and would be interested in the outcome of the study.

Data Analysis

Descriptive statistics were used to analyze responses to the survey questions. Comments and additional information provided were analyzed for content and summarized as part of the report. The demographic information was used for discriminant analysis using ANOVA (Analysis of Variance). Investigation was made into the inter-relationships of demographic variables and the attitudinal scales.

Descriptive analysis was obtained for each statement in each section of the questionnaire. For each attitudinal scale, a reliability analysis was performed in order to determine the Cronbach's Coefficient ALPHA (Internal Consistency of the Scale). This provided some assurance that each item was measuring what it was purported to measure. With a reliable scale, there is the assurance that there is no analysis of extraneous material.

A factor analysis was also done to obtain a determination of whether each scale measured only one dimension. The factor score of each scale was used as a dependent variable for further discriminant analysis such as ANOVA and MANOVA (Multivariable ANOVA) and multiple regression to determine group differences such as education, experience, age etc. The data collection and analysis from the study was extensive and required extensive data management and statistical analysis.

The study will identify and describe attitudes which may impact on mid-career nurses' efforts to maintain current knowledge and skills while meeting the needs of present and future nursing practice for PWAs. The study will provide data which could be applied to program planning for lifelong learning and improved nursing practice and care for PWAs.

VALIDITY AND RELIABILITY

Ensuring ***VALIDITY*** of the survey instrument was very important to this study. The intent of each question should mean the same things to all respondents and that responses correspond to what they are supposed to measure or determine (Best and Khan, 1986). In this study, an attempt to assure "face" validity was made through the panel of reviewers. Each member of the panel of reviewers was asked to comment on the clarity of instructions, the understood meaning or intent of each question, and also on the coherency and completeness of the survey as a whole.

RELIABILITY is the degree of consistency that the instrument demonstrates (Best and Khan, 1986). It is the extent to which individuals in comparable positions and situations will respond in similar ways. In this type of survey design, good questions are reliable provided that there is consistency in response in comparable situations. In other words, respondents will provide the same answer if the questionnaire were administered at different intervals of time in different situations. Providing consistent wording and the use of easily understood terms goes a long way in maintaining reliability. That was another area where the panel of reviewers provided some valuable assistance. The final return of useable responses was 141 of 240 assumed delivered which is fifty-eight (58%). Ten questionnaires were returned undelivered.

In a study of this type, the report consists of tabular presentation of the material with explanatory text and is presented in more detail in Chapter 4 which follows.

CHAPTER 4

ANALYSIS AND INTERPRETATION OF THE DATA

Introduction

The focus of the study is "Education for Nursing Care of AIDS Patients: A Study of Lifelong Learning and Mid-Career Professional Attitudes."

The purpose is to identify and describe attitudes which may impact on mid-career professionals' efforts to maintain current knowledge and skills while meeting the needs of present and future nursing practice of AIDS care. This chapter reports the data collected from one hundred and forty-one (141) mid-career nurses currently working in the province of Ontario, Canada.

Research Questions and Interpretation of Findings

The following major/primary research questions were identified because they represented the areas of attitudes towards AIDS and AIDS care and lifelong learning.

Question 1 - What knowledge do mid-career nurses have about AIDS and AIDS care?

The mid-career nurses agreed that their *knowledge about AIDS and AIDS care* was good to fair with the exception of five issues. These issues were: *the needs of PWAs at different stages of AIDS, community resources available for PWAs, legal and financial needs of PWAs and their families, the quality of education and instruction received,* and the *preparation of these nurses to care for PWAs* were all rated fair.

A ranking of the data showing response mean for each item of the question regarding *knowledge about AIDS and AIDS care* revealed that item 1.15 (1.94) produced the highest level of knowledge. The item receiving the lowest level of knowledge was item 1.6 with a mean score of 3.57 followed closely by item 1.18 with a mean score of 3.50. The mid-career nurses' response to item 1.17 which asked *quality of education and instruction received* ranked poor with mean score of 3.23. The overall response mean for the question was 2.67 and the number of valid cases was 138. The reliability of the eighteen (18) items of this question in the Cronbach Coefficient ALPHA Internal Consistency Scale was 0.94.

TABLE 2.1.0

RESPONSE MEAN FOR EACH ITEM OF QUESTION 1
KNOWLEDGE/EDUCATION

No.	Your Knowledge About AIDS and AIDS Care	Response Mean
1.1	Universal Precautions procedures	2.06
1.2	Symptoms and stages of AIDS	2.68
1.3	Needs at different stages of AIDS	3.15
1.4	Community resources available for PWAs	3.15
1.5	Psychosocial and spiritual needs of PWAs and families	2.81
1.6	Legal and financial needs of PWAs and families	3.57
1.7	Providing supportive care until death	2.69
1.8	Nurses' psychological needs (to prevent burnout)	2.67
1.9	Sources of bloodborne infections in the workplace	2.27
1.10	Primary ways of getting bloodborne infections at work	2.25
1.11	Risky jobs, tasks, and work practices	2.21
1.12	Steps to be taken after an exposure incident to prevent infection	2.47
1.13	Use of Personal Protective Equipment for different tasks/situations	2.40
1.14	Limitations of Personal Protective Equipment (PPE)	2.58
1.15	Disposing of used needles and other sharp equipment	1.94
1.16	Decontaminating work areas, instruments, and equipment	2.50
1.17	Quality of education/instruction received	3.23
1.18	Preparation to care for PWAs	3.50

Rating Scale - Excellent - 1; Good - 2; Fair - 3; Poor - 4;
No instruction on this topic - 5

TABLE 2.1.1

VALID RESPONSES, RESPONSE MEAN AND STANDARD DEVIATION QUESTION 1

Question Items & N Values	Valid Responses - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
1.1 (139)	25.2	52.5	15.8	2.2	4.3	2.06	0.95
1.2 (139)	7.2	31.7	48.2	11.5	1.4	2.68	0.83
1.3 (136)	5.1	14.0	49.3	22.1	9.6	3.15	0.97
1.4 (139)	2.9	22.3	36.0	32.4	6.5	3.15	0.93
1.5 (138)	10.1	23.9	41.3	20.3	4.3	2.81	0.97
1.6 (139)	3.6	12.2	27.3	42.4	14.4	3.57	1.00
1.7 (139)	10.8	32.4	38.8	12.2	5.8	2.69	0.99
1.8 (137)	13.9	27.7	43.8	11.7	2.9	2.67	0.97
1.9 (138)	21.0	44.2	28.3	2.2	4.3	2.27	0.98
1.10 (137)	19.7	45.3	29.2	2.2	3.6	2.25	0.94
1.11 (134)	20.9	47.0	25.4	2.2	4.5	2.21	0.97
1.12 (137)	13.1	46.7	23.4	11.7	5.1	2.47	1.03
1.13 (138)	20.6	39.0	23.5	13.2	3.7	2.40	1.08
1.14 (138)	15.9	35.5	29.7	13.8	5.1	2.58	1.11
1.15 (138)	36.2	41.3	15.9	3.6	2.9	1.94	0.98
1.16 (136)	18.4	33.8	30.1	14.7	2.9	2.50	1.04
1.17 (134)	4.5	20.9	28.4	40.3	6.0	3.23	1.01
1.18 (138)	4.3	17.4	20.3	40.6	17.4	3.50	1.10

Rating Scale - Excellent - 1; Good - 2; Fair - 3; Poor - 4;
No instruction on this topic - 5

*Reliability Coefficients - ALPHA = Cronbach Coefficient Alpha Internal Consistency of the Scale. ALPHA = 0.94.

Question 2 - What experience and education do mid-career nurses have about AIDS and AIDS care?

The mid-career nurses were able to provide a high level of agreement on their experience with AIDs and AIDS care. The top choices are presented in Table 2.2.0 which is a record of the Response Mean for each of the eighteen (18) items of Question 2.

A ranking of the data showing response mean for each item of the question regarding experience and education about AIDS and AIDS care revealed that item 2.17 (1.98) produced the highest level of agreement that mandatory continuing education will not make a difference. Items 2.18 (1.92) - *I regularly pursue continuing education activities*; 2.6 (1.81) - *I never practice Universal Precautions procedures;* 2.12 (1.53) - *protective equipment should always be available*; 2.9 (1.49) - *exposure to AIDS through blood/body fluids should be reported;* 2.16 (1.47) - *employers should facilitate continuing education on site*; received strong agreement by respondents. The items receiving the lowest rating of experience/education were item 2.14 with a mean score of 3.54 and item 2.1 with a mean score of 3.47. The overall response mean for Question 2 was 2.32 and the number of valid cases was 135. The reliability of the eighteen (18) items of this question on the Cronbach Coefficient ALPHA Internal Consistency Scale was 0.79. This was the lowest of all the questions. The items 2.2 - *never given care to PWAs* (2.82); 2.4 - *caring for PWAs has been a negative experience* (2.44); 2.6 - *I never practice Universal Precautions*

procedures (1.81); 2.7 - *nursing practice should be different for PWAs* (2.24); 2.8 - *family members, friends, spouse/significant other would be upset about your caring for PWAs* (2.72); 2.13 - *use of protective equipment hinders performance* (2.66); 2.17 - *mandatory continuing education will not make a difference* (1.98); were negatively worded in this question. Therefore, this question was not as easy for respondents to understand, perhaps resulting in a lower reliability score on the Cronbach Coefficient ALPHA Internal Consistency Scale of 0.79.

TABLE 2.2.0

RESPONSE MEAN FOR EACH ITEM OF QUESTION 2 EXPERIENCE/EDUCATION

No.	Your Experience with AIDS and AIDS Care	Response Mean
2.1	Frequently given care to PWAs	3.47
2.2	Never given care to PWAs	2.82
2.3	Caring for PWAs has been a positive experience	2.57
2.4	Caring for PWAs has been a negative experience	2.44
2.5	I always practice Universal Precautions procedures	2.10
2.6	I never practice Universal Precautions procedures	1.81
2.7	Nursing practice should be different for PWAs	2.24
2.8	Family and friends would be upset about your caring for PWAs	2.72
2.9	Exposure to AIDS through blood/body fluids should be reported	1.49
2.10	Trusts in official guidelines about precautions when providing care	2.25
2.11	Experts' estimates of the risk of HIV infection are accurate	2.63
2.12	Protective equipment should always be available	1.53
2.13	Use of protective equipment hinders performance (i.e. dexterity)	2.66
2.14	Use of protective equipment interferes with nurse/patient relationship	3.54
2.15	Self-directed educational programs are helpful	1.81
2.16	Employers should facilitate continuing education on site	1.47
2.17	Mandatory continuing education will not make a difference	1.98
2.18	I regularly pursue continuing education activities	1.92

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

TABLE 2.2.1

VALID RESPONSES, RESPONSE MEAN AND STANDARD DEVIATION QUESTION 2

Question Items & N Values	Valid Responses - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
2.1 (136)	3.7	23.5	10.3	34.6	27.9	2.06	1.20
2.2 (135)	20.0	29.6	7.4	20.7	22.2	2.68	1.44
2.3 (126)	9.5	28.6	54.8	5.6	1.6	3.15	0.79
2.4 (126)	16.7	25.4	52.4	4.8	0.8	3.15	0.81
2.5 (131)	25.2	40.5	26.7	6.6	3.1	2.81	0.86
2.6 (128)	43.0	32.0	23.4	1.6	0.0	3.57	0.82
2.7 (130)	23.1	43.8	14.6	15.4	3.1	2.69	1.01
2.8 (131)	19.8	32.1	10.7	33.6	3.8	2.67	1.25
2.9 (135)	58.5	38.5	3.0	0.0	0.0	2.27	0.57
2.10 (133)	24.1	44.4	18.0	12.8	0.8	2.25	1.01
2.11 (135)	8.9	35.6	40.7	14.1	0.7	2.21	0.87
2.12 (136)	53.7	44.1	2.2	0.0	0.0	2.47	0.55
2.13 (135)	8.9	35.6	35.6	17.8	2.2	2.40	0.92
2.14 (135)	2.2	5.9	39.3	42.2	10.4	2.58	0.78
2.15 (135)	31.1	56.3	8.9	3.7	0.0	1.94	0.71
2.16 (135)	54.8	43.0	2.2	0.0	0.0	2.50	0.55
2.17 (134)	24.6	59.7	9.7	3.7	2.2	3.23	0.85
2.18 (137)	34.3	40.1	19.0	6.6	0.0	3.50	0.88

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

*Reliability Coefficients - ALPHA = Cronbach Coefficient Alpha Internal Consistency of the Scale. ALPHA = 0.79.

Question 3 - What attitudes/opinions are shared by mid-career nurses about the barriers which hamper their pursuit of lifelong learning activities about AIDS and AIDS care?

The respondents of the study were able to provide a high level of agreement on which factors negatively impacted on their attempts at lifelong learning activities. The top choices are presented in Table 2.3.0 which is a record of the Response Mean for each of the sixteen (16) items of Question 3. The popular choices of the top five barriers which hamper pursuit of lifelong learning about AIDS and AIDS care were items 3.15 - *accessibility of educational programs* (2.28); 3.9 - *inadequate course offerings* (2.41); 3.1 - *fear of AIDS* (2.51); 3.3 - *fear of acquiring AIDS from patients* (2.56); 3.2 - *social stigma attached to AIDS* (2.60). These were chosen from the list of sixteen (16) provided. The lowest scoring item was 3.13 - *continuing education is not an expectation of employers* (3.42). The overall response mean for Question 3 was 2.89 and the number of valid cases was 136. The reliability of the sixteen (16) items of this question on the Cronbach Coefficient ALPHA Internal Consistency Scale was 0.88.

TABLE 2.3.0

RESPONSE MEAN FOR EACH ITEM OF QUESTION 3
OPINION OF BARRIERS

No.	Lifelong Learning Activities by Mid-Career Nurses About AIDS are Negatively Impacted by	Response Mean
3.1	Fear of AIDS	2.51
3.2	Social stigma attached to AIDS	2.68
3.3	Fear of acquiring AIDS from patients	2.56
3.4	Disgust when considering the immorality of IV drug abusers	3.26
3.5	Anger re caring for PWAs who contracted the disease through high-risk sexual behaviors	3.17
3.6	Not enough information to protect myself against AIDS in the workplace	3.18
3.7	Religious and/or spiritual beliefs	2.94
3.8	Job workload	2.79
3.9	Inadequate course offerings	2.41
3.10	Distance from home	3.00
3.11	Personal responsibilities related to home life	2.86
3.12	Lack of money	2.91
3.13	Continuing education is not an expectation of employers	3.42
3.14	Perceiving continuing education to be of low personal value	3.35
3.15	Accessibility of educational programs	2.28
3.16	Low probability of increased financial reward (no pay increase)	2.86

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

TABLE 2.3.1

VALID RESPONSES, RESPONSE MEANS AND STANDARD DEVIATION QUESTION 3

Question Items & N Values	Valid Responses - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
3.1 (137)	11.7	11.8	16.5	3.6	5.1	2.51	1.14
3.2 (136)	57.7	52.9	48.1	25.5	27.9	2.60	1.19
3.3 (133)	4.4	7.4	9.0	24.1	22.1	2.56	1.23
3.4 (137)	19.7	18.4	15.0	35.8	35.3	3.26	1.03
3.5 (136)	6.6	9.6	11.3	10.9	9.6	3.17	1.07
3.6 (135)	4.4	31.9	14.8	36.3	12.6	3.18	1.15
3.7 (137)	3.6	40.1	19.0	29.9	7.3	2.94	1.04
3.8 (136)	7.4	41.9	17.6	27.9	5.1	2.79	1.05
3.9 (136)	14.7	51.5	15.4	14.7	3.7	2.41	1.01
3.10 (134)	3.0	35.8	25.4	29.1	6.7	3.00	1.02
3.11 (136)	3.7	44.1	19.9	26.5	5.9	2.86	1.05
3.12 (136)	5.1	39.7	20.6	28.7	5.9	2.91	1.04
3.13 (135)	0.7	28.9	10.4	45.2	14.8	3.42	1.08
3.14 (135)	5.2	29.6	3.7	45.2	16.3	3.35	1.19
3.15 (136)	24.3	45.6	12.5	12.5	5.1	2.28	1.08
3.16 (136)	7.4	42.6	18.4	19.9	11.8	2.86	1.15

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

*Reliability Coefficients - ALPHA = Cronbach Coefficient Alpha Internal Consistency of the Scale. ALPHA = 0.88

Question 4 - What are the perceived benefits by mid-career nurses in pursuing lifelong learning about AIDS and AIDS care?

What are the potential consequences for nursing practice for PWAs?

The choices for perceived benefits were made from eighteen (18) items. The top six (6) items were 4.3 - *increased knowledge in caring for PWAs* (1.61); 4.1 - *current information about AIDS* (1.64); 4.7 - *increased information to protect against acquiring AIDS in the workplace* (1.66); 4.16 - *increased knowledge of how to decrease the spread of AIDS* (1.69); 4.9 - *increased knowledge of community resources* (1.69); 4.18 - *improved nursing practice for PWAs* (1.70). The lowest ranked item was 4.14 - *increased morale* (2.20). The second lowest ranked item was 4.13 - *increased level of job satisfaction* (2.16). The overall response mean for Question 4 was 1.86 and the number of valid cases was 138. The reliability of the eighteen (18) items of this question on the Cronbach Coefficient ALPHA Internal Consistency Scale was 0.95.

TABLE 2.4.0

RESPONSE MEAN FOR EACH ITEM OF QUESTION 4
PERCEIVED BENEFITS

No.	Lifelong Learning for Mid-Career Nurses About AIDS and AIDS Care Provides for...	Response Mean
4.1	Current information about AIDS	1.64
4.2	Decreased fear of AIDS	1.75
4.3	Increased knowledge in caring for PWAs	1.61
4.4	Increased willingness to care for babies and women with AIDS	1.83
4.5	Increased willingness to care for homosexual and heterosexual men with AIDS	1.97
4.6	Increased willingness to care for IV drug users with AIDS and PWAs from blood transfusions	1.96
4.7	Increased information to protect against acquiring AIDS in the work place	1.66
4.8	Increased understanding of sexuality issues	1.91
4.9	Increased knowledge of community resources	1.69
4.10	Increased knowledge of psychosocial and spiritual needs of patients and families	1.75
4.11	Increased comfort level in providing supportive care until death	1.76
4.12	Improved communication skills	2.02
4.13	Increased level of job satisfaction	2.16
4.14	Increased morale	2.20
4.15	Increased decision-making ablilty	2.00
4.16	Increased knowledge of how to decrease the spread of AIDS	1.69
4.17	Increased social acceptance of PWAs	2.07
4.18	improved nursing practice for PWAs	1.70

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

TABLE 2.4.1

VALID RESPONSES, RESPONSE MEAN AND STANDARD DEVIATION QUESTION 4

Question Items & Values	Valid Responses - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
4.1 (138)	39.1	56.5	4.3	0.0	0.0	1.64	0.56
4.2 (138)	36.2	53.6	7.2	2.9	0.0	1.75	0.68
4.3 (137)	41.6	55.5	2.9	0.0	0.0	1.61	0.54
4.4 (138)	32.6	52.9	12.3	2.2	0.0	1.83	0.71
4.5 (138)	28.3	50.0	17.4	4.3	0.0	1.97	0.79
4.6 (138)	27.5	52.2	15.9	4.3	0.0	1.96	0.78
4.7 (138)	37.0	59.4	3.6	0.0	0.0	1.66	0.54
4.8 (138)	29.0	55.1	11.6	4.3	0.0	1.91	0.76
4.9 (138)	34.1	63.0	2.2	0.7	0.0	1.69	0.54
4.10 (138)	31.9	61.6	5.8	0.7	0.0	1.75	0.59
4.11 (138)	34.8	55.1	8.0	2.2	0.0	1.76	0.67
4.12 (138)	26.8	48.6	20.3	3.6	0.7	2.02	0.82
4.13 (138)	25.4	42.0	23.9	8.0	0.7	2.16	0.92
4.14 (138)	22.5	42.8	26.8	7.2	0.7	2.20	0.90
4.15 (138)	26.1	52.2	17.4	3.6	0.7	2.00	0.80
4.16 (138)	34.8	60.9	4.3	0.0	0.0	1.69	0.54
4.17 (138)	28.3	45.7	17.4	7.2	1.4	2.07	0.93
4.18 (138)	34.8	60.1	4.3	0.7	0.0	1.70	0.58

Rating Scale - Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

*Reliability Coefficients - ALPHA = Cronbach Coefficient Alpha Internal Consistency of the Scale. ALPHA = 0.95

PROFILE OF RESPONDENTS

Table 2.5.0 and Table 2.5.1 provide a summary of responses to the demographic items as requested in Section 5 of the questionnaire. That information has been utilized to compile a profile of the individuals who participated in the study. There were 95.7% females and 4.3% males responding to the survey. They reported the average time spent with present organizations was 10.4 years and the average number of years of experience as a registered nurse was 22 years.

As for the "Highest Level of Education" attained, this category showed that 29.8% of individuals reported diplomas from community colleges as their educational level while 33.3% possessed a baccalaureate in nursing and 13.5% a baccalaureate in "Other" category was reported. The completion of a masters degree was reported by 14.2% of the respondents. There were 9.2% of the respondents with doctoral degrees. One individual did not provide information on the highest level of education attained.

TABLE 2.5.0

DEMOGRAPHICS OF RESPONDENTS

5.1 - SEX/GENDER	**5.5 - AGE**
135 - Female (95.7%)	0 - less than 30 years (0.0%)
6 - Male (4.3%)	46 - between 30 - 39 (32.7%)
	58 - between 40 - 49 (41.1%)
	37 - between 50 - 59 (26.2%)
	0 - more than 60 plus (0.0%)
5.2 - EDUCATION (Highest Level)	**5.6 - PROFESSIONAL BACKGROUND**
42 - Diploma (29.8%)	Clinical Specialty/Other TABLE 2.6.0
47 - Baccalaureate in Nursing (33.3%)	
19 - Baccalaureate in Other (13.5%)	
10 - Masters in Nursing (7.1%)	
10 - Masters in Other (7.1%)	
13 - Doctorate (9.2%)	
0 - Other (0.0%)	
5.3 - NURSING EDUCATION (Location)	**5.7 - HOURS OF WORK**
City/Province/Country TABLE 2.5.1	95 - Full-time (70.9%)
	35 - Part-time (26.1%)
	4 - Casual (3.0%)
	7 - Missing (0.0%)
5.4 - EXPERIENCE AS A NURSE	**5.8 - YEARS WITH ORGANIZATION**
141 Years (Mean average = 22 years)	0 - Less than 1 year (0)
	141 Years (Mean average = 10.4 years)

TABLE 2.5.1

DEMOGRAPHICS OF RESPONDENTS
NURSING EDUCATION

5.3	CITY	NURSING EDUCATION
No.	89	Toronto (63.2%)
	20	Hamilton (14.2%)
	12	London (8.5%)
	5	Ottawa (3.5%)
	3	Peterborough (2.1%)
	6	Windsor (4.3%)
	2	New York/Ann Arbor (1.4%)
	1	Thunder Bay (0.7%)
	2	Moncton (1.4%)
	1	Montreal (0.7%)
5.3	**PROVINCE**	**NURSING EDUCATION**
No.	136	Ontario (96.5%)
	1	Michigan (0.7%)
	1	New York (0.7%)
	2	New Brunswick (1.4%)
	1	Quebec (0.7%)
5.3	**COUNTRY**	**NURSING EDUCATION**
No.	139	Canada (98.6%)
	2	USA (1.4%)

The location of where Nursing Education was obtained is shown in Table 2.5.1. The largest category for cities was Toronto (63.2%); followed by Hamilton (14.2%); London, (8.5%); Ottawa (3.5%); Peterborough (2.1%); Windsor (4.3%); New York/Ann Arbor (1.4%); Thunder Bay (0.7%); Moncton (1.4%) Montreal (0.7%). As far as the provinces/states were concerned, the largest category was Ontario (96.5%) followed by New Brunswick (1.4%); Quebec (0.7); New York (0.7%); Michigan (0.7%). Respondents reported having received "Nursing Education" in Canada (98.6%) and the United States of America (1.4%). Twenty-nine percent (29%) reported "Other" clinical areas as administration/nursing, education/nursing (61.3%) and research/nursing (9.7%). One hundred and eleven (111) did not respond to the request for information in this category, therefore not enough data was received to be meaningful for further discussion.

TABLE 2.6.0

DEMOGRAPHICS OF RESPONSES
PROFESSIONAL BACKGROUND

5.6	CLINICAL	VALID RESPONSES
	AREA	PERCENT
No.		
11	Administration/Nursing	7.8%
27	Community Health	19.2%
14	Emergency/Occupational Health	9.9%
47	Medical/Surgical/Rehabilitation	33.3%
9	Obstetrics/Gynecology	6.4%
13	Psychiatry	9.2%
3	Research	2.1%
17	Gerontology/Chronic Care	12.1%

1 - Missing

141 - Valid Responses

5.6	OTHER	VALID RESPONSES
		PERCENT
No.		
9	Administration/Nursing	29.0%
19	Education/Nursing	61.3%
3	Research/Nursing	9.7%

111 - Missing

131 - Valid Responses

The age of respondents showed 30 - 39 (32.7%); 40 - 49 (41.1%); 50 - 59 (26.2%). One individual did not respond to the question. The hours of work reported showed full-time employment (70.9%); part-time (26.1%); casual (3.0%), and seven did not report hours of work.

Table 2.6.0 provides a summary of "Professional Background" of respondents. Respondents reported clinical areas as being in the following disciplines: administration/nursing (7.8%); community health nursing (19.1%); emergency/occupational health nursing (9.9%); medical/surgical/rehabilitation nursing (33.3%); obstetrical/gynecological nursing (6.4%); psychiatric nursing (9.2%); research/nursing (2.1%); gerontological/chronic care nursing (12.1%). One individual did not respond to the request for information.

Findings of the Study

The findings of this study showed that mid-career nurses were most fearful about AIDS, the social stigma attached to AIDS, and of becoming infected by a patient with AIDS. These three items would form the basis of sound educational programming for in-house offerings. When offered in-house, there would be opportunities for evaluation, follow-up and reinforcement. There has to be a commitment from the organization not only to provide opportunities, but also to provide quality opportunities which will be facilitated by competent and qualified individuals.

The data indicated that mid-career nurses had a variety of academic backgrounds but the skills and knowledge level desired for these individuals should be the same regardless of their academic preparation and position within the health care organizations or educational institutions. Mid-career nurses need to change their perception of the pursuit of professional development to realize that it is an important part of their growth and that it is an expectation.

SUMMARY

A presentation and analysis of the data has appeared in this chapter. The summary was comprised of issues for nursing practice which solicited the attitudes and opinions of mid-career nurses regarding lifelong learning, AIDS, and AIDS care. Section 5 of the questionnaire provided demographic information (Tables 2.5.0, 2.5.1, and 2.6.0) which included detailed information on "Location of Nursing Education" and "Professional Background" including clinical specialty.

The overwhelming message from the study sample was that attitude affected the pursuit of lifelong learning activities about AIDS. It was also learned from the study sample that knowledge about caring for People With AIDS (PWAs) was important for improving nursing practice for mid-career nurses. Targeted skills for mid-career nurses should be learning about the current information concerning AIDS and AIDS care as the top priority. Educational programs should be facilitated by employers and educational facilities to include on-site courses, mentoring, and accessible programs offered by local educational institutions. Personal enhancement of skills and knowledge should not be interpreted as being of no benefit to organizations and institutions. On the contrary, the organization or institution stands to benefit from the increased knowledge of mid-career nurses about AIDS and AIDS care and the potential for improved nursing practice for PWAs.

The activities of mid-career nurses with increased knowledge and skills should also provide proof of the currency of AIDS care information. There was no expectation that salary increases would be a natural outcome of the increased knowledge and skills of these nurses but it could be an indirect benefit. Increased career opportunities for these nurses could also be an indirect benefit. Mid-career nurses are very aware of cost restraints but the message was that creative ways could be found to sponsor lifelong learning and skill/knowledge development concerning AIDS and AIDS care in the ever-changing health care system without adding to the financial burden of the organization or institution.

Increased knowledge was not perceived as a "nice-to-have" but as a necessity based on the needs of a dynamic health care system. It was also acknowledged that such values had to be embodied by the management personnel of the health care organizations and educational institutions. The overall message was that educational programs were high priorities for most mid-career nurses but some respondents did not agree with this. Themes were identified throughout the questionnaire that reflected the context in which the respondents were experiencing the AIDS epidemic. They showed biases that surfaced in attitudes towards PWAs, lack of knowledge about AIDS, fear of the disease, and fear of acquiring the disease from PWAs. An understanding of these themes is important because it helps to define the problems in caring for PWAs as seen by the respondents themselves.

There were neutral responses to some items of the questions. These neutral responses suggested that there was some ambivalence on the part of the respondents. It is possible that the responses were influenced by the job positions of respondents within a health care organization or educational institution.

Chapter 5, which follows, provides a more detailed discussion of the findings, conclusions, implications and recommendations for future research.

CHAPTER 5

FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Mid-career professionals work in an environment that is constantly changing. The external environment has caused the health care system to re-evaluate its service delivery and re-direct its focus to such areas as community care and patient-centered care. The system cannot be expected to provide new ways of serving its clients without undergoing some changes itself. Many of these changes have resulted in many nursing positions being eliminated for more cost-effective service delivery models. For mid-career nurses to function effectively in these changing environments, they must possess the skills and knowledge which are demanded by the new health care organizations and the new external environment. For some mid-career nurses, this would require a new commitment to lifelong learning but for the majority, the requirement might be a shift in focus to recognize the value of non-traditional methods of lifelong learning to include how positive attitudes can be developed toward PWAs.

The purpose of the study was to identify and describe attitudes which may impact on mid-career professionals' efforts to maintain current knowledge and skill while meeting the needs of present and future nursing practice for AIDS. To facilitate the task, a questionnaire was developed and mailed to two hundred and fifty (250) mid-career nurses working in the Province of Ontario, Canada. The source of the population and study sample were members of the Registered

Nurses Association of Ontario, 1996. It is the opinions of one hundred and forty-one (141) respondents or 58% of delivered questionnaires which form the results of this study. Questions were developed in order to address the main question which was stated as follows: What are the attitudes and perceived benefits for mid-career nurses in pursuing lifelong learning about AIDS and AIDS care and what are the potential consequences for nursing practice for PWAs? The responses have provided some answers and direction for assuring that mid-career nurses will be equipped to provide the best nursing care possible for PWAs in the future. Excerpts from written comments are interspersed with the narrative.

SUMMARY OF FINDINGS

Knowledge and Education About AIDS and AIDS Care - The responses to Question 1 showed that mid-career nurses' knowledge about AIDS and AIDS care was good to fair with the exception of five issues. These five issues were all rated fair — *the needs at different stages of AIDS; legal and financial needs of PWAs and their families; quality of education/instruction received, and preparation to care for PWAs.* The findings should not be surprising to anyone who is aware of the demands of the changing health care system. The new problem of AIDS and AIDS care demands new knowledge and skills which will only be possible with different values and more positive attitudes towards AIDS and PWAs. Acquiring a positive attitude towards AIDS and PWAs means behavioral changes for mid-career nurses.

One respondent articulated her concerns in the following:

> *"The nurses of my vintage are generally well-trained in basic concepts and the principles have not changed over the years. What has changed is equipment and technnology."*

Another respondent stated the following:

> *"I believe very strongly in continuing learning and education for everyone, particularly in this rapidly changing work environment."*

The respondents agreed that the quality of education/instruction about AIDS and AIDS care had been fair to poor.

One respondent remarked:

> *"My only knowledge about AIDS is gained through nursing newsletters and public information."*

Another respondent commented that:

"I have never had any instruction in caring for people with AIDS."

In a constantly changing health care environment, one must be concerned with the abililty of mid-career nurses to meet the future requirements of the system in terms of their skills and currency of knowledge. There was an indication that mid-career nurses remain in the field for long periods of time and if that is so, there is a further assumption that skills maintenance and knowledge currency and a positive attitude towards AIDS would be concerns to be addressed even if the mid-career nurse did not remain with the same employer but did continue to work within the health care system. The length of time that participants remained in health care work settings ranged from 1 to 30 years with a mean of 10 years. There were several individuals who had been employed by their current organization for over 25 years. Health care organizations should not be concerned about the loss of a mid-career nurse who has received financial assistance for upgrading skills and knowledge about AIDS and AIDS care. More often than not, if the individual leaves the organization, the destination will most likely be another health care organization, hence, the training is not lost but redeployed within the health care system.

One respondent's summary of education was:

"Education is a holistic concept -- clear information, concepts, attitudes, self-awareness, stress management etc."

Because health is multidimensional, nursing care should also be multidimensional, that is, reflect a holistic approach to care. Within a holistic context, an ill person does not have an illness that must be located and eliminated. Instead, when a person is ill, there is a collaborative effort both by the person and the health care team to manage the illness and its effects on the person's everyday life experiences. Therefore, quality of life should be viewed more as an accomplishment than as a variable. Accomplishment means that the quality of life results from the interaction of all members of the health team during all phases of the health care encounter. The holistic approach to care requires the return of ultimate responsibility to the patient for control over her/his health and illness. Holistic concepts include physical, emotional, cognitive, interactional, spiritual, and political aspects of the individual. Better understanding by nurses of the patient's individuality can improve the quality of care given.

Experience and Education About AIDS and AIDS Care - The response to Question 2 showed that mid-career nurses were able to provide a high level of agreement that mandatory education will not make a difference. The issue of mandatory lifelong learning activities has generated considerable debate among health professionals, educators and legislators. Concerns have been expressed about cost. Mandatory continuing education has always proved to be controversial. The literature has cited concerns about the impact and effects on learner receptivity. It has been stated that mandatory continuing education does not necessarily ensure either utilization of knowledge or increased competence. Proponents of mandatory continuing education have stated that it might be the only method of ensuring participation by the majority of practitioners in the health field as those most in need would be least likely to participate. Preference was stated for self-directed educational programs and employers facilitating continuing education on site. The 1991 study by Williams showed that respondents preferred educational program delivery modes that were short, intensive seminars offered as night classes.

One respondent commented that:

> *"I am highly committed to continuing education but have not made AIDS my specialty and therefore my knowledge is limited."*

Another respondent stated that:

> *"I have been involved with self-directed learning since graduation in 1969, even while unemployed. I'm disappointed that many of my colleagues do not share my views on the importance of self-directed learning but see that as evidence of burnout and lower morale generally with the climate of the time".*

Comments by other respondents:

> *"Professional development is the individual's responsibility. It may not lead to increased financial rewards such as a new position, but it will definitely increase nursing knowledge and skills."*
>
> *"Training specific to the job and/or work setting is the responsibility of the employer."*
>
> *"The employers have a responsibility to provide inservice updates to keep all staff on top of things. Regular changes are accepted by most nurses and as a group we have inquiring minds regarding the advances of medicine."*
>
> *"I am a nurse in independent practice. I am not involved with AIDS care in my specialty and I have not sought continuing education about AIDS. I seek continuing education in my own specialty."*

The frequency of mid-career nurses giving care to PWAs was low. This was the reason given for the lack of knowledge about AIDS and PWAs by the respondents. Considering that AIDS is a disease that is of epidemic proportions in many parts of the world including Canada and the United States, the response of 57% never having given care to PWAs in the province of Ontario which has the highest number of AIDS cases in Canada was very surprising. This could be positive or negative. Closely related to knowledge about AIDS are attitudes towards AIDS and AIDS care. Early studies of nurses working in hospitals found fear of contagion related to AIDS and anxiety about providing care for PWAs. One respondent articulated her experience in the following way:

> *"In 1985 we had two patients with AIDS on our unit and the staff received very good information. Since then, we have received very few patients with AIDS which has limited my involvement and my need for an in-depth base."*

Other respondents' comments:

> *"As a nurse and now a pastor in a church which has no PWAs attending, to my knowledge, I have very limited contact with volunteers or family members of PWAs."*

> *"I was an AIDS Educator for the local Health Department for three and a half years (I have since left the program). My job involved giving care in the community to PWAs and AIDS clients and their families as well as educational HIV/AIDS programs to high schools, correctional facilities, nursing students, Home Support workers, Nursing Homes, and the general public. I left the program because I began to seriously disagree with the way the program was directed at the Ministerial level in Ontario."*

Another respondent expressed her experience with the following:

> *"I have recently attended funerals of sons of two families who are close friends of mine. These young men in their twenties were gay. One died after living at home with his parents for a year and a half. He had threatened to commit suicide as his disease progressed. The other died last week at Casey House in Toronto, Ontario. Both families were supportive especially toward the end. They both were appreciative of the emotional support especially since some of the relatives such as aunts and uncles were critical and self-righteous. I have thought of someday doing hospice volunteering for PWAs."*

Understanding the use of Universal Precautions is crucial for designing educational programs to modify behavior, to reduce the risk of HIV exposure to nurses, and to improve patient care. The respondents to this study were in agreement about knowing what Universal Precautions were and the importance of using these procedures in HIV/AIDS care.

One respondent stated:

> *"Universal Precautions and procedures should be practised by all nurses dealing with HIV/AIDS patients."*

Barriers - The top three barriers were identified as social stigma attached to AIDS, fear of acquiring AIDS from patients, and fear of AIDS. The attitudes of mid-career nurses towards caring for PWAs are important because institutional policies regarding expectations for treatment and care of PWAs potentially affect all staff. Negative attitudes towards PWAs can lead to avoidance, unwillingness to provide care, poor care, and even mistreatment of PWAs. The respondents of this study expressed fear and concern about AIDS and caring for PWAs. Response to the fear of AIDS showed 69% of mid-career nurses responded negatively.

Only two respondents made comments about these barriers:

> *"Hepatitis B is also a concern for nurses or anyone in the health care field. Whether you have been a nurse for 30years or 5 years, it is only in the last 5 years that we, as nurses, have been concerned abour protective measures."*

> *"I don't find dealing with or caring for AIDS patients any different from caring for other patients with infectious diseases. Certainly much less scary than caring for polio patients years ago."*

Inadequate course offerings and accessibility of educational programs were also identified as barriers.

One respondent articuated her concerns in the following:

> *"In our locality, nurses do not have easy access to any medical library or university. I live in a tiny village. Ongoing learning may be self-directed mainly by reading professional journals obtained by subscription only and by work experience."*

Senge (1990) has stated that individuals cannot be expected to learn when they have so little time to think and reflect. It would appear that having activities

on the job premises would assist in decreasing barriers to learning activities. The inference being that it would be easier to participate during work hours. Loebs (1992) warned that the speed of change has so many roots in the external environment, and that the knowledge of these changes is limited to internal staff only so that most organizations do not have the capacity to provide the necessary exposure and learning to keep knowledge current. If there are going to be opportunities for learning on the job, someone has to assume the responsibility of ensuring that the learning experiences will be beneficial to the individual and also to the organization.

In this study, the prime responsibility of lifelong learning activities has been given to employers. The facilitation by the employer could be in the form of agreeing to be part of a secondment process. The message has to be communicated to the employers that there is an expectation for them to share some of the responsibilities for facilitating lifelong learning activities. In the age of budget restraints and cost cutting, employers are less inclined to budget for lifelong learning activities for mid-career nurses as a significant financial outlay.

The respondents in this study also assigned responsibility to the employee. The individual mid-career nurse has a responsibility to improve and develop her or his knowledge and skill, hence, much of the development begins with her or him. The information from the opinions on the facilitation role should be of interest to educational institutions by providing them with a perspective on who should take the lead and from whom input should be received.

Perceived Benefits - Mid-career nurses, in their responses, showed an agreement that increased knowledge in caring for PWAs, current information about AIDS, and increased information to protect against acquiring AIDS in the work place would be benefits from lifelong learning activities along with increased knowledge of community resources. Another benefit perceived was improved nursing practice for PWAs. Overall, all eighteen (18) items were perceived to be favorable outcomes when pursuing lifelong learning activities about AIDS and AIDS care with the exception of two items. These two items included increased morale and increased level of job satisfaction which rated the lowest of perceived benefits. Decreased job opportunities due to the ongoing downsizing of health care organizations and increased work-related stress could be reasons for the low response rate to these two questions, or, the fear of AIDS could be the motive. A mix of both is also a possibility. Respondents provided a high level of agreement with the skills which were identified as being needed for the future in caring for PWAs.

With the continuing decreases in the number of nursing positions in Ontario, mid-career nurses are forced to compete for positions either within their present organizations or within another organization. Having current knowledge and required skills will add value to the mid-career nurse who is forced into the competitive job market. Roberts (1993) postulated that after the year 2000 the definition of health will be greatly expanded. Hence, in seeking lifelong learning opportunities mid-career nurse should focus on areas of future needs that are

not traditionally a part of the health care curricula. This study identified some areas of future skills as perceived by mid-career nurses.

Overall, the respondents to the survey were positive about knowledge and skill development concerning AIDS and AIDS care. There was a strong indication that many would like to see some form of support from the organization but at the same time they were cogniscent of financial restraints faced by health care organizations.

CONCLUSIONS

1. Lifelong learning needs of mid-career professionals must be addressed.

The changes and needs of the health care system with new initiatives and new policy directives require a co-ordinated approach that will be more supportive of mid-career nurses in their quest for new and current knowledge about AIDS and AIDS care. Mid-career nurses must be encouraged to develop lifelong learning skills. By taking an active role in lifelong learning for themselves and their peers, mid-career nurses can decrease the fear and stress of caring for PWAs as well as protect themselves by routinely practicing Universal Precautions. This will allow mid-career nurses to plan their own development and will assist them in the development of an appreciation for further learning. Reliance on the education and professional development staff may be lessened.

2. Attitudes towards AIDS and PWAs must be addressed.

The negative attitudes of mid-career nurses towards AIDS and the fear of AIDS, the social stigma attached to AIDS, and the fear of acquiring AIDS from patients need to be changed in order to improve nursing care to PWAs. Negative attitudes have been reported by nurses on a variety of survey questionnaires. A survey of New England hospital nurses uncovered both AIDS phobia and homophobia among these nurses and determined that these two

types of attitudes were significantly correlated. Positive attitudes towards required knowledge and skills need to be developed in mid-career nurses concerning AIDS and AIDS care.

Attitudes are recognized as an important influence on behavior. Therefore, in order to improve the quality of the holistic care, including psychosocial support and education that mid-career nurses should be providing to PWAs and their significant others, opportunities must be provided for positive attitude development towards AIDS related issues. Turner (1990) warned that, failure to combine the elements of knowledge and opportunity for attitudinal examination and modification of behavior may result in a nurse who, though knowledgeable, is immobilized by personal feelings and is poorly prepared to deliver quality care.

3. Performance appraisal systems for mid-career professionals should emphasize professional development.

This will assist mid-career nurses to plan for their own professional development but the performance appraisals must be done on a regular basis, at least annually, by the employer. During a performance appraisal, among other things, the nurse is provided with a confidential summary of her/his strengths, areas for improvement, and strategies for obtaining additional knowledge and skill.

4. Partnerships should be pursued between health care organizations and academic institutions for mid-career professionals to be more actively involved in program delivery.

This will assist in the further development of mid-career nurses while also providing performance appraisals where that is a regular occurrence. Part of this facilitation is the inclusion of personal growth activities. There is much to be gained from involvement in program delivery. It adds depth and value to mid-career nurses' experiences.

5. A system should be organized to allow academic faculty to spend time in health care organizations for their own professional development.

This will facilitate the building of a relationship which will provide input into the initial and continuing education of mid-career nurses. It would also provide partnerships for mid-career nurses' development and other collaborative endeavours. The pursuit of professional development is an important part of an educator's growth and should be an expectation.

6. Professional development must be considered an organizational expectation for its mid-career professionals.

The organization must have policies to support mid-career nurses' professional development and recognize its value to the organization. This will send a strong positive message to the mid-career nurses who, in turn, will be more motivated to pursue professional development. Lifelong learning continually improves nursing practice regardless of position, role, or experience. Whether nurses are involved in direct nursing care, education, administration, or research, nursing practice can always be improved.

7. Nursing education programs need to be established consisting of two components: quality control and quality improvement.

The quality control component of nursing education programs involves setting and following certain requirements for registration and maintenance of practice. Quality control works to ensure that quality care is being provided by appropriately prepared individuals.

Quality improvement methods for nursing education programs need to consider both individuals and the systems in which they function in order to identify potential problems and find ways to prevent them from occurring. Each mid-career nurse would be responsible for possessing and continually acquiring

current knowledge relevant to nursing practice. Nursing education programs that include these quality assurance components would help mid-career nurses to engage in lifelong learning to include self-directed learning for the purpose of continually improving their nursing practice.

8. Collaborative learning strategies need to be addressed.

Learning models can range from simply "depositing" material into individuals' minds to collaborative approaches in which educators and students are active co-learners. Collaborative learning strategies capitalize on individual ways of learning through self-reflection and through interaction with others (Young, 1995). To learn "actively" means "to process" information rather than "to receive" input passively. Effective learning experiences encourage active involvement, questioning, and processing of information. Creating personal knowledge means to increase understanding. Personal understandings evolve as new information is considered. Personal understandings are shaped by our perceptions and our choices. Since to learn is to change, effective learning experiences will enable personal understandings to evolve (Young, 1995).

Tough (1990) described adult learning projects as independent, self-directed, and goal-oriented learning experiences. Learning occurs over a lifetime, not only within formal programs. Collaborative learning strategies recognize and value the knowledge and past experience of all participants. Learners work with

others to create shared meanings and develop understandings. Co-learners create shared learning experiences. The goal of the experience is to deepen understandings, create shared meaning, and develop insight through reflection and interaction (Young, 1995). Collaborative learning strategies are designed to promote active processing of information and creation of new understandings. These learning strategies can be applied as we progress through our lives building our personal knowledge and reflecting on our experiences.

9. The teaching and mentoring function is integral to good nursing care.

Through this, mid-career nurses take what is foreign and fearful to the patient and make it familiar and thus less frightening. Understanding can change as perceptions and perspectives change. Attentions can be refocused to "see" what was previously unnoticed. Personally meaningful learning enables the individual to perceive the world differently and to see things that were not seen before. Time and content are carefully structured so that the learner can work with the teacher/mentor on well-defined, planned activities.

10. Professional support groups for nurses must be formed in Canada.

Professional support groups can be valuable in improving the attitudes and behaviors of nurses by increasing communication, decreasing isolation,

increasing self-esteem, and enhancing morale through peer support. The understanding of information, advice, and insight offered by support groups can be very beneficial. Support groups can provide encouragement to work together in order to provide emotional support for each other. The mutual process between one individual and another is a powerful energy presence that promotes confidence, patience, and perseverance.

IMPLICATIONS

What do the findings suggest for the health care system regarding mid-career nurses' professional development? The findings showed that there was a need for attitude change and the development of skills which would improve nursing practice for PWAs. These changes cannot be done in isolation because the health care system has structures, values, and procedures which demand examination and change.

Implications for Mid-Career Professionals

All mid-career nurses, regardless of their location or professional backgrounds, need to be prepared to deal with HIV/AIDS either through direct patient care or educational efforts. More and more people with AIDS or PWAs are returning to their families of origin for support and care as their disease progresses so that in the future, most hospitals and community health agencies throughout our country will be serving PWAs.

Less negative attitudes towards AIDS and PWAs will only result from lifelong learning and understanding. It is encouraging that affective educational experiences have been shown to have a significant effect towards positive attitude change. Such experiences offer opportunities for mid-career nurses to express their anxieties, in either a general or personal way, and examine the causes of these anxieties to determine if they are founded or unfounded.

Fear of contagious diseases is not always eliminated with education as demonstrated in several surveys of health care workers (Jemmott and Jemmott, 1991). Thus, the literature seems to suggest that fear of contagion is more an emotional than a cognitive reaction to the threat of AIDS. Lack of knowledge about HIV transmission is a logical predictor of fear of contagion. Several studies showed the relationship between classes about AIDS and decreased fear (Campbell et al., 1991). Lower levels of fear are also associated with more accurate scores of knowledge of transmission (Ficarrotto et al., 1991). Mid-career nurses need to find a balance so as to avoid becoming overly committed or dysfunctionally detached. Other studies showed that nurses who personally knew individuals with HIV or had experience working with PWAs were significantly less fearful (Anderson and Kimber, 1991; Campbell et al., 1991, Raffin et al., 1993). The more people can identify with a known person with AIDS, the less symbolic meaning is applied to the disease. Homophobia and fear of the unknown may both represent fears of being out of control. Fear of the unknown or the element of mystery threatens one's sense of control over external factors. Both concepts may possibly indicate that the most frightening aspect of any disease is the lack of control people feel concerning it.

Implications for Health Care Organizations

Organizations need to re-evaluate their values regarding the importance of lifelong learning activities. Greater importance has to be placed on the services which are being offered or should be offered. It must be perceived as an integral part of the organization and not as an area of budget reserve so that in times of difficulty, of organizational restructuring and down-sizing, the lifelong learning activities should be given an enhanced role especially in preparing surviving mid-career nurses for expanded and/or new roles. Education services within health care organizations need to be kept centralized to avoid fragmentation and compartmentalization of lifelong learning activities for mid-career nurses. With a centralized service, there will be greater flexibility in meeting needs, both urgent and non-urgent, in a timely manner.

Implications for Educational Institutions

Providers of education should seek out opportunities for alliances and partnerships for lifelong learning offerings. There needs to be a higher level of co-operation between academic faculty and health care organizations in the delivery of educational programs. Utilizing the resource of knowledgeable staff in teaching roles will enhance the theoretical offerings. Academic faculty will be well advised to spend time in the health care environment as part of their own

lifelong learning. The increased interaction will also provide some partnership for improving educational programs offered.

Implications for Education and Health Care Beyond the Year 2000

The forces driving change for education and health care will be economic, demographic, environmental, social, technological, and political. Together, these can be regrouped according to the major elements of globalization, empowerment, technology and the economy.

Globalization refers to the holistic perspective, the ability to see the big picture, bridge cultural gaps, and take a broad approach to education, learning and problem solving. With globalization, communication and transportation technologies will facilitate movement of ideas, capital, and people across fixed boundaries.

Empowerment will support a new leadership paradigm for the 21st century. The emphasis will be on continuous quality improvement, team learning, more problem-solving to reduce conflicts, and a more collaborative approach to health care issues.

Technology will provide an expanded information capacity, user-friendly accessibility, flexible communication techniques. Health promotion will be enhanced as health professionals use technology to accelerate patient learning.

The development of integrated technological systems will create a continuum of health care that will link a patient's home, the doctor's office and the hospital.

Economics will be a concern due to soaring health care costs. Alternate ways to decrease health care costs will need to be developed.

Consumers and health professionals will be affected by emerging trends in the way health care is delivered. Some of these trends are multi-skilled workers, health information specialists, and a new type of leadership that focuses less on managing knowledge and more on harnessing creative energies to manage the total health care organization. This type of leadership will view change as an opportunity for innovation requiring imagination and creative experimentation. There will be an increased ability to study outcomes of health care given by professionals, organizations, institutions, and countries. Therapies and treatments given to individuals will be evaluated and then the consumer will be able to seek out specific health care professionals who establish and maintain effective outcomes and high standards of care. There will also be an increased demand for effective methods of measuring resources and describing health care processes being developed and used around the globe.

RECOMMENDATIONS FOR FURTHER STUDY

Education for health care professionals has to be changed in order to meet the health care needs of the future. Education is essential in order to keep pace with the rapid changes in the health care system and practice. Learning will have to be a lifelong process for all nurses. With new consumer demands, rapidly growing information resources, and high technology, specialized nursing courses will be commonplace. New curriculum and more collaboration between academic and practice areas will help the design and delivery of educational programs and nurses in academic settings will assume duties related to their area of expertise. There will be more specialization throughout the profession resulting in the need for more specialized educational programs. Education programs will have to teach nurses how to be independent learners and be capable of applying the facts and knowledge they have learned. Advanced educational preparation will be a necessity. With changing health care needs and resources, education must prepare nurses to keep one step ahead of the trends.

Clearly, more research needs to be conducted to determine those factors that influence the quality of care that mid-career nurses give to PWAs with a larger population of mid-career nurses in both rural and urban settings. In addition, future research involving mid-career nurses in other geographical locations and settings is encouraged in order to determine similarities and differences concerning frequency of and influences upon AIDS attitudes of mid-career

nurses throughout the country. Due to the voluntary response rate and specifics of this study sample, the findings cannot be generalized to other nursing populations. The relationship between AIDS related attitudes and actual nursing behaviors also needs to be explored.

It is hoped that through educational efforts, more mid-career nurses will express the attitude of one respondent in the study:

> *"I am not afraid of AIDS and nursing allows me to show the patients with AIDS that they are not alone and not everyone fears them."*

Strategies for attitudes change, such as gaining more information and experience and more interaction with others, including PWAs, should be offered. Mid-career nurses also need to develop better advocacy skills so that they can advocate tor better resources for themselves and their patients in fighting AIDS. Attitude changes cannot occur without proper education in the schools of nursing curricula for lifelong learning at all levels and in health care organizations.

Critical thinking is an important strategy for change. Thinking critically about the way things are and reflecting on "accepted practice" leads to change. The "widely accepted" may become the "unaccepted" such as racism, ageism, gender stereotyping, and different lifestyles. First comes awareness, then comes planning and working together to create the desired change. Today, more than ever, we need to examine issues in the social context, explore ways to manage change, and learn how to learn.

Enabling partnerships are important for collaborative learning strategies. Education and students must come together as co-learners to build on each other's strengths and share responsibility for learning. Co-learners work together to investigate issues, collect information, reflect on events, explore different viewspoints, consider other perspectives and participate in dialogue. Co-learners create shared learning experiences. The goal of this experience is to deepen understandings, create shared meaning, and develop insight through critical thinking, reflection, and interaction.

Educators of mid-career nurses must be able to provide appropriate cognitive and affective learning experiences that will best meet the needs of this group of nurses they are teaching. Therefore, it is recommended that educators assess nurses' attitudes in these areas in order to better plan, implement, and evaluate educational programs about AIDS as part of the lifelong learning for mid-career nurses. Attitudes expressed by nurses' family members should also be explored and ways to improve communication with significant others about their AIDS anxieties should be taught. Workshops might even be provided for the nurses' families.

All lifelong learning courses/programs aimed at decreasing fear need to incorporate an effective intervention to promote identification with those at risk for AIDS. Examples of such teaching strategies include psychodrama, personal journals, structured controversy, and incorporating people with AIDS into educational sessions. Adequate knowledge of transmission and extended

contact with a person with AIDS appear to be two most effective interventions for decreasing the fear of HIV/AIDS exposure.

In addition to focusing on individual behavioral changes, AIDS service programs must acknowledge the social context of AIDS which includes the response of the community to the epidemic and the relationship between the individual and the community. By taking an active role in the community organizations and speaking out against discrimination towards persons at risk for AIDS, mid-career nurses can decrease the public stigma of AIDS. Mid-career nurses can be advocates for the inclusion of PWAs concerns in the development of public health policy and education.

Mid-career nurses are in a unique position to provide holistic care, education and counseling, to coordinate services, and to conduct and disseminate knowledge about HIV and AIDS. They can also provide leadership as advocates through professional and political action. Mid-career nurses are traditionally concerned about health prevention and about making health care accessible to all members of society.

As mid-career nurses struggle with what they feel and what they need to do, they also struggle to protect themselves from feeling overwhelmed. These findings can serve as a basis for mid-career nurses who work with PWAs to achieve and maintain a functional level of involvement in the needs of PWAs. The focus of the study was to identify and describe lifelong learning and attitudes which may impact on mid-career nurses' efforts to maintain current

knowledge and skills while meeting the needs of present and future nursing practice for AIDS care. Health care organizations are "re-organizing", "downsizing", and "re-engineering" jobs in an effort to cope with decreased funding and at the same time to try and satisfy client and patient needs and expectations. These activities have caused the health care environment to be one of constant change with demands of current knowledge of health care and related issues. Identification of the issues faced by mid-career nurses in their pursuit of lifelong learning activities will help to provide insight into the needs of the present and future health care system regarding the necessary skills and knowledge. Without a clear identification of the needs of PWAs, current knowledge about AIDS and AIDS care, and positive attitudes towards PWAs, mid-career nurses will not be equipped to provide good-quality nursing care to People With AIDS.

> *"There is still much to be learned about learning that takes place in adulthood."*
>
> Merriam and Caffarella, 1991

APPENDICES

APPENDIX A

APPENDIX A

LETTER OF INTRODUCTION

248 The Kingsway North
Islington, Ontario
M9A 3T5

April 2, 1996

Dear Colleague:

The problems of caring for people with AIDS has become of great concern to nurses. This questionnaire has been developed for use as a tool to solicit the opinions of mid-career nurses on the topic of **Lifelong Learning.**

The health environment is constantly changing and some mid-career nurses might wonder how they can maintain the knowledge and skills required to meet future needs of the health care system. **Lifelong Learning** could be the way to maintain currency.
The information you provide will be used to help improve educational programs for nurses and nursing care of people with AIDS.

You may be assured of complete confidentiality.

Completing and returning the questionnaire will indicate your voluntary agreement to participate in this study.

Thank you for your kind assistance.

Sincerely,

Gail Skornschek
BScN., MSc., PhD Candidate

mfl
Enclosure

APPENDIX B

APPENDIX B

LIFELONG LEARNING

LIFELONG LEARNING QUESTIONNAIRE

APPENDIX B

LIFELONG LEARNING

Rating Scale
Excellent - 1; Good - 2; Fair - 3; Poor - 4; No instruction on this topic - 5

Using the rating scale provided please indicate your level of knowledge of the following statements

1. KNOWLEDGE/EDUCATION

No.	Your Knowledge about AIDS and AIDS Care	1	2	3	4	5
1.1	Universal Precautions Procedures					
1.2	Symptoms and stages of AIDS					
1.3	Needs at different stages of AIDS					
1.4	Community resources available for PWAs					
1.5	Psychosocial and spiritual needs of PWAs and families					
1.6	Legal and financial needs of PWAs and families					
1.7	Providing supportive care until death					
1.8	Nurses' psychological needs (to prevent burnout)					
1.9	Sources of bloodborne infections in the workplace					
1.10	Primary ways of getting bloodborne infections at work					
1.11	Risky jobs, tasks and work practices					
1.12	Steps that should be taken after an exposure incident in order to prevent infection					
1.13	Use of Personal Protective Equipment (PPE) required for different tasks or situations					
1.14	Limitations of Personal Protective Equipment					
1.15	Disposing of used needles and other sharps					
1.16	Decontaminating work areas, instruments and equipment					
1.17	Quality of education/instruction received					
1.18	Preparation to care for PWAs					

APPENDIX B

LIFELONG LEARNING

Rating Scale
Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

Using the rating scale provided please indicate your level of agreement/disagreement with the following statements

2. EXPERIENCE/EDUCATION

No.	Your Experience with AIDS and AIDS Care	1	2	3	4	5
2.1	Frequently given care to PWAs					
2.2	Never given care to PWAs					
2.3	Caring for PWAs has been a positive experience					
2.4	Caring for PWAs has been a negative experience					
2.5	I always practice Universal Precautions procedures					
2.6	I never practice Universal Precautions procedures					
2.7	Nursing practice should be different for PWAs					
2.8	Family members, friends, spouse/significant other would be upset about your caring for PWAs					
2.9	Exposure to AIDS through blood and body fluids in the workplace should be reported					
2.10	Trust should be placed in official guidelines about what precautions should be taken when providing care					
2.11	Experts' estimates of the risk of HIV infection are accurate					
2.12	Protective equipment should always be available					
2.13	Use of protective equipment hinders performance (hinders dexterity)					
2.14	Use of protective equipment interferes with the nurse/patient relationship					
2.15	Self-directed educational programs are helpful					
2.16	Employers should facilitate continuing education on site					
2.17	Mandatory continuing education will not make a difference					
2.18	I regularly pursue continuing education activities					

APPENDIX B

LIFELONG LEARNING

Rating Scale
Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

Using the rating scale provided please indicate your level of agreement/disagreement with the following statements

3. OPINIONS OF BARRIERS

	Lifelong Learning Activities by Mid-Career Nurses about AIDS are Negatively Impacted by	1	2	3	4	5
3.1	Fear of AIDS					
3.2	Social stigma attached to AIDS					
3.3	Fear of acquiring AIDS from patients					
3.4	Disgust when considering the immorality of IV drug abusers					
3.5	Anger about caring for a person with AIDS who contracted the disease through high-risk sexual behaviors					
3.6	Not enough information to protect myself against AIDS in the workplace					
3.7	Religious/spiritual beliefs					
3.8	Job workload					
3.9	Inadequate course offerings					
3.10	Distance from home					
3.11	Personal responsibilities related to home life					
3.12	Lack of money					
3.13	Continuing education is not an expectation of employers					
3.14	Perceiving continuing education to be of low personal value					
3.15	Accessibility of educational programs					
3.16	Low probability of increased financial reward (no pay increases)					

APPENDIX B

LIFELONG LEARNING

Rating Scale
Strongly Agree - 1; Agree - 2; Neutral - 3; Disagree - 4; Strongly Disagree - 5

Using the rating scale provided please indicate your level of agreement/disagreement with the following statements

4. PERCEIVED BENEFITS

No.	Lifelong Learning for Mid-Career Nurses about AIDS and AIDS Care Provides for	1	2	3	4	5
4.1	Current information about AIDS					
4.2	Decreased fear of AIDS					
4.3	Increased knowledge in caring for PWAs					
4.4	Increased willingness to care for babies and women with AIDS					
4.5	Increased willingness to care for homosexual and heterosexual men with AIDS					
4.6	Increased willingness to care for IV drug users with AIDS and PWAs from blood transfusions					
4.7	Increased information to protect against acquiring AIDS in the work place					
4.8	Increased understanding of sexuality issues					
4.9	Increased knowledge of community resources					
4.10	Increased knowledge of psychosocial and spiritual needs of patients and families					
4.11	Increased comfort level in providing supportive care until death					
4.12	Improved communication skills					
4.13	Increased level of job satisfaction					
4.14	Increased morale					
4.15	Increased decision-making ability					
4.16	Increased knowledge of how to decrease the spread of AIDS					
4.17	Increased social acceptance of PWAs					
4.18	Improved nursing practice for PWAs					

APPENDIX B

LIFELONG LEARNING

5. DEMOGRAPHICS

No.	Sex/Gender	No.	Age
5.1	Female	5.5	less than 30
	Male		30 - 39
			40 - 49
			50 - 59
			60 plus
5.2	Education (Highest Level)	5.6	Professional Background
	Diploma		Clinical Specialty
	Baccalaureate (Nursing)		
	Baccalaureate (Other)		
	Masters (Nursing)		Other
	Masters (Other)		
	Doctorate		
	Other		
5.3	Nursing Education (Location)	5.7	Hours of Work
	City		Full-time
	Province		Part-time
	Country		Casual
5.4	Experience as an RN	5.8	Years with Organization
	Years		Less than one (1)
			Number of Years

THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS SURVEY
PLEASE ADD ANY FURTHER COMMENTS YOU MAY HAVE ON THE BACK

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