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TENDERNESS & TECHNIQUE:

NURSING VALUES IN TRANSITION

by Genevieve Rogge Meyer

Institute of Industrial Relations • University of California, Los Angeles

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INSTITUTE OF INDUSTRIAL RELATIONS
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Foreword

There has been in recent years an increased awareness of and interest in the problems of medical care. A nation's medical program must be a compound of several factors: medical research and education, doctors, hospitals, pharmaceuticals, and, by no means least, nurses. Dr. Meyer's *Tenderness and Technique: Nursing Values in Transition* is a careful analysis of nursing as a profession. Her theme is the interplay of the traditions, on the one hand, of the lady with the lamp tending the sick and, on the other, of the professional nurse in a highly organized, technically advanced "industry." The Institute of Industrial Relations is pleased to offer this study as the sixth volume in its Monograph Series.

Genevieve Rogge Meyer was educated at Northwestern University and the University of California, Los Angeles, receiving her Ph.D. in psychology from the latter institution. She wrote *Tenderness and Technique* as a staff member of the Institute of Industrial Relations. She is presently pursuing further her researches in nursing at the UCLA School of Nursing under a grant from the United States Public Health Service.

The Institute of Industrial Relations, the School of Nursing, and the Graduate School of Business Administration of the University of California, Los Angeles are grateful to the United States Public Health Service for a grant to underwrite this research project. The Institute reading committee for the manuscript consisted of Melville Dalton, Lulu W. Hassenplug, and Robert Tannenbaum. Mrs. Anne P. Cook edited the manuscript. The cover was designed by Marvin Rubin.

The viewpoint expressed is that of the author and is not necessarily that of the Institute of Industrial Relations or of the University of California.

BENJAMIN AARON, *Acting Director*
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Preface

This report is the outcome of three and a half years of research on the nursing profession. The study, which was begun in the winter of 1955–56, was supported by a grant from the U. S. Public Health Service awarded to the Human Relations Research Group. The cosponsors were the Institute of Industrial Relations, the School of Nursing, and the Graduate School of Business Administration at the University of California, Los Angeles. All views expressed are those of the writer.

The first two years of the project were devoted to the collection of questionnaire data from a large sample of registered nurses and student nurses. Robert Tannenbaum and Fred Massarik gave many fruitful suggestions on the development of the questionnaire. During part of this period Craig MacAndrew and Jo Eleanor Elliott were members of the project, and a list of their reports is given in Appendix A. During the third year of the project, additional data were gathered in a separate study by Martha Adams, Joan Butler, Marilyn Folck, Bruce Gordon, Phyllis Nie, and Jeanne Quint. The report of their study, in which Charles K. Ferguson and Irving R. Weschler were of special help, constitutes Chapter 10 of this work.

Others who contributed greatly to the research were Maurice Schaeffer, who served as consultant on statistical procedures, and Nicholas Rose, who served as consultant on the construction of the Nursing Picture Item Test. Dean Lulu Wolf Hassenplug, Dorothy Johnson, and Marjorie Dunlap of the School of Nursing were fruitful sources of ideas about nursing and the data.

Miriam Horowitz was an able research assistant in the first year, and Marlene Kincaid was a thorough and devoted assistant in the period of data collection and analysis. Pat Shepherd was invaluable as project secretary. Donald Meyer read the manuscript with an historian's perspective and an editorial eye.

There were many others who contributed to this research. Several agencies and institutions, including many of their nursing staff, and three schools of nursing, including their students, contributed generously of their time. Many thanks are due them, for the research literally could not have been accomplished without them. Perhaps the report itself may be some return for their interest and cooperation.

GENEVIEVE ROGGE MEYER

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Chapter 1

Tenderness and Technique

The nursing profession is experiencing a period of sharp, profound change. Amid increasingly complex technological, institutional, and bureaucratic pressures, nursing functions together with roles and values are being defined and redefined. All this is generally recognized, but it is not so clearly recognized that turbulent change has characterized the progress of nursing since the advent of Florence Nightingale.

Even before Miss Nightingale's time the development of nursing did not follow a smooth or steady course. After the early Christian era—when nursing was in the hands of such remarkable women as Phoebe, Fabiola, Marcella, and Paula—nursing care in the Middle Ages became the business of the monasteries, passing into the hands of monks and nuns. Then, as Jamieson and Sewall (1949) continue the story, nursing went into a decline during the sixteenth, seventeenth, and eighteenth centuries as the power of the monasteries was weakened. The control of nursing shifted to men with civil appointments, and the nursing itself was carried out by women with little or no training and, sometimes, of dubious morality.

Although the eighteenth century saw the beginnings of a resurgence of nursing in Europe, though not in England, it was really through the long struggles of Florence Nightingale that the decline was reversed. Her biographer, Woodham-Smith (1951, p. 352) uses Miss Nightingale's own words to describe her achievement: "In thirty years she had, she said, 'raised nursing from the sink.' " In 1860, against powerful opposition, she established the first Nightingale training school whose object was "to produce nurses capable of training others. . . . They were to be missionaries, and as such they must be above suspicion" (p. 234). Monthly reports on each student were divided into two main categories: "Moral Record" and "Technical Record." This division—a forecast of the modern split in images of the nurse as *either* a virtuous and tender ministrant to the sick *or* a knowledgeable and disciplined technician—served to implement her philosophy that the education of a nurse involved the development of two equally important things: character as well as knowledge.

This philosophy led her to fight a plan supported by the British Nurses' Association to give official recognition and registration to nurses through examination. Miss Nightingale felt that character could not be tested by formal examination even though knowledge could. "Devotion, gentleness, sympathy, qualities of overwhelming importance in a nurse, could never be ascertained by public examination" (Woodham-Smith 1951, p. 352). The battle for registration in Britain was not finally won until some years after Miss Nightingale's death.

Meanwhile, in the United States, the first schools based on the Nightingale system were established in 1873. In 1896 the organization that was to become the American Nurses' Association was founded, and the year 1900 saw the start of its official organ, the *American Journal of Nursing*. Its editorial pages, from the very beginning, reflected a continual and sometimes stormy struggle to improve education, to raise standards, and, generally, to increase the excellence of nursing—all with a view to finer care for the patient. The early editorials exhorted, lectured, and, on happy occasions, congratulated. One such occasion was the passage of the Indiana bill for state registration, which was hailed in the April issue of 1905 as "a matter for great congratulation." In the March, 1913, issue the tenth anniversary of the first moves for state registration was observed—a contest that had to be won state by state. Almost a year later the invitation of leading nurse educators to the inauguration of the New York State Commissioner of Education was welcomed as clear recognition of the nursing profession (February 1914). A $10 per month salary increase for army nurses evoked the editorial comment "Hurrah!" (October 1918).

The long pursuit of complete and adequate state registration, though a major problem, was not the only one facing the nursing profession. In November, 1919, the training of attendants was considered "a menace to the nursing profession" unless there could be proper licensing of the trained attendant as well as of the nurse; and the idea of training attendants in the same school as nurses was "not for a moment to be considered." There was more than one editorial exclaiming indignantly at the U. S. Immigration Bureau's classification of immigrant nurses, particularly Canadian nursing students coming into the United States, as contract laborers (April 1909 and February 1915). In March, 1922, the proposed civil service reclassification act was advocated as an effort to have nurses classified as professionals. The editorial page of the August, 1926, issue indicted the twelve-hour special-duty day with the comment that "self immolation is no longer considered the good life."

But these early struggles for improved standards and better educa-

tion were only one side of the matter—the same matter that concerned Miss Nightingale when she insisted that knowledge and character be given *equal* weight. Thus the early editorials also articulated, and in some instances appealed to, the nurse's sense of devotion and service. In the third year of its existence the *American Journal of Nursing* defined the difference between a trade and a profession in terms of motives—selfish ones for the trade but educational and altruistic ones for the profession—and then reminded readers that nursing fell in the professional category. A September, 1905, editorial deplored the weak response to the Surgeon General's appeal for a national list of volunteer nurses and warned: "It is a sorry day when the attractions of that alluring path called selfishness lead us out of sight of the rough and rugged road of duty and loyalty." In October, 1906, the spirit of nursing was defined as "self-forgetfulness" and, in the same issue, another editorial expressed concern about the "spirit of commercialism" that was emerging in the "humane professions of medicine and nursing." The January, 1909, issue discussed the place of the young graduate, pointing out that higher education means increased obligations since such improvements "are not for our own selfish use but are to fit us to be better instruments for the use of humanity." One editorial, describing the Red Cross Central Committee on Nursing, summed up both themes: Nursing care calls for "courage, and endurance with womanly dignity, *tenderness,* and *professional skill*" (February 1910, italics added).

Before consideration of the later expression of these two themes, there is another matter to be touched on—the identification of nursing as a *woman's* profession. Although this circumstance is not central to the present research, it is central to an understanding of the general position of the nursing profession at any point in its history. In her account of American nursing education Stewart, referring to "the struggles of women for freedom and for better education," points out that "the story of the nurses' struggle parallels that of the sex to which most nurses belong" (1947, p. 31). Jamieson and Sewall (1949) relate the decline in nursing after the Middle Ages to the decline in the general position and freedom of women, and its later revival as a secular profession for women—largely through the work of Florence Nightingale—to the fact that English women were securing greater independence and privileges.

One sociological analysis (Devereux and Weiner 1950) considers our customary cultural division of labor according to sex a factor to be reckoned with in describing the occupational status of nurses. It points out that the care of children and of sick or dependent adults has typ-

ically fallen to women and that it has been a "near-universal" assumption that women have a "natural" bent for "drudgery" types of work. The "Victorian conception of woman as being far loftier and finer in nature than are men, and therefore 'willing' to glory in drudgery on behalf of the helpless and dependent" suited nicely the conclusion that women were "especially well qualified by nature to minister to the ill" (p. 629).

Other social scientists have not given much attention to the relationship of nursing to the general role of women.[1] Thus one article on the changing role of nurses (Saunders 1954) lists six basic characteristics of nursing. At least four of these are basic not only to nursing but also to the cultural role that has generally been expected of women. These are: (1) great diversification of tasks from caring for patients to ordering supplies (or from rearing children to doing the marketing); (2) ambiguous status with inadequate prestige and rewards (or are women "housewives" or "homemakers"?)—though Saunders does suggest that the low rewards for female occupations, including schoolteaching and social work as well as nursing, may stem from "lingering notions we all have about the relative capabilities of men and women" (p. 1094); (3) social isolation both during training and later when relationships with other personnel are limited (or the restricted environment of the home); and (4) conservatism, stability, and caution, with imagination and a liking for change discouraged (or the image of the woman who, as the firm center of the family, safeguards established values).

Another study (Argyris 1956) had occasion to measure the dominant predispositions of a group of nurses, and four important ones were isolated: indispensability or the desire to be needed by others, self-control or the endurance of strong tension without overt expression of it, compatibility or the ability to maintain overt harmony, and passivity or the desire to have others initiate activity. (In contrast, management executives were directive, variety-seeking, challenge-accepting, and problem-solving-minded.) The nurses' predispositions are rather reminiscent of what are usually called the "feminine virtues."

The fact that many common conceptions about nurses are, in large measure, the same stereotypes that are entertained about women in general should be recognized by anyone who wants to understand and,

[1] A similar concentration on nursing per se—isolating it from the larger social scene—is shown in those studies which conclude that nursing is a means for "upward social mobility" (Reissman and Rohrer 1957; Deutscher 1956). Historians could perhaps argue that, given industrialization, urbanization, and increasingly widespread educational opportunities, upward mobility has simply been a fact of life for most Americans—not only for nurses.

perhaps, to change the expectations that others have toward nurses and, indeed, that nurses often have toward themselves. Certainly some of the early *American Journal of Nursing* editorials demonstrated a clear awareness of the relationship and favored a conscious identification with the larger "woman question."

In January, 1901, the *Journal* looked forward to an alliance of nursing with the National Council of Women. Another editorial, urging nurses to work with members of other professions, pointed out that "we are part of the great women's movement of the age in which we live" (January 1903). An engaging editorial of October, 1903, warned against faults of character such as "heedlessness, thoughtlessness and carelessness." Faults such as these, claimed the editors, are the problem of the women of our age and are "a part of what we commonly call the woman question, of which the nursing problem is but a unit." The suggested remedy was broader education and experience. In October, 1906, the *Journal* urged all nursing associations to work for equal suffrage and in March, 1913, rejoiced because nurses occupied a special section in a suffrage procession.

This early mood of spirited struggle was deflected by the onset of the Great Depression and its far-reaching consequences. Some of the consequences were reflected in the editorials. One, in April, 1930, discussed limiting nursing school enrollment because "yesterday we had 276 nurses on call and 57 calls to fill." Another announced in March, 1932, that in order to alleviate the unemployment situation for Missouri nurses, 40 schools in Missouri had not admitted January classes.

But something else happened during the depression and predepression periods that is important for our analysis of the two nursing traditions. The balance between the two themes of tenderness and technique—or character and knowledge as Florence Nightingale conceived them—was upset. Their earlier equilibrium in Miss Nightingale's day and for some time after was based on the use of technique and knowledge as a *means* to the tender care rendered by a dedicated nurse of developed character. (At least that was the ideal, and it is ideals and guiding values which concern us.) Although the planned development of character and knowledge in the student nurse took place in an atmosphere of severe and autocratic discipline—conditions we would today consider detrimental to learning—the balanced emphasis on their equal importance was nonetheless there.

Miss Nightingale was herself a remarkable blend of both. Though she is best remembered for her inspired nursing in the Crimea, symbolized in the image of the devoted lady with the lamp, she was also a fine ad-

ministrator and a brilliantly logical thinker.[2] Her *Notes on Nursing* included many shrewd and pungent points. She proposed that nurses develop their capacity to think, observe, and learn so that they could, for example, say " 'A. took about an oz. of his meat today'; 'B. took three times in 24 hours about ½ pint of beef tea'; instead of saying 'B. has taken nothing all day,' or 'I gave A. his dinner as usual' " (1946 ed., p. 113). But she also made clear the ultimate purpose of skilled observation, and the following statement sums up nicely the balanced relationship between the two themes:

> In dwelling upon the vital importance of *sound* observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort. The caution may seem useless, but it is quite surprising how many men (some women do it too), practically behave as if the scientific end were the only one in view, or as if the sick body were but a reservoir for stowing medicines into, and the surgical disease only a curious case the sufferer has made for the attendant's special information (p. 125).

But during the 1920's and 1930's the pursuit of technique and knowledge seems to have become an end rather than a means. The idea that techniques were but the tools of the thoughtful and devoted nurse was submerged. Of course this did not happen overnight. Stewart (1947) has observed that the emphasis on efficiency and standardization in business and industry before World War I had a considerable effect on nursing; as a result, nursing education moved in the direction of inflexibility, with nurses expected to follow a set pattern and with spontaneity discouraged.

Another factor that perhaps contributed to this shift in nursing values was the marked upsurge in medical knowledge and technology that characterized the thirties. This might have made an increased emphasis on technique inevitable.

Yet another factor was the harsh effect of the depression itself. There is some research data on this point. Burling, Lentz, and Wilson, describing interviews with nurses undertaken for *The Give and Take in Hospitals,* concluded:

> . . . the concept of the nurse as an angel of mercy . . . came into disrepute among nurses during the 1920's and 30's when wages were falling and the devoted nurse saw herself and her kind exploited on every hand. It was about this time that nurses began to restructure their idea of what the profession should be. . . . They began to emphasize higher education and technical competence. The nurse as comforter, the person who provided "tender loving care," continued

[2] Florence Nightingale's contributions to the field of vital statistics, to British Army hospital administration, and to the general field of sanitation were considerable.

to be seen as part of the ideal picture, but certainly this aspect was less emphasized.... [They were] somewhat shamefaced about tenderness as an element in good patient care. They weren't quite sure it was "professional" (1956, p. 105).

It is always a problem when dealing with developing movements and trends to mark off definite periods, but it appears, particularly in view of the Burling data, that it was these decades that witnessed an imbalance between the two themes, with the greater concentration on the theme of technical skills. Although some future historical research may provide a more precise dating, it is clear that the technical role did emerge as a *separate* tradition in nursing.[3]

The twenties and thirties also saw, however, the flowering of great concern about nursing education. A recent article on liberal education and nursing suggests that "some of the strongest programs of nursing education came into existence during this period" (Russell 1958, p. 120). The new direction—and the one that the nursing profession has since followed—aimed at integrating nursing into the new democratic philosophy of education set forth by, notably, John Dewey. This redefinition of the philosophy of nursing education and the consequent increase in the number and the influence of collegiate (as distinguished from hospital) nursing programs showed the way to reintegration of the two themes.

The aim of the democratic philosophy was the "development of the individual and the progressive enrichment of his life experience, on the one hand, and the reconstruction and improvement of society on the other" (Stewart 1947, p. 319). More specifically in terms of education for the professions, the growth and fulfillment of the individual are necessary for effective professional work; "it takes a stable, well-nourished personality to render the best professional service" (Russell 1958, p. 123).

In terms of nursing it means the development of professional individuals whose *technical* competence necessarily involves *tenderness,* or the ability to assess a patient's psychological needs and to care for them. Along with service to the patient, there is the matter of personal growth for the nurse. Here one must take into account the primary motivation of most nurses to help and serve others. It follows that self-interest for nurses requires satisfaction of this personal desire to be of service. In this sense nursing is a humanitarian profession, and its unremitting

[3] The technical tradition later encompassed administrative duties as well, which were partly necessitated by the very emergence of the technical role. That is, as nurses did more in the way of techniques, they also had to assume responsibility for new groups of subsidiary workers (first aides and later practical nurses) who were introduced to handle those bedside tasks for which nurses no longer had time.

drive to improve nursing, to raise standards, and to better the lot of the nurse has always been intertwined with the need to improve the lot of the patient.

As the nursing profession has moved forward in the work of creating a democratic framework suitable for liberal education and development of the nurse as an individual, it has made use of research findings as an aid to the redefinition of functions, roles, and values.[4] The social scientists involved in the mushrooming research on nursing have all been struck by the keen sense of change and conflict that pervades the profession today—though, judging by the *Journal* editorials, an energetic mood of transition and progress has rarely been absent—and they have variously assessed the environmental conditions and choices that face nurses. On the whole these investigators have observed nursing from only one major perspective—a sociological analysis of roles.

Everett C. Hughes, who has contributed greatly to research in nursing, has discussed the changes in the role and functions of the nurse as they relate to changes in medical technology:

> As medical technology develops and changes, particular tasks are constantly down-graded; that is, they are delegated by the physician to the nurse. The nurse in turn passes them on to the maid. But occupations and people are being up-graded, within certain limits. The nurse moves up nearer the doctor in techniques and devotes more of her time to supervision of other workers. . . . [T]he question arises of the effect of changes in technical division upon the roles involved. Sometimes a desired change of role is validated by a change in technical tasks (the nurses are an excellent example). Sometimes a change in technical division creates a role problem, or a series of them. I think we may go further and say that when changes of either kind get under way, the repercussions will be felt beyond the positions immediately affected, and may indeed touch every position in the system (1958, pp. 73–74).

Habenstein and Christ have also described this "ladderlike" ascension:

> As the professional nurse arrogates—however reluctantly—tasks and prerogatives of higher statused physicians, she finds commensurate excuse, if not need for sloughing off tasks which to her demand the least skill or are the least "professional." These sloughed-off tasks, for the most part, consist of direct patient care functions (1955, p. 147).

This research study, which was concerned with general duty nurses in nonmetropolitan Missouri hospitals, reported that, in the relationship

[4] A recent book, *Twenty Thousand Nurses Tell Their Story,* has summarized the reports that resulted from a five-year research program supported by the American Nurses' Association (Hughes, Hughes, and Deutscher 1958).

between the nurse and the auxiliary personnel who took over her "sloughed-off" tasks, the professional nurse complained that the auxiliary did not "keep her place" (p. 152). Similarly, in their study of institutional nurses in three Alabama hospitals, Ford and Stephenson (1954) found that confusion about who was to do what produced "discord" between graduate nurses and the practical nurses whom they supervised. The same phenomenon was observed in the study of a premature infant center, reported by Reissman and Rohrer, where "it was found that anxiety and confusion arose due to the differences that nursing service personnel saw in their informal and formal roles" (1957, p. 39).

Thus the continuing change in nursing functions has meant an increase in supervisory duties for the nurse, while the practical nurse and the aide, whom the nurse supervises, have assumed many direct patient care tasks which used to belong to the nurse. These changes have commonly been referred to, and just as commonly deplored by nurses, as "the move away from the bedside." Saunders has discussed the implications of this "move" and has argued that, since this change is here to stay, nurses should "redefine their professional function to the point where they could come to see themselves as managers and be proud of that fact . . . [and] give students a better and more realistic preparation for the jobs they are going to hold" (1954, p. 1098).

All these findings are valuable, both for the sociology of occupations and a theory of roles and to the nursing profession in its task of understanding and dealing with problems important to nurses. However, these findings are also limited—contained within a closed system of status considerations and concerned with the ways in which the personnel above and below the nurse affect her role and functions.

There is another vantage point from which one can view the changes and conflicts within nursing. Beyond the image of the nurse moving up the hierarchical ladder lies the fact of the developed, and developing, liberal philosophy of nursing education. There is also the fact of the self-interested desire to be of service that has attracted, and apparently continues to attract, women into the nursing profession. From this vantage point one could say that rather than, or along with, moving up, nursing is moving *outward* to a different, and perhaps unique, definition of its professional role. This move outward has been prompted by several things. On the one hand, there is the desire to become a complete, full-fledged profession and the belief that this can be achieved only by defining roles and functions unique to nurses, not by simply acquiring new functions from doctors while delegating others to prac-

tical nurses and aides.[5] On the other hand, there is the vital personal need of nurses to restructure the upward course that is, step by step, removing them from patients.

This outward direction has been characterized by an increasing use of concepts from the social sciences, particularly in the areas of personality theory and communications theory. Concomitantly there has been the development of the philosophy of team nursing. In this new approach, the psychological needs of the patient have been consciously and systematically integrated into the realm of things that concern the nurse.

Mary Roberts, long-time editor of the *American Journal of Nursing,* has described the team approach:

> Nursing teams are composed of at least one professional nurse, who is the team leader, and other workers, such as student nurses, practical nurses, and attendants in varying combinations. Team leaders function as truly professional people since success depends on diagnosing each patient's nursing needs and making, with the team, a comprehensive plan to meet them.... The psychological and social as well as the physical needs of patients are grouped, with the medical orders, to provide the focal point of nursing planning when the team method of assignment is used (1954, pp. 495, 559).

Thus the professional nurse is to function in a more creative way—for the benefit of herself, her patients, and the team members whom she supervises—and there is to be a nursing diagnosis as distinguished from the medical diagnosis.

An example is perhaps the best way to show the implications of this approach. Johnson (1958) has described the hypothetical case of a newly hospitalized young child. Along with the medical problem, the nursing diagnosis would include the problem of "separation anxiety"; and part of the nursing care would be concerned with providing "frequent and prolonged contact with a mothering figure" as well as "keeping to a minimum the number of persons contacting the infant" (pp. 6–7).

This approach has put the old-fashioned, and sometimes indiscriminately applied, "tenderness" on a new, self-conscious, and scientific level. It has paved the way for skillful and varied application of TLC (tender loving care), based on technical knowledge, according to the individual requirements of each patient.

In terms of our analysis, this approach has provided the solution to the problem of reintegrating the traditions of tenderness and technique

[5] One investigator, after studying what nurses think of their profession, has concluded: "Currently, there is among nurses a resistance to acceptance of functions which they feel might better be performed by some other type of worker.... Nurses do not want to be aides, nor do they want to be 'substitute doctors.' Instead, they seek security and recognition in a function belonging uniquely to the professional nurse" (Bullock 1954, p. 104).

which, for some time, have seemed so contradictory. Once again technique is seen, in a fresh way, as a means rather than an end in itself—a means to the end of comprehensive nursing care of the whole patient. The idea of nursing the *whole* patient has given new dignity and meaning to the concept of tenderness.

Just as it took some years for the emphasis on technique to establish the technical role as a separate tradition in nursing (and it is safe to say that never did all nurses subscribe to it), it will take some time for the new approach to become widely accepted. Certainly at the present time some nurses hold to one or the other of the old traditions, while others are attempting a reintegration of them.

This brings us to the heart of our research. Its purpose was to explore the current manifestations of these two traditions in the values of present-day nurses. In this sense it is a study of nursing values in transition. To anticipate the data, some nurses were found whose dominant values exemplified the tenderness ("ministering angel") theme as a separate tradition. Others were found who valued most the opposing theme of technique (the "efficient, disciplined professional"). Then there were two groups of nurses who represented different attempts to integrate both traditions into one image.

These are the four types of nurses which the research was able to isolate. This report is concerned with how they were isolated, what they were like, and how they got that way.

Chapter 2

The Plan of the Research

Any final research report, written as it is out of hindsight, is to some degree different from the original conception. This one is no exception. The research covered a period of three years, and the experiences over those years—both the continued contact with nurses and nursing problems and the continual process of analyzing data and thinking about their significance—have enriched and sometimes changed the original hypotheses.

Focus and Orientation of the Research

At the outset the area of major emphasis was, and has remained, the *human* world of the nurse, that is, the people she works with and how she feels about them. In preliminary talks and observation sessions with nurses—including nursing faculty members, nursing supervisors, and head and staff nurses—it soon became obvious that the center of the nurse's world actually *was* the patient. This seemed to be true even for faculty members and higher-echelon supervisors, though their thinking and planning revolved around an abstract image of the patient and his needs.

Perhaps the next most frequently mentioned person was the doctor, particularly among faculty members. There was considerable talk about what the relationship between the nurse and the doctor should be, for the sake of the nurse as well as the patient, and about how nurses could achieve more satisfactory relationships with doctors.

The list of people whom the nurse often deals with must also include her sister R.N., the practical nurse, and the aide. Although there were not many overt references to the practical nurses and aides who work under the supervision of registered nurses, observation sessions soon showed that they were important figures in the nurse's world—perhaps especially important in view of the infrequent, and seldom spontaneous, mention of them.

Since the nurse's relationship to her subordinates, as well as to the R.N.s who are her superiors, is based on supervising and being supervised, attitudes in this area were also felt to be of some significance. A related area of more than passing interest concerned the staff as com-

pared to the administrative position. In the former the nurse is closer to the patient; in the latter her supervisory responsibilities are greater.

These considerations defined the *focus of the research.* The purpose was to explore nurses' attitudes toward the *people* they work with: the doctor, the sister R.N., the practical nurse, the aide, and last but certainly not least, the patient. This exploration also included an assessment of nurses' attitudes toward supervision and toward staff and administrative positions.

Another recurrent theme in these early talks with nurses was deep concern about "the move away from the bedside." But there was by no means complete agreement about what this meant or what should be done about it. Some were worried because nurses did not have, or would not take, enough time for individual and intimate contact with patients. One typical head nurse, assailed with increasing paper work and administrative duties, was waiting for the proverbial day when the utilization of ward clerks or floor managers would free her to devote more time to her patients and her nursing staff. One supervisor, taking another tack, blamed the training of present-day graduates for their "carelessness about details" and "their lack of devotion"; she felt that "something fine had gone out of nursing."

Finally, another group of nurses, mostly in the field of nursing education, expressed more concern about what was done during the time spent with the patient than about the availability of such time. They felt that the needs of the "whole patient" often got lost in the pursuit of technique and efficiency. One instructor described the care given by an overly efficient nurse this way: "You'd be taken care of all right. You'd be spick and span and all done up in no time, but I don't know how you'd *feel.*"

From the very beginning, then, the researcher was confronted with the seemingly opposite themes of tenderness and technique. It was not long before these two traditions defined the *orientation of the research.* The initial plan called for a classification of nurses into two groups according to which tradition they represented, as measured by whether they did or did not want, most of all, to be with the patient. The attitudes of the whole sample, and of each of these two groups separately, were then to be explored. However, a further conception emerged during preliminary analysis of the data—that there were two other groups, between the two poles, which represented attempts to resolve or integrate the two traditions. Thus the orientation evolved toward four, rather than two, types of nurses. The focus became the attitudes toward fellow workers and toward nursing functions that were characteristic of each of the four types.

The Research Instruments

Four instruments[1] were constructed to get at the desired attitudes, that is, attitudes toward the patient and his visitors, toward fellow workers, toward supervision, and toward staff and administrative positions. The usual background data as well as reasons for entering nursing were also included. The original instruments have been reproduced in Appendix A. The structure and scoring methods for each will be described in those chapters that deal with the data obtained from each instrument. This discussion can therefore be limited to a general characterization of the instruments.

One instrument was the Nursing Picture Item Test, whose purpose was to measure the nurse's attitudes toward the patient, toward fellow workers, and toward the patient and fellow workers in relation to one another. One section of the instrument became the means for sorting the sample of nurses into four groups depending on which value tradition, or combination of traditions, was most important to the respondent (Chapters 3, 4, 5, and Appendix C).

The second instrument was a questionnaire which included several kinds of items. One section used the incomplete sentence technique to get at attitudes toward the model patient (Chapter 4), reasons for entering nursing (Chapter 6), attitudes toward supervision and staff and administrative jobs (Chapter 7), and further attitudes toward the doctor, aide, practical nurse, and the patient's visitors (Chapter 8). Along with this semiprojective technique, the questionnaire also included some straightforward items designed to get at the feelings toward fellow workers (Chapter 8). Finally, the questionnaire included several items of the forced choice variety (Chapters 4 and 7).

The third instrument was a salary schedule. It measured feelings toward fellow workers in terms of opinions about how adequately they were paid (Chapter 8).

The fourth instrument was the usual biographical data sheet. It asked for information about the respondent's family background, education, and work history (Chapter 6).

The instruments were administered, either individually or to small groups of nurses, in the order in which they have been described. The time needed for administration varied from one and a half to, in extreme cases, three hours. Most of the subjects were tested at their place of work on worktime. The public health nurses, however, who were

[1] There was a fifth instrument constructed by Dr. Craig MacAndrew which measured characterological orientations of nurses. For a description of MacAndrew's instrument and a list of reports on the resulting data, see Appendix A.

more often in the field than in the office, generously received an interviewer at home on their own time. The questionnaires were filled out anonymously.

The Sample

The complete sample of 697 female respondents included two large groups: 292 practicing R.N.s and 405 students (including a group of 43 high school girls who were members of Future Nurse Clubs). All the R.N.s had received their nursing education in the United States.

With respect to the R.N.s, it was initially hoped that a random sample of all nurses practicing in the Los Angeles metropolitan area could be obtained. However, no complete and up-to-date list existed. It was then decided to concentrate on getting adequate samples of several different nursing specialties rather than trying to cover the whole gamut. Four specialties were selected because they represented common, as well as different, kinds of nursing. They were medical nursing, psychiatric nursing, public health nursing, and surgical nursing. The surgical specialty was defined to include nurses who worked on a surgical floor, and operating room nurses were thus excluded.

Another dimension was included in the delimitation of the sample, namely, level of position. This stratification was considered necessary so that significant differences along other variables could also be systematically analyzed for the possible influence of job level. Therefore, it was decided to draw at least one fourth of the sample from nurses at the junior administrative level (head nurse or above), and the rest from among staff nurses (defined as those working at the staff level who did not supervise any other R.N.).[2] The actual distribution of staff and junior administrative nurses among the samples drawn from each of the four specialties was as follows:

	Staff nurses	*Junior administrative nurses*	*Total*
Medical	49	23	72
Psychiatric	60	17	77
Public Health	60	15	75
Surgical	52	16	68
Total	221	71	292

A random sample of public health nurses was obtained from the complete list of all public health nurses working in the Los Angeles area. As

[2] This ratio was chosen to insure a sufficiently large base group of staff nurses in each specialty so that, if it proved necessary, comparisons could be made among specialties without involving higher-echelon nurses (the junior administrators).

indicated earlier, the public health group filled out the questionnaire at home. Before this, each one received a letter describing the survey and explaining that an interviewer would contact her at home. Out of 76 cases, there was only one refusal—a testimony both to the cooperativeness of respondents and the persistence of the interviewers, all of whom were themselves nurses.

The remaining samples were obtained through arrangement with nursing service departments at eight different hospitals. In all cases a certain number of staff and junior administrative nurses was specified, and it was indicated that respondents should be selected more or less randomly. In some instances, this meant random selection from the complete personnel list. In others, respondents were chosen at the last minute depending on which floors could most easily spare the personnel on that particular day.

The group of psychiatric nurses was obtained from three large psychiatric hospitals. Several hospitals were used so that possible effects due to any one hospital's particular atmosphere would be minimized. Two hospitals were under state control and one under federal. Two were located in the metropolitan area while the third was in a rural community.

The medical and surgical samples were drawn from five different hospitals of varying sizes as follows: two had over 1,000 beds, two were in the 300–500 range, and one had 250 beds.[3] Hospitals smaller than that could not be included since they did not have separate medical and surgical floors. Hospitals run by Protestant denominations were not included nor were Catholic hospitals, since it was felt that nurses who were nuns as well would constitute a special group. However, the sample turned out to be approximately 25 per cent Catholic, a figure that is comparable to the proportion of Catholics in the population at large.[4]

The sample of nursing students was obtained from three accredited schools of nursing—a collegiate school (baccalaureate program), a two-year community school (associate degree program), and a hospital school (diploma program). Again, no Catholic schools were included, but a comparable proportion of Catholic girls turned up in the sample. All students attending classes on the day the research instruments were administered were tested.

It also proved possible to obtain a sample of 43 high school girls who

[3] There were no general medical-surgical hospitals in the 500–1,000-bed range in the Los Angeles area.

[4] In a research study covering all nurses working in the Kansas City Standard Metropolitan Area 23 per cent were found to be Roman Catholic (Deutscher 1956).

belonged to Future Nurse Clubs. Two high schools were included, one in a middle to lower-middle class neighborhood and the other in an upper-class neighborhood.

The distribution of the student sample was as follows:

Collegiate school with baccalaureate program: Total N = 130	24 seniors (members of this group were retested two years after graduation) 38 juniors 68 sophomores (members of this group were retested during their senior year)
Two-year community school with associate degree program: Total N = 110	26 practicum (third-year) students 34 second-year students 50 first-year students
Hospital school with diploma program: Total N = 122	38 third-year students 62 second-year students 22 first-year students
High schools:	43 students (members of Future Nurse Clubs)
Total students = 405	

The major part of this report (Chapters 3–8) will be devoted to the data from the sample of practicing R.N.s. Chapter 9 will present the data for the student sample. Chapter 10 will introduce a separate study undertaken during the third year of the research project, and its sample and methodology will be described at that time. Finally, Chapter 11 will present conclusions and implications for further research.

Chapter 3

Today and Yesterday in Nursing

The Nursing Picture Item Test

The essence of every nurse's job lies in her work *with people.* In some professions human relationships are secondary to the main purpose—manipulation of physical objects, for instance, or of ideas and concepts. But in nursing the human relationship has always been primary. In the modern era the job of instructing and supervising practical nurses and aides has been added to the graduate nurse's established duties of caring for patients and conferring with or assisting doctors and other graduate nurses. All these functions—whether approached from a tender, technical, or other point of view—involve, in an important way, people.

One research instrument, the Nursing Picture Item Test, was concerned with how nurses in the sample felt about these work relationships and about the different people involved. Which ones did they like most, and which were only second best? Which were considered more typical of nursing today, and of nursing 20 years ago? The NPIT consists of nine pages of various photographs of a hospital nurse in relation to her patient and several fellow workers: a doctor, another R.N., and an aide.[1] On these pages certain work relationships are opposed to others. The nurse was asked to look at the pictures and decide how much the different relationships appealed to her. Her choices showed which work-people situations were highly charged for her. Preference for a particular work relationship represented more than a simple liking for certain people. Since the ultimate nature of the nurse's work concerns people, her images of her proper role and function as a nurse were also involved.

The nine pages of the NPIT were broken down into three different sections: the Five-Way Section, the Sharing Section, and the Compound Section.

The Five-Way Section. This was one page consisting of five photo-

[1] The Nursing Picture Item Test was developed by the author specifically for this study. The original instrument consisted of ten pages of photographs, but one page was later dropped. For a description of the development of the NPIT as well as the statistical analysis of its effectiveness and stability as a measurement instrument, see Appendix C. For reproduction of the instrument itself, see Appendix A.

graphs which showed the nurse in the following work-people situations: (1) the nurse with her patient, (2) the nurse with a doctor, (3) the nurse working with another nurse, (4) the nurse with an aide, and (5) the nurse alone at the nurses' station. The respondents ranked the pictures from first to fifth place according to their personal preferences. Responses to these five pictures, which did not include any "sharing" or group relationships, provided a straightforward ordering of the subject's preferences for her work companions as well as for working alone.

The Sharing Section. The Sharing Section showed three work-people situations in which the nurse "shared" her patient with a third person, but the identity of that third figure varied: (1) the nurse and the doctor together with the patient, (2) the nurse in company with another nurse and the patient, and (3) the nurse and the aide together with the patient. Now the implicit decision for the respondent was: with whom was she most willing to share her patient?

The instructions asked the respondent to indicate the situation she would "most like to be working in" and the one that would be her "second choice." The former received a rank of 1, the latter a rank of 2, and the remaining situation was automatically scored as 3. Since this section consisted of two similar pages[2]—permitting two measurements of the respondent's attitudes which were then combined to obtain her scores—the number of points (ranks) that a respondent allocated over all three situations totaled 12.

There were two other instructions on each page which asked the respondent to express her opinion as to which of the three situations was "most typical of nursing today" and "least typical of nursing today."

The Compound Section. The remaining six pages of the NPIT were called the Compound Section because both sharing and nonsharing situations, as well as situations that did not involve the patient at all, were included. There were three series within the Compound Section, and two pages (i.e., two separate measurements) were devoted to each series. The instructions and scoring procedure followed the same pattern as those for the Sharing Section.

The first series placed three relationships in opposition to one

[2] The groups of people were the same on both pages of the Sharing Section, but the activities and settings of the photographs were different. This method of "double measurement" was also used in the Compound Section. The purpose was to check whether the subjects were in fact responding to the people in the photographs or to other factors such as the type of activity. Another check, to determine whether the instrument was actually getting at preferences for people, was introduced in the Sharing Section and on some pages of the Compound Section in the form of an additional instruction. This was a direct question about the people in the pictures in contrast to the less pointed wording of the regular instruction. Evidence that our purposes were accomplished is presented in Appendix C.

another: (1) the nurse working with a patient, (2) the nurse working with another nurse, and (3) both nurses working together with the patient. A direct, undivided relationship with the patient was opposed on the one hand to a sharing of the patient with another nurse, and on the other hand to a relationship with a fellow nurse which did *not* include the patient. On this series, the respondent decided whether she would rather work alone with her patient, share her patient with another nurse, or bypass the patient entirely and work with her fellow R.N.

The second series of the Compound Section was also based on nurse and patient, but the nurse's colleague[3] in this case was the doctor. The three photographs presented (1) the nurse working alone with the patient, (2) the nurse working with the doctor, and (3) the nurse and doctor working together with the patient. Again the direct, exclusive relationship with the patient was opposed to a sharing one and to a relationship with the doctor alone.

The structure of the third series of work-people relationships paralleled that of the first two sets, but this time the fellow worker was the aide or attendant. Although sharing the patient with the aide may be different from sharing the patient with the doctor or another nurse, nonetheless it is a sharing relationship. The respondent decided on this set whether she preferred (1) the nurse working alone with her patient, or (2) the nurse and the aide together working with the patient, or (3) the nurse working alone with the aide.

In addition to personal preferences, respondents also indicated their beliefs about what is *most* and *least* typical of nursing today for each series in the Compound Section. The first and second series were also judged as to which work-people situations were *most* and *least* typical of nursing 20 years ago. This instruction was omitted from the third series, with the aide as the fellow worker, because the aide was not a usual figure in the hospital of 20 years ago.

Responses of Total Sample of R.N.s

The nurses in the sample came from four different specialties and represented both staff and junior administrative positions. These factors, along with differences in age and religion, could have influenced their responses. Even more important was the effect of each R.N.'s approach to nursing—efficiency, compassion, or a blend of both. In

[3] For simplicity, the term "colleague" will be used to refer to all three figures—doctor, other nurse, and aide—though by strict definition only the other nurse is a colleague. The term "nurse-colleague relationship" will refer to all three situations—the nurse with a doctor, the nurse with another nurse, and the nurse with an aide.

fact, our major purpose will be to separate the nurses into groups according to their dominant values as expressed on the Compound Section and then to examine the differences in their responses to the other two sections of the NPIT. But a general characterization of the attitudes of the total group of nurses, regardless of their diverse backgrounds, should come first.

Responses to the Five-Way Section. Responses to the Five-Way Section are shown in Table 1.[4] Working with the doctor proved to be the favorite situation, while a working relationship with the patient ranked

TABLE 1

PREFERENCES OF THE TOTAL GROUP OF R.N.S ON THE FIVE-WAY SECTION
(N = 267)

Picture items	Mean rank	Rank order
Nurse with doctor	1.97	1
Nurse with patient	2.25	2
Nurse with another nurse	3.22	3
Nurse with aide	3.70	4
Nurse alone	3.86	5

second. Working with another R.N. was third, and working with an aide placed fourth. Working alone at the desk placed last.

In preferences as complex as these, many factors are involved. One is status. Another is authority or power. Yet another is the force of the usual cultural roles that are expected of men and women, or doctors and nurses, with the woman (nurse) generally taking direction from the male (doctor). Apart from expectations there is the real fact that the health team (as distinguished from the smaller nursing team) is headed by the doctor. All these could be effective common denominators for the whole group of nurses that would result in the observed order of choices, with the doctor holding top position. The patient came next, for nursing *is* a profession devoted to service. (As one nurse explained her choice: "First I'd like to be in the picture talking to the doctor about the patient. The next logical step is to go in to the patient.")

Next in line was the fellow R.N. (third place) who outranked the aide (fourth place). Aside from the real difference in authority and responsibility between the nurse and the aide, there are the problems

[4] Although the NPIT was administered to a total group of 292 R.N.s, the N varies for each table because of the failure of some subjects to respond to all items. The appropriate N is indicated in each table throughout the report.

generated by the fuzziness of the lines dividing functions properly belonging to each level. Confusion and contention have frequently resulted (Christ 1956 and Ford and Stephenson 1954); and many nurses must feel disturbed about their increasing loss of contact with patients and uncertain about the motives of those who work under their direction.

Last in rank was working alone at the desk. In fact, only 13 of the 267 nurses selected it as their first choice. (One respondent, who even managed to avoid identifying with the nurse in this photograph, said:

TABLE 2

RESPONSES OF THE TOTAL GROUP OF R.N.S ON THE SHARING SECTION
(N = 266)

Picture items	Like		Typical of nursing today	
	Mean rank	Rank order	Mean rank	Rank order
Nurse with patient with doctor	3.25	1	3.46	1
Nurse with patient with another nurse	4.25	2	4.71	3
Nurse with patient with aide	4.50	3	3.83	2

"That's somebody with about 15 charts to do. I feel sorry for the kid.") This bears out the current low status of paper work noted by other researchers (Argyris 1956 and Reissman and Rohrer 1957). Another factor (or perhaps it underlies the dislike for doing solitary paper work) is the overwhelming importance of the human relationship to nurses, and this is certainly missing when the nurse works alone at her desk.

Responses to the Sharing Section. Table 2 shows the responses of the total group to the section in which every photograph showed both the nurse and her patient along with some colleague. There was no conflict here about "having" or "not having" the patient; it was simply a question of which colleague the nurse would rather share her patient with. Again the doctor dominated and the fellow R.N. outranked the aide.

In terms of opinions about what is more typical of nursing today, the nurse-patient-doctor relationship placed first. There was some discrepancy, however, in the case of the other two sharing relationships. Although the nurse-patient-nurse relationship was liked second best, it was thought to be least typical; the nurse-patient-aide situation was liked least and placed second in terms of beliefs about what is typical of nursing today. This is not surprising in view of current hospital

conditions. It is not easy to spare two professional nurses to be with one patient.

Responses to the Compound Section. This section involved complex oppositions of work relationships, and it was here that real discrepancies appeared between what nurses wanted and what they thought was most typical today. Table 3 gives the responses.

TABLE 3

RESPONSES OF THE TOTAL GROUP OF R.N.S ON THE COMPOUND SECTION
(N = 205)

Picture items	Like		Typical of nursing today		Typical of nursing 20 years ago	
	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order
Series I						
Nurse with patient with another nurse	3.63	1	4.57	2	3.71	2
Nurse with patient	3.91	2	4.69	3	2.91	1
Nurse with another nurse	4.46	3	2.74	1	5.38	3
Series II						
Nurse with patient with doctor	3.14	1	3.92	2	3.96	2
Nurse with patient	4.59	3	5.04	3	2.69	1
Nurse with doctor	4.27	2	3.03	1	5.35	3
Series III						
Nurse with patient with aide	3.69	1	3.96	2	....	..
Nurse with patient	3.90	2	4.92	3	....	..
Nurse with aide	4.41	3	3.12	1	....	..

The most popular relationship in all three series was the sharing situation. In the first and third series, the nurse's direct, exclusive relationship with her patient ranked second, while nurse-with-colleague (fellow R.N. in the first series and aide in the third) placed last. The series with the doctor as colleague revealed again his special prestige: nurse-doctor ranked second rather than third, and the nurse alone with her patient was relegated to the bottom position.

Speculation about the significance of these findings leads quickly to the realities of the modern nursing situation. Nurses have to share their patients, along with knowledge about them and plans for their care, if they are to maintain the prevalent, and noble, image of what nursing means. The finding that the sharing preference was strong in

this sample could mean that the idea of team nursing will come to be seen by many nurses as a necessary and desirable solution to the move away from the bedside and its resulting frustration. Or it could mean, as Reissman and Rohrer (1957) argue, that nurses prefer to avoid being alone with patients, though the fact that being completely away from the patient (the nurse-colleague situation) was generally considered *least* preferable is evidence against that possibility. These are questions that can be raised, but not yet answered.

It should be kept in mind that these averages, for all three sections

TABLE 4

CORRELATIONS (KENDALL'S TAU) FOR THE TOTAL GROUP OF R.N.S BETWEEN PREFERENCES, OPINIONS ON WHAT IS TYPICAL, AND WHAT WAS TYPICAL OF NURSING[a]

(N = 205)

	Typical today	Typical 20 years ago
Like	−.11	−.07
Typical today	.....	−1.00[b]

[a] These correlations were obtained in the following fashion: The work-people relationships shown in the first three series were combined into one group of nine situations and then ranked from 1 to 9 on the basis of overall preference. These nine items were next ranked in a separate order on the basis of opinions as to how typical they are of current nursing practice. These two rankings were then compared to get the relationship between preferences and beliefs about what is most typical today. Only six of the nine situations (i.e., those in series I and II) could be ranked as to how typical they were of nursing 20 years ago. (The third series involved the aide, who has only recently become a standard figure within nursing.) Comparisons of beliefs about the situation 20 years ago with both preferences and opinions about nursing today were based, then, on rank orders of six, rather than nine, items.

[b] Significant at least at the .01 level.

of the NPIT, represent what was most common to *all* the nurses in the sample and that effects due to differences in values, level of position, and the like were minimized. (For example, there were some groups of nurses, as Chapter 4 will show, who did *not* place the doctor first.)

Preferences Compared to Opinions. Perhaps the most significant finding from Table 3 is that the work relationships nurses generally preferred were not the same as those they believed to be most typical today; and conversely, the relationships considered to be most typical tended to be the ones they least preferred. This conflict is summarized in Table 4 in the form of nonparametric correlations (Kendall's tau as described by Schaeffer and Levitt 1956) showing the amount of correspondence between what nurses liked, what they thought was typical of nursing today, and what they believed to have been typical 20 years ago.

There was a significant negative relationship (–1.00) between nurses' opinions as to what *is* versus what *was* typical of nursing. Since it seems

natural that nurses would believe that changes have occurred, that today is not the same as yesterday, it is the nature of the change and attitudes toward it that will be of greater interest.

Looking back at Table 3, it is apparent that the predominant change from yesterday concerned the nurse-colleague relationship: it was believed to have become *more* typical. This particular change was not a welcome one, however, for the nurse-colleague relationships were (except for the doctor-colleague) the least liked of the possibilities offered to respondents. A second change concerned the undivided nurse-patient relationship: it was thought to be *less* typical today. This change was more welcome for, on the whole, the nurses of today would rather share their patient with a colleague than remain alone with the patient.

Again, it is to be remembered that these findings are based on averages over the whole group of nurses, and, in that sense, they tell only the "surface" of the story. That some nurses were quite satisfied with the situations considered typical today, while others definitely preferred the ways of yesterday, will be shown in the next chapter.

Chapter 4

Four Types of Nurses Defined

Classification of the R.N.s into Four Value Types

The first chapter, sketching the historical development of two traditions in nursing, suggested that, probably in the twenties and thirties, these themes came to be contradictory and that currently a new integration of them has been taking place. One tradition was that of the "ministering angel," which included dedication and compassion and embodied the image of the nurse in an undivided relationship with her patient. The other was the later, *separate* emphasis on skilled performance of technical and administrative functions which overshadowed the values of simple patient care.

The development of a method of sorting nurses into groups corresponding to these opposing and, for some, reintegrated traditions was a major aim of the research; and another use for the Nursing Picture Item Test emerged. A classification scheme was devised which used the respondent's *preference* responses to the Compound Section, and it yielded four value groups or types—one for the "tenderness" tradition, one for the "technical," and two for modern reintegrations of them.

The scoring procedure was as follows: Over all three series, for each respondent, the points (ranks) assigned the *nurse alone with her patient* pictures were summed into one score. A second score combined all the points assigned to the *nurse with colleague* pictures. A third score represented the combined points given to the *sharing* pictures. The score that was lowest of the three determined the subject's classification. If the first score was lowest, the classification was Type I ("ministering angel"). If the second score was lowest, the respondent was classified Type IV ("efficient professional"). If the third score was lowest, the subject was placed in Type II or III ("modern integrations") depending on the second lowest score—Type II if the respondent liked "nurse-patient" second best or Type III if "nurse-colleague" was second best. Cases of tied scores were omitted.

Type I is conceived as representing the nurse who places the highest

value on direct patient care and who is oriented to the oldest tradition of all—the ministering angel who nurses her patient unaided. In terms of the actual responses to all three series of the Compound Section, these nurses liked the undivided relationship with the patient more than either the sharing situation or the nurse-colleague relationship. When their responses to the two rejected situations were compared, it was found that sharing the patient was generally preferred to working just with the colleague. It should be easy to see why this group was chosen to represent those who derive their dominant values from the older tradition: they want direct patient care most, next they will share the patient, and only last will they bypass the patient to work alone with a colleague.

Type IV is conceived as representing the nurse who finds her dominant values in the technical-administrative tradition which emphasizes planning and supervisory functions carried out with other workers more than with the patient. In terms of actual responses to the Compound Section, these nurses liked the nurse-colleague relationship most. Analysis of their responses to the other two situations showed that, on the whole, the sharing situation placed second and being alone with the patient was third. Because of this orientation away from an undivided relationship with the patient, Type IV is seen as fulfilling the technical-administrative role of the efficient, disciplined professional. (It is this sort of role, perhaps, that makes some patients feel that the nurse is "off somewhere being very busy running things.")

The responses of Types II and III fell between those of Types I and IV, and the attempt to understand their significance led to the formulation of two kinds of integration of the different values separately symbolized by Types I and IV. Types II and III in fact resolved the conflict implicitly presented in the Compound Section by preferring those photographs in which the nurse worked with *both* patient and colleague (i.e., the sharing pictures). From this comes our interpretation of these types as representing two somewhat different attempts to combine into one role or image the seemingly opposing traditions of I and IV. Their attempts at resolution are said to be different since, in terms of their choices for second best, the figures of patient and colleague did not have the same drawing power.

Type II nurses generally placed the nurse-alone-with-patient pictures second, leaving the nurse-colleague relationships for last place. This suggests that the primary orientation of this group is still toward the patient, that it was the patient more than the colleague that drew the

respondent into choosing the sharing situation first. This type makes great sense interpreted as, to some degree, an outgrowth of the developing modern philosophy of team nursing which recognizes the importance of the newer functions of supervising, planning, teaching, and generally sharing the patient's nursing needs, and yet still emphasizes the patient as the heart of the activity. In this sense, Type II is closer to I than IV and has perhaps achieved an integration of the values of both which does not remove her too far from her original motivations for entering nursing. (As will be shown in the chapter on student nurses, the majority of our sample of girls selecting nursing today scored as Type I and therefore seemed to be predominantly attracted by the image of the ministering angel.)

Type III, on the other hand, ranked the nurse-colleague relationships second to sharing situations and placed the undivided nurse-patient relationship last. This suggests that these nurses, with their high regard for the colleague relationship, are closer to IV than to I. This type seems to represent another kind of modern integration, one which relies more heavily on the technical-administrative tradition.

The reason for numbering the modern types II and III should now be clear—II lies closer to the values of I, and III has a closer relationship to IV. The rest of this chapter, and the following ones, will be devoted to analysis of other attitudes and characteristics of these four types.[1]

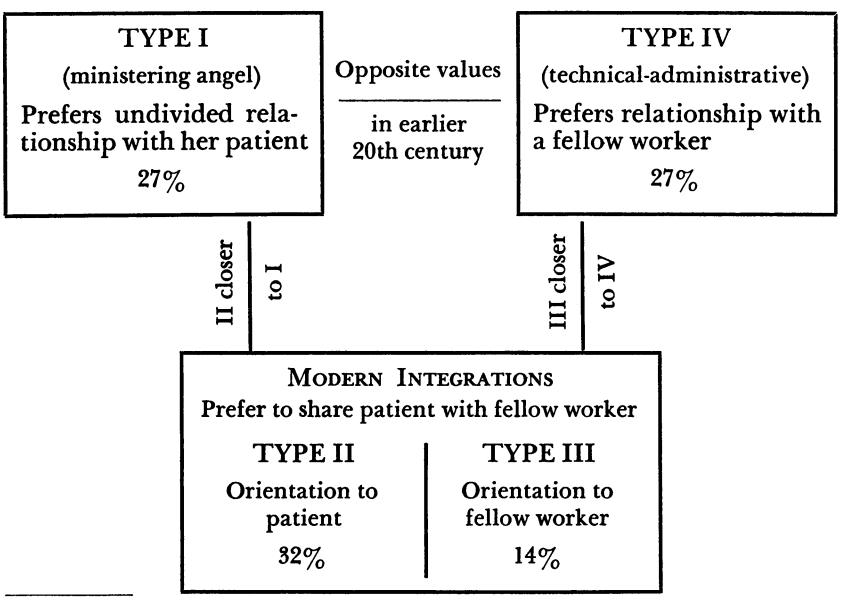
Some limitations should be noted. These types are both abstractions and interpretations. They are abstractions in the sense that no nurse is a pure type. In real situations every nurse's behavior is affected by many different pressures and needs. These types correspond to a *dominant* set of values or orientation toward patients and fellow workers, and values are only one force toward action.

The types are interpretations in the sense that historical analysis of important value traditions in nursing suggested them, and in the sense that the basis for separating nurses into groups corresponding to these types was a series of inferences about the significance of different responses to various photographs. The data to be presented in the following sections should shed light on the plausibility of the

[1] Two of the value types resemble types proposed by Habenstein and Christ (1955). These researchers used three types: professionalizer, traditionalizer, and utilizer. Our Type I is related to their traditionalizer, and Type IV resembles their professionalizer. Their utilizer represents the type of nurse who is not centrally committed to nursing as a profession but sees it only "as a job" (p. 43). This dimension was not relevant to our data, while their framework was not concerned with types representing integrations of the divergent values.

interpretations as well as provide information for enlarging the characterizations of the four types.[2]

Sorting the total sample of 292 R.N.s into the four value types on the basis of their *preference* responses to the Compound Section resulted in the following groups: Type I, 58; Type II, 70; Type III, 31; and Type IV, 58. (Seventy-five cases were lost because of failure of subjects to respond to every item on the Compound Section or because of ties.[3]) Types I and IV, representing the two opposite traditions, were equal in size and together accounted for somewhat more than half the sample. Types II and III, representing different attempts at integration, together accounted for a little less than half, with Type II (closer to the old nurse-patient tradition) being the single most frequent type. This distribution is shown in terms of percentages in the accompanying diagram, which also summarizes the definitions of the types.[4]



[2] Unless otherwise indicated, all value type differences that will be discussed were also checked as to the influence of age, religion, and job level and were found to be *not* significant. Any significant differences due to nursing specialty will be discussed in Appendix B, which contains "portraits" of the specialties.

[3] The basic N for the following chapters will therefore be 217 although it will vary from table to table because some of the 217 nurses did not respond to all other items in the questionnaire. The appropriate N will be indicated in each table.

[4] In conversations with faculty members of the UCLA School of Nursing the types rapidly acquired nicknames. Type I became known as "Mrs. TLC" while Type IV was called "Miss Ironhand." Type II was "Miss Modern Grad" and Type III was "Miss Transition" or "Miss Confused" since she seemed to represent only a partial move toward the modern values of team nursing. (Actually, "Miss Ironhand" does not catch the essence of Type IV. "Quick Hand" or "Thorough Hand" would be more appropriate.)

Opinions of the Four Value Types on Typical Situations

The *opinion* responses of the subjects provide more data about the value types. Table 5 shows that the four value types significantly agreed that the work relationships most typical of nursing today are not the same as those of 20 years ago (–.87 to –1.00), and Table 6 indicates that they significantly agreed in their beliefs about which relationships *are*

TABLE 5

TAU CORRELATIONS SHOWING, FOR EACH VALUE TYPE, THE AMOUNT OF AGREEMENT BETWEEN PREFERENCES FOR WORK RELATIONSHIPS AND OPINIONS ABOUT THEIR TYPICALNESS TODAY AND 20 YEARS AGO

(N = 185)

	Typical today	Typical 20 years ago
Like		
Type I	−.72[a]	+ .60
Type II	−.39	+ .20
Type III	+.22	− .47
Type IV	+.93[a]	−1.00[a]
Typical today		
Type I	.....	−1.00[a]
Type II	.....	− .87[b]
Type III	.....	− .87[b]
Type IV	.....	−1.00[a]

[a] Significant at least at the .01 level.
[b] Significant at least at the .05 level.

most typical and which *were* most typical (+.72 to +1.00). In other words, they not only agreed that the old era is gone, but they also held quite similar opinions as to what the old era was like and what has taken its place today. The undivided nurse-patient relationship seemed to symbolize the old era, while the nurse-colleague was considered the hallmark of today.

These images of today and yesterday were essentially the same as those already described for the total group regardless of value type. In this case, averaging all nurses together did little violence since they all apparently entertained similar opinions on typicalness, as shown by the high correlations among the value types. In view of this similarity, separate tables for the value types are not given since Table 3 in the preceding chapter has already presented the data on opinions about today and yesterday over the total group. In comparing preferences to opinions, however, combining the four value types did have

a leveling effect, for there was no significant relationship between what the total group preferred in the way of work companions and what it felt is typical today and was typical 20 years ago. This lack of correlation does not hold for the separate value types, precisely because their preferences, described in the first section of this chapter, were different.

Type I, representing the older tradition, preferred the old era by far (+.60 between preferences and typical 20 years ago as against –.72

TABLE 6

TAU CORRELATIONS SHOWING THE AMOUNT OF AGREEMENT AMONG THE FOUR VALUE TYPES AS TO THEIR PREFERENCES AND OPINIONS OF TYPICALNESS FOR WORK RELATIONSHIPS
(N = 185)

	Type II	Type III	Type IV
Type I			
Like vs. like	+ .39	− .22	− .71[a]
Typical now vs. typical now	+ .89[b]	+ .83[b]	+ .89[b]
Typical 20 years ago vs. typical 20 years ago	+1.00[b]	+ .73[c]	+1.00[b]
Type II			
Like vs. like	.....	+ .39	− .26
Typical now vs. typical now	.....	+ .83[b]	+ .78[b]
Typical 20 years ago vs. typical 20 years ago	.....	+ .73[c]	+1.00[b]
Type III			
Like vs. like	.....	.....	+ .26
Typical now vs. typical now	.....	.....	+ .72[b]
Typical 20 years ago vs. typical 20 years ago	.....	.....	+ .73[c]

[a] Significant at least at the .05 level.
[b] Significant at least at the .01 level.
[c] Significant at least at the .10 level.

between preferences and typical today). Type IV, mistress of the technical-administrative role, was drawn to the ways of today (+.93 between preferences and typical today as against –1.00 between preferences and typical 20 years ago). Apparently it was the increase in nurse-colleague relationships and the decrease in undivided nurse-patient relationships that accounted for the difference, with Type IV profiting by these changes from the ways of yesterday.

The correlations for Types II and III were less extreme with, as expected, II closer to I and III more similar to IV. Type II showed a slight but definite preference for the past (+.20) as against some dislike of today (–.39). Type III, on the other hand, was similar to IV by pre-

ferring today (+.22) and not yesterday (−.47). It was the strong preference for sharing relationships that differentiated these two from their more extreme counterparts, so that II was not as dissatisfied with today as was Type I, while III was not as pleased as Type IV.

Other researchers have discussed these opposing traditions. Argyris (1956), studying nurses' attitudes, found that their preference for patient contact tended to make them poor administrators who resented paper work. On the other hand, Reissman and Rohrer (1957), studying both attitudes and actual behavior of nurses, came to the conclusion that, for the total group observed and questioned, their expressed preference for patient contact contradicted their actual practice of avoiding patients in favor of administrative work. They reasoned that nurses were caught in a dilemma between what they were really drawn to do—and in fact did—and what they felt they "ought to value," namely, patient contact. In spite of the contradiction between expressed attitude and overt behavior, both studies indicated that nurses generally said that patient contact came first.

Both these studies dealt with nurses as one total group. Their central focus necessarily was the typical nurse or the attitudes common to all nurses studied. This is valuable for generalizing about the nursing profession as a whole, just as this report presented first the findings for the total sample regardless of individual or type differences. But the opposing forces catch individual nurses differently. Indeed, separating nurses into the four value types showed not only that the opposing traditions had differential appeal, but also that a substantial number did not even indicate that they wanted patient contact most of all, namely, Type IV and to a lesser extent Type III. (Furthermore, some expressed definite preferences for administrative work, as Chapter 7 will show.) This sentiment on the part of some types of nurses will become more vivid in the next section.

Responses of the Four Value Types on the Five-Way and Sharing Sections

The Five-Way Section responses of the total group of R.N.s, described in Chapter 3, showed that the doctor was most popular, the patient next, the fellow nurse third, the aide fourth, and working alone was last. This order changed when the four value types were dealt with separately, as Table 7 shows.

The most important change concerned the position of the nurse-patient relationship. Unlike the findings for the total group, both Types I

and II put the patient first and relegated the doctor to second place. For Type III, however, the patient remained second to the doctor. Type IV also ranked the doctor first, but—and this is the striking change—working with the patient dropped to fourth place. The finding that, over the total group, the nurse-doctor relationship was most popular can now be seen in a new light. It was not that the whole sample especially liked the doctor, but rather that Type IV, preferring the patient so little, greatly lowered the average for the patient.

Thus there were two types of nurses (I and II) who indicated that

TABLE 7

PREFERENCE RESPONSES OF THE FOUR VALUE TYPES ON THE FIVE-WAY SECTION

Picture items	Type I (N = 55)		Type II (N = 66)		Type III (N = 30)		Type IV (N = 54)	
	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order
Nurse with patient....	1.51	1	1.53	1	2.50	2	3.59	4
Nurse with doctor....	2.38	2	2.18	2	1.67	1	1.67	1
Nurse with aide.....	3.71	4	3.53	3	3.77	4	3.81	5
Nurse with nurse.....	3.65	3	3.58	4	2.97	3	2.65	2
Nurse alone.....	3.75	5	4.18	5	4.10	5	3.28	3

a relationship with the patient was the most important thing for them, while the other two types (III and IV) did not. Instead they accorded greatest preference to the doctor. Of course the doctor still had considerable significance for I and II, being in second place for both of them. These differences in preferences for patient and for the doctor were significant at the .001 level (Tables A and B, Appendix D).

The sister R.N. relationship showed a difference in preferences among the types (significant at the .001 level, Table C, Appendix D) which followed a pattern that will become increasingly familiar—the types following each other in an orderly sequence from I to IV. (This pattern was also true of the preferences for the nurse-patient and the nurse-doctor relationships, as Table 7 shows.) In the case of the nurse-nurse relationship, Type I was least drawn to it, with Type II next, followed by Type III, while Type IV showed the greatest preference for working with another nurse. This difference was illustrated in interview material from two nurses representing the extreme types. One Type IV nurse, talking about the picture of the two R.N.s together, said: "I like to explain new orders or procedures to a staff

nurse. I know I sound biased toward the administrative side, but the other girls rely on my judgment." A Type I nurse, on the other hand, talking about the same photograph, interpreted the situation as one in which she was "just talking to another team member."

Preferences for the nurse-aide relationship were not significantly different (Table D, Appendix D). (There were differences in other aspects of attitudes toward the aide among the four value types. These are presented in Chapter 8.)

The situation of working alone at the desk did reveal a significant

TABLE 8

PREFERENCE RESPONSES OF THE FOUR VALUE TYPES ON THE SHARING SECTION

Picture items	Type I (N = 56)		Type II (N = 67)		Type III (N = 30)		Type IV (N = 58)	
	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order
Nurse with patient with doctor.....	3.70	1	3.36	1	2.93	1	2.78	1
Nurse with patient with another nurse..	4.23	3	4.13	2	3.90	2	4.26	2
Nurse with patient with aide.....	4.07	2	4.51	3	5.17	3	4.97	3

difference among the types (Table E, Appendix D). Type IV preferred the solitary nurses' station more than the other types. Next, and here the usual sequence shifted, came Type I, while Type III and then Type II found it less appealing. This unusual adjacency of I and IV (which are, after all, alike in representing the old traditions) suggests a respect for functioning alone at the nurses' station which may be diminishing in more modern nursing values. Another possibility is a difference in symbolic images of the nurses' station, with Type IV seeing the desk as the place where technical, administrative functions are performed, while Type I may see the desk, with the patients' charts, as an important link in her relationship to her patient.

The Sharing Section, it may be recalled, did not oppose the patient relationship to colleague relationships but, including nurse and patient in all pictures, contrasted the three fellow workers. Table 8 shows the Sharing Section preference responses of the four value types. (See Table F, Appendix D, for the relevant chi square values.)

The nurse-patient-doctor relationship was the most popular situation for all four types but there was, nonetheless, a significant difference (at the .001 level) as to *how much* each type preferred it. Type I was least drawn to it, II next, then III, and Type IV was most attracted to sharing the patient with the doctor. Nurse-patient-aide also showed a significant difference (at the .001 level), with Types I and II preferring it more than III and IV. The nurse-patient-nurse relationship did not reveal a significant difference in preferences among the four types.

There was another, perhaps more interesting, finding and this concerned the *spread* of the responses, that is, how much *more* or much *less* a relationship was liked compared to any other. Looking at the responses this way, Type I stood out. There was very little spread in their mean ranks: nurse-patient-doctor was only slightly preferable to nurse-patient-aide, which, in turn, was only slightly preferable to nurse-patient-nurse. This suggests that, as long as she is with the patient, it does not make too much difference to Type I whether it is the doctor, an aide, or another nurse who is also there. Type II followed Type I, showing some spread but not as much as III and IV. In terms of mean ranks, the identity of the sharing colleague did make a difference to Types III and IV: nurse-patient-doctor was much more preferable than nurse-patient-nurse, which was much more preferable than nurse-patient-aide. These more technically and administratively oriented types apparently had different feelings about their role with the patient depending on who was there with them, and there was no doubt about whom they preferred—being with the patient along with the doctor won hands down.

Other Attitudes toward Patients as Measured by Verbal Instruments

The four value types were defined according to the kind and amount of patient orientation displayed in their responses to photographs. Another research instrument contained three verbal sections designed to get at other aspects of attitudes toward patients. Analysis of the responses to these sections supported and, in the case of the last two sections, extended our knowledge of the value types.

The first section, a simple and straightforward one, asked the nurses to rank their general feelings about patients on a scale from 1 to 5 (unfavorable to favorable). The results were straightforward, with the types falling in the usual pattern: Type I, averaging 4.12 on the scale, was most favorable to patients. Types II and III were next, each aver-

TABLE 9

PREFERENCE FOR PATIENTS BY AGE AND SEX AMONG THE FOUR VALUE TYPES[a]

Preferred patients	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Women	5	11	10	18	6	22	11	23	32	18
Children	16	35	6	11	10	37	6	12	38	21
Men	25	54	40	71	11	41	31	65	107	60
Total	46	100	56	100	27	100	48	100	177	99

[a] There was always some variation in the N's due to "no responses," but the unusual variation in this table was due to the fact that a number of subjects insisted they liked all patients equally. The chi square value with six degrees of freedom was 17.13, significant at the .01 level.

aging 3.97. Type IV, with an average rank of 3.84, was least favorably disposed.

The second section asked whether the respondent preferred to have men, women, or children as patients. Table 9 gives the results and shows that there was a significant difference among the preferences of the four types.[5] Men were the favorite over the whole sample and for each type separately, but Types II and IV liked them even better than I and III. The reasons usually given (in informal write-in responses) were that "men are easier to care for" and "less demanding."

This unusual affinity between II and IV was complemented by an affinity between I and III in their greater preference for children. A certain motherliness is quite compatible, indeed essential, in our interpretation of Type I as the ministering angel, but why Type III should be especially drawn to children is not clear.

With regard to women patients, the types once again followed their usual pattern. Types I and II were similar in liking them somewhat less, while Types III and IV liked them somewhat more than would be expected considering the distribution of preferences over the whole sample.

The third section consisted of three incomplete sentences, as follows:

The really model patient .....

I like patients who .....

The best patients .....

The subject was asked to complete each sentence with the first thought that came to mind.

This type of item has frequently been used as a projective device to get at a deeper layer of feeling than that usually tapped by direct questions. This method also lessens the distortion involved when the subject is asked to judge and report on his own feelings, for the incomplete sentence technique merely elicits the feeling and it is the researcher's job to judge the significance of whatever feeling is expressed. This does, however, carry with it the responsibility of devising a *reliable* system for interpreting the attitude responses.[6]

[5] The difference among nursing specialties was also significant. It is discussed in Appendix B.

[6] The method of reliability analysis used on the categories designed to code these incomplete sentence items—as well as on other items that will be discussed in later chapters—involved the use of independent judges. After familiarizing themselves with a description of the categories, they separately scored a random sample of at least 10 per cent of the total number of responses, and the resulting level of mutual agreement constituted the reliability index. For a detailed account of the method see Rogge (1953, p. 13).

The idea of delineating the "model consumer" for particular professional groups is not a new one. A characterization of the various views that members of a profession have as to who makes an "ideal" consumer of their services can give insight into the goals and values of that profession. In the case of nursing, some research has been done by Reissman and Rohrer (1957), using the question "What kind of person makes the best patient?" Responses were categorized into three groups ranging from (1) the passive patient, through (2) the cooperative and pleasant patient to (3) the more active and verbal patient. Reissman found that, as one moves up the job hierarchy from aide to head nurse, the active patient became more desirable.

In adapting this concept of a passive-active continuum to our data, which involved a wider range of responses to three somewhat different items, it was necessary to describe a fourth point on the continuum beyond the active patient. This point represented an even more active patient—active in the sense that he was permitted to be himself. The following four categories were devised to code the data:[7]

1) *The passive patient* was obedient, followed orders, and in general presented no difficulties to the nurse. This category included descriptions of the ideal patient which emphasized what he should *not,* or does *not,* do. Examples of some actual responses follow: "The really model patient is the one who follows orders." "I like patients who don't whine." "The best patients obey their doctor's orders." Not getting in the way of the nurse's regular duties and not interfering with regular routine were the essential features of this passive category.

2) *The cooperative patient* was a little livelier. He was cheerful, or grateful, or courteous, or the like. Instead of simply obeying, he was *willing* to make adjustments. The category differed from the first in that, here, the nurse wanted some response or feeling from the patient, though it had to be a pleasant or cooperative response. In any case, it was not just a matter of being quiet and keeping out of the way as it was in the first category. For example: "The really model patient is friendly" and "well-liked." "The best patients are cooperative" and "use common sense." "I like patients who are appreciative." (Incidentally, the term "cooperative" was probably the single most frequently used word over the whole sample.) This category also included images of the patient which expected him to "conform" in the sense that he cooperated by being sick in the first place and then getting well, but this conformity allowed the patient a little more leeway than in the case of the first category.

3) *The active patient* did more than just cooperate. He showed interest. He gave more in the sense that he expressed his feelings verbally and tried to help himself. For example: "The really model patient shows interest in himself." "I

[7] There were some miscellaneous responses (e.g., "I like patients who are children") which could not be coded on the continuum and so were omitted from the analysis. The four categories were submitted to a reliability analysis using two independent judges, and the level of agreement was 92.2 per cent.

like patients who talk of their troubles." "The best patients think things out and help their own recovery." The new element in this category was a certain independence on the part of the patient, particularly in terms of "trying." Yet this independence still involved some conformity, for the implication was that the model patient was "to try" and "to talk" in ways that conformed to the nurse's expectations.

4) *The independent patient* was, in one sense, beyond the various ideas of conformity. Responses that fell in this category indicated that the nurse did not hold systematic expectations of what the patient should be like, or do, and many of the responses rejected the very idea of model patient. Implied here was a sense of the unpredictability of people, which both caused rejection of the concept of ideal patient and also allowed for more independence and activity on the part of the patient than did the other three categories. For example: "The model patient does not exist" or "there is no such thing" or "may be hiding his true feelings." "The best patients are as unpredictable as the worst."

The results were both interesting and significant. The cooperative patient was the most popular category for each type; but there was the usual variation, with Type IV nurses most favorably inclined to this category (54.9 per cent of their responses), followed by Type III (54.6 per cent), then Type II (50.6 per cent), and, finally, Type I (48.6 per cent). The greater concern with the cooperative patient on the part of Type IV and Type III undoubtedly reflected their greater emphasis on the technical role. (This brings to mind Florence Nightingale's admonition that the sick body is not just "a reservoir for stowing medicines into," nor, it might be added, just a *cooperative* reservoir.) Type II and especially Type I were relatively less concerned about the cooperativeness of the patient, and this trend was also revealed in the relative ordering of the other three categories. For both Types I and II, the independent patient ranked second, with the active patient third, and the passive patient last. For Type III the active patient ranked second, the independent was third, and the passive was last. Type IV was the least concerned with the active end of the continuum, for the passive patient ranked second, the active one third, and the independent one last. Again, the four value types showed their regular pattern, with Type I toward the active-independent end of the continuum, followed by II, and with III, and much more so IV, toward the passive-cooperative end.

Each respondent was given a total score by adding her responses to all three incomplete sentences (one point for the first category, two points for the second, three for the third, and four for the fourth). Scores ranged from 3 to 12, with a little more than half the sample scoring 7 points or less. The sample was accordingly divided, with those

mentioning more passive images of the patient (3–7 points) compared to those mentioning more active images (8–12 points), and the difference among the value types was significant at the .05 level (Table G, Appendix D). Types I and II more frequently described the model patient in active terms (60.9 and 51.9 per cent respectively), while Types III and IV were more concerned with passive characteristics (64 and 66.7 per cent respectively).

It is of some interest to compare these responses to Reissman's earlier finding. There was, in our data, some tendency for staff nurses to be more oriented toward the passive end of the continuum—as Reissman found—but the difference was not statistically significant (Table H, Appendix D). Apparently the value type differences were stronger than the effect of job level.[8]

[8] There was a significant difference among the nursing specialties, which is discussed in Appendix B.

Chapter 5

Significance of the Four Types

Before we proceed to an analysis of other attitudes that characterize the four value types, there is one matter that must be raised and then settled. It concerns the significance of the types: are they what they seem to be or could they simply be a function of some other factor?

An example may help make the problem clear. Nurses in junior administrative positions, who have extensive supervisory functions, could be a very different breed from staff nurses, who have the direct link to the bedside. Supposing—and it is a reasonable possibility—that staff nurses, as a group, actually value TLC most highly (like Type I), while the junior administrators, as a group, pay most attention to the technical-professional role (like Type IV). Then the meaning of the types would be rather confused. If this hypothetical case were shown to be true in terms of NPIT responses, it could mean that Type I is not really an independent type at all but simply another name for staff nurses, and Type IV just another label for junior administrative nurses. Or it could mean that the types are genuine, with Type I nurses preferring staff positions and Type IV nurses gravitating to junior administrative posts, though this alternative would be more difficult to prove.

To determine the significance of the value types, therefore, it was necessary to analyze the data for the effects of such factors as level of position. Four factors were felt to be of sufficient importance to warrant an analysis of their relation to the value types and of their effect on NPIT responses.

One was the *nursing specialty* of the respondents. The very fact that a nurse chose a particular specialty (medical, psychiatric, public health, or surgical nursing), and the effect of the experiences she has had in that specialty, could mean differences in preferences and values that might affect NPIT responses and the resulting classification into types.

Another factor that might have influenced responses, as the above example suggested, was *level of position*—whether the respondent was a staff nurse or a junior administrator.

A third variable was the *age* of respondents. The cumulative influence of general experiences as well as the particular effect of continued nursing experience could have resulted in basic differences in preferences and values.

The fourth factor was the *religious background* of respondents—whether Catholic or Protestant. (The Jewish group was so small in the sample, as it is in the general population of nurses, that the effect of a Jewish heritage could not be tested.) The early history of nursing was interwoven with the history of religious orders, and in modern times nursing in Catholic hospitals has been controlled by nuns. This could, in the eyes of Catholic girls, invest nursing with a special dignity. In contrast, there has been the influence of the old-fashioned notions of certain sections of Protestant society that nursing was not quite "nice" or "suitable" for a young lady. (Florence Nightingale had to fight such attitudes in her own lifetime.) There is also the possibility that differences in religious ethic between the two groups could color their values and attitudes about nursing.

It is to be expected that these factors would be related to some differences in attitudes among nurses, but the problem for this research was whether they had any important effect on the value types. The method of analysis was to examine the distribution of the four value types for each of the four variables (Tables 10, 11, 12, and 13) and then to test whether any of the relationships were significant. None of the chi square values was significant. It may thus be inferred that the value types are genuine types, that they are relatively independent of the four background variables, cutting across them rather than being produced by them.

Accordingly, the rest of this report will be devoted to the value types. This will include an examination of their origins, their attitudes toward different levels of organization within nursing, and their attitudes toward different personnel with whom nurses work, as well as an analysis of the effect of education to see how the value types become what they are.

TABLE 10

DISTRIBUTION OF THE VALUE TYPES AMONG FOUR NURSING SPECIALTIES[a]

Specialty	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Medical	14	24	19	27	5	16	16	28	54	25
Psychiatric	14	24	13	19	7	23	23	40	57	26
Public health	17	29	23	33	8	26	9	16	57	26
Surgical	13	22	15	21	11	35	10	17	49	23
Total	58	99	70	100	31	100	58	101	217	100

[a] The chi square value with nine degrees of freedom was 14.04, which reached the .20 level.

TABLE 11

DISTRIBUTION OF THE VALUE TYPES AMONG STAFF AND JUNIOR ADMINISTRATIVE NURSES[a]

Job level	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Staff	44	76	59	84	22	71	40	69	165	76
Junior administrative	14	24	11	16	9	29	18	31	52	24
Total	58	100	70	100	31	100	58	100	217	100

[a] The chi square value with three degrees of freedom was 4.63, which reached the .30 level.

TABLE 12

DISTRIBUTION OF THE VALUE TYPES AMONG FOUR AGE GROUPS[a]

Age groups	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
20–29 years	22	38	29	42	10	32	13	23	74	35
30–39 years	14	24	15	22	9	29	21	38	59	28
40–49 years	9	16	17	25	7	23	15	27	48	22
50 years and over	13	22	8	12	5	16	7	12	33	15
Total	58	100	69	101	31	100	56	100	214	100

[a] The chi square value with nine degrees of freedom was 11.25, which reached the .30 level.

TABLE 13

DISTRIBUTION OF THE VALUE TYPES AMONG NURSES OF PROTESTANT, CATHOLIC, OR OTHER RELIGIOUS BACKGROUND[a]

Religious background	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Protestant	34	59	52	74	19	61	34	59	139	64
Catholic	19	33	13	19	7	23	17	29	56	26
Other	5	9	5	7	5	16	7	12	22	10
Total	58	101	70	100	31	100	58	100	217	100

[a] The small group of nurses of "other" religious backgrounds was not included in the chi square analysis. Comparing Protestant to Catholic, the chi square value with three degrees of freedom was 4.30, which reached the .30 level.

Chapter 6

Origins of the Four Types

With the isolation of the four value types and an analysis of their varying attitudes toward patients now accomplished, let us consider the kinds of families from which these nurses came. After that, Chapters 7 and 8 will continue the analysis of their different attitudes toward nursing and fellow workers.

Family Backgrounds

The family background factors that were analyzed included father's and mother's birthplace (Table 14), father's occupation (Table 15), the location of the respondent's own birthplace (Table 16), and the size of the respondent's birthplace (Table 17). Only one of these variables showed a significant difference among the value types, namely, father's birthplace. There were not as many nurses among the modern Types II and III who had American-born fathers as among the two extreme Types I and IV. Since none of the other background factors revealed a significant difference, the actual significance of this one difference is questionable and only further research could determine whether it would hold up statistically.

The absence of significant differences among these various background factors (with the one exception of father's birthplace) means that we will have to look elsewhere for an explanation of why these nurses became the types they did.

Reasons for Entering Nursing

Before exploring why these nurses chose the profession they did, some general background about various realities and alternatives that perhaps influenced them may be helpful. The alternatives varied to some extent for different age groups.

Earlier in the century alternatives for women were quite restricted, particularly if time or money was an issue. (Probably the only serious competitor to nursing was teaching. In fact there were several nurses in the sample who said they wanted to be a nurse because they "didn't

TABLE 14

BIRTHPLACE OF PARENTS AMONG THE FOUR VALUE TYPES[a]

	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Father										
American-born	37	67	40	58	16	52	43	78	136	65
Foreign-born	18	33	29	42	15	48	12	22	74	35
Total	55	100	69	100	31	100	55	100	210	100
Mother										
American-born	37	67	46	67	17	55	42	76	142	68
Foreign-born	18	33	23	33	14	45	13	24	68	32
Total	55	100	69	100	31	100	55	100	210	100

[a] For father's birthplace the chi square value, with three degrees of freedom, was 8.23, significant at the .05 level. For mother's birthplace, the chi square was 4.25, which reached the .30 level.

TABLE 15

FATHER'S OCCUPATION AMONG THE FOUR VALUE TYPES[a]

Occupational group	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
1. Unskilled	5	9	6	9	2	6	5	9	18	9
2. Semiskilled	3	5	0	0	3	10	3	5	9	4
3. Skilled	13	23	17	25	2	6	11	20	43	21
4. White collar	7	13	3	5	0	0	6	11	16	8
5. Small businessmen (including farmers)	8	14	17	25	11	35	11	20	47	22
6. Business management	3	5	5	8	3	10	2	4	13	6
7. Large business	0	0	0	0	0	0	0	0	0	0
8. Semiprofessional	2	4	4	6	0	0	2	4	8	4
9. Professional	5	9	4	6	1	3	8	15	18	9
10. Unclassifiable (e.g., deceased or retired)	10	18	11	16	9	29	7	13	37	18
Total	56	100	67	100	31	99	55	101	209	101

[a] A chi square was computed by combining categories 1 through 4 into one group and categories 6 through 10 into another. The resulting value of 3.38, with three degrees of freedom, reached the .50 level. The occupations were coded according to the classification scheme of Turner (1956).

TABLE 16

PLACE OF BIRTH FOR THE FOUR VALUE TYPES[a]

	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Eastern U.S.	12	21	15	22	8	26	8	15	43	20
Southern U.S.	10	18	6	9	1	3	10	19	27	13
Midwestern U.S.	17	30	28	41	15	48	24	44	84	40
Western U.S.	14	25	15	22	3	10	9	17	41	19
Foreign-born	4	7	5	7	4	13	3	6	16	8
Total	57	101	69	101	31	100	54	101	211	100

[a] The chi square value, with six degrees of freedom (the East and South were combined into one group and the foreign-born were not included), was 4.68, which reached the .70 level.

TABLE 17

SIZE OF BIRTHPLACE FOR THE FOUR VALUE TYPES[a]

(American-born subjects only)

	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Under 5,000	17	33	19	30	12	46	15	31	63	33
5,001 to 50,000	14	27	13	21	7	27	15	31	49	26
50,001 to 500,000	12	24	19	30	3	12	10	20	44	23
Over 500,000	8	16	12	19	4	15	9	18	33	17
Total	51	100	63	100	26	100	49	100	189	99

[a] The 1940 census figures were used to establish the size of the birthplace listed by the respondent. The chi square value, with three degrees of freedom (50,000 and under was compared to over 50,000), was 4.03, which reached the .30 level.

TABLE 18

Reasons for Entering Nursing Among the Four Value Types[a]

Stated reason for being a nurse	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
1. Help people	20	36	31	49	9	29	21	40	81	40
2. Be useful	3	5	4	6	2	6	2	4	11	5
3. Liking for people	7	12	7	11	4	13	4	8	22	11
4. Personal satisfaction	11	20	7	11	8	26	11	21	37	18
5. Family influence	5	9	7	11	4	13	8	15	24	12
6. External pressures	10	18	7	11	4	13	7	13	28	14
Total	56	100	63	99	31	100	53	101	203	100

[a] A chi square was computed by combining the frequencies in category 1 with category 2, category 3 with 4, and category 5 with 6. The resulting value of 5.03, with six degrees of freedom, reached the .70 level.

want to be a school teacher.") To those women who did not have to earn their living as soon as possible and who did not want immediately to settle their future by marriage, nursing represented an opportunity for a career as well as for advanced education which did not require a financial investment. (As one nurse, who entered a hospital school of nursing some twenty years ago, expressed it: "After graduating from high school, an allowance of $25 plus tuition was great.") Though this pattern is changing, especially in the collegiate programs where the time and cost of a nurse's education are comparable to the time and cost for any student acquiring a bachelor's degree, it has been a definite inducement in the past and continues to be in many hospital schools.

The attainment of personal and financial independence—certainly an obvious factor in the past when the general position of women was one of dependence on family and, later, husband—still carries weight today. Consider the current and very appealing advertising slogan for a career in nursing: "Learn to take care of others and you'll always take care of yourself."

This slogan also points up a more subtle, and yet psychologically powerful, aspect of the independence acquired by becoming a nurse. This independence is not an unattached, risky one—the nurse also gains the security of a guaranteed place in the world. The need for her is clear. To be needed also brings power, for the nurse is important to those who depend on her. Yet this power is not selfish, nor is it accompanied by guilt, because it is power over others for *their* sake, and not one's own. Suggestions or orders the nurse gives are not for her benefit but for the welfare of the patient.[1] This could be an important factor for women nurtured on traditional religious values unmodified by the more aggressive, individualistic values embodied in the common male goal of success.

With these considerations in mind, individual reasons for entering nursing can be analyzed. The subjects were asked to complete the sentence "I wanted to be a nurse because....." The responses were coded into the following six categories:[2]

1) A desire to *help people,* to serve them, to care for the sick or suffering, to see them get well. For example: I wanted to be a nurse because "I always wanted to help others" or "I like caring for sick people."

[1] This kind of motivation may be involved in the difficulty sometimes experienced by nurses in giving orders to personnel, as against patients. The tendency to "want to do the dirty job myself rather than tell someone else to do it" could result from the fact that it would be power used, in a sense, for one's own benefit.

[2] The categories were submitted to a reliability analysis using two independent judges. The level of agreement was 94.3 per cent.

TABLE 19

TYPE OF NURSING EDUCATION RECEIVED BY THE FOUR VALUE TYPES[a]

Educational program	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Baccalaureate	7	12	19	28	4	13	9	17	39	19
Hospital-diploma	50	88	49	72	26	87	45	83	170	81
Total	57	100	68	100	30	100	54	100	209	100

[a] The chi square value, with three degrees of freedom, was 6.04, which reached the .20 level.

2) A desire to *be useful,* to do some good for society. This differs from the first category in its abstract emphasis—people as such are not mentioned. For example: I wanted to be a nurse because "I wanted to do some good" or "I wanted to feel useful and accomplish something worthwhile."

3) A *liking for people,* a wish to do work that involves dealing with people. For example: I wanted to be a nurse because "I enjoy working with people" or "I like people."

4) *Personal satisfaction* such as the feeling that nursing would be interesting and enjoyable; or, simply, it had always been a goal. For example: I wanted to be a nurse because "the work interested me" or "I never wanted to be anything else."

5) *Family influence* or some special experience, usually a childhood one. For example: I wanted to be a nurse because "my mother was" or "I admired those who cared for my father."

6) *External pressures* such as financial necessity, a desire for an education within one's financial means, a second choice after some other career goal proved unobtainable. For example: I wanted to be a nurse because "education was comparatively cheap" or "I wanted to be a doctor and couldn't afford it so nursing was second best."

Table 18 shows the responses. The largest category was the desire to help people, which accounted for 40 per cent of all responses. Although Type II was somewhat more concentrated in this category, there was no significant difference among the value types. This suggests that a marked differentiation into types is something that happens *after* entering nursing. There is some other evidence in this connection. The respondents were asked to indicate *how long* they had wanted to be a nurse and *how much* they wanted it when they entered nursing. The responses showed the same thing—no significant differences among the types.[3] (The family background data, with the exception of father's birthplace, also support this since there were no significant differences among the types.)

The finding that the most frequently stated reason for becoming a nurse was a wish to help others supports some general images of the nurse—the "devoted angel of mercy," for example. One can only speculate on how this widespread mention of unselfish motives would compare with other professions, but some research has been done in the case of the American psychological profession (Clark 1957). Among some 22 reasons given for their choice of psychology as a career (from a sample of more than 1,000), only three could be said to involve a primary de-

[3] Over the whole sample, 45 per cent had wanted to be a nurse since grade school days or earlier, 26 per cent since high school, and 29 per cent decided after high school. At the time of entering nursing, 56 per cent wanted to be a nurse more than anything else, 31 per cent simply liked the idea, and 13 per cent were more or less neutral.

sire to help others (e.g., a desire to solve society's problems). Other motives mentioned were: wanting to know more about human beings, being influenced by a particular teacher, desire to enter a fairly lucrative field. In the case of some other professions, one can imagine a heavier concentration of "success" and financial motives.

Only in the categories of family influence and external pressures was there some indication of incidental reasons for entering nursing, and together they accounted for only 26 per cent of the responses.

Education

After making a career decision for nursing the next step is to enter training. Since early in the century two types of nursing education have been available—the hospital or diploma program and the collegiate or degree program—though they have by no means been equally available. (A consideration of the new two-year community or associate degree program will be delayed until Chapter 9, which deals with current nursing students, because the sample of R.N.s did not include any graduates of this very recent program.) In 1955, although there were 147 schools offering a degree program, the great majority of schools (86 per cent) still offered diploma programs and accounted for 85 per cent of nursing student enrollments (*Facts About Nursing,* 1955–56). Over the years the philosophy that has pervaded each type of school has certainly varied; our data, however, did not provide a direct measure of that, but only a relative measure of the hospital as compared to the collegiate program.

Table 19 shows the distribution of respondents according to the type of nursing education they received. As one would expect in view of the greater availability of the hospital program, most (81 per cent) of them trained in a hospital school of nursing.[4] The overall difference among the value types was not significant;[5] but there was one noteworthy trend. A higher proportion of Type II's received their nursing education in a collegiate program. This difference also holds, as will be shown in Chapter 10, for current educational programs, with Type II being the predominant product of the collegiate program studied.[6]

[4] Thirty of this group later took college work to obtain a B.S. degree, but there is some evidence (see Chapter 10) that such later educational experience does not have a strong effect on a nurse's value type.

[5] There was a significant difference due to age (at the .01 level), with more younger nurses having been educated in a collegiate program. This undoubtedly reflects the increase over the years in the number of collegiate programs in operation.

[6] In a search for factors other than educational which could have influenced value type, several other variables were examined. Neither number of years spent practicing nursing, nor number of years in present job, nor marital status showed a significant difference among the value types.

Chapter 7

Levels of Organization

While a nurse receives her training and after she has started to practice her profession, she develops attitudes about all aspects of her professional life. Two important ones are attitudes toward supervision and toward staff and administrative positions in nursing. This chapter is devoted to the data collected on these attitudes.

Attitudes toward Supervision

Supervising is an essential and important part of nursing. All R.N.s, regardless of the level of their position, are engaged in both ends of the process: they continually supervise personnel under them and in turn they are supervised by those at higher levels.

Several factors which distinguish supervision in nursing from that in other fields (teaching and social work, for example) should be mentioned. Perhaps the single most important one is that nurses deal with sick people. In handling the sick, things must be done quickly and correctly the first time. Mistakes can be serious, and rarely are there leisurely time periods in which a supervising nurse can discuss another worker's performance or problems with her. In addition to the busy pace, there is, at least for hospital nurses, the busy work area. The constant coming and going of aides, practical nurses, registered nurses, doctors, and so on, means that the R.N. is rarely alone and rarely away from the need to supervise or the chance of being supervised. All this is no doubt related to the authoritarian hierarchy that has been typical of nursing as well as the common idea that supervising usually means "checking up." Though the newer collegiate philosophy in nursing stresses a more creative side of supervision, which aims for better nursing care through personal growth and insight, these environmental pressures can never be eliminated.

Several facets of attitudes toward supervision were explored by means of the incomplete sentence technique: feelings about the process of supervising others, about doing the supervision oneself, and about having one's own work supervised. Responses to all three items gen-

TABLE 20

RESPONSES TO "SUPERVISING THE WORK OF OTHERS ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Personally favorable	9	17	13	19	7	25	24	46	53	26
Impersonally favorable	20	38	32	47	12	43	16	31	80	40
Unfavorable	24	45	23	34	9	32	12	23	68	34
Total	53	100	68	100	28	100	52	100	201	100
Average score	....	2.28	....	2.15	....	2.07	....	1.77	....	2.07

[a] The chi square value, with six degrees of freedom, was 16.82, significant at the .01 level.

erally ranged from a favorable or positive pole to an unfavorable or negative pole, with the technical Type IV expressing the most favorable attitudes in each case; but there was sufficient variation in specific emotional content to warrant scoring each item separately.[1]

The first item ("Supervising the work of others.....") elicited rather general comments about supervising, and a three-step coding system, from favorable to unfavorable, seemed the most meaningful way to handle the data. The categories were:[2]

1) *Personally favorable*—responses showing that personal enjoyment or reward was experienced through supervising. For example: Supervising the work of others is "fun," "stimulating," "fulfilling."

2) *Impersonally favorable*—responses that characterized supervision as an important or essential function and/or as one needing special skills, competence, or preparation. Such responses were considered favorable because they attached importance to the job and impersonal because there was no mention of personal satisfaction in doing the job. For example: Supervising the work of others is "essential," "carries a great deal of responsibility," "requires wisdom."

3) *Unfavorable*—responses that indicated a negative attitude. For example: Supervising the work of others is "unpleasant," "a thankless job," "a burden."

The results, in Table 20, were treated in two ways: first, in terms of the frequency of responses in each category for each of the value types —and the difference among them was significant—and second, in terms of an *average score* for each type. This was obtained by assigning one point to a category 1 response, two points to 2, and three points to 3; thus the smaller the score, the more favorable the attitude.

This general measure (average score) showed the usual pattern of the types: the technical-administrative Type IV was most favorable, next Type III, then Type II, and finally, the exclusively patient-oriented Type I was least favorable. Comparing Types I and IV in terms of individual categories, the most popular response among Type IV's was personally favorable; while the most frequent response among Type I's was unfavorable, that is, many of them considered supervising a burden and found it unpleasant. This is consistent with the original definition

[1] Since positions above the staff level involve greater supervisory responsibilities, one would expect to find differences between staff and junior administrative nurses in their attitudes toward supervision. On the first two items, dealing with supervision of others, the differences were significant at the .01 level and the .02 level respectively, with, of course, the junior administrators being more favorable. On the third item—being supervised oneself—the difference was not significant although the junior administrators were again somewhat more positive in their attitude. There were no significant differences due to nursing specialty.

[2] The categories were subjected to a reliability analysis, and the resulting agreement level, using two independent judges, was 94.4 per cent.

TABLE 21

RESPONSES TO "WHEN I SUPERVISE OTHERS ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Personally uneasy	10	18	20	30	5	17	4	7	39	19
Oriented to task itself	10	18	14	21	8	27	7	13	39	19
Oriented to feelings of supervisee	29	53	30	45	16	53	35	65	110	54
Personally at ease or happy	6	11	2	3	1	3	8	15	17	8
Total	55	100	66	99	30	100	54	100	205	100

[a] The chi square value, with nine degrees of freedom, was 18.51, significant at the .05 level.

of the types. Type I, preferring an unshared relationship with the patient, could hardly be expected to view with pleasure the business of supervising others. While 17 per cent of Type I were personally favorable, 45 per cent were personally negative. An impressionistic reading of the unfavorable responses suggested that it was an "interference" effect that was unpleasant—supervising others took time away from other things (apparently the patient). Type IV's opposite preference for colleague relationships goes hand in hand with their most frequently mentioned feeling (46 per cent) that supervising others is personally enjoyable and rewarding.

The two modern types were again in the middle, with Type II (drawn into a sharing relationship by the patient) closer to Type I, and Type III (drawn into a sharing relationship by her colleague) closer to Type IV. The largest category was the middle one in which supervising the work of others was seen as a necessary, indeed an important, affair regardless of reward or enjoyment. Again an impressionistic reading was suggestive: an aura of weightiness suffused the many responses which emphasized the supervisory function per se—its importance and the qualifications needed to perform it. (This was less obvious in the case of both Types I and IV where fewer responses concerned the process itself and more responses concerned personal reactions.) This trend, along with the related fact that Types II and III, by definition, preferred sharing the patient with colleagues, is reminiscent of the philosophy of team nursing. This philosophy depends on a sense of the importance of colleague relationships as they lead to the patient and on a creative use of supervision which encourages growth and development.

The second item ("When I supervise others .....") elicited responses about doing the supervision oneself. There were, as before, personal feelings representing both positive and negative poles, though here they had more to do with uneasiness versus confidence than with like versus dislike. But the responses in between, in this case, revealed an orientation away from personal feelings and toward either the task itself or the feelings of the other person. The specific categories designed to code the data were:[8]

1) *Personally uneasy*—responses emphasizing negative feelings. For example: When I supervise others "I am insecure," " feel unpopular," "am unhappy."

2) *Oriented to the task itself*—responses emphasizing what the respondent would do about the task per se rather than personal feelings about it. For exam-

[8] The reliability analysis of these categories, with two independent judges, yielded an agreement level of 88.6 per cent.

ple: When I supervise others "I check their work," "I like to get results," "my job is to get the work done."

3) *Oriented to feelings of the supervisee*—responses that laid the emphasis on the person who was being supervised. For example: When I supervise others "I put myself in their place," "I try to help them," "I follow the golden rule," "I am tolerant."

4) *Personally at ease or happy*—responses emphasizing positive feelings. For example: When I supervise others "I feel exhilarated," "I am happy," "I feel more confident."

The results, in Table 21, showed that over the whole group, as well as for each type separately, the most popular response was to orient oneself to the feelings or position of the other person. In fact, this one category accounted for more than half of all responses. This seems quite consistent with the strong service motives typical of nurses. Another manifestation of this general desire to serve others (also revealed in their stated reasons for wanting to become a nurse) was the absence, in their feelings about supervision, of a drive for power or a need to push upward in the supervisory hierarchy.

The difference among the value types was significant, and Type IV was again most favorable. Of all the types, Type IV showed the highest proportion of nurses who mentioned being personally at ease or happy when supervising others (15 per cent); and, conversely, IV had the lowest percentage (7 per cent) of respondents who indicated uneasiness.

Among the modern Types II and III there was a scarcity of expressions of personal ease or enjoyment (3 per cent each). This is similar to the importance that many of them attached to the general process of supervision regardless of personal pleasure.

There was one interesting trend in regard to the modern Type II. Compared to the other types, a higher proportion of Type II's expressed feelings of personal uneasiness when supervising others. These feelings of inadequacy may or may not, from the point of view of effective supervision, be a drawback. They could constitute an interference; or, on the other hand, awareness of them could pave the way for increased insight and growth.

The last supervision item ("When I am being supervised .....") dealt with the respondent's feelings when she herself was being supervised. The responses were classified into four categories, again with positive and negative poles and, in the middle categories, a displacement of personal feelings by orientation to the task or the other person, as follows:[4]

[4] The reliability analysis of these categories, with two independent judges, yielded an agreement level of 88.0 per cent.

1) *Negative*—responses that expressed nervousness, discomfort, resentment, or a generally apprehensive attitude. For example: When I am being supervised "I don't like it," "it annoys me," "it slows me down."

2) *Emphasis on what the supervisor does*—attempts to cope with the situation by concentration on what the supervisor does or should do. For example: When I am being supervised "I want my supervisor to be capable" or "know her job," "I want to be treated like a human being," "I want to feel trusted." Such responses have a faintly apprehensive quality, but definitely not as much as those in the first category.

3) *Emphasis on what the respondent does*—responses that stressed what the respondent would do regardless of personal feelings. For example: When I am being supervised "I do my work as usual," "I listen" or "try to cooperate," "I try to do things correctly." These responses have a flavor of task orientation as well as cooperativeness.

4) *Positive*—responses showing a favorable attitude in the sense that the respondent liked to be supervised or else expected to benefit or profit from the experience. For example: When I am being supervised, "I like it," "I learn a lot," "I like the attention," "I find new ways of doing things."

The results, in Table 22, showed that a task concentration or an emphasis on what *I do* was most frequent over the total group. Negative responses ranked second for the total group. These "uneasiness" responses probably reflected a very human apprehension about having one's own work supervised and, often, evaluated.

The difference among the types was significant and the trends were in a familiar direction. Type IV again had the highest proportion of positive responses (31 per cent). The modern Types II and III displayed the highest proportion of negative or apprehensive responses (33 and 43 per cent respectively).

The outstanding trend was the consistently strong positive attitude among Type IV's, both on this and on the other supervision items. While it is to be expected that more Type IV's would respond favorably on the matter of supervision—this type was, after all, the one that most preferred colleague relationships and represented the efficient, disciplined approach—it is also possible that a deeper probing of these positive attitudes might reveal more about this type. An impressionistic reading of responses to being supervised showed that feelings such as "I like the attention" or "I like to be praised" were almost unique to Type IV. (This does not mean that the other types were immune to praise, but that more Type IV's were sufficiently alive to it to mention it.) This suggests a dependence on the opinions of others.

Further evidence along this line is presented in Table 23, which shows responses to an item on which the nurses were forced to decide

TABLE 22

RESPONSES TO "WHEN I AM BEING SUPERVISED ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Negative	14	25	23	33	13	43	11	20	61	29
Emphasis on what supervisor does	11	19	3	4	5	17	6	11	25	12
Emphasis on what respondent does	23	40	30	44	7	23	21	38	81	38
Positive	9	16	13	19	5	17	17	31	44	21
Total	57	100	69	100	30	100	55	100	211	100

[a] The chi square value, with nine degrees of freedom, was 17.10, significant at the .05 level.

which they disliked: having to cut corners *or* the indifference of other people. The difference among the types was significant. Sixty-five per cent of Type IV were more upset by the indifference of others—a higher proportion than for any of the other types.

The fact that relatively more Type IV's expressed dependence upon the opinions of others supplies a hint as to why they became the efficient professional who found colleague relationships so attractive. In a nurse's relationship with a patient, it is the patient's needs that are the focus and the nurse who does the giving. The relationship with a colleague, regardless of whether that colleague is at a higher, equal, or lower level, is more likely to evoke direct response and appraisal. Furthermore, though the patient may be grateful for what the nurse does for him, he cannot fully appreciate the quality of her care. Only a fellow professional can do that; and, though it is still only speculation, the technical-administrative Type IV may have a greater need to use outside measures to know where she stands. A similar advantage accrues from an emphasis on technique and efficiency—more certain standards for judging and for deciding how others will judge competence and performance, both one's own and others'.

Attitudes toward Staff and Administrative Positions

Attitudes toward different levels in the administrative hierarchy of nursing are not unrelated to attitudes toward supervision, since as one goes up the ladder supervisory responsibilities necessarily become greater. Three incomplete sentences were used to get at these attitudes. One concerned relative preferences for a staff as against an administrative position. The other two, which were scored together due to the similarity in responses, dealt with differences between the two jobs.

Responses to the first item ("Comparing the staff to the administrative job, I .....") were scored into three categories[5] according to whether the respondent expressed a *preference for a staff job* (e.g., "I enjoy doing staff work much better"), a *preference for an administrative job* (e.g., "I prefer administration because I like to supervise"), or *neutrality* (e.g., "I think they have an equal place in nursing").

The results, in Table 24, showed that over the total group the staff position was more popular (47 per cent) than the administrative position (17 per cent). This was partly because the sample was composed of at least three times as many staff as junior administrative nurses. Comparing the preferences of staff and of junior administrative nurses

[5] A reliability analysis of these categories, using two independent judges, yielded an agreement level of 88.2 per cent.

TABLE 23

Responses to Forced Choice Item[a]

I do not like it:	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
When corners have to be cut....	32	55	44	63	15	48	20	35	111	51
When people are indifferent.....	26	45	26	37	16	52	37	65	105	49
Total.....	58	100	70	100	31	100	57	100	216	100

The chi square value, with three degrees of freedom, was 10.18, significant at the .02 level.

TABLE 24

Responses to "Comparing the Staff Job to the Administrative Job, I ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Prefers staff.....	22	42	40	62	11	39	20	37	93	47
Neutral.....	24	45	21	33	11	39	17	32	73	37
Prefers administrative.....	7	13	3	5	6	21	17	32	33	17
Total.....	53	100	64	100	28	99	54	101	199	101

[a] The chi square value, with six degrees of freedom, was 20.37, significant at the .01 level.

revealed that 56 per cent of the staff group preferred staff jobs and only 11 per cent chose administration; while 33 per cent of the junior administrators preferred administrative work and 20 per cent the staff job.[6] The staff nurses preferred staff work far more than the junior administrators preferred administration, which indicated that the staff-junior administrator ratio in the sample was not the whole explanation of the generally "friendlier" attitude toward staff positions. Another factor may be that nursing is a profession dedicated to service, with the patient as the vital center; consequently, the staff position, which involves more direct service to the patient, would be held in esteem. This is in contrast to other careers where "service to others" is not the paramount theme—a business profession, for example, where "successful" positions higher up the ladder generate the highest respect.

Apart from this job level difference, there was a significant difference among the value types. Type IV was most frequently represented among those who preferred administrative positions, followed by Type III. Among those who expressed a preference for the staff level, Type II was most frequently represented, followed by Type I. This fits with the trends revealed in their various attitudes toward supervision.

A characterization of specific differences between the two positions as well as any preference for either of them was derived from the second two items ("Unlike the administrative person, the staff person ....." and "Staff positions differ from administrative positions in that ....."). The categories that were devised to code the data were as follows:[7]

1) *Bias toward the administrative position*—responses indicating that administration, or the administrator, was better or that the staff person was not as good. For example: "The administrative person is warmer" or "more capable," or "The staff person is not as creative."

2) *Bias toward the staff position*—responses indicating that the staff person was better or that staff work was more enjoyable. For example: "The staff person works harder," "The staff position is more fun" or "more interesting."

3) *Responses describing factual differences between the two:*

a) *Staff closer to bedside*—responses (and this was the single largest category) mentioning that the staff person was closer to, or the administrator farther from, the patient or the bedside or "actual" nursing care. For example: "The staff person has more direct contact with the patient" or "Unlike the administrative person, the staff person is a work horse."

b) *Responsibility, training, pay, and the like are different for the two*

[6] The chi square comparing staff and junior administrative nurses on these preferences was significant at the .001 level.

[7] A reliability analysis of these categories, using two independent judges, gave an agreement level of 94.1 per cent.

TABLE 25

COMBINED RESPONSES TO "UNLIKE THE ADMINISTRATIVE PERSON, THE STAFF PERSON ....." AND "STAFF POSITIONS DIFFER FROM ADMINISTRATIVE POSITIONS IN THAT ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Biased toward administrative..	2	4	2	3	2	7	8	15	14	7
Biased toward staff.....	12	22	14	20	6	21	13	23	45	22
Factual description of job differences:										
a. Staff closer to bedside care.	18	33	20	29	7	24	19	35	64	31
b. Responsibility, training, pay, etc. different.....	15	27	12	17	5	17	6	11	38	18
c. Both (a) and (b) mentioned	8	15	22	31	9	31	9	16	48	23
Total.....	55	101	70	100	29	100	55	100	209	101

[a] The chi square value, with twelve degrees of freedom, was 18.23, which reached the .20 level.

positions. For example: "For the staff position less advance education is necessary" or "The staff person is concerned with an area while the administrator has the whole hospital."

c) Both (a) and (b) are mentioned.

Table 25 shows the results. The most frequent response over the whole sample was that the staff job was closer to bedside care. The least frequent response was to show bias in favor of the administrative job; and here, as one would expect, the technical-administrative Type IV showed the highest proportion of responses. The difference among the value types was not significant, but there was one interesting trend: more Type II's and III's gave mixed (category 3c) responses than did Type I's and IV's. That is, relatively more Type II's and III's mentioned more than one kind of difference between staff and administrative jobs. This greater diversity suggests less stereotyping, and goes along with our original interpretation of these two types as representing modern attempts to integrate different value traditions.

Chapter 8

Levels of Personnel

This chapter will explore attitudes toward different levels of personnel, that is, toward some of the different groups with whom nurses interact. Data will be presented on attitudes toward doctors, aides, and two groups that have not yet been mentioned in this report—practical nurses[1] and visitors who come to see patients.

Chapter 4 has already presented and discussed some data on attitudes toward the doctor, the fellow nurse, and the aide; and a brief review is in order. The reader may recall that, after the four values types were defined on the basis of their responses to the Compound Section of the NPIT, their responses to the Five-Way Section were analyzed (see Table 7). For present purposes, relative preferences for working with the patient and for working alone at the desk—though they certainly differentiated the value types—will not be reviewed. Only preferences for the doctor, fellow nurse, and aide are pertinent at this point.

There was a significant difference in preferences for working with the doctor, with the colleague-oriented Type IV being most favorably disposed, followed by Type III (modern and drawn to colleague), then Type II (modern and drawn to patient), while the exclusively patient-oriented Type I was least favorably disposed. But, beyond this significant difference, all four value types preferred the doctor over the fellow nurse and the aide. Regarding the fellow nurse, there was also a significant difference. Type IV showed the greatest preference for working with another nurse, followed by Type III, then Type I, while Type II was the least inclined. Nonetheless, beyond the significant difference, the majority of the sample ranked the nurse-nurse work relationship above the nurse-aide relationship. The one exception was Type II, but the difference was very slight—the mean rank of nurse-aide was 0.05 points higher than that of nurse-nurse.

Thus, the general preference order was: doctor first, fellow nurse

[1] "Practical nurse" is the commonly used term, though in California the specific legal title is "Licensed Vocational Nurse" (L.V.N.).

second, and aide last.[2] This brings us to a major characteristic of hospital organization which has thus far been mentioned only in passing and which now should be dealt with directly, that is, the hierarchical status structure of the hospital. (A similar status system characterizes the organization of public health nursing.)

It is almost a truism that the hospital is organized along very definite, some would say rigid, lines with power and authority carefully circumscribed at each level.[3] The pattern of NPIT preferences reflects this: doctor at the top, nurse his "assistant" and responsible for seeing that his orders are carried out, and the aide her "helper." The practical nurse ranks between the registered nurse and the aide. Many researchers have discussed the status hierarchy, and a very obvious reality has been frequently pointed out. In dealing with matters of health, and at times of life or death, it is quite necessary that authority, and the responsibility that goes with it, be stringently controlled. Thus the ordering is not only organizational but, in the case of doctors and nurses, legal as well. Or, to put it in more human terms, the doctor and the nurse are at the upper levels because they are, to use Whiting's (1958) phrase, the heart of the healing process.

This status system[4] and the distribution of authority and responsi-

[2] The results from the Sharing Section were of the same general nature (see Table 8). Nurse-patient-doctor, while it significantly differentiated the types, with Type IV preferring it most, followed by III, II, and then I, was nonetheless in first place for all four types. Nurse-patient-nurse was in second place for Types II, III, and IV and it did not show a significant difference among the types. Nurse-patient-aide was therefore in last place for three of the types. This item did show a significant difference but, as the reader may recall, it was primarily due to the small spread that characterized the mean ranks for Type I. For this group, it did not seem to matter so much who the colleague was as long as the nurse was with her patient.

[3] While it is true that responsibility for some particular tasks is shifting (e.g., some tasks once exclusively done by doctors are now being carried out by nurses and others are being shifted from the nurses to practical nurses to aides), the fact still remains that the "amount" of responsibility is defined at each level.

[4] There were two other manifestations of this status ordering. In one case, the respondents were asked to rate their feelings toward the different groups on a five-point scale from extremely favorable to unfavorable. The average ranks for the four value types combined—differences among them were not significant—put the doctor in first place, practical nurse second, and aide third. In the other case, responses to the salary schedule, which asked for a ranking on a three-point scale from overpaid to underpaid, showed the doctor to be seen as most adequately rewarded (in the overpaid direction), with the practical nurse next (underpaid direction), while the aide was considered to be least adequately rewarded of the three (in the underpaid direction). This pattern held for each of the four value types, and there were no statistically significant differences. As for attitudes toward R.N.s, in the case of both these items the respondents ranked R.N.s in general (that is, as the group to which they personally belonged) rather than, as on the NPIT items, ranking R.N.s other than themselves. Thus, as one would expect, R.N.s were seen most favorably of all and they were felt to be the least adequately paid, with all four value types agreeing on this.

bility that it represents are part of the dynamic field in which attitudes operate, and the atmosphere so created naturally shapes their formation and effect. Consequently, an awareness of this status system is a necessary backdrop for the analysis of the attitudes of the four value types toward teammates at different levels in the system.

But this is not the only reason for interpolating this discussion. Something unanticipated occurred during the process of analyzing the attitudes of the four value types. There were many themes running through the attitudes expressed about doctors. By comparison, the material on practical nurses and aides was constrained—so much so that the range of analysis of attitudes toward practical nurses and aides had to be restricted. Because of this, a separate dimension was added, namely, a simple measure of the amount of repetition or stereotyping in the various attitudes. As it turned out, the amount of repetition paralleled the status scale, being least for the doctor, more so for the practical nurse, and most for the aide. This held for all four value types.

The stereotypy measure was based on responses to items of the incomplete sentence form. Each respondent had three opportunities to say something about doctors, about practical nurses, about aides, and about visitors. Each set of three responses was checked to see whether a respondent used the same word or phrase more than once. This measure was crude in that repetition of themes was ignored and only literal repetition of words was counted. For example, one nurse said that by and large aides "are a help to nurses" and, later, that aides "help relieve nurses." This was scored as a repetition. Another respondent thought that the practical nurse "has a place in nursing" and, later, that practical nurses usually "have a role to fill." Though the themes were similar, there was no literal repetition and it was not scored as such. In other words, this measure is only a relative one and is not indicative of the "absolute" amount of stereotypy.

Since there was little difference among the value types on this measure, the results will be given for all types combined as follows:[5]

	Proportion of respondents who:	
Attitude toward:	*Repeated words*	*Did not repeat*
Doctors	17%	83%
Visitors	20	80
Practical nurses	30	70
Aides	39	61

[5] The total N varied slightly because of some failures to respond to all items. The actual numbers were: doctor items, 206 respondents; visitor items, 212 respondents; practical nurse items, 207 respondents; and aide items, 210 respondents.

The relative positions of doctor, practical nurse, and aide followed the usual status lines.

It is sometimes true that stereotyping is a countermeasure to "threat," and there is ample evidence (see Hughes, Hughes, and Deutscher, 1958) that practical nurses and aides do constitute a threat to the established role of the nurse. So, at first glance, it seems reasonable that expressions of attitudes toward practical nurses and aides would show more stereotypy than attitudes toward doctors. However, other research studies have shown that the practical nurse, the immediate competitor of the R.N., is generally seen as a greater "threat" than the aide, whereas the stereotypy measure showed greater repetition about the aide than the practical nurse. Apparently "threat," though it may well be involved, cannot account for the observed pattern.

An intriguing theory of social interaction put forth by Goffman (1955) is relevant here. In his conceptualization, people at higher levels in the status hierarchy have more "faces" to present to the world or, to oversimplify, more roles to play. There is a greater variety of expectations about them and images of them. If this theory is applied to our data, there should be more kinds of things said about the doctor because he has more "faces" (least stereotypy). Practical nurses, with lower status, do not have so many "faces" (more stereotypy); and aides, who have the lowest status of the three, have even fewer "faces" (most stereotypy). The visitor, who is outside the hospital organizational system, approximates the many different kinds of people the nurse would meet outside the hospital. This suggests more "faces" and, in fact, the visitor ranks close to the doctor in the lack of repetition in nurses' expressions about him.[6]

With these status considerations in mind, we now turn to the content of the attitudes.

The Doctor

Because of the variety of things said about the doctor, it was possible to devise two meaningful sets of categories for coding the responses to the incomplete sentence items. These items were: "I think that the doctor ....."; "Most doctors ....."; and "Doctors usually ....." Responses to the first item constituted the subject matter for one set of

[6] Responses to three incomplete sentence items about the "model patient" were described in Chapter 4. On the stereotypy measure, 31 per cent of the respondents repeated words or phrases and the patient can be placed just below the practical nurse and definitely below the visitor. One may reason that, though the patient has as many "faces" as his visitor, the nurse is accustomed to seeing him only in his "patient" role.

TABLE 26

RESPONSES TO "I THINK THAT THE DOCTOR ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Doctor seen:										
As authority figure	6	11	11	16	10	32	8	14	35	17
In relation to patient	22	41	22	32	11	35	16	29	71	34
In relation to nurse	15	28	8	12	5	16	22	39	50	24
In relation to no one or only to himself	11	20	27	40	5	16	10	18	53	25
Total	54	100	68	100	31	99	56	100	209	100

[a] The chi square value, with nine degrees of freedom, was 26.16, significant at the .01 level.

categories, while responses to the other two items, which were similar in content, were combined and coded according to the second set.

The first set of categories was built around the kinds of relationships in which the doctor was pictured, either explicitly or implicitly. That is, the doctor could be described as an authority figure, or be seen in relation to a patient, in relation to a nurse, or in relation to no one—just to himself. This scoring procedure ignored any favorable or unfavorable tone, though it can be said that negative comments were certainly in the minority. For example, both the favorable thought that the doctor was "alert to the patient's needs" and the unfavorable one that he "overcharged his patients" were classified as describing the doctor in relation to a patient. Similarly, the doctor could be thought of as "unappreciative of nurses" or as "glad for the nurse's assistance," and both responses were scored as doctor in relation to nurse.

The categories were as follows:[7]

1) *Doctor seen as authority figure.* For example: I think that the doctor "is always right," "knows best," "is a person to be respected," "is the head man," "is the boss."

2) *Doctor seen in relation to patient.* For example: I think that the doctor "is the bright spot in the patient's day," "should spend more time at the bedside," "should explain more to the patient," "helps the patient."

3) *Doctor seen in relation to nurse.* For example: I think that the doctor "can make or break a good nurse," "is our best friend," "should have a better understanding of the nursing shortage."

4) *Doctor seen in relation to no one or only to himself*—responses describing the doctor's personal situation or qualities without reference to another person. For example: I think that the doctor "has a heavy work load," "who is interested in his work is the happiest," "doesn't get enough credit," "is good."

Table 26 shows the results. The most frequent response over the whole sample was to talk of the doctor in relation to the patient. Seeing the doctor in relation to no one but himself came next, while the doctor in relation to the nurse was just slightly less frequent. Seeing the doctor primarily as an authority figure was the least frequent type of response. Lest the impression be given that nurses only infrequently relate to the doctor as an authority figure—an impression that should be contradicted by any realistic consideration of the hospital's authoritarian structure—it is perhaps advisable at this point to recall the special nature of the incomplete sentence method. The response elicited by this technique is supposed to be the *first* thought that the subject associates with the phrase given him. (Of course not all respondents,

[7] The reliability analysis of these categories, using two independent judges, yielded an agreement level of 87.8 per cent.

TABLE 27

COMBINED RESPONSES TO "MOST DOCTORS ....." AND "DOCTORS USUALLY ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Doctor's behavior seen as:										
Busy or hurried	15	29	24	38	6	19	8	17	53	27
Agreeable or pleasant	21	41	17	27	8	26	24	50	70	36
Competent or conscientious	15	29	23	36	17	55	16	33	71	37
Total	51	99	64	101	31	100	48	100	194	100

[a] The chi square value, with six degrees of freedom, was 14.36, significant at the .05 level.

nor all item phrases, conform to the theoretical ideal.) The main virtue of the technique is that, ideally, it gets at the dominant feeling. It by no means elicits *all* the feelings. No doubt all nurses see the doctor as an authority figure, but this is obviously not the only attitude taken toward him or, for many nurses, necessarily the paramount one. It is the differences among nurses as to what particular attitudes are dominant that are revealing about the value types.

The value types did differ significantly,[8] and this revealed both predictable and enlightening trends. One predictable tendency concerned the technical-administrative Type IV: significantly more Type IV's described the doctor in relation to the nurse. This confirms, in a new context, the original definition of this type as primarily colleague-oriented (Compound Section of the NPIT) and the finding that relatively more Type IV's preferred the nurse-doctor relationship (Five-Way Section of the NPIT). Also to be expected, though the trend was not large enough to be significant, was the tendency for more Type I's, who preferred the nurse-patient relationship (Compound and Five-Way Section), to see the doctor in relation to the patient.

The trends that shed new light concerned the modern Types II and III. Significantly more Type II's described the doctor in relation to no one but himself, that is, in terms of his personal situation and qualities. This could reflect, and it is only speculation at this point, a tendency to see others *first* as separate individuals—an initial perception of others that does not immediately place them in direct relation to one's own pursuits.

The significant trend for Type III concerned seeing the doctor as an authority figure. Compared to the other value types, relatively more Type III's gave a response of this kind. Contrasting this with the significant trend for Type IV—seeing the doctor in relation to the nurse—suggests that Type III tends toward a somewhat different image of the doctor. In the original definition of the types, the primary orientation of Type III was to "share the patient with a colleague" in a three-way relationship in which the colleague, as against the patient, exerted greater drawing power for the nurse. By comparison, Type IV was completely oriented to the colleague. But this original definition was based entirely on preferences for work relationships. Therefore it could not indicate whether the doctor, as one colleague, was seen similarly by both types—with only the degree of preference for him varying—or whether

[8] There was also a significant difference in regard to the nursing specialties (see Appendix B), primarily because relatively more medical nurses gave "doctor in relation to nurse" responses while relatively more psychiatric and public health nurses gave responses describing the doctor as an authority figure.

a difference in what was seen was also involved. The data in Table 26 suggest a difference in viewpoint, with more Type III's reacting to the doctor as an authority, and more Type IV's mentioning a nurse-doctor relationship per se without overtones of power or authority.

The second set of categories, designed to code responses to "Most doctors ....." and "Doctors usually ....." dealt with his behavior. As with the first item, there was a paucity of truly negative responses,[9] so that no category for negative behavior was used. The categories were:[10]

1) *Doctor described as busy or hurried.* For example: Doctors usually "are in a great hurry," "are in a rush." Most doctors "have too long hours," "don't have enough time."

2) *Doctor described as agreeable or pleasant,* as friendly or nice. For example: Doctors usually "are appreciative," "are good natured." Most doctors "are good Joes," "are wonderful." (Responses that tied the doctor's pleasant behavior directly to the work, such as being cooperative or helpful, were put in category 3.)

3) *Doctor described as competent or conscientious,* that is, his behavior seen as good in terms of the work sphere. For example: Most doctors "are on hand when needed," "are conscientious, hard workers." Doctors usually "know what they are doing," "are cooperative," "give clear orders."

Table 27 gives the distribution of responses. The value types differed significantly, and the important trends concerned Types II, III, and IV.[11]

The most frequent response among Type II's was a description of the doctor as busy, overworked, or hurried. This finding is a nice extension of the trend evidenced earlier in Table 26 which showed that more Type II's saw the doctor in relation to no one but himself, that is, in relation to his personal situation. Apparently there is a genuine tendency for Type II's to perceive the doctor in his own terms and quite separate from themselves. The later sections of this chapter will show whether this kind of orientation holds for people other than the doctor.

Among Type III's the most frequent response was to mention the

[9] Hughes, Hughes, and Deutscher (1958, p. 159), summarizing other research that also found a relative lack of negative comments about doctors, have pointed out that it is dangerous for nurses to criticize doctors.

[10] The reliability analysis of these categories, using two independent judges, yielded an agreement level of 93.3 per cent. In cases where more than one theme was mentioned, category 1 took precedence over category 2, and category 2 took precedence over category 3. This particular order was established in terms of the relative frequency of each theme so as to gain sufficiently high expected frequencies for chi square treatment. There were 23 respondents who gave negative responses and were therefore not classified.

[11] Type I showed no marked trend in these items. In working with coding systems that are limited, for statistical or other reasons, to three categories, it will not be possible to establish *different* trends for each of the four value types.

competence of the doctor or to describe his hard-working and conscientious behavior. Taking this together with the earlier finding that relatively more Type III's related to the doctor as an authority figure suggests a certain matter-of-fact concentration on work, on what has to be done.

The original definitions of the two modern types may be elaborated to include these evolving interpretations. The Type III nurse prefers to share the patient (the job to be done) with a colleague (one means to getting the job done), with the colleague being relatively more important. Type II, on the other hand, who also prefers to share the patient, tends to see the colleague as a separate, independent person, and thus the patient is relatively more important. (These oversimplifications can perhaps be excused if they serve to illustrate the distinction being made.)

Concerning Type IV, significantly more nurses in this group described the doctor as agreeable, pleasant, or friendly. This is of course not surprising. According to the original definition, this type was the colleague-oriented one and, as was later shown, a relationship with the doctor as colleague was most preferred. Now these data from the sentence completion items have indicated that an image of a cordial relationship in which the doctor is appreciative and friendly tends to be the dominant one. Thus our conception of this type has been both reconfirmed and enlarged.

The Practical Nurse and the Aide

The factor of greater stereotypy in the responses to the sentence completion items dealing with the practical nurse (three items) and the aide or attendant (three items) has already been mentioned. Owing to this lack of variation—both in terms of repetition of the same word or phrase (stereotypy measure) and in terms of a narrower range of themes mentioned—only one set of categories could be constructed. It proved feasible to use this coding system for responses to both the practical nurse and the aide items. This is one reason why the two levels of personnel are discussed here in the same section.

For purposes of comparison as well as for consistency, this set of categories was modeled after the first set designed for the doctor, which described the kind of relationship in which he was pictured. Thus the practical nurse (or aide) could be seen in relation (1) to the patient, (2) to the nurse, or (3) to no one but herself. Any favorable or unfavorable tone was, as for the doctor, ignored in the scoring. It is probably worth noting, however, that, in contrast to the paucity of negative responses

TABLE 28

COMBINED RESPONSES TO "I THINK THAT THE PRACTICAL NURSE ....," "PRACTICAL NURSES USUALLY ....," AND "GENERALLY SPEAKING, THE PRACTICAL NURSE ...."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Practical nurse seen in relation to:										
Patient	15	26	14	20	5	16	7	12	41	19
Nurse	39	67	36	52	17	55	36	62	128	59
No one or only herself	4	7	19	28	9	29	15	26	47	22
Total	58	100	69	100	31	100	58	100	216	100

[a] The chi square value, with six degrees of freedom, was 12.63, significant at the .05 level.

about the doctor, there were a fair number of negative responses about the practical nurse and the aide. The "authority" category (seeing the doctor as authority figure) could not be applied since in this case the respondent (nurse) was an authority figure to the persons she was describing. The possibility was considered that a response might describe the practical nurse (or aide) in relation to the nurse's authority, but clear-cut expressions of this (e.g., I think that aides "should follow my orders") were not sufficiently frequent. Also, such responses specifically indicated a relationship to the nurse, which qualified them for scoring in the second category. Such overlapping did not arise directly in connection with the categories for the doctor.

The categories were:[12]

1) *Practical nurse (or aide) seen in relation to patient.* For example: I think that the practical nurse "enjoys caring for people." Practical nurses usually "make good bedside nurses." I think that aides "should do simple bedside care." By and large aides "are kind to patients."

2) *Practical nurse (or aide) seen in relation to nurse.* For example: Generally speaking, the practical nurse "relieves the nurse of a lot." Practical nurses usually "aid the nurse." As a rule, attendants "are a big help." I think that aides "take away many physical burdens of nurses."

3) *Practical nurse (or aide) seen in relation to no one or only herself.* Often these responses described personal qualities, background, or situation. For example: I think that the practical nurse "has a place." I think that aides "are needed." As a rule, attendants "are fine people."

Table 28 shows the distribution of responses to the practical nurse items. The majority of respondents (59 per cent) described the practical nurse in relation to a nurse. Next came "in relation to no one or only herself" (22 per cent), while the smallest proportion (19 per cent) mentioned the practical nurse in relation to a patient. This differs from the distribution of responses to the doctor item, where more respondents described the doctor in relation to the patient than to the nurse. This is particularly interesting in view of actual work conditions. In the hospitals from which the sample was drawn, most nurses usually have more opportunity to see practical nurses dealing with patients than to see doctors with their patients. But, also in terms of work conditions, nurses are probably more acutely aware of what they have to do with the practical nurse in the way of supervising her.

The value types differed significantly, primarily because significantly fewer Type I's described the practical nurse in relation to no one but

[12] The reliability analysis of these categories, with two independent judges, yielded an agreement level of 93.5 per cent. In cases where more than one kind of relationship was mentioned, category 1 took precedence over category 2, and 2 over 3.

TABLE 29

COMBINED RESPONSES TO "BY AND LARGE, AIDES ....," "I THINK THAT AIDES ....," AND "AS A RULE, ATTENDANTS ...."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Aide seen in relation to:										
Patient	17	30	11	16	6	19	12	21	46	21
Nurse	36	63	46	66	22	71	36	63	140	65
No one or only herself	4	7	13	18	3	10	9	16	29	13
Total	57	100	70	100	31	100	57	100	215	99

[a] The chi square value, with six degrees of freedom, was 6.89, which reached the .50 level.

herself (her background, personal qualities, or situation). Conversely, there was a tendency for relatively more Type I's to mention the practical nurse in relation to the patient. This is similar to the slight tendency of this group to describe the doctor in relation to the patient.

The tendency for relatively more Type II's to see the individual, in the case of the doctor, in his own terms (in relation to no one but himself) did not extend to the case of the practical nurse. But it is difficult on the basis of these data, blurred as they are by the stereotypy already noted, to judge how accurately this reflects the "real" situation. More sensitive techniques capable of penetrating beyond the repetition and narrow range of the responses might show other trends, not only for Type II but for the other value types as well. On the other hand, they might indicate that the heavy concentration of responses in the "practical nurse seen in relation to nurse" category genuinely reflects the dominant point of view.

The distribution of responses to the aide items, in Table 29, shows an even heavier concentration of responses in the "relation to nurse" category (65 per cent). This was followed by "aide seen in relation to patient" (21 per cent). Thirteen per cent of the respondents described the aide in relation to no one, and, as with the practical nurse, there was no particular tendency for Type II to predominate in this category. Relatively more Type I's described the aide in relation to the patient (as in the case of the doctor and the practical nurse), but the value types did not differ significantly.

Data presented in Chapter 4 are relevant at this point. It may be recalled that, of all the situations presented in the Five-Way Section of the NPIT, only nurse-with-aide did not yield a significant difference. Thus, in both instances of attitudes toward the aide, the value types showed no important differences. It could be, in view of their typically busy day, that nurses are left with little emotional energy to expend thinking about the aide, who is low man on the status totem pole; and that consequently nurses really do not differ much in how they see and feel about the aide. Only further research with more sensitive methods could clarify the matter.

One other tally will round out our data on the practical nurse and the aide. While the stereotypy count was being made, the writer was impressed by the fact that there was one word that appeared time and again in the responses to the practical nurse items: *place*. (The practical nurse "has her place," "should know her place," "has a definite place in nursing," and so on.) A similar phenomenon occurred in the aide items,

and there the word was *help* or *helpful.*[18] (The aide "is a big help," "helps the nurse," "is helpful," etc.) So a count was made of the total number of respondents, regardless of whether they repeated themselves, who used the word "place" when describing practical nurses. The result was 45 respondents (21 per cent). In talking about the aide, 106 respondents (49 per cent) used "help" or "helpful." This marked popularity of certain words represents another form of stereotypy, that is, recurrence of a particular theme over the total group as distinct from literal repetition of words by individual respondents; and the aide items again showed the greatest amount of it.

These results tie in with the findings of other researchers, already mentioned, that practical nurses, as compared to aides, are in closer "competition" with the registered nurse and therefore constitute a greater "threat" to her. In terms of our data, it seemed as though some of the R.N.s were assuring themselves and others that the practical nurse really did have a place rather than just stating a fact which they accepted. By contrast, many nurses seemed willing to concede that the aide was helpful.

At this point we should like to examine the findings of other researchers in more detail. Hughes, Hughes, and Deutscher (1958) have summarized 15 studies supported by the American Nurses' Association, and the picture they present is painted in terms of conflict, threat, confusion, and, at a minimum, discomfort. These various studies, carried out in different states and in different kinds and sizes of hospitals, showed considerable disagreement and stress between registered nurses and practical nurses and between nurses and aides as to who should be doing what. At the root of the trouble, according to these authors, are the "cherished" bedside tasks which practical nurses and aides have inherited from the R.N. The loss of such tasks as bathing and feeding has presumably deprived the R.N. of a major area of satisfaction—ministering to the patient; and it has had the effect of redefining her role away from the bedside and toward administration and teaching.

This redefinition of role is seen as the inevitable outcome of a recurrent process: as medical technology and invention create more things to be done (such as new kinds of treatments or diagnostic procedures), the R.N. takes over tasks from the doctor and passes on, though at times unwillingly, some of her duties to her subordinates. Concurrently her

[18] There was at least as much stereotypy (31 per cent) in the responses to the "model patient" items. In that case the common word was *cooperative* or *cooperation,* and 34 per cent of the respondents used some form of the word to describe the model patient (see Chapter 4).

subordinates, in the case of practical nurses, are carving out their own field. Thus, to quote from Hughes, Hughes, and Deutscher:

> The practical nurse, in effect, is repeating the history of the R.N., building up her career by the piecemeal accretion of activities which someone higher up has no time for; and once she has undertaken a task, she is likely to think it is hers, and from that, to think that she ought to do it and that it is expected of her, while the R.N. continues to claim it as her own (p. 147).[14]

This conceptualization of changes in the nursing profession certainly accounts for some of the things that are happening. But there are other parts to the story, and the usual concept of TLC (tender loving care)—the traditional sine qua non of the nurse's role—needs some re-examination. TLC, or rather the opportunity for providing it, has customarily been seen as part of the physical care given at the bedside—soothing words along with the pills, a comforting touch as dressings are changed. But are these the only, and always the right, methods of giving emotional support?

Recent developments in the knowledge and philosophy of nursing (outlined in the first chapter) are recasting the notion that the art of giving TLC is the unlearned heritage of the "born" nurse. (As one respondent put it: "A lot of what's called mothering is really smothering!") Along with the current view that different patients need different treatment at different times, there is the realization that good nursing care of the psychological as interwoven with the physical needs of the patient has to be based on knowledge. And this involves learning, not *just* intuition.

The full scope of this new perspective[15] is expressed in the concept of *comprehensive care*— seeing the total patient (his psychological as well as physical needs and reactions) in his total situation (extending to his reinstatement in the family and community after treatment). Since this approach is affecting nursing and medicine alike (see Simmons and Wolff 1954), appreciation of its effects means getting away from the idea of a "closed" system in which tasks are recurrently downgraded. It is not as though the doctor, being pressed for time to handle physical ailments, is delegating the psychological understanding of the patient to the nurse.

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[14] Of course, this is not the entire history of the R.N. Many of the functions that originally made up her work—such as bathing, feeding, and "keeping watch"—never belonged to persons at higher levels (e.g., doctors).

[15] Though this perspective is new, it also has roots in the methods of the general practitioners who flourished before the age of specialization with its concomitant emphasis on technology.

Thus, different research studies have analyzed nursing from different vantage points and therefore have tended to look at different phenomena. A comparison of two particular studies will illustrate this. One of the studies summarized by Hughes, Hughes, and Deutscher, Christ's *Nurses at Work* (1956), developed a master list of 90 tasks which aides, practical nurses, and registered nurses rated as to who should do each, who was expected to do each, and who was doing each. These 90 tasks ranged from cleaning up the delivery room to assisting with blood transfusions; and all of them, with the possible exception of phoning nearest of kin concerning death of patient, were obviously physical in nature. Whiting (1958), on the other hand, categorized the activities involved in the nurse-patient relationship into four areas (Liaison, Physical Care, Supportive Emotional Care, and Patient Education) and devised 100 statements (25 covering each area) which were ranked by nurses, aides, and patients as to their relative importance. ("The nurse helps the patient express his fears about his illness" and "The nurse calms down the upset patient" are examples of statements from the category of Supportive Emotional Care.)

These two investigators are clearly looking at different realities and, in that sense, each reports only a part of the truth. To apply this in interpreting our data means that any conflict or resentment among registered nurses, practical nurses, and aides is only one part of the story. Another part (as outlined in the first chapter) concerns the move outward, away from the "fixed" hierarchy of functions, toward the incorporation of new perspective. As it is expressed in the philosophy of team nursing, this perspective requires the development of *new* relationships between the R.N. and her teammates. Further research is needed along this line—both now and in the future to see what changes will have been effected.

The Visitor

The total situation of the patient includes his visitors. Though this group is not, strictly speaking, part of personnel, it is an important one in the social world of the nurse: nurses frequently interact with visitors.

Three incomplete sentence items dealt with the visitor. Since the amount of stereotypy was lower on these items (roughly the same as on the doctor items), two sets of categories were devised to code the responses. The first set covered responses to the item "The patient's visitors ....."; and these categories were comparable to the common set used for the doctor, practical nurse, and aide. The visitor could be described in relation to the patient, the nurse, or the hospital. The third

category differed because responses that did not relate visitors to either the patient or the nurse did not seem to focus on the visitor's own self or situation (though the second set will include a category on this order). As before, any favorable or unfavorable emotional tone in the response was ignored for scoring purposes. Compared to the doctor, practical nurse, and aide items, however, the visitor item elicited more negatively toned responses, and this was taken into account in the second set of categories.

The categories were:[16]

1) *Visitor seen in relation to patient.* For example: The patient's visitors "help build up his morale," "may help or interfere with his health," "cheer him up."

2) *Visitor seen in relation to nurse.* For example: The patient's visitors "like to talk to nurses," "ask too many questions," "are a nuisance," "are resource material for the nurse."

3) *Visitor seen in relation to hospital*—responses describing the visitor in connection with the general hospital environment. This usually meant hospital rules and regulations. For example: The patient's visitors "should come at visiting hours," "should not overstay visiting hours."

Table 30 shows the distribution of responses. More than half the respondents described the visitor in relation to the nurse (56 per cent), while visitor in relation to patient was next (31 per cent). Only 13 per cent mentioned the visitor in relation to hospital. The value types differed significantly,[17] primarily because relatively more in both the modern Types II and III, as compared to I and IV, saw the visitor in relation to the patient. This suggests that the two modern types, as compared to the two traditional—yet opposite—types, are more likely to recognize the total situation of the patient and the place that visitors have in it.

The interesting switch concerns Type I, which until now has tended to conform to the expectations set up in the original definition of this "ministering angel" type. There was a tendency, as far as the doctor, practical nurse, and aide were concerned, for relatively more Type I's to describe them in relation to the patient. But in the case of the visitor, this patient orientation did not hold true. In terms of the proportion describing the visitor in relation to the patient, Type I ranked third (outdistanced by both II and III) rather than first. Interpretation of

[16] The reliability analysis of these categories, with two independent judges, yielded an agreement level of 93.3 per cent.

[17] There was also a significant difference in regard to nursing specialty (see Appendix B). Relatively more public health nurses described visitors in relation to the patient, which is quite reasonable in view of the fact that their work takes them into the patient's home and family.

TABLE 30

RESPONSES TO "THE PATIENT'S VISITORS ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Visitor seen in relation to:										
Patient	13	24	25	38	13	46	11	20	62	31
Nurse	37	69	30	46	12	43	34	63	113	56
Hospital	4	7	10	15	3	11	9	17	26	13
Total	54	100	65	99	28	100	54	100	201	100

[a] The chi square value, with six degrees of freedom, was 12.34, which reached the .10 level. Combining Types II and III, the chi square value, with four degrees o freedom, was 11.58, which was significant at the .05 level.

this new and unusual facet should deepen our understanding of Type I. It has already been noted, in connection with attitudes toward supervising the work of others, that some Type I's felt this function interfered with their work with the patient. The modern types, on the other hand, tended to take a broader view and to incorporate supervision as an important and necessary part of their work—presumably as one avenue to good patient care. Type I's perspective, by contrast, seems narrow and almost has a flavor of "rugged individualism." Extrapolating this narrowness to the present data, it could be that some Type I's see the patient as "theirs" while he is sick—not the family's. This could account for the tendency, unusual for them, to see the visitor relatively more in relation to the nurse than the patient.

The second set of categories was designed to code responses to two items combined: "Visitors usually ....." and "Most visitors ....." These categories, modeled after the second set used for the doctor, concerned the behavior of visitors. Unlike responses to the second two doctor items, however, there were enough negative remarks about the visitor to warrant making a category for them. The categories were:[18]

1) *Visitor's behavior described in terms of his personal qualities or situation: anxiety, fear, curiosity, etc.* For example: Visitors usually "are worried and curious," "are quite concerned." Most visitors "are anxious about their patient," "have come a long way."

2) *Visitor described as helpful or cooperative to the nurse or patient.* For example: Visitors usually "are willing to cooperate with the nurse's request," "leave the patients in good spirits." Most visitors "add to the patient's security," "are cooperative."

3) *Visitor's behavior described as negative or disruptive to the nurse or patient.* For example: Visitors usually "expect the patient to entertain them," "never fail to upset our peace and quiet." Most visitors "don't understand ward routine," "are noisy and inconsiderate."

Table 31 shows the results. The most frequent response was to see the visitor in terms of his personal situation. Next came helpful or cooperative behavior, while the least frequent response was to describe the visitor's behavior as negative or disruptive.

The value types were significantly different,[19] mainly due to differ-

[18] The reliability analysis of these categories, with two independent judges, yielded an agreement level of 92.5 per cent. In cases where more than one category applied, category 1 took precedence over 2, and 2 over 3.

[19] The nursing specialties also differed significantly (see Appendix B). Relatively more psychiatric nurses discussed visitors in terms of their personal situation, as befits those who are more concerned in their work with emotional factors. Relatively more public health nurses described visitors as helpful and cooperative. Relatively more surgical nurses, to whom routine is probably especially important, mentioned negative or disruptive behavior of visitors.

TABLE 31

COMBINED RESPONSES TO "VISITORS USUALLY ....." AND "MOST VISITORS ....."[a]

Response	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Visitor's behavior seen:										
In terms of his personal qualities or situation: anxiety, fear, curiosity, etc.	22	40	39	57	6	19	25	45	92	44
As helpful or cooperative to nurse or patient	21	38	16	23	16	52	12	22	65	31
As negative or disruptive to nurse or patient	12	22	14	20	9	29	18	33	53	25
Total	55	100	69	100	31	100	55	100	210	100

[a] The chi square value, with six degrees of freedom, was 17.33, significant at the .01 level.

ences concerning the modern Types II and III. Type II showed a greater tendency than the other types to focus on the visitor's own qualities or situation, particularly anxiety or curiosity. This extends the finding, observed in the case of attitudes toward the doctor (though not the practical nurse or aide), that relatively more Type II's are ready to see another individual in his own terms rather than immediately incorporating him into their own situation.

Only a small proportion of Type III's, however, gave this type of response; and by far the most frequent response in this group was to speak of the visitor's behavior as cooperative or helpful. Apart from the laudatory tone of such responses, the interesting thing is the ease with which they seemed to fit the visitor into the ongoing scheme of things. This is reminiscent of the task-orientation displayed by Type III in their attitudes toward the doctor (relatively more emphasis on his authority and on his hard-working behavior).

Thus it becomes increasingly clear that a major line of difference between the modern Types II and III is that Type II is more oriented toward the "personal equation" while III is more concerned with the "work equation."

Chapter 9

Three Styles of Nursing Education

Up to this point we have been concerned with defining the value types and with broadening our conception and understanding of them by examining their attitudes toward supervision, practical nurses, visitors, and so on. Now the time has come to ask: how do the value types become what they are? Of course an initial, and exploratory, research study such as this one is not designed to encompass the many forces, both internal and external, that are bound to be involved in the lengthy process of developing and modifying values. However, data were gathered on what turned out to be a very important factor—the education of the student nurse.

The purpose of this phase of the study was to analyze the distribution of value types among various student groups to see (1) the general effect of education and (2) the individual effects of the different types of nursing education available. Three styles of nursing education were represented in the study. One was the collegiate or baccalaureate program in which the student, after four academic years of college work, receives a bachelor of science in nursing. This program represents the newer nursing philosophy which focuses on comprehensive or total patient care and the concept of team nursing, and which incorporates knowledge from the social as well as the biological sciences. The second was the more traditional hospital or diploma program which covers three calendar years. Its philosophy is still grounded in the rather authoritarian approach that has characterized nursing in the past, and this type of program still accounts for the majority of nurses being trained today. The third program, historically quite recent, is the two-year community or associate degree program in which the student spends two calendar years in junior college plus, at the time the study was done, a third year as a practicum student still enrolled in nursing. Its orientation is perhaps a cross between the other two approaches, and it has been set up to cover in two calendar years what the hospital program covers in three.

Three hundred and sixty-two students in the three types of programs were tested, including: (1) beginning students—sophomores in a collegiate program (68) and first-year students in an associate degree (50) and a hospital (22) program; (2) middle students—juniors in a collegiate (38) and second-year students in an associate degree (34) and a hospital (62) program; and (3) terminal students—seniors in a collegiate (24), practicum students in an associate degree (26), and third-year students in a hospital (38) program.[1] Also, 43 high school students who were members of Future Nurse Clubs were tested. Two high schools were used, one in an upper-class area and one in a middle to lower-middle class area, so that potential candidates for all three types of programs were included.

A total of 313 of the 405 students tested could be classified as to value type, according to their responses to the Compound Section of the NPIT, with 92 cases lost due to failure to respond to all items or to ties in responses (see Chapter 4 for the scoring method). Table 32 shows the resulting distribution of value types.

With respect to the beginning students in all three kinds of schools, there is one predominant fact: most of them scored as Type I (ministering angel). This was also true of the high school girls who wished to become nurses. Most of the students—actual and potential—would like to care for a patient, and would like to care for him directly and unaided. In statistical terms, comparison of the four beginning groups (the three educational programs plus the high school group) over all four value types revealed no significant differences among them. Thus, apart from, or in spite of, possible differences in family and socio-economic background, there was a common thread running through all these groups: in their choice of nursing, most of the students apparently were motivated by an elemental desire to "nurse" a patient.

Considering these data, one can guess at some of the fantasies that shaped and expressed their desire to enter nursing—images of a dedicated heroine in white creating hope and well-being out of illness and pain, her usefulness and importance mirrored in the grateful comfort of the sick. No doubt many such images have been generated by the widespread public myth of the woman in white and the still appealing

[1] The questionnaire was administered during the first half of the student's school year—late fall in the case of the baccalaureate and associate degree program students. The hospital school used in the study admitted students twice during the calendar year and students were tested at different times to make their placement comparable to the other schools. As it turned out, the beginning hospital group that was available corresponded to a "February class" and consequently was a somewhat smaller group.

TABLE 32

DISTRIBUTION OF THE FOUR VALUE TYPES AMONG STUDENTS[a]

Education program	Student group	Type I		Type II		Type III		Type IV		Total	
		N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
High school	Members of Future Nurse Clubs.	17	52	10	30	1	3	5	15	33	100
Hospital-diploma	Beginning	15	75	3	15	1	5	1	5	20	100
	Middle	18	47	9	24	5	13	6	16	38	100
	Terminal	5	17	10	34	7	24	7	24	29	99
Associate degree	Beginning	21	48	13	30	3	7	7	16	44	101
	Middle	6	30	7	35	4	20	3	15	20	100
	Terminal	8	36	7	32	4	18	3	14	22	100
Collegiate-baccalaureate	Beginning	35	58	15	25	2	3	8	13	60	99
	Middle	14	45	13	42	2	6	2	6	31	99
	Terminal	3	19	13	81	0	0	0	0	16	100

[a] The first step was to test for differences over years, regardless of the particular program. Accordingly, chi squares were computed comparing all beginning nursing students (not including the potential high school students) to all middle students, and both of these groups to all terminal students. The beginners vs. the middle students yielded a chi square value of 6.91 (three degrees of freedom) which reached the .10 level; but on comparing these groups as to Type I vs. the other three types combined (one degree of freedom), the resulting value of 4.40 was significant at the .05 level. Comparing the middle to the terminal students over all four types, the chi square value was 6.05 (three degrees of freedom) which reached the .20 level; but, again, making the comparison on Type I vs. the other three combined (one degree of freedom), the value was 5.98, significant at the .02 level. Finally, the beginning vs. the terminal students over all four types (three degrees of freedom) gave a value of 22.66, significant at the .001 level.

The second step was to test for differences among educational programs. Accordingly, chi squares were computed comparing the four groups of beginning students (including the high school girls as a potential beginning group) to each other, the middle groups to each other, and the senior groups to each other. These chi square values should be regarded only as approximate ones since some Ns were quite small—particularly in the totals of Types III and IV. The beginning groups were not significantly different, nor were the middle groups. The senior groups were significantly different: the chi square value of 19.45 (six degrees of freedom) was significant at the .001 level. This was due to the senior collegiate group, as shown in further comparisons: the terminal collegiate group differed significantly from the terminal associate degree group (chi square of 10.36, three degrees of freedom, .02 level) and from the terminal hospital group (chi square of 12.14, three degrees of freedom, .01 level); but the terminal hospital and associate degree groups were not significantly different from each other. The percentage results have been presented in graph form in *Nursing Outlook* (Meyer 1959).

legend of the lady with the lamp.[2] But, regardless of whether this picture is more mythical than typical, there is the important fact that it apparently has had real drawing-power for many girls choosing nursing today. The girls in our sample did not choose to be teachers, or secretaries, or social workers. They chose nursing. So the appeal of such images is probably related to an underlying need for the kinds of satisfactions the images promise—a point to be remembered when evaluating current developments in the nursing profession. Whatever the outcome of changes now in process—a more thorough removal from the bedside *or* a renewal, a recasting, of some of those "lost" functions through new, and probably psychotherapeutically oriented, conceptions of the nurse's role—there is the matter of the underlying needs which prompted the choice of nursing. It is easier to alter a job description than the original motivation that attracted the nurse to her job. In the case of the second kind of outcome, such needs presumably could be satisfied, though in a somewhat different fashion. In the case of the first kind of outcome, the one that some researchers think inevitable, frustration is bound to result unless such original motives can be transmuted. Of course, there is the possibility that recruitment appeals will change and, if so, a different kind of person, with different motivation, would be attracted to a nursing career.

At the moment, however, at least at the time this study was made, the majority of beginning students tested turned out to be the patient-oriented Type I; and this was true regardless of the type of program. The next stage, after choosing a school, involves the process of learning to be a nurse, and one of the things the student discovers is that nurses do not spend all their time single-handedly caring for patients. She finds that there is much behind-the-scenes activity that is essential and that some time has to be spent, not with patients, but with fellow

[2] The public myth also plays up the nurse-doctor relationship. Consider its expression in the mass media: motion pictures and their rerun on television (e.g., the "Dr. Kildare" series with Laraine Day as the lovely young nurse and Lew Ayres as the bright young doctor); radio drama (e.g., the weekly "Dr. Christian" series in which the young office nurse, Judy Price, devotedly worked for the kindly, old doctor); radio soap opera (e.g., "Young Dr. Malone" in which the skilled, and human, surgical nurse Mollie West appears from time to time and almost married a doctor); comic strips (e.g., "Rex Morgan, M.D." whose attractive office nurse, June Gale, occasionally comes close to marrying him); and novels (e.g., "Not as a Stranger" in which a dedicated, but plain, nurse marries and comes to the financial aid of a ruthlessly dedicated, but poor, intern who later becomes an earnestly dedicated doctor). So images of the nurse-heroine working side by side with the doctor-hero are probably included in the fantasies of girls aspiring to be nurses. Although this chapter is not concerned with preferences for particular colleagues, it is relevant here to recall that, for Types I and II, the average choice after the patient, on the Five-Way Section of the NPIT, was the doctor. For Types III and IV the doctor was, of course, in first place. (For data on the popularity of nurse-doctor pictures in the NPIT among the students, see Meyer 1958.)

workers: aides, practical nurses, and other R.N.s as well as doctors. Horizons are expanded and, if all goes well, elemental motives spread to larger images of how the nurse can affect her patient.

Now, how have the middle or second-year students integrated the knowledge that the nurse has much to do with people other than the patient; or, to reduce the problem to the limited terms in which our present data can illuminate it, what is the distribution of value types among the three groups of middle students? The data in Table 32 show that the middle students had a different distribution from that of the beginners. The proportion of Type I was smaller in all three groups of middle or second-year students, and this difference was significant. Thus preferences for nursing the patient *unaided* lost ground as the educational process unfolded. With respect to shifts to each of the other three value types and the particular effects of the separate educational programs, differences were not yet significant. However, some trends are worth noting. There were more modern Type II's and Type III's in all three groups. There were more administrative, colleague-oriented Type IV's in the hospital-diploma program. But the significant difference was the overall drop in Type I.

The terminal students, those in the third and last year of their nursing education, showed further changes in the distribution of the value types; and at this stage several differences were significant both as to the overall distribution of types and as to the particular effect of the collegiate versus the other two programs. First, from the middle to the senior students, there was a further drop in Type I; and in comparison to the beginners, the terminal group included more modern Type II's and III's and, of course, fewer Type I's.

Second, comparison of the three senior groups shows that the collegiate program was significantly different from the hospital-diploma and the associate degree programs, while the last two were not significantly different from each other. In the case of the collegiate seniors, Type I accounted for just 19 per cent of the group; and *all* the rest (81 per cent) scored as the modern Type II who wants the patient but prefers to share him with a colleague. Neither the technical-administrative Type IV nor the related modern Type III were represented among the collegiate seniors.

In comparison to the collegiate group, the hospital seniors had about the same proportion of Type I (17 per cent). (Note that the fall-off of Type I was the largest for the hospital program since its beginning students showed the highest concentration of this type—75 per cent.) But in the hospital program only 34 per cent of the seniors scored as

the modern Type II. The rest, almost half the group (48 per cent), were evenly divided between Types III and IV. (In the beginning group these two types combined accounted for only 10 per cent.)

Finally, the associate degree program practicum students, as compared to the collegiate seniors, showed a somewhat larger proportion of Type I (36 per cent) and, like the hospital program, a much smaller proportion of Type II (32 per cent). Types III and IV accounted for the rest of this group, with the former having a slight edge (18 per cent to 14 per cent).

To return to the question raised at the start of this chapter—how do the value types become what they are?—it is clear from these data that the education of the student nurse is an important factor.[3] To summarize these findings on the effects of education: the four groups of beginning students, at the threshold of their education in nursing, were alike and they were predominantly Type I. The picture changed with the middle students. The proportion of Type I's dropped significantly; but among the three different schools the value type distributions were not yet significantly different. Presumably the discovery that today's nurse has important relationships besides an exclusive relationship with the patient had the same effect in all three schools—a fall-off in Type I. With the senior or terminal groups the proportion of Type I's dropped further; and at this stage the nature of the shift to other types depended on the particular kind of education received. The collegiate group was overwhelmingly Type II. On the other hand, the hospital-diploma and associate degree program groups showed a fair share of Types III and IV along with a concentration of Type II—though the associate degree program also maintained a concentration of Type I. Thus, students' preferences or values changed in all schools away from *unaided* patient care toward a great emphasis on sharing the patient in the collegiate program[4] and toward a more colleague-

[3] The problem of *how* education produces such changes in values is a big and intriguing one, but it is beyond the scope of this research. Suffice it to say that these values are probably not learned through obvious course content, as is the medical-technical knowledge necessary to nursing. It is more likely that the philosophy underlying the different educational programs predisposes their faculties to certain values which are then, somehow, communicated to the students. Some idea of the differences in nursing philosophy, with particular reference to the newer philosophy which is the hallmark of the collegiate program, has already been given in the first chapter. See also MacAndrew and Elliot (1959). Their article, covering other data gathered during the course of this research project, describes personal characteristics of the "ideal graduate" of the collegiate program as compared to the average nursing graduate.

[4] If one cares to take a big speculative jump to the idea that the collegiate emphasis on sharing the patient may reflect a more democratic attitude, there is some support for it in one goal of collegiate faculties, namely, to move away from the authoritarian approach that has been so typical of nursing. Relevant here are Nahm's findings (1948) that senior students in a degree program connected with a university were more democratic in their beliefs than seniors in other nursing schools.

TABLE 33

COMPARISON OF DISTRIBUTION OF VALUE TYPES IN TWO SENIOR COLLEGIATE GROUPS

Senior groups	Type I		Type II		Type III		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Original group	3	19	13	81	0	0	0	0	16	100
Beginning group as retested in senior year	5	19	21	78	0	0	1	4	27	101

oriented and, to some extent, administrative approach in the hospital and associate degree programs.

In evaluating the implications of these findings, several matters should be taken into account. First, there is the question whether these results would hold for schools in other areas. Only schools in the Los Angeles metropolitan area were studied. Certainly further research is needed on this point.[5]

Second, this was not a longitudinal study in which the same students were followed through their education, being retested each year. Instead the testing was done all at one time; and in comparing, for example, beginning with terminal students, it had to be assumed that the senior group represented what the beginners would become. This type of design, as well as the assumption on which it is based, is a common one because it is not often feasible to undertake the time-consuming longitudinal study. Fortunately, however, it did prove possible to obtain some longitudinal data for this study. The beginning collegiate students were retested two years later, when they had reached that point in their senior year at which the original senior collegiate group had been tested. The question is: does the distribution of value types among the senior group studied longitudinally tally with that found in the original senior group described in Table 32? Table 33 shows the distributions to be almost identical and thus confirms, at least in the case

[5] Another study has been done on student nurses in collegiate, three-year public, and three-year church-connected programs (McPartland 1957). Although one of its findings is relevant—concerning the ultimate aspirations of senior students—a direct comparison with our findings unfortunately cannot be made because the data for the collegiate and the three-year public (which would correspond to our collegiate and hospital) programs were lumped together. Nevertheless, one assumes the data could be lumped because of similarity, which is not like our finding of differences between collegiate and hospital seniors, with the former *more* patient-oriented. (See also the report of our student data on the Five-Way Section of the NPIT (Meyer 1958), which showed that significantly more of the collegiate seniors preferred to work with the patient than the hospital seniors.) McPartland classified his sample as to whether they aspired to direct patient care jobs or to other jobs such as nursing education or administration and found that 72 per cent of the combined group aspired to other jobs. This means, assuming similarity, that *both* groups were *less* patient-oriented. But there is another difficulty: McPartland classified public health nursing in the "other" category. While the public health nurse does not function at the hospital bedside, a large part of her work involves direct patient contact and this author would be inclined to classify it as such rather than as "other." Now it is most likely that the seniors who aspired to public health were from the collegiate program since the courses necessary for employment in public health nursing are given only at the collegiate level. Granting these assumptions, and looking at McPartland's data in this light, the direction of his finding would change, with the majority of the collegiate group being patient-oriented in contrast to the "other" orientation of the hospital group. (There were 9 seniors who wanted public health and the collegiate group at best numbered 17—probably less since about 20 per cent of the total senior group could not be classified on this item.)

of the collegiate students, that the original senior group did represent what the beginners in fact became.

Third, there is the selection or "drop-out" problem. That is, how much of the year-to-year change among the student groups is attributable to changes in individuals as a result of their education, and how much is due to the fact that some students drop out or are "selected out," thus altering the distribution of value types? In the case of the collegiate group on which there are longitudinal data, the original number of classifiable beginning students was 60 (out of 68 tested) and the senior retest N was 27 classifiable cases (out of 33 tested). This drop-out covers two selection points: one between the sophomore and junior year and the other between the junior and senior year.

The beginning students in this collegiate program received their first exposure to nursing in their sophomore year, the year they were first tested, in the form of one clinical and three nonclinical courses (18 units). At the end of the sophomore year the decision was made as to who would be admitted to the School of Nursing. (The nursing major officially started in the junior year.) This selection point accounted for most of the drop-out. Since the questionnaire was administered anonymously, it was not possible to determine the value types of those students who did not continue in nursing at this point.

The transition from junior (middle) to senior (terminal) year involved some reduction, mainly due to marriage and pregnancy, but not enough to account for the shifts in the distribution of value types. So it seems likely that a genuine educational effect was involved. However, further research on the shift in types from the sophomore to the junior year would clarify the matter.

Fourth, what happens to the students after they finish school and begin to practice nursing? Do they remain constant as to value type or do they shift? Do the collegiate seniors continue to be overwhelmingly the modern, share-the-patient Type II, or, under the pressure of administrative and supervisory responsibilities, do some of them become the modern but more colleague-oriented Type III or the administrative Type IV? Some data were gathered on the original senior collegiate group—the only group that did not take the questionnaire anonymously. All those who could be located two years after graduation were retested. Of the 16 who could be classified as to type, 11 were found. Ten of them had scored as Type II during their senior year; and, on the later retest, seven were still Type II, two were tied between Types I and II, and one had shifted to Type I. The eleventh

one scored as Type I both in her senior year and two years later. In addition to these 11, four more were located who originally could not be classified because of tied responses; but they were classifiable on the retest. Three of them scored as Type I and one as Type II. While this is admittedly a small sample, the results are suggestive. There were no switches to either Type III or Type IV. The concentration of Type II remained high—a tribute perhaps to the strength of their education. Interestingly enough, what changes there were involved a reassertion of the Type I preferences which, it has been inferred, were the values that drew the majority of these students into nursing in the first place.

This brings up a fifth point: how does the distribution of value types among senior students compare with that for the R.N. sample? The figures for the 217 R.N.s and the corresponding figures for the total group of 69 senior students were:

	Type I	*Type II*	*Type III*	*Type IV*	*Total*
R.N.s	27%	32%	14%	27%	100%
Seniors	26	43	16	14	99

Allowing for the fact that our student sample had a larger proportion from a collegiate program (23 per cent)—the one program that produced mostly Type II's—than our R.N. sample (19 per cent) or than nursing in general (15 per cent college enrollments in 1955–56), the distributions were rather similar. As would be expected, there were more Type II's among the students. The proportion of Type I's was about the same in both samples. The proportion of Type IV's was smaller among the students, particularly in relation to Type III. Even excluding the collegiate senior group in which there were no Type III's or IV's, the remaining seniors showed about as many Type IV's as III's while the R.N. sample had about twice as many Type IV's as III's.

If one could predict from these data, it would appear that the modern Type II has been one product of the hospital school in the past (accounting for about one third of the R.N. sample which was mostly hospital trained) and is continuing to be a product of all schools (still about one third in our senior student samples of the hospital and the historically new associate degree programs). The striking fact about this type is, of course, that the collegiate school is producing nurses who are almost entirely Type II (about four fifths of the two samples of collegiate seniors). The technical-administrative Type IV (whose preferences and values, in terms of our historical interpretation in the first chapter, represented one kind of accommodation to the pressures of

rapidly increasing medical technology as well as the depression) seems to be on the decline, while the related, but modern, Type III is becoming an increasing product of the hospital-diploma and associate degree programs. Type I, on the other hand, is not fading away—a testimony not just to the needs, even ideals, that still attract the majority of students to the nursing profession (after all, many of them apparently changed type through their education), but also to a stubborn independence that allowed a rather constant proportion of nurses to remain Type I.

Since the education of the student nurse has been shown to influence the value type she becomes, one wonders what would be the effect of further education for nurses. At the time of writing there was a study underway[6] which included the NPIT as one of a group of instruments administered to a sample of hospital-school-trained R.N.s who later took collegiate work for their B.S. or a master's degree in the same school from which our collegiate sample was drawn. Out of 158 cases which could be classified on the Compound Section of the NPIT, 23 per cent were Type I, 40 per cent Type II, 13 per cent Type III, and 24 per cent Type IV. This distribution is similar to that for our R.N. sample. Although there were more Type II's in this new sample than in our R.N. sample (40 per cent as compared to 32 per cent), the proportion was only half that found in the two collegiate senior groups (around 80 per cent). It would appear that the potent educational effect is at the student nurse level and that the values of R.N.s who later go on to a collegiate school of nursing are more resistant to change.

Finally, there is one rather involved point to be raised. It has to do with the complicated distinction between the visible physical and the not so visible emotional care that together mean nursing care. This implies another kind of change that takes place as many of the students—the majority of whom began as Type I—shift away from that type; but first it leads to speculation about the fuller nature of the four value types.

The distinction between physical and emotional care is complicated because, to take three examples, sometimes they are as naturally intertwined as in the whole man (for example, a nurse can give a patient emotional support and reassurance by arranging pillows to make him more comfortable), sometimes the act of giving physical care can be stripped of any positive emotional significance (as when medication

[6] Data were being gathered in the spring and summer of 1959 by Norberta Wilson Brown in connection with her doctorate in education. The completed thesis will be filed with the Library of the University of California, Los Angeles.

is efficiently, but only efficiently, dispensed), and sometimes emotional care is given apart from physical care (for example, a nurse may simply go in to talk with a patient about his impending surgery and any fears he may have concerning it). Admittedly these are oversimplified examples, and, to exaggerate still further, they can be forced onto the value types. (The term "forced" is used advisedly since most people, and most behavior, are complex combinations and rarely is there a pure or extreme case.) Thus, Type I is most likely to include the nurse who always gives emotional support in terms of, or along with, physical care. In fact, as hinted in earlier chapters, this type may tend toward a too undifferentiated, though cheerful, approach to meeting emotional needs—the kind who can smother as well as mother. The Type IV nurse, on the other hand, would be most likely to prize efficient physical care at the expense, if need be, of emotional or supportive care (though one imagines she is unaware of the cost). Then there is the modern Type II who would probably give direct emotional care more frequently than the other types. (At least in the case of the collegiate Type II's, the program with which this writer is most familiar, conscious consideration is given to principles underlying the psychological aspects of nursing care. The greater range of hospital programs would no doubt show more variety in this.) The modern, but more colleague-oriented, Type III would fall somewhere between Types II and IV.

Now, the original classification into value types was based on a nurse's preferences for certain work relationships: nurse-patient vs. nurse colleague vs. nurse-patient-colleague. The NPIT did not go beyond the level of preferences to the level of what kinds of activities might be the favored means for expressing those preferences. In the above extrapolation, it was really hypothesized that certain activities would be differentially typical of the ways in which the different value types would express their preferences. This would be a fascinating line of inquiry for further research.

In the meantime, this extrapolation leads to speculation about another kind of year-to-year change among the students. It has already been shown that the majority of students started out preferring to nurse a patient unaided (Type I) and that later, presumably as a result of the discovery that important colleagues exist, many students shifted to more colleague-oriented types—II, III, or IV, depending on the kind of education they received. Now another kind of discovery that awaits the beginning student is the distinction between physical and emotional care. In light of the general public image that nurtured

the beginners' expectations in the absence of real knowledge about nursing, it seems likely that these novices—with their shown preference for nursing the patient unaided—would tend to think in terms of the concrete things one might do for the patient, that is, physical care. It is also likely that their idea of emotional care would not be so distinct as to be thought of separately, but rather would be vaguely embedded within their notion of physical care. This would fit with their Type I preferences, for this type, we have suggested, would be most inclined to give emotional care *within* physical care.

There is research evidence (Whiting and Murray, 1959) that beginning nursing students do place great emphasis on physical care and that this emphasis shifts among senior students, who stress supportive emotional care and patient education as well as physical care activities. Thus student nurses, in addition to learning about colleagues (with the result that some shift from Type I to another value type), also learn about supportive emotional care as separate from physical care; and it seems a reasonable hypothesis that this second discovery would also be a factor in the process of changing one's value type. To carry the hypothesis a step further, one would guess that the particular kind of education received would influence how this new knowledge is integrated into the student's values, with the collegiate program valuing supportive emotional care highly (Type II) and the hospital and associate degree programs placing some value on it (Type II) along with technical-administrative values (Types III and IV). This is an important area for further research.

Chapter 10

The Nurse Looks at Her Changing World

This chapter reports some findings of a separate study undertaken during the third year of the research project.[1] It explored current opinions about various changes that have taken place in the nurse's world as well as others that may come about in the future, and analyzed those opinions by two variables—value type and job position.

The changes that were examined centered around what could be called the "move upward" in nursing. That is, as the R.N. takes over functions from the doctor, she must delegate some of her duties to the L.V.N.,[2] or practical nurse, and the aide in order to have time for her new responsibilities. This has generally meant that the nurse has been moving away from her traditional role with the patient. This shift has been, and continues to be, of crucial importance to nurses.

Sample and Procedure

The sample consisted of 119 R.N.s who were working in a general medical or surgical hospital setting, and a structured interview approach was used to ascertain their opinions. The questions dealt with the use of L.V.N.s and aides to relieve the R.N. of some of her duties, with the shift of functions from doctor to R.N. and from R.N. to the L.V.N., and with attitudes toward the R.N.'s immediate supervisor whose own role is undergoing change. The interviews were conducted by six nurses who had at least a master's degree in nursing and who had participated in three training sessions on how to conduct the interviews. The specific questions asked will be introduced when the data for each are first presented.

Arrangements were made to include nurses from seven different general hospitals in the Los Angeles area, so that any effect due to the unique atmosphere of any one hospital would be minimized. Unlike the sample for the earlier study, only medical and surgical nurses were

[1] The study was done by Martha Adams, Joan Butler, Marilyn Folck, Bruce Gordon, Phyllis Nie, and Jeanne Quint. Further findings will be reported in other publications.

[2] Licensed Vocational Nurse.

used since the changes in nursing with which our study is concerned apply mainly to the standard hospital setting—and not to public health or, generally speaking, to psychiatric nursing.

An initial sample of 140 nurses was tested on work time. It was requested that they be randomly selected and that about half be from the staff level and half from the head nurse or supervisor level. In practice the "random" selection frequently became a matter of who could spare the time on the day of testing. The instruments used in this initial testing were the NPIT and the biographical data sheet which were developed for the earlier study.

From the 140 nurses, 119 were selected to be interviewed on the basis of (1) willingness to be interviewed on their own time and (2) the need to secure adequate numbers in the categories to be analyzed. The latter included two job positions (staff nurses vs. junior administrative nurses including head nurses and supervisors) and three value types (I, II, and IV). Type III was omitted since the number of nurses who fit this type is small (only 14 per cent in the earlier, and larger, sample), and the present sample would have had to be much larger to insure an adequate representation of Type III. Also, it was felt that a comparison among Types I (ministering angel), II (modern), and IV (technical-administrative) would be sufficient to explore the effect of the different nursing orientations upon opinions. Thus, it should be kept in mind that this sample may be an especially motivated one, and that it represents a weighted rather than a natural distribution of nurses at large. (Actually, apart from the exclusion of Type III, this distribution is not significantly different from the distribution in the earlier sample—though it does have a somewhat smaller proportion of Type II.)

The final sample of 119 R.N.s included 58 staff nurses and 61 junior administrative nurses. As for value type, 32 subjects either could not be classified because of failure to respond to all items or because of ties in responses, or were classified as Type III, which was not included in this study. The distribution was as follows:

	Staff nurses	*Junior administrative nurses*	*Total*
Type I	16	14	27
Type II	16	14	30
Type IV	11	19	30
Not scorable as to value type	15	17	32
Total	58	61	119

The relationship between the two variables of value type and job position was tested by chi square and was found to be not significant, as was the case for the earlier sample.[8] Thus significant results for either of the variables can be discussed independently.

The data will be presented in three sections and, because of the loss of cases on the value type variable, the total N to be reported will vary. In the sections dealing with opinions on the use of L.V.N.s and aides and on shift of functions from doctor to R.N. and from R.N. to L.V.N., findings will be given for the total sample of 119, with no breakdowns by value type or job position since there were no significant differences. In the section which treats opinions about supervisors, there were significant differences among the value types; so the N will vary from 119 (when the total sample is described) to 87 (when value-type differences are reported). There will also be some minor fluctuation in the two N's because a few respondents neglected to answer every question.

Changes Involving the L.V.N. and Aide

Perhaps the most talked about change in the nurse's world over the last two decades has been the use of aides and, since World War II, L.V.N.s to take over some of the nurse's ever expanding duties. Such time-honored functions as bathing and feeding the patient no longer belong exclusively to the nurse; and other duties which up to now have remained exclusively hers, such as dispensing medication, may change hands in the future. As a consequence of having to share some of her traditional functions with L.V.N.s and to a lesser extent with aides, the nurse may feel that her own relationship with the patient has been affected. Our sample of R.N.s was asked about this. They also expressed their opinions as to what type of contribution L.V.N.s and aides could make to nursing care and how these auxiliary workers would feel about assuming even more responsibility for patient care. Table 34 presents these data.

The first questions asked whether the use of L.V.N.s and aides had changed the nurse's own relationship with the patient. More than half

[8] There are three other points on which this sample can be compared to the earlier one—keeping in mind that the distribution of value types in this sample is weighted by selection, containing fewer Type II's and no Type III's, whereas, in the earlier sample, the distribution was an unselected or natural one. In the earlier sample, age, religion, and choice of nursing specialty (including public health and psychiatric as well as medical and surgical nursing, to which the present sample was limited) were examined for their relation to value type, and no significant differences were found. The present sample was also checked on these variables, and, again, value type was found to be independent of age, religion, and nursing specialty.

TABLE 34

NURSES' OPINIONS ABOUT THE USE OF L.V.N.S AND AIDES AND ON SHIFT OF FUNCTIONS FROM M.D. TO R.N. AND FROM R.N. TO L.V.N.[a]

Question	Response					
	Yes		No		Total	
	N	Per cent	N	Per cent	N	Per cent
Has the increase in the amount of time spent by the L.V.N. with the patient changed the relationship between the R.N. and the patient?	67	56	52	44	119	100
Has the increase in the amount of time spent by the aide with the patient changed the relationship between the R.N. and the patient?	51	43	68	57	119	100
	Releases R.N. for other functions		Contributes directly to patient care		Total	
	N	Per cent	N	Per cent	N	Per cent
What is the L.V.N.'s contribution to nursing care?	55	48	60	52	115	100
What is the aide's contribution to nursing care?	45	41	66	59	111	100

	N	Per cent	N	Per cent	N	Per cent	N	Per cent
How do you think L.V.N.s feel when they are asked to take over more completely in the care of a patient? They are..	17	14	48	41	53	45	118	100
How do you think aides feel when asked to take over more completely in the care of a patient? They are.....	44	37	50	42	25	21	119	100

	Yes		No		Total	
	N	Per cent	N	Per cent	N	Per cent
Are L.V.N.s taking on a greater amount of the traditional responsibilities of the R.N.?.....	106	89	13	11	119	100
Are R.N.s taking on a greater amount of the traditional responsibilities of the M.D.?.....	85	71	34	29	119	100

	R.N. more from M.D.		L.V.N. more from R.N.		Total	
	N	Per cent	N	Per cent	N	Per cent
Are R.N.s taking on more or less from M.D. than L.V.N.s are taking from R.N.s?.....	24	22	87	78	111	100

	Yes		No		Total	
	N	Per cent	N	Per cent	N	Per cent
Should L.V.N.s be given adequate training to give medication and hypos?.....	61	53	55	47	116	100

[a] Only the figures for the total group are given since there were no significant differences due to value type or job position.

of the R.N.s felt that the time spent by the L.V.N. with the patient had changed the R.N.-patient relationship, but less than half felt that the use of the aide had had such an effect. The higher percentage regarding the L.V.N. bears out the reality of the nursing situation. That is, the L.V.N. carries greater responsibility than the aide and performs tasks more closely approximating those of the R.N. The interesting thing, however, is that a large number of R.N.s stated that they felt unaffected by the L.V.N. and aide, at least as far as their own relationships with patients were concerned.

The next question dealt with the type of contribution to nursing care that could be made by the L.V.N. and aide. In this case the percentages for the two were closer, with more than half the sample describing both L.V.N. and aide as contributing directly to patient care. Somewhat less than half described the contribution in terms of releasing the R.N. for other important nursing functions. This ties in with the finding, presented in Chapter 8, that many R.N.s described practical nurses and aides in relation to R.N.s. However, in that free-ending sentence situation, as compared to the forced choice here, the proportion relating practical nurses and aides to the R.N. was much higher than the proportion relating the auxiliary worker to the patient. (See Tables 28 and 29.) Actually, these different ways of describing the contribution of the L.V.N.s and aides refer to the same phenomenon: L.V.N.s and aides do some things for patients so that R.N.s can be freed to do other things. It is a matter of personal choice whether the R.N. sees the situation in relation to herself or to the patient, and almost half the sample preferred *not* to characterize it directly in relation to the patient. This probably reflects a very human desire imaginatively to protect one's own position with the patient. It can also be interpreted as evidence of the ambivalence and threat inherent in the nurse's relation to her auxiliary helpers which has been described in detail by other researchers (Hughes, Hughes, and Deutscher 1958).

The third set of questions asked the R.N.s to estimate whether L.V.N.s and aides were eager to take over the care of the patient more completely. Eighty-five per cent of the sample felt that the L.V.N. was willing or eager, as compared to 63 per cent for the aide. The remaining R.N.s felt that the auxiliary personnel were hesitant. In light of the educational background of the two groups, there is a reason why more R.N.s would view the L.V.N. as eager. The L.V.N. has had to take formal training for her work, whereas the aide has received only on-the-job training. It follows that the L.V.N. would be expected to have more of a career commitment and consequently would be more

motivated to take on greater responsibility. On the psychological level, however, the interpretation becomes more complicated. Undoubtedly feelings of threat and an unwillingness to abdicate further from patient care are involved in the R.N.'s belief that the L.V.N. and to a lesser extent the aide are ready to assume even more responsibility. Consider what would happen should the R.N. gain more released time. Presumably some of it would be transferred to administrative matters, and there is ample evidence (Argyris 1956) that many R.N.s are not charmed by the prospect of administrative duties. Furthermore the L.V.N., who is next in line to the R.N., would "profit" more by such a shift than the aide—hence another reason for viewing the L.V.N. as more eager than the aide.

The next three questions presented in Table 34 show that the L.V.N. is thought to be taking over more functions from the R.N. than the R.N., in turn, is taking over from the doctor. In response to the first two questions, 71 per cent of the sample thought that R.N.s were taking on some of the doctor's traditional responsibilities, while an even larger number (89 per cent) thought that L.V.N.s were taking over some traditional responsibilities from R.N.s. This feeling was clearly summed up in response to the next question, where the general consensus (78 per cent) was that the L.V.N. was taking more from the R.N. than the R.N. from the doctor.

One particular transfer of functions from the R.N. to the L.V.N. that could take place in the future involves the responsibility for giving medication and hypodermic injections. At the present time the R.N. usually performs these tasks. But, in view of the ever increasing work pressures on the R.N., this area of responsibility may become one that will have to be partially delegated to others. In fact, in some hospitals practical nurses are already giving oral medications, particularly where personnel shortages are acute. (See, for example, Ford and Stephenson 1954.)

The last question presented in Table 34 asked whether L.V.N.s should be given adequate training to dispense medication and give "hypos." The opinions of the R.N.s were pretty evenly divided between "yes" and "no." In other words, nurses are by no means in agreement about what changes should take place in the future. Certainly further research would be helpful on this point to determine why some nurses favor, and others look askance at, additional delegation of their responsibilities to subordinates.

With regard to the general pattern of the findings about the use of L.V.N.s and aides, there are two interesting points. First, there were

TABLE 35

NURSES' OPINIONS ABOUT THEIR SUPERVISORS

Question	Staff nurses		Junior administrative nurses		Total group		Type I		Type II		Type IV		Total group	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent
In what kinds of situations do staff nurses consult their supervisors?[a]														
Administrative	40	69	36	61	76	65	11	42	23	79	19	63	53	62
Nursing judgment	18	31	23	39	41	35	15	58	6	21	11	37	32	38
Total	58	100	59	100	117	100	26	100	29	100	30	100	85	100
Do you feel most supervisors should be closer to the actual nursing situation?[b]														
Yes	51	88	44	72	95	80	24	89	24	80	24	80	72	83
No	7	12	17	28	24	20	3	11	6	20	6	20	15	17
Total	58	100	61	100	119	100	27	100	30	100	30	100	87	100

[a] Comparing the value types on this item, the chi square value, with two degrees of freedom, was 7.56, which was significant at the .05 level.
[b] Comparing staff to junior administrative nurses on this item, the chi square value, with one degree of freedom, was 4.61, which was significant at the .05 level.

no significant differences by value type or job position. This is in line with the finding, discussed in Chapter 8, that sentence-completion responses about practical nurses and aides showed no significant differences. This was attributed in part to the fair degree of stereotypy among those responses. Second, Table 34 shows that the L.V.N., generally speaking, was credited with a greater effect on the R.N.-patient relationship than the aide. According to other research findings (Hughes, Hughes, and Deutscher 1958), this greater effect means greater threat to the R.N. This also ties in with the stereotyped responses referred to above since, in terms of their content, the L.V.N. was conceded to "have her place" whereas the aide, protected perhaps by greater status distance, was seen as "helpful."

The Nurse and Her Supervisor

In her changing world, the nurse can look for guidance and help to her immediate supervisor. In the case of the staff nurse this would be the head nurse; in the case of the head nurse, the supervisor; and in the case of the supervisor, the assistant director of nursing service. One obvious difference among the supervisory levels is that the higher positions tend to be closer to administrative problems, while the lower positions, particularly the head nurse, are closer to the patient and the problems of making the nursing judgments relative to his care. Two questions concerning this difference were put to our sample of R.N.s (Table 35).

The first question asked whether staff nurses consulted their supervisors on administrative matters or on problems of nursing judgment. The majority of the nurses (65 per cent) thought that administrative problems were the ones that received attention. There was no significant difference between staff and junior administrative nurses on this item, but the value types did show a significant difference. While the majority of Types II (79 per cent) and IV (63 per cent) agreed that administrative problems were the subject of consultation, the majority of Type I did not. True to their exclusive orientation to the patient, 58 per cent of the Type I's felt that staff nurses went to their supervisors with nursing judgment problems. This probably reflects the psychological fact that one's estimate of what others do is influenced by one's own behavior; and Type I nurses would, of course, be more likely to focus on nursing judgment problems than on administrative ones.

Considering the pressures to "move upward" in nursing, this greater emphasis on administrative problems seems reasonable. Yet there is another possibility. Problems of nursing judgment necessarily involve

the complicated human factor, and it may be more difficult to ask for, and to give, advice on these kinds of problems. Since it is the head nurse to whom the staff nurse would go for guidance, a recent analysis of the head nurse's future role[4] will prove helpful at this point.

According to that analysis, the head nurse's role will actually involve three interrelated roles: supervisor, expert practitioner, and consultant. In her role as expert practitioner the head nurse would carry some patient load herself; and, partly because of her actual work with patients, her role as supervisor and resource person to the staff nurse would be enhanced. That is, on problems of nursing judgment (as distinct from administrative problems), she would have some immediate experience with patient care on which to draw. The fact that this is described as part of her *future* role suggests a present need, and our second question to the sample touched on this.

The nurses were asked whether they felt that most supervisors should be closer to the actual nursing situation. Eighty per cent said yes. The value types were in agreement on this, with the patient-oriented Type I especially in favor of closer contact by supervisors. There was, however, a significant difference between staff and junior administrative nurses, with relatively more staff nurses (88 per cent) than junior administrators (72 per cent) wanting the supervisor in closer touch. Even so, the majority of the junior administrative group, including head nurses and supervisors, favored closer contact. There does indeed seem to be a felt need for nurses in supervisory positions to become more acquainted with the actual nursing situation.

Conclusion

The general picture of change and conflict that comes out of the third-year study is not a new one. Other researches have commented on these problems, particularly on the tension between the L.V.N. and R.N. Our findings have also pointed to a possible source of difficulty in the R.N.'s relation to her supervisor. Most of our sample felt (1) that staff nurses consulted their supervisors on administrative rather than on nursing judgment problems and (2) that supervisors should be closer to the actual nursing situation. Further research would be interesting on this point to determine whether, if supervisors were closer, more staff nurses would consult them on problems involved in patient care.

[4] Our discussion of the head nurse's future role is drawn from an unpublished speech by Dorothy Johnson, Associate Professor of Nursing, University of California, Los Angeles. We are indebted to Miss Johnson for making her material available to us.

Chapter 11

Conclusion

This research has been a study of nursing values in transition, and its organizing theme has been the fluctuating relationship between the two major nursing traditions of *tenderness* and *technique*. In terms of our historical interpretation, the startling changes in nursing brought about during the last half of the nineteenth century by the persevering efforts of Florence Nightingale included the raising of both moral and technical standards for nursing. To use her words, nurses had to have both character and knowledge. Thus, in her program tenderness and technique were contained in a balanced and integrated relationship. Both were essential to sound nursing practice.

Then in the early part of the twentieth century, at least in the United States, the balanced relationship between tenderness and technique began to shift and the technical tradition gained greater prominence. (The first schools based on the Nightingale system had been started in this country in 1873.) This shift represented a response to the demands of rapidly developing medical technology during the 1920's and 1930's, though it had earlier origins perhaps in the general emphasis on more scientific business and industrial organization that characterized this country in the years surrounding World War I. Nurses found themselves involved in more technical procedures, and the value placed on tenderness receded somewhat as the image of the efficient, coolly controlled practitioner gained prestige. Apparently the depression also played a role in this transition as nurses began to learn that altruistic tenderness did not in itself bring economic security.

But the very need for nurses to take on an expanding number of technical functions created another sort of need. Someone had to take over the simpler tasks that nurses no longer had time for; and other workers began to be added to the roster of nursing service personnel—first the aide, and later the trained practical nurse. This added still other duties, of an administrative and supervisory character, to the nurse's load; as a result, the technical role has actually grown into the administrative-technical role.

How these added administrative and supervisory responsibilities affected the nurse's typical work situation was the first question explored by the research. According to our sample of R.N.s, the work situation that was most typical of nursing 20 years ago consisted of the nurse working alone with her patient. This was followed by the nurse working with her patient plus a colleague—either a doctor or another nurse. The nurse at work just with her colleague was felt to have been least typical. Today, however, the situation believed to be most typical consisted of the nurse working with a colleague, whereas the nurse alone with her patient was considered least typical. The sharing work relationship was again in the middle. Attitudes toward these changes—measured in terms of personal preferences for the three types of work situations—were varied. Some nurses preferred the work situation typical of nursing 20 years ago, some liked the situation typical today, and two other groups preferred the sharing work relationship.

This introduced the main part of the research. Four types of nurses were defined on the basis of their responses to the Nursing Picture Item Test, and these four value types were conceived as representing different adaptations to the fluctuating relationship between the two value traditions of tenderness and technique. Type I (ministering angel) preferred an unshared relationship with her patient and was interpreted as representing the nurse who places a higher value on tenderness than on technique. Type IV (efficient, disciplined professional), on the other hand, preferred to work in an exclusive relationship with her colleague, and her orientation was interpreted as a valuation of technique over tenderness. As it turned out, Type I preferred the ways of yesterday while Type IV liked the work situations typical of nursing today. The other two groups were the modern Types II and III who solved the potential conflict between patient and colleague, between tenderness and technical-administrative values, by integrating them, that is, by preferring to work in a situation which included the nurse, her patient, and her colleague too. The two modern groups were differentiated by the fact that Type II was drawn into the sharing situation more by the patient, while Type III was more attracted by the colleague. In this sense Type II's solution was closer to the dominant orientation of Type I, while Type III was closer to Type IV.

The integrations that seem to be happening in the case of Types II and III indicate that a new relationship between tenderness and technique is, and has been, in the making. It has been suggested at several points in this report that the new balance between tenderness and technique has been facilitated, if not prompted, by a move "outward" in

nursing, as distinct from the move "upward" to more complex technical functions. The move "outward" has involved a growing concern with (1) the *full* problem of health, including its maintenance as well as its restoration, and (2) the psychological aspects of illness. This has meant the application of the scientific as well as the intuitive method to the problems of supportive emotional care and patient education. To advance these ends the nursing profession has been making use of knowledge from the social sciences, in addition to already accepted knowledge from the biological sciences. This development is making tenderness as worthy as technique. Furthermore, at least in the writer's opinion, the new trend augurs well for the satisfaction of the desire to care for the patient, which, as this research has shown, continues to draw women[1] into nursing.

The rest of the research examined the personal backgrounds of the nurses in each of the four value types and explored other attitudes toward patients, visitors, doctors, practical nurses, aides, the process of supervision, and toward staff as compared to administrative nursing positions, to see what particular attitudes were characteristic of each type. As these findings were presented, the interpretation of each type was extended. Finally, the effect of education was explored. It was found that most of the nursing students tested started out as Type I, but by the end of the educational process many students' preferences and values had shifted away from unaided patient care, that is, an exclusive relationship with the patient. The nature of this change depended on the kind of education received. In the collegiate program the seniors were overwhelmingly the modern Type II who preferred to share her patient with a colleague. The traditional hospital-diploma program produced some Type II's, but also some modern but more colleague-oriented Type III's and some technical-administrative, or exclusively colleague-oriented, Type IV's. Between these two schools was the historically more recent two-year associate degree program, which proved to be similar to the hospital school in output, though it produced more Type I's than the other schools.

This raises a most important question. What kinds of value types should be produced? Obviously this is a question for the nursing profession itself, but two points can be made here.

First, nursing is becoming increasingly specialized. To cite Brown's

[1] Because our research concerned only women, nothing can be said about male nurses who constitute an important part of the nursing profession; but it seems unlikely that their motivations would be radically different. Research on this would be most helpful since, as the Brown (1948) report points out, men are needed in nursing and could be a valuable source for future recruitment.

report on *Nursing for the Future* (1948), nursing needs clinical specialists, public health specialists, educators, administrators, and researchers as well as the general bedside nurses who have traditionally made up the profession. In view of these diversified roles, it may well be that all value types are needed, though in what proportion is again a question for the nursing profession to answer.

Second, and this is a related point, the value types represent different, and of course human, adaptations to sometimes conflicting values. Consequently each type has particular strengths and weaknesses. They are differently suited to meet the increasingly diversified responsibilities that are collectively called nursing; and this should be taken into account in any evaluation of the types.

Our research findings provide several illustrations of this point. The admirably strong patient orientation of Type I sometimes meant a narrow orientation toward other aspects, including the importance of the supervisory process and the need to take the large view of patient care—at least large enough to see the relation of the visitor to the patient. Type IV, on the other hand, may be well suited for the administrative and supervisory functions which she prefers because of the personal pleasure and satisfaction they apparently give her. But there seems to be an element of dependence on objective, technical standards mixed with her colleague orientation that could perhaps interfere with the creative, "people-oriented" supervision for which nursing leadership is striving.

The two modern Types II and III who prefer to share their patient with their colleague may be best suited to carry out team nursing, which is expected to become more widely practiced in the future. But Type II's greater awareness of others as separate individuals in their own right apparently also means a greater awareness of herself, including her own feelings of uneasiness when supervising others. This could be a deterrent to effective supervision. Type III, on the other hand, seems to be more task-oriented than people-oriented; and, like Type IV, she may experience some difficulty in providing the creative, people-oriented kind of supervision currently advocated.

In conclusion, attention should be directed to some questions not touched on by the research and to new questions raised by the findings. First, there is the question of how representative the findings are of nursing in general. Our sample was drawn entirely from the Los Angeles area and covered only four nursing specialties. Only further research—using samples in different parts of the country, including respondents from all branches of nursing, and covering other examples

of the collegiate, hospital, and associate degree schools of nursing—can answer the question of representativeness.

Second, there is the problem, already reviewed in Chapter 9, of the relationship between the preferences that defined the value types and actual nursing behavior. An important next step would be to determine how each type behaves with patients, and under what circumstances. One particular circumstance that would be most interesting to investigate is the "mixed" work situation—for example, a ward staffed with ministering-angel Type I nurses working under a technical-administrative Type IV head nurse, or a Type IV staff nurse working in the midst of modern, share-the-patient Type II nurses. In the first case, would there be friction, or forbearing accommodation, or simply a fortunate adjustment, with the head nurse doing her administrative-supervisory work while the staff nurses care for their patients? In the second case, would the behavior of the Type IV nurse be modified by the values of the Type II nurses, or would the Type IV nurse gravitate to certain duties such as dispensing medications and supervising aides?

Third, on what points do nurses of the same value type diverge in their attitudes and behavior? For example, do the young Type I's who have only recently been graduated differ in certain ways from the older Type I's who were trained in an earlier period? Or, to take an example with implications for educational policy, does the orientation of the Type II nurse from a collegiate program differ in some respects from that of the Type II nurse trained in a hospital school?

Fourth, there is the problem of how nurses change from one value type to another. The research showed that the education of the nurse was an important factor in producing change, at least in the case of the student nurse. There was not much change in the case of graduate nurses who had returned to school for further education. It would be valuable to determine the effect of in-service educational programs on the value types of nurses.

Finally, what about the patient? Does he prefer one type of nurse to another; and, if so, does this affect his acceptance of nursing care? Furthermore, and this is quite likely, are there differences among patients as to what kind of nursing care they want and need that are related in some significant way to the value types of the nurses caring for them? Research on these questions concerning the patient would be of the first importance, for it is caring for a patient that holds the ultimate possibility for genuine integration of tenderness and technique.

References

American Journal of Nursing. Editorial pages of the following issues: January 1901, January and October 1903, April and September 1905, October 1906, January and April 1909, February 1910, March 1913, February 1914, February 1915, October 1918, November 1919, March 1922, August 1926, April 1930, and March 1932.

Argyris, C. *Diagnosing Human Relations in Organizations: A Case Study of a Hospital.* New Haven, Conn.: Labor and Management Center, Yale University, 1956.

Brown, E. L. *Nursing for the Future.* New York: Russell Sage Foundation, 1948.

Bullock, R. P. *What Do Nurses Think of Their Profession?* Columbus, Ohio: The Ohio State University Research Foundation, 1954.

Burling, T., E. Lentz, and R. Wilson. *The Give and Take in Hospitals.* New York: G. P. Putnam's Sons, 1956.

Christ, E. A. *Nurses at Work.* Columbus, Mo.: University of Missouri, 1956.

Clark, K. E. *America's Psychologists.* Washington, D.C.: American Psychological Association, 1957.

Deutscher, I. *A Survey of the Social and Occupational Characteristics of a Metropolitan Nursing Complement.* Kansas City, Mo.: Community Studies, Inc., November 1956.

Devereux, G., and F. R. Weiner. "The Occupational Status of Nurses," *American Sociological Review,* 1950, 15, 628–34.

Facts About Nursing. A statistical summary, 1955–56 edition. New York: American Nurses Association.

Ford, T. R., and D. D. Stephenson. *Institutional Nurses: Roles, Relationships and Attitudes in Three Alabama Hospitals.* Tuscaloosa, Ala.: University of Alabama Press, 1954.

Goffman, E. "On Face-Work," *Psychiatry,* 1955, 18, 213–31.

Habenstein, R. W., and E. A. Christ. *Professionalizer, Traditionalizer, and Utilizer.* Columbia, Mo.: University of Missouri, 1955.

Hughes, E. C. *Men and Their Work.* Glencoe, Ill.: The Free Press, 1958.

Hughes, E. C., H. M. Hughes, and I. Deutscher. *Twenty Thousand Nurses Tell Their Story.* Philadelphia: Lippincott, 1958.

Jamieson, E. M., and M. F. Sewall. *Trends in Nursing History.* Philadelphia: W. B. Saunders Co., 1949.

Johnson, D. E. "The Nursing Care Plan: Objectives, Principles, Methods." Paper read at the Western Interstate Committee for Higher Education Continuing Education Conference at Tucson, Ariz., 1958 (mimeographed copy available from the School of Nursing, University of California, Los Angeles).

MacAndrew, C., and J. E. Elliott. "Varying Images of the Professional Nurse: A Case Study," *Nursing Research,* 1959, 8, 33–35.

McPartland, T. S. *Formal Education and the Process of Professionalization: A Study of Student Nurses.* Kansas City, Mo.: Community Studies, Inc., March 1957.

Meyer, G. R. "The Attitude of Student Nurses Toward Patient Contact and Their Images of and Preferences for Four Nursing Specialties," *Nursing Research,* 1958, 7, 126–30.

Meyer, G. R. "Conflict and Harmony in Nursing Values," *Nursing Outlook,* 1959, 7, 398–99.

Nahm, H. "Autocratic vs. Democratic Beliefs and Practices of Senior Students in Schools of Nursing," *Journal of Social Psychology,* 1948, 27, 229–40.

Nightingale, F. *Notes on Nursing.* New York: D. Appleton Century, 1946. (Facsimile of first edition published in 1860.)

Reissman, L., and J. H. Rohrer. *Change and Dilemma in the Nursing Profession.* New York: Putnam, 1957.

Roberts, M. M. *American Nursing.* New York: Macmillan, 1954.

Rogge, G. O. "Personality Factors and Their Influence on Group Behavior: A Questionnaire Study," Technical Report No. 265. Cambridge, Mass.: Research Laboratory of Electronics, Massachusetts Institute of Technology, August 31, 1953.

Russell, C. H. "Liberal Education and Nursing," *Nursing Research,* 1958, 7, 116–26.

Saunders, L. "The Changing Role of Nurses," *American Journal of Nursing,* 1954, 54, 1094–98.

Schaeffer, M. S., and E. E. Levitt. "Concerning Kendall's Tau, a Nonparametric Correlation Coefficient," *Psychological Bulletin,* 53, 1956, 338–46.

Simmons, L., and H. G. Wolff. *Social Science in Medicine.* New York: Russell Sage Foundation, 1954.

Stewart, I. M. *The Education of Nurses.* New York: Macmillan, 1947.

Turner, R. "A Prestige Subcultural Classification of Occupation" (mimeo.). Los Angeles: Department of Sociology, University of California, 1956.

Whiting, J. F. *The Nurse-Patient Relationship and the Healing Process.* New York: American Nurses Foundation, Inc., 1958.

Whiting, J. F., and M. A. Murray. "Becoming a Nurse: A Study of Changing Values in Nursing Students" (mimeo.). New York: American Nurses Foundation, Inc., 1959.

Woodham-Smith, C. *Florence Nightingale.* New York: Grosset & Dunlap, 1951.

Appendix A: Reproduction of the Instrument

The research instrument was divided into four parts which have been reproduced in this appendix. At the time of administration the instrument contained some additional items which were later discarded. For example, in Part II, one item inquired whether the respondent preferred the day, P.M., or night shift; but the item turned out to be valueless since almost the entire sample favored the day shift.

The Biographical Data Sheet (Part IV) was administered in a shortened form to the student sample—items on work history were omitted. The sample of high school girls filled out only a portion of the instrument, namely, the NPIT (Part I), some items of the incomplete sentence variety from Part II, and a short version of the Biographical Data Sheet. The other items were considered inappropriate since these girls had not had any training or experience in nursing.

Another instrument, not reproduced, which was administered to the whole sample of R.N.s and students was the Characterological Orientation Profile designed by Craig MacAndrew. MacAndrew has reported his findings in a series of mimeographed reports, available from the Human Relations Research Group of the Institute of Industrial Relations, University of California, Los Angeles. They are entitled: "Structured Samples and the Description of Self," "How Nurses Perceive Themselves," and "Recruitment Appeals in a Period of Change" (with Jo Eleanor Elliott).

An additional study of attitudes of the faculty and students of a collegiate school of nursing, undertaken by MacAndrew and Elliott, has been reported in *Nursing Research* (1959). Also, the Salary Schedule (Part III) in its original form covered 17 groups of workers. (As reproduced here it includes only the four groups relevant to this research report.) The responses to the complete Salary Schedule have been reported in mimeographed form by MacAndrew as "A Note on Nurses' Images of Just and Equitable Wages."

Questionnaire on Nursing

The Human Relations Research Group has received a U. S. Public Health Service grant to study Interpersonal Influence and the Nursing Function. The UCLA School of Nursing, the Graduate School of Business Administration, and the Institute of Industrial Relations are co-sponsors of the project. The first phase of our research is being devoted to a questionnaire study of attitudes toward nursing.

This questionnaire is composed of three parts. Your responses on the questionnaire will be anonymous, so don't sign your name. Please answer all of the items in terms of your first, quick impression. Your immediate reactions are the ones we want, so don't spend much time on any one item. *Please do not omit any item* since a complete questionnaire from each and every subject is essential. Thank you for your cooperation.

PART I

The first part of the questionnaire is attached to this sheet. It includes a series of pictures showing nurses, doctors, aides and patients.

On each page of pictures, you will be asked to make certain choices among those pictures. Read through the items quickly and put down your initial response. It is important not to spend much time on any item, but *please don't leave any item out.*

All of the pictures have to do with the hospital setting. However, some of you who are filling out this questionnaire are not working in a hospital; this need not make it difficult for you. Just respond according to your current feelings. Again, it will be easier if you put down your first reaction and then go on to the next item.

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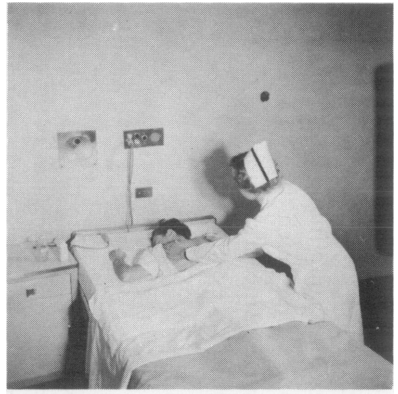

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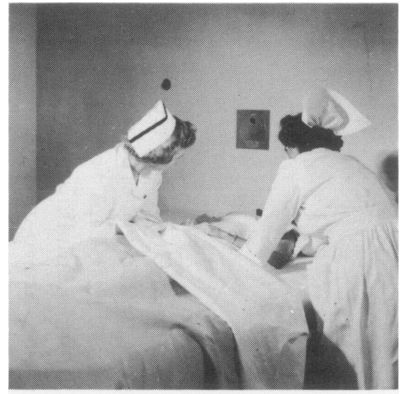

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Circle the letter of the picture which is your *second* choice.	A	B	C
Circle the letter of the picture which is *most* typical of nursing today.	A	B	C
Circle the letter of the picture which is *least* typical of nursing today.	A	B	C
Circle the letter of the picture which is *most* typical of nursing 20 years ago.	A	B	C
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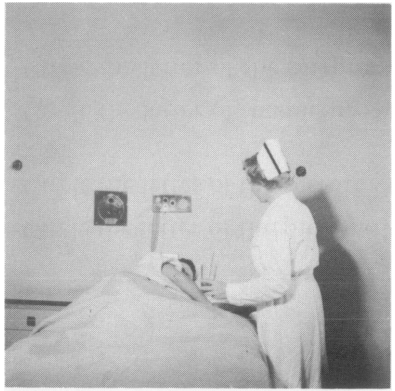

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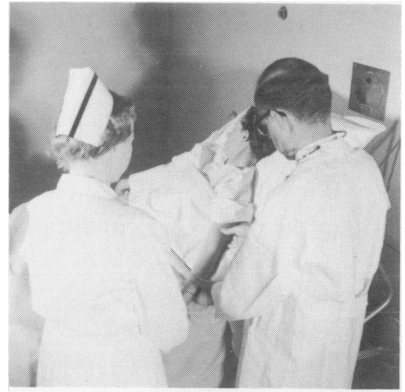

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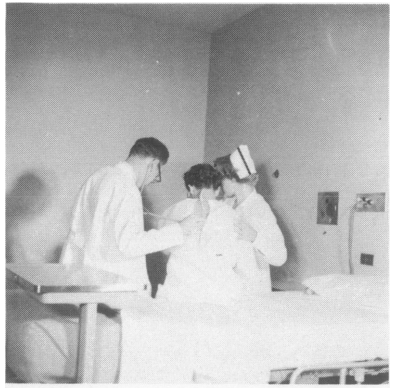

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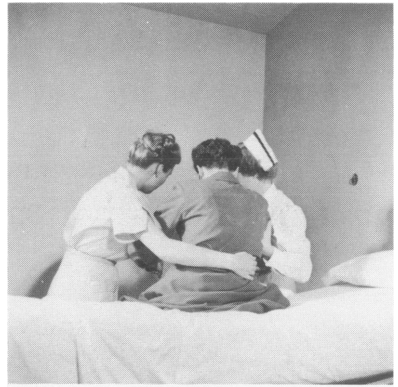

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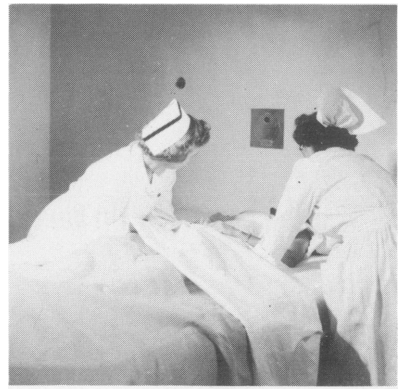

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Circle the letter of the picture which is *least* typical of nursing today.	A	B	C
Circle the letter of the picture which shows the people you would *most* like to be working with.	A	B	C
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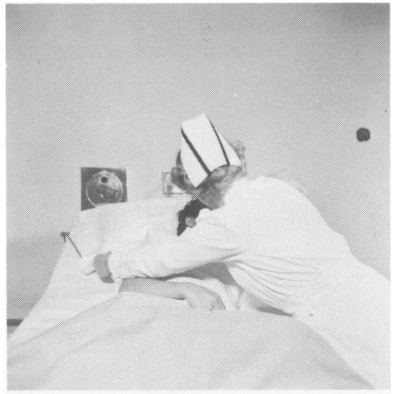

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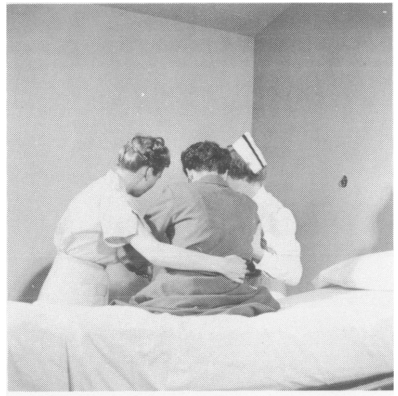

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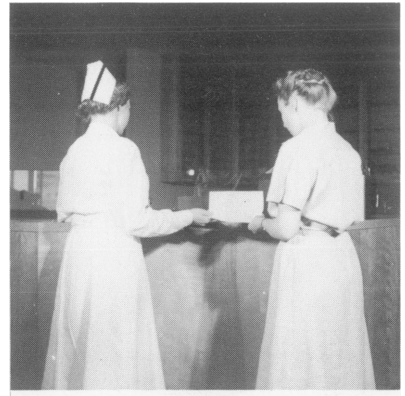

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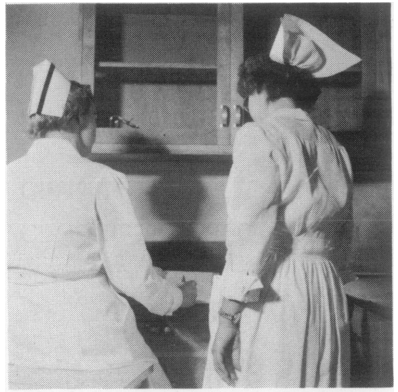

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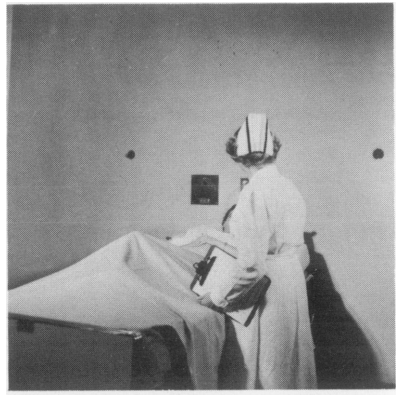

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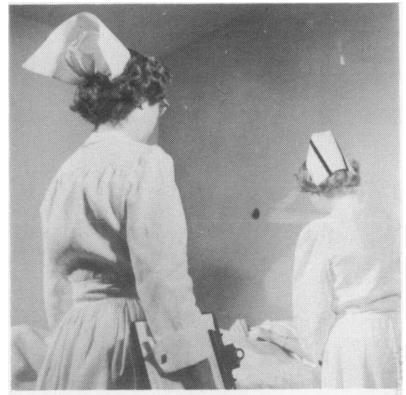

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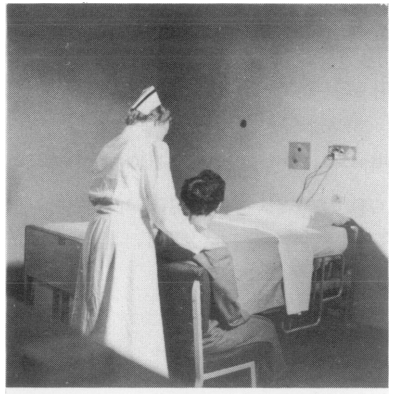

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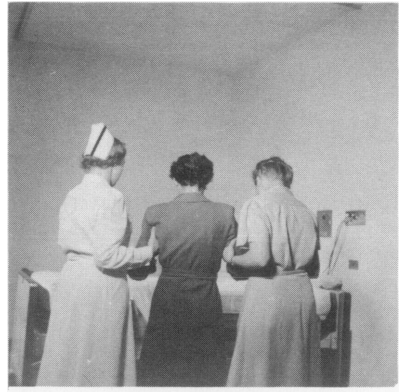

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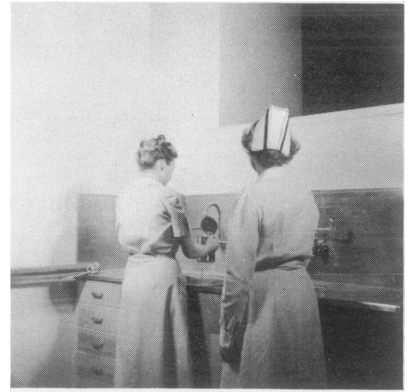

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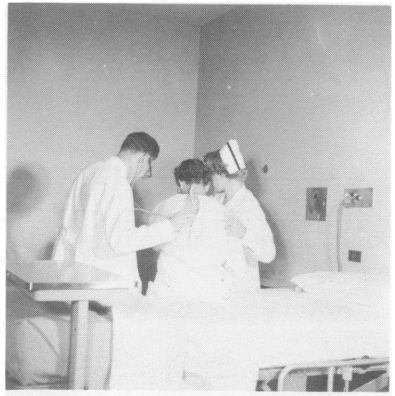

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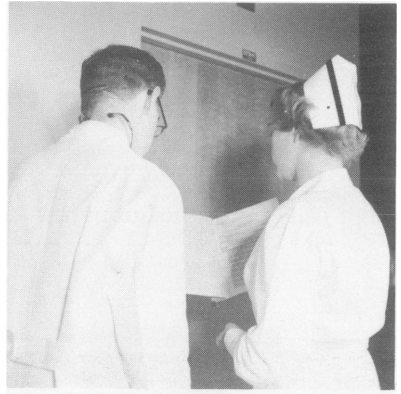

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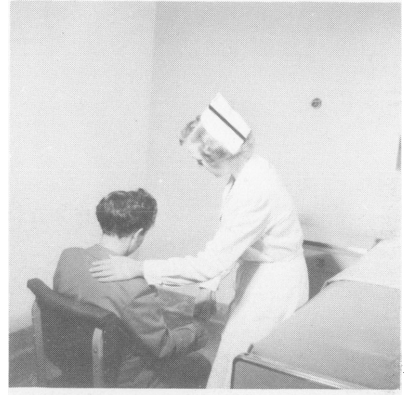
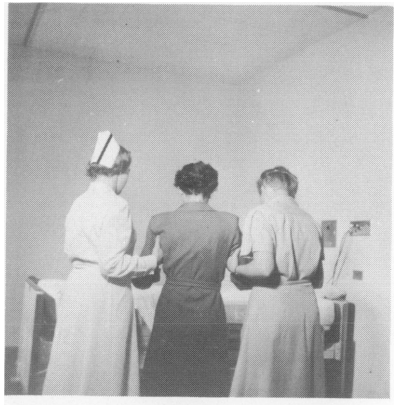
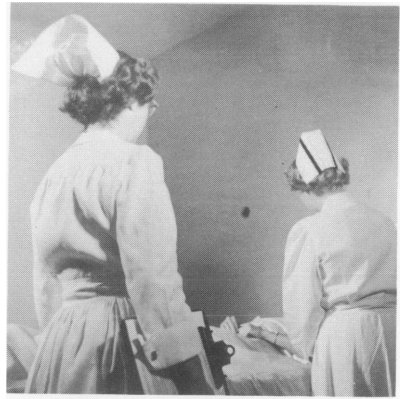


C

Circle the letter of the picture that shows the situation you would *most* like to be working in.	A	B	C
Circle the letter of the picture which is your *second* choice.	A	B	C
Circle the letter of the picture which is *most* typical of nursing today.	A	B	C
Circle the letter of the picture which is *least* typical of nursing today.	A	B	C
Circle the letter of the picture which is *most* typical of nursing 20 years ago.	A	B	C
Circle the letter of the picture which is *least* typical of nursing 20 years ago.	A	B	C



A



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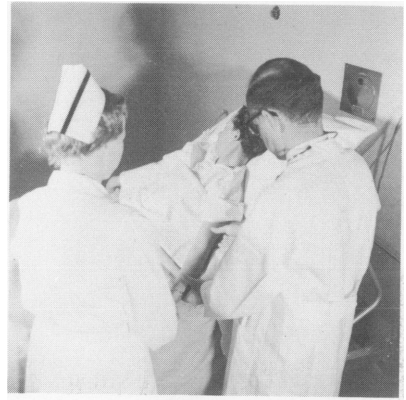
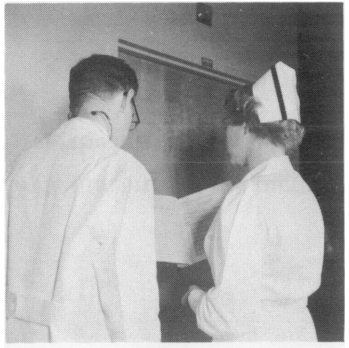


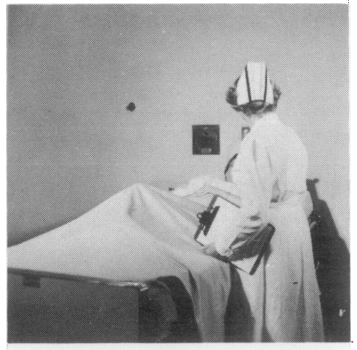
C

Circle the letter of the picture that shows the situation you would *most* like to be working in.	A	B	C
Circle the letter of the picture which is your *second* choice.	A	B	C
Circle the letter of the picture which is *most* typical of nursing today.	A	B	C
Circle the letter of the picture which is *least* typical of nursing today.	A	B	C
Circle the letter of the picture which shows the people you would *most* like to be working with.	A	B	C
Circle the letter of the picture which is your *second* choice.	A	B	C

Choose the picture that is *closest* to what *you* like best to do. Write the letter of that picture on the line for "Rank 1" below. Next, choose the picture that is *farthest* from what *you* like to do and write its letter on the line for "Rank 5." Then make your selections for ranks 2, 3, and 4 and write in the appropriate letter for each.



A



B

Rank 1 _____

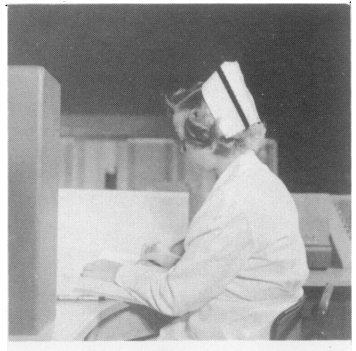
Rank 2 _____

Rank 3 _____

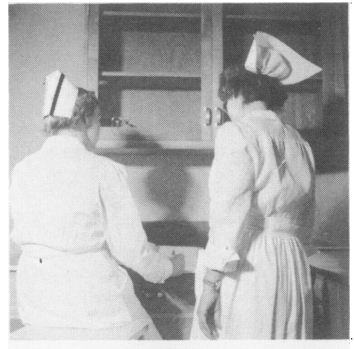
Rank 4 _____

Rank 5 _____

C



D



E

PART II

Below are some incomplete sentences. Each is followed by a blank line. On each line you are to write down something to complete each sentence. Don't worry about spelling or grammar. Just write down THE FIRST THING YOU THINK OF to finish the sentence—no matter how silly or strange it may seem to you. Don't spend much time on them—just write down the first thing that comes to mind.

1. Supervising the work of others .....
2. The patient's visitors .....
3. The really model patient .....
4. By and large, aides .....
5. I think that the practical nurse .....
6. When I supervise others .....
7. Visitors usually .....
8. Most doctors .....
9. Comparing the staff job to the administrative job, I .....

.....

10. When I am being supervised .....
11. Practical nurses usually .....
12. Most visitors .....
13. I think that the doctor .....
14. I like patients who .....
15. I think that aides .....
16. Generally speaking, the practical nurse .....
17. As a rule, attendants .....
18. Unlike the administrative person, the staff person .....

.....

19. Doctors usually .....
20. The best patients .....
21. Staff positions differ from administrative positions in that .....

.....

Below are some incomplete sentences. Each is followed by some alternatives. Please check the *one* alternative that seems to complete the sentence best. Don't spend much time on them. Just respond in terms of your first, quick impressions.

I do not like it
..... when corners have to be cut.
..... when people are indifferent.

On the whole, my feelings about patients are
..... on the unfavorable side.
..... rather neutral.
..... favorable.
..... quite favorable.
..... extremely favorable.

On the whole, my feelings about doctors are
..... extremely favorable.
..... quite favorable.
..... favorable.
..... rather neutral.
..... on the unfavorable side.

On the whole, my feelings about visitors are
..... extremely favorable.
..... quite favorable.
..... favorable.
..... rather neutral.
..... on the unfavorable side.

On the whole, my feelings about aides are
..... on the unfavorable side.
..... rather neutral.
..... favorable.
..... quite favorable.
..... extremely favorable.

On the whole, my feelings about practical nurses are
..... extremely favorable.
..... quite favorable.
..... favorable.
..... rather neutral.
..... on the unfavorable side.

On the whole, my feelings about other R.N.s are
..... on the unfavorable side.
..... rather neutral.
..... favorable.
..... quite favorable.
..... extremely favorable.

I wanted to be a nurse
..... ever since I can remember.
..... ever since I was in grade school.
..... from the time I went to high school.
..... after I graduated from high school.
..... other (please specify).....
.....

When I first entered nursing
..... I didn't really want to be a nurse.
..... I was rather neutral about the whole thing.
..... I liked the idea of being a nurse.
..... I wanted to be a nurse more than anything else.

I prefer patients who are
..... women
..... children
..... men
because .....
.....

I wanted to be a nurse because .....
.....

In the list of nursing specialties below, write the number one (1) by the specialty you prefer *most.* Then number the items from two (2) to twelve (12) according to what you would prefer *next,* ending with the specialty you prefer *least* (rank #12).

..... industrial nursing
..... medical nursing
..... obstetric nursing
..... office nursing
..... outpatient clinic nursing
..... pediatric nursing
..... private duty
..... psychiatric nursing
..... public health nursing
..... school nursing
..... surgical nursing
..... teaching

Below is a list of adjectives numbered from one (1) to seventeen (17). Please write the numbers of the two adjectives which best describe your feelings about:

nursing on a medical floor	#.....	#.....
nursing on a psychiatric floor	#.....	#.....
public health nursing	#.....	#.....
nursing on a surgical floor	#.....	#.....

Please be sure you have written two numbers for each of the four specialties. You may use the same adjective more than once if you wish.

1. challenging
2. depressing
3. difficult
4. dramatic
5. dull
6. enjoyable
7. exacting
8. exciting
9. frightening
10. high-pressure
11. impersonal
12. rewarding
13. slow
14. sociable
15. specialized
16. technical
17. undemanding

PART III

In relation to the various groups working in hospitals, I think that in general:

(Of course you may not know about all of these groups. Even so, give your general impression. Please do not omit any item.)

1. aides:
   ..... are overpaid.
   ..... are underpaid.
   ..... receive a just and equitable wage for their services.
2. doctors:
   ..... are underpaid.
   ..... are overpaid.
   ..... receive a just and equitable wage for their services.
3. R.N.s:
   ..... receive a just and equitable wage for their services.
   ..... are overpaid.
   ..... are underpaid.
4. practical nurses:
   ..... are overpaid.
   ..... are underpaid.
   ..... receive a just and equitable wage for their services.

PART IV

BIOGRAPHICAL DATA SHEET

Present position .....

Marital status: single ( ); married ( ); separated ( ); divorced ( ); widowed ( ).

If married, please indicate whether first marriage: .....

If married, husband's occupation: .....

If you have children, please list them by age and sex: .....

.....

Employment: (Begin with first job after nursing school up to the present. Please include any military service.)

Position (Staff, head nurse, supervisor, etc.)	*Organization (For example, name of hospital)*	*Address of Organization (City & State only)*	*Dates of Employment*

Comments or additional information, if any:.....

.....

Education:

	Name and Location	*Dates Entrance-Leaving*	*Diploma or degree received*
College			
University			
School of Nursing			

Comments or additional information, if any.....

.....

Family Background:

Age: (Please check your age group)

..... under 20 ..... 35–39 55–59
..... 20–24 ..... 40–44 60–64
..... 25–29 ..... 45–49 65–69
..... 30–34 ..... 50–54 ..... 70 and over

Place of birth: City..... State.....

Religion:.....

Father's occupation:.....

Was your father the head of the household during your years in grade and high school?

Yes ( ) No ( ) Other ( )

If other, please specify.....

Mother's occupation:.....

Place of birth of parents:

Father..... Mother.....

National origin of parents:

Father..... Mother.....

List below by relationship (such as father, sister) the members of your family:

Family member	*Age*	*Occupation*	*Grade reached in school*	*Living?*

Appendix B: Some Characteristics of the Four Nursing Specialties

This appendix will describe some characteristics of the four nursing specialties from which the sample of R.N.s was drawn—medical, psychiatric, public health, and surgical nursing. This involves an analysis of some new data, as well as consideration of any value type differences which were *also* significant with respect to the nursing specialties.[1]

One section of the questionnaire asked each respondent to rank twelve nursing specialties according to her personal preference. Table A shows the results. Each specialty preferred itself by a large margin. (The second choice in each case was several mean rank points lower.) Preferences for other specialties were widely scattered except for a rather high preference for surgical nursing among both medical and psychiatric nurses but not among public health nurses.

In general, all four specialties expressed a rather high preference for outpatient clinic nursing. Pediatrics was ranked rather high by all except the psychiatric nurses. School nursing was ranked moderately high by all except the medical nurses. All four groups agreed in ranking private duty nursing last, and there was also a generally negative feeling for office nursing.

Another section of the questionnaire asked the respondent to choose, from a list of 17 adjectives, those adjectives that best described her feelings about medical, psychiatric, public health, and surgical nursing. The adjectives were: challenging, depressing, difficult, dramatic, dull, enjoyable, exacting, exciting, frightening, high-pressure, impersonal, rewarding, slow, sociable, specialized, technical, and undemanding.

Table B shows the adjectives most frequently chosen to describe medical nursing by nurses in each of the four specialties. Table C gives the adjectives for psychiatric nursing, Table D for public health nursing, and Table E for surgical nursing. In these four tables the rank order, as

[1] The N for Tables A-G covers the total sample of 292 R.N.s, while Tables H-K concern only the 217 nurses who could be classified as to value type. Other variations in N were due to the failure of some subjects to respond to all items, and the appropriate N has been indicated in each table.

TABLE A

PREFERENCES OF FOUR GROUPS OF R.N.S FOR TWELVE NURSING SPECIALTIES

Medical nurses (N = 66)		Psychiatric nurses (N = 73)		Public Health nurses (N = 70)		Surgical nurses (N = 58)	
Rank order	Mean rank	Rank order	Mean rank	Rank order	Mean rank	Rank order	Mean rank
1. Medical	2.71	1. Psychiatric	1.85	1. Public health	1.26	1. Surgical	2.95
2. Surgical	5.27	2. Outpatient clinic	5.77	2. School	4.66	2. Outpatient clinic	5.46
3. Outpatient clinic	5.83	3. Surgical	5.93	3. Outpatient clinic	5.46	3. Obstetric	6.16
4. Pediatric	5.91	4. Teaching	6.41	4. Teaching	5.56	4. School	6.36
5. Teaching	6.09	5. School	6.47	5. Industrial	5.80	5. Pediatric	6.53
6. Obstetric	6.88	6. Public health	6.60	6. Pediatric	6.33	6. Industrial	6.59
7. Industrial	6.98	7. Medical	6.71	7. Psychiatric	7.00	7. Medical	6.62
8. Public health	7.11	8. Industrial	6.74	8. Obstetric	7.18	8. Office	6.79
9. Psychiatric	7.39	9. Obstetric	6.99	9. Medical	7.47	9. Teaching	6.88
10. Office	7.53	10. Pediatric	7.14	10. Surgical	8.07	10. Public health	6.96
11. School	7.65	11. Office	7.70	11. Office	8.54	11. Psychiatric	7.78
12. Private duty	8.64	12. Private duty	9.70	12. Private duty	10.67	12. Private duty	8.91

determined by the total number of times a given adjective was used, is shown in parentheses.

In every case there was one adjective which R.N.s in a specialty did *not* use very often to describe their own specialty, but which all other R.N.s did use frequently. In each table this word has been *italicized,* and in each case the difference in frequency of choice of this word between R.N.s in a specialty and those in other specialties was significant by chi square test at least at the .05 level.

For medical nursing this adjective was "slow." Thus, medical nurses did not feel that their specialty was "slow," while other R.N.s (that is,

TABLE B

DESCRIPTION OF THE SPECIALTY OF MEDICAL NURSING IN TERMS OF FOUR MOST POPULAR ADJECTIVES

Medical R.N.s (N = 67)	Psychiatric R.N.s (N = 74)	Public Health R.N.s (N = 70)	Surgical R.N.s (N = 59)
(1) Challenging	(1) Depressing	(1) Challenging	(1) Depressing
(2) Rewarding	(2) *Slow*	(2.5) Depressing	(2) Difficult
(3.5) Depressing	(3) Exacting	(2.5) Rewarding	(3) Challenging
(3.5) Difficult	(4) Challenging	(4) *Slow*	(4) *Slow*

those in psychiatric, public health, and surgical) did feel it was "slow." For psychiatric nursing, the word was "depressing." Again, psychiatric nurses did not see their specialty as "depressing," while other R.N.s did. For public health nursing, the adjective was "sociable." For surgical nursing there were two words—"dramatic" and "high-pressure."

In the case of psychiatric nursing, those nurses who chose it apparently thought it would be enjoyable rather than depressing; while those nurses who selected some other specialty apparently felt that psychiatric nursing was depressing. In the case of medical nursing, however, the word "depressing" did not seem to bother medical nurses. They went along with the rest of the R.N.s in describing their specialty as depressing. For them the key word was "difficult" as opposed to "slow." Perhaps they regarded the "difficultness" of medical nursing as a challenge, while other R.N.s saw it as "slow" instead.

Public health nurses described their specialty as "exciting," whereas other R.N.s used the word "sociable" rather than "exciting" to describe this specialty. Surgical nurses also liked to use the word "exciting" to describe their own work, while other R.N.s described the surgical specialty as "dramatic" and "high-pressure."

Of the various non-self-descriptive adjectives (that is, used by R.N.s in other specialties but *not* by R.N.s in the specialty itself), "depressing" and "slow" have negative implications while "sociable," "high-pressure," and "dramatic" do not. This suggests that public health and surgical nursing should be generally more preferred than medical and psychiatric nursing. To check this idea, average ranks for the four specialties

TABLE C

DESCRIPTION OF THE SPECIALTY OF PSYCHIATRIC NURSING IN TERMS OF FOUR MOST POPULAR ADJECTIVES

Medical R.N.s (N = 67)	Psychiatric R.N.s (N = 74)	Public Health R.N.s (N = 70)	Surgical R.N.s (N = 59)
(1) *Depressing*	(1) Challenging	(1) Specialized	(1) *Depressing*
(2) Specialized	(2) Rewarding	(2) Challenging	(2) Challenging
(3) Challenging	(3.5) Enjoyable	(3) *Depressing*	(3) Specialized
(4.5) Frightening and rewarding	(3.5) Specialized	(4) Difficult	(4) Difficult

TABLE D

DESCRIPTION OF THE SPECIALTY OF PUBLIC HEALTH NURSING IN TERMS OF FOUR MOST POPULAR ADJECTIVES

Medical R.N.s (N = 67)	Psychiatric R.N.s (N = 74)	Public Health R.N.s (N = 70)	Surgical R.N.s (N = 54)
(1) *Sociable*	(1) *Sociable*	(1) Challenging	(1) *Sociable*
(2) Enjoyable	(2) Enjoyable	(2) Rewarding	(2) Enjoyable
(3) Challenging	(3.5) Challenging	(3) Enjoyable	(3) Specialized
(4) Dull	(3.5) Rewarding	(4) Exciting	(4.5) Challenging and technical

TABLE E

DESCRIPTION OF THE SPECIALTY OF SURGICAL NURSING IN TERMS OF FIVE MOST POPULAR ADJECTIVES

Medical R.N.s (N = 67)	Psychiatric R.N.s (N = 74)	Public Health R.N.s (N = 70)	Surgical R.N.s (N = 59)
(1) Rewarding	(1) Specialized	(1) Technical	(1) Challenging
(2.5) *Dramatic*	(2) Exacting	(2) Exacting	(2) Rewarding
(2.5) Exacting	.....	(3) *Dramatic*	(3) Enjoyable
(4.5) Challenging	(4.0) *Dramatic*	(4) Specialized	(4) Exacting
(4.5) *High-pressure*	*High-pressure*	(5) *High-pressure*	(5) Exciting
	Technical		

were computed by adding together the total group of R.N.s, regardless of their chosen specialties. These ranks were: public health nursing, 5.4; surgical nursing, 5.7; psychiatric nursing, 5.8; and medical nursing, 5.9. Thus, public health and surgical nursing indeed tended to be more preferred than medical and psychiatric nursing.

The age distribution was not significantly different among the four

TABLE F

FATHER'S BIRTHPLACE AMONG THE FOUR NURSING SPECIALTIES[a]

Father	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
American-born	41	61	43	39
Foreign-born	27	16	31	22
Total	68	77	74	61

[a] The chi square value, with three degrees of freedom, was 9.11, significant at the .05 level.

TABLE G

PREFERENCES FOR PATIENTS BY AGE AND SEX AMONG THE FOUR NURSING SPECIALTIES[a]

Preferred patients	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
Women	8	12	7	15
Men	37	49	27	30
Children	11	7	27	8
Total	56	68	61	53

[a] The chi square value, with six degrees of freedom, was 28.72, significant at the .001 level.

specialties, though there was a tendency for more public health nurses to be in the older age groups (median age of 44.1 years). The psychiatric group followed with a median age of 36.8 years, while medical and surgical nursing had more younger nurses (both with a median age of 31.5 years). This probably reflects the fact that many young graduating nurses begin their careers as general duty nurses.

Among the family background factors only one, father's birthplace, showed a significant difference among the value types; and it also showed a significant difference among the four nursing specialties. Table F shows the distribution. Public health showed the highest proportion of foreign-born fathers. This may be related to the fact that this group had the largest proportion of older nurses whose parentage

TABLE H

DIFFERENCES AMONG THE FOUR NURSING SPECIALTIES IN THEIR PREFERENCE FOR ACTIVE VS. PASSIVE PATIENTS[a]

Preferred	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
Patients toward the passive end of the continuum	29	21	18	24
Patients toward the active end of the continuum	19	22	29	11
Total	48	43	47	35

[a] The chi square value, with three degrees of freedom, was 8.84, significant at the .05 level.

TABLE I

DIFFERENCES AMONG THE FOUR NURSING SPECIALTIES IN THEIR RESPONSES TO "I THINK THAT THE DOCTOR ....."[a]

Response	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
Doctor seen:				
As authority figure	4	8	15	8
In relation to patient	21	14	22	14
In relation to nurse	18	15	8	9
In relation to no one or only to himself	8	19	11	15
Total	51	56	56	46

[a] The chi square value, with nine degrees of freedom, was 18.07, significant at the .05 level.

TABLE J

DIFFERENCES AMONG THE FOUR NURSING SPECIALTIES IN THEIR RESPONSES TO "THE PATIENT'S VISITORS ....."[a]

Response	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
Visitor seen in relation to:				
Patient	12	13	29	8
Nurse	30	41	18	24
Hospital	9	0	4	13
Total	51	54	51	45

[a] The chi square value, with six degrees of freedom, was 40.92, significant at the .001 level.

would reach back to the time when immigration to the United States was more common. The psychiatric group showed the highest proportion of American-born fathers. This could be related to the fact that this group tended to include more Type IV's, who, it may be recalled, revealed the highest proportion of American-born fathers.

Preference for patients by age and sex showed a significant difference among the nursing specialties (Table G). Compared to the other specialties, a higher proportion of surgical nurses expressed a preference for

TABLE K

DIFFERENCES AMONG THE FOUR NURSING SPECIALTIES IN THEIR RESPONSES TO "VISITORS USUALLY ....." AND "MOST VISITORS ....."[a]

Response	Medical R.N.s	Psychiatric R.N.s	Public Health R.N.s	Surgical R.N.s
Visitor's behavior seen:				
In terms of his personal qualities or situation: fear, anxiety, etc.....	17	35	22	18
As helpful or cooperative to nurse or patient.....	17	14	25	9
As negative or disruptive to nurse or patient.....	17	7	10	19
Total.....	51	56	57	46

[a] The chi square value, with six degrees of freedom, was 23.03, significant at the .001 level.

women patients. Relatively more psychiatric nurses preferred male patients and relatively few of them expressed a preference for children. This may very well be related to their actual work situation in which child patients account for only a small percentage of the patient population. The reverse was true for the public health group, in which relatively more preferred children and relatively less expressed a preference for male patients.

The remaining differences to be described in this appendix concern the attitudes expressed on the sentence-completion, or free-ending, items. Only the responses of those nursing specialty members who could also be classified as to value type were analyzed. Thus the total N of Tables H, I, J, and K will be somewhat smaller.

The free-ending attitude toward patients showed a significant difference among nursing specialties. Table H shows the preference of the specialty groups for active versus passive patients, as measured by incomplete sentences which tapped images of the model patient. Public health

nurses were most attracted to the more active patient (62 per cent) and more than half of the psychiatric group (51 per cent) showed the same tendency. Medical and surgical nurses, on the other hand, tended to express a more passive image (60 and 69 per cent respectively).

One aspect of attitudes toward the doctor and two attitudes toward visitors showed a significant difference among the nursing specialties (Tables I, J, and K). Relatively more medical nurses described the doctor in relation to the nurse, while relatively more psychiatric and public health nurses described him as an authority figure (Table I). In the case of the visitor, relatively more public health nurses, who probably have more contact with the patient's family than nurses in other specialties, mentioned the visitor in relation to the patient (Table J) and described the visitor as helpful and cooperative (Table K). On the other hand, relatively more psychiatric nurses mentioned the visitor's personal situation (e.g., anxiety or concern), whereas relatively more surgical nurses referred to negative or disruptive behavior of visitors (Table K).

Appendix C: The Construction of the Nursing Picture Item Test and an Analysis of Its Effectiveness as a Measurement of Attitudes Toward the Nurse's Fellow Workers

The Nursing Picture Item Test (NPIT) probed attitudes toward the key people with whom nurses work—the patient, the doctor, the fellow nurse, and the aide. The choice of a picture-technique, rather than a strictly verbal instrument, was made on the supposition that photographs would provide a more potent stimulus and would more likely elicit true feelings, without conscious examination and evaluation of these feelings by the respondent. For the same reason, the photographs were designed to focus on the people, and not on any particular work activity.

Structure of the Instrument. The organization of the instrument for purposes of scoring and classifying respondents has already been indicated in Chapters 3 and 4. The page structure of the instrument is shown in Table A, along with the types of instructions used for each page and the section to which each page belongs. (See Appendix A for complete reproduction of the instrument and instructions.)

Instruction I asked, without obviously seeming to, for preferences for work companions. The subtlety was a deliberate attempt to avoid the distortion in responses sometimes caused by the use of pointed questions. Instruction III B—a more pointed wording of the intent underlying Instruction I—was designed as a check on I. (III B was used only on those pages for which III A, typical 20 years ago, was inappropriate—that is, pages which included the figure of the aide who was not commonly employed 20 years ago.) The results of this check, which indicate that Instruction I served its purpose, are given in the next section.

The Sharing Section and each series in the Compound Section were presented twice (i.e., appeared on two separate pages). The pictures on one page of a series were *not* the same as those on the other page, though they shared identical combinations of people, For example, one of the

TABLE A

STRUCTURE OF THE PICTURE ITEM TEST[a]

Page	Photographs	Instructions	Section
1.	a) Nurse with nurse	I. Situation most like to be working in and second choice.	Compound (Series I)
	b) Nurse with patient	II. Situation most typical today and least.	
	c) Nurse with patient with nurse	III A. Situation most typical 20 years ago and least.	
2.	a) Nurse with patient	I. Situation most like to be working in and second choice.	Compound (Series II)
	b) Nurse with doctor	II. Situation most typical today and least.	
	c) Nurse with patient with doctor	III A. Situation most typical 20 years ago and least.	
3.	a) Nurse with patient with doctor	I. Situation most like to be working in and second choice.	Sharing
	b) Nurse with patient with aide	II. Situation most typical today and least.	
	c) Nurse with patient with nurse	III B. People most like to be working with and second choice.	
4.	a) Nurse with patient	I. Situation most like to be working in and second choice.	Compound (Series III)
	b) Nurse with patient with aide	II. Situation most typical today and least.	
	c) Nurse with aide	III B. People most like to be working with and second choice.	
5.	a) Nurse with nurse	I. Situation most like to be working in and second choice.	Compound (Series I)
	b) Nurse with patient	II. Situation most typical today and least.	
	c) Nurse with patient with nurse	III A. Situation most typical 20 years ago and least.	
6.	a) Nurse with patient	I. Situation most like to be working in and second choice.	Compound (Series III)
	b) Nurse with patient with aide	II. Situation most typical today and least.	
	c) Nurse with aide	III B. People most like to be working with and second choice.	

[a] Both the page ordering and the arrangement of pictures on any page were determined randomly with the qualification that similar pages (e.g., p. 1 and p. 5) would not follow each other.

TABLE A—*Continued*

Page	Photographs	Instructions	Section
7.	a) Nurse with patient with doctor b) Nurse with doctor c) Nurse with patient	I. Situation most like to be working in and second choice. II. Situation most typical today and least. III A. Situation most typical 20 years ago and least.	Compound (Series II)
8.	a) Nurse with patient with aide b) Nurse with patient with nurse c) Nurse with patient with doctor	I. Situation most like to be working in and second choice. II. Situation most typical today and least. III B. People most like to be working with and second choice.	Sharing
9.	a) Nurse with doctor b) Nurse with patient c) Nurse with aide d) Nurse alone e) Nurse with nurse	Rankings from 1 to 5 of what best like to do.	Five-Way

two nurse-aide photographs showed the nurse and aide at the nurses' station (page 4) while the other showed them in the utility room (page 6). This double presentation was the basis for determining whether subjects were in fact responding to the *people* in the pictures or to other features, e.g., the kind of work activity.

The photographs were taken in the Nursing Fundamentals Laboratory of the School of Nursing, University of California, Los Angeles. This classroom contained demonstration equipment such as: nurses' station, utility room, patient's room with bed, etc. The photographs were taken with a Rolleiflex camera, size 2¼ by 2¼, using Eastman Plus-X film with normal processing and printing. Lighting consisted of three No. 2 photofloods in conventional arrangement.

The poses in the photographs were arranged to obscure faces as much as possible on the assumption that respondents could then project themselves into the picture more easily. Since the point of the instrument essentially concerned responses to *people,* other features in the photographs were either varied or obscured. The exact nature of the work activity was not indicated. For example, the two nurses photographed

at the nurses' station might have been charting or ordering supplies. Potentially loaded activities were not used—such as a dressing-change involving surgical instruments or a telephone call possibly suggesting a nonprofessional function. Since preferences for patients at various stages of illness might distort responses, the patient was variously shown: lying down, sitting in a wheelchair, walking. Similarly, the other figures were shown sitting, standing, walking.

A sample of 23 nurses was used to pre-test the photographs and various page arrangements of them. Some were eliminated. The final version was printed by the photo-offset process.

Effectiveness of the Instrument. Responses from 292 practicing nurses and 405 students of nursing (including 43 high school girls who intended to enter nursing) provided data for judging the effectiveness of the instrument. This involved two questions: (1) Did the pictures truly evoke responses to people, or did extraneous factors such as type of activity, esthetic or dramatic quality of the photograph, and the like dominate the respondents' reactions? This question applied to all three instructions: preferences for particular people, opinions as to what is typical of nursing today, and opinions as to what was typical 20 years ago. (2) Was the first instruction (intended as a subtle request for preferences for work companions) adequate for its purpose or did it misfire?

An analysis of the responses to any two pages showing the same series, or to two instructions on the same page, provided evidence that the NPIT was an effective measuring device. If responses to one page of a series were in close agreement with the responses to the second page of that series, presumably the people in the photographs determined the rankings since the particular people were the only things common to both pages. As explained earlier, the pictures on one page of the series were not the same as those on the second page, though they showed identical combinations of people. By similar logic, if responses to one instruction were in agreement with those evoked by another instruction on the same page, one could infer that both instructions were getting at the same thing.

The statistic for this analysis was chi square with expected chance frequencies determined theoretically as follows. The response to any given series consisted of first-second-third rankings of the three pictures. If the rank order was exactly the same on the second presentation of that series (or on the presentation of a second instruction for the same series), there was complete agreement (no numerical discrepancy). Cases of partial agreement resulted in a numerical discrepancy of two points,

e.g., 1–2–3 with 2–1–3. For example, the nurse-patient picture was ranked as first choice and later as second, the nurse-doctor picture as second and later as first, and the nurse-patient-doctor picture was third choice on both presentations. Lack of agreement resulted in a four-point discrepancy, e.g., 1–2–3 with 3–1–2 or 1–2–3 with 3–2–1. For example, the nurse-patient picture was ranked first and later as third, the nurse-aide picture as second and later as first, and the nurse-patient-aide picture as third and later as second.

Statistically speaking, there are six possible rank orders. Hence there are six possible comparisons between the two pages of a series once a given ordering has been selected for the first page (or between two instructions on the same page once a given ordering has been established for one of the instructions). Of the six possible comparisons, one results in complete agreement, two result in partial agreement, and three result in lack of agreement. If chance alone determines responses, that is, if each of the six possible comparisons is *equally probable,* then 1/6 of the comparisons should give no discrepancy in points, 2/6 should give a two-point discrepancy, and 3/6 or 50 per cent should yield a four-point discrepancy.

Using these three expected chance frequencies, chi squares were computed for each series for each instruction. This treatment, rather than overall chi squares for each instruction, satisfied the independence assumption that only one response from any subject be included in any given chi square table.

Table B gives the chi square values for the total group of subjects. Chi squares computed separately for the R.N.s and the students (Tables C and D) ruled out the possibility that students might differ appreciably from practicing nurses in the stability of their responses.

All chi squares were significant at the .001 level and the null hypothesis was rejected. The resulting inference that feelings toward the people, the one variable in common, produced the response rankings satisfied question one.

A check on question two (the adequacy of the first instruction) was made by comparing responses to the indirect request for preferences for work companions (Instruction I) and responses to the direct request (Instruction III B) for the four pages which used Instruction III B. These chi squares (Table E) were computed by the method already described, that is, with expected frequencies determined theoretically. All values were significant and it was therefore inferred that the first instruction did evoke preferences for people.

The NPIT included one other page,[1] which asked for a preference ranking of five pictures showing the nurse (1) with a patient, (2) with an aide, (3) with a doctor, (4) with another nurse, and (5) alone at the nurses' station. Since the requested ranking was straightforward, a built-in check of effectiveness was considered unnecessary.

TABLE B

CHI SQUARE VALUES FOR RESPONSES FROM TOTAL GROUP
(N's from 649 to 673)

Instruction	Compound section			Sharing section
	Series I	Series II	Series III	
I	215.74	245.68	351.75	170.88
II	215.35	213.46	239.00	151.10
III A	355.45	346.58	.....	.....
III B	.....	.....	490.35	272.67

TABLE C

CHI SQUARE VALUES FOR RESPONSES FROM PRACTICING NURSES
(N's from 262 to 277)

Instruction	Compound section			Sharing section
	Series I	Series II	Series III	
I	76.17	151.27	134.74	59.85
II	138.26	72.43	182.51	69.77
III A	202.13	151.73	.....	.....
III B	.....	.....	179.39	124.79

[1] The original instrument also included a page intended as a measure of preference for physical contact. It proved to be inadequate although the pre-test results had been promising. Of the four pictures on this page, two showed the nurse in physical contact with the patient while the other two did not. If the page had been successful, the two photographs showing contact would have been ranked first and second if the respondent preferred physical contact or third and fourth if she did not. Results from the total group of subjects did not show sufficient consistency between the pair of physical contact pictures to justify using this page. One of the contact pictures turned out to be very popular with all subjects, regardless of their feelings about physical contact. This may have been responsible for the confusion among responses to the "touch" and "non-touch" pictures.

TABLE D

CHI SQUARE VALUES FOR RESPONSES FROM STUDENT NURSES AND INTENDED STUDENTS
(N's from 387 to 401)

Instruction	Compound section			Sharing section
	Series I	Series II	Series III	
I	144.98	109.11	219.24	111.71
II	87.59	141.87	86.09	81.72
III A	162.24	195.73	.....	.....
III B	.....	.....	312.20	149.11

TABLE E

CHI SQUARE VALUES FOR COMPARISON OF DIRECT AND INDIRECT INSTRUCTIONS ON THE SAME PAGE

	R.N.s (N's from 271 to 281)	Students (N's from 394 to 401)	Total group (N's from 665 to 682)
Page 4	243.82	426.20	668.76
Page 6	358.97	580.69	939.07
Page 3	196.13	331.98	526.95
Page 8	288.29	419.60	703.99

Appendix D: Chi Square Tables Referred to in Chapter 4

In all of the following tables some rank and point categories were combined as necessary to obtain sufficiently high expected frequencies for Type III, which was the smallest group. The combinations used have been indicated in each table.

TABLE A

DIFFERENCES AMONG THE FOUR VALUE TYPES IN THEIR PREFERENCES FOR A RELATIONSHIP WITH THE PATIENT

	Type I	Type II	Type III	Type IV	Total
Placed the nurse-patient relationship first	40	44	4	1	89
Placed the nurse-patient relationship 2nd, 3rd, 4th, or 5th	15	22	26	53	116
Total	55	66	30	54	205

Chi square = 82.76 p smaller than .001 $df = 3$

TABLE B

DIFFERENCES AMONG THE FOUR VALUE TYPES IN THEIR PREFERENCES FOR A RELATIONSHIP WITH THE DOCTOR

	Type I	Type II	Type III	Type IV	Total
Placed the nurse-doctor relationship first	10	15	19	32	76
Placed the nurse-doctor relationship 2nd, 3rd, 4th, or 5th	45	51	11	22	129
Total	55	66	30	54	205

Chi square = 34.50 p smaller than .001 $df = 3$

TABLE C

DIFFERENCES AMONG THE FOUR TYPES OF NURSES IN THEIR PREFERENCE FOR THE RELATIONSHIP WITH ANOTHER NURSE

	Type I	Type II	Type III	Type IV	Total
Placed the nurse-nurse relationship 1st, 2nd, or 3rd	20	29	18	39	106
Placed the nurse-nurse relationship 4th or 5th	35	37	12	15	99
Total	55	66	30	54	205

Chi square = 16.73 p smaller than .001 $df = 3$

TABLE D

DIFFERENCES AMONG THE FOUR TYPES OF NURSES IN THEIR PREFERENCE FOR THE RELATIONSHIP WITH THE AIDE

	Type I	Type II	Type III	Type IV	Total
Placed the nurse-aide relationship 1st, 2nd, or 3rd	24	32	12	19	87
Placed the nurse-aide relationship 4th or 5th	31	34	18	35	118
Total	55	66	30	54	205

Chi square = 2.18 p between .70 and .50 $df = 3$

TABLE E

DIFFERENCES AMONG THE FOUR TYPES OF NURSES IN THEIR PREFERENCE FOR WORKING ALONE

	Type I	Type II	Type III	Type IV	Total
Placed the nurse working alone 1st, 2nd, 3rd, or 4th	36	35	13	40	124
Placed the nurse working alone last (5th)	19	31	17	14	81
Total	55	66	30	54	205

Chi square = 9.97 p between .02 and .01 $df = 3$

TABLE F

DIFFERENCES AMONG THE FOUR VALUE TYPES IN THEIR PREFERENCES ON THE SHARING SECTION

	Type I	Type II	Type III	Type IV	Total
NURSE WITH PATIENT AND DOCTOR					
Like more (2–3 points)	26	38	23	47	134
Like less (4–6 points)	30	29	7	11	77
Total	56	67	30	58	211
Chi square = 18.32 p smaller than .001 $df = 3$					
NURSE WITH PATIENT AND ANOTHER NURSE					
Like more (2–4 points)	33	41	22	32	128
Like less (5–6 points)	23	26	8	26	83
Total	56	67	30	58	211
Chi square = 2.81 p between .50 and .30 $df = 3$					
NURSE WITH PATIENT AND AIDE					
Like more (2–4 points)	36	29	8	18	91
Like less (5–6 points)	20	38	22	40	120
Total	56	67	30	58	211
Chi square = 16.99 p smaller than .001 $df = 3$					

TABLE G

DIFFERENCES AMONG THE FOUR VALUE TYPES IN THEIR PREFERENCE FOR ACTIVE VS. PASSIVE PATIENTS

	Type I	Type II	Type III	Type IV	Total
Prefer patients toward the passive end of the continuum (3–7 points)	18	26	16	32	92
Prefer patients toward the active end of the continuum (8–12 points)	28	28	9	16	81
Total	46	54	25	48	173

Chi square = 8.88 p between .05 and .02 $df = 3$

TABLE H

DIFFERENCES BETWEEN STAFF AND JUNIOR ADMINISTRATIVE NURSES IN THEIR PREFERENCE FOR ACTIVE VS. PASSIVE PATIENTS

	Staff nurses	Junior administrative nurses	Total
Prefer patients toward the passive end of the continuum (3–7 points)	72	20	92
Prefer patients toward the active end of the continuum (8–12 points)	61	20	81
Total	133	40	173

Chi square = .22 p between .70 and .50 $df = 1$

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