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CERTAIN SOCIOLOGICAL PERCEPTIONS OF NURSES IN PULASKI COUNTY, ARKANSAS

A Thesis

Presented to

the Faculty of the Graduate School

Ouachita Baptist University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

Mary Ann Todd

August 1968

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CERTAIN SOCIOLOGICAL PERCEPTIONS OF NURSES IN PULASKI COUNTY, ARKANSAS

by

Mary Ann Todd

APPROVED:

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90703

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CHAPTER I

INTRODUCTION

In the last fifty years, the nation's population has more than doubled while the number of workers needed in the health fields has quadrupled. Shortages in all the health professions exist with the shortage in nursing being the most serious. Currently the national supply of active nurses is 640,000.[1] The Surgeon General's Consultant Group on Nursing has established a need of 850,000 professional nurses by 1970, although 680,000 by 1970 is a more realistic goal.[2]

At present 75,000 more registered nurses are urgently needed by our nation's hospitals just to provide minimal care.[3] This is the conclusion of a 1963 report jointly released by the United States Public Health Service and the American Hospital Association.

In 1963 the report of the Surgeon General's Consultant Group on Nursing called for 680,000 active nurses as a feasible goal for 1970. By 1967 those numbers had practically been

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[1] Howard A. Rusk, "Nursing Education," _The New York Times_, May 14, 1967, p. 68.

[2] _Ibid_.

[3] Barbara G. Schutt (ed.), "Getting and Keeping Nurses," _American Journal of Nursing_, September, 1967, p. 1839.

reached. Yet those figures are obsolete, for there are still acute demands in the hospitals.

The problems confronting nursing, as listed by the Surgeon General's Consultant Group on Nursing in 1963, are:

1. Too few schools are providing adequate education for nursing.
2. Not enough capable young people are being recruited to meet the demand.
3. Too few college-bound students are entering the nursing field.
4. More nursing schools are needed within colleges and universities.
5. The continuing lag in the social and economic status of nurses discourages people from entering the field and remaining active in it.
6. Available nursing personnel are not being fully utilized for effective patient care, including supervision and teaching as well as clinical care.
7. Too little research is being conducted on the advancement of nursing practice.[4]

Today nursing is the largest of the health professions with more than twice as many practicing nurses as there are physicians. Nursing is the only other health profession concerned with the general welfare of the patient. Nursing has a heavy responsibility for coordinating other professional services, and directing the care given by thousands of subprofessionals.[5]

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[4] Rusk, op. cit.

[5] Barbara G. Schutt (ed.), "Conflicts in Medicine Raise Questions for Nursing," American Journal of Nursing, November, 1966, p. 2419.

A hierarchy of professions exists in society. In the United States, nursing is not high in this hierarchy. Nursing is not accorded the status and prestige that its members would like. Of particular importance right now is the relation of status and prestige to the recruitment of new talent to the profession. Nursing is finding it difficult to attract a fair share of creative and intellectual young people. Status and prestige assume great importance. The profession's function and its relevance to the welfare of the community, as well as the profession's influence in the community, enhance its status.[6]

> At the heart of the special something which turns an occupation into a profession are three related elements. First, there is a body of knowledge which requires specialized and extended training. The second essential quality of a profession is the sense of identity a person feels with others who have gone through the same training, as well as with the work itself. The third essential element is commitment to the idea of service. Given these core elements, professions take on a number of secondary characteristics which are often identified as professional attributes: prestige, good income, and sometimes political influence. These other characteristics are generally possible only when the three core elements exist.[7]

STATEMENT OF THE PROBLEM

The purpose of this study was to discover certain sociological perceptions of nurses in regard to their

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[6] Max R. Goodson, "Professional Education," American Journal of Nursing, April, 1966, p. 799.

[7] Emily Mumford and J. K. Skipper, Jr., Sociology in Hospital Care (New York: Harper & Row, Publishers, 1967), p. 174.

profession in Pulaski County, Arkansas.

SIGNIFICANCE OF THE STUDY

Except for Alaska and Hawaii, Arkansas has fewer registered nurses per capita than any state in the United States. The critical shortage of registered nurses is a concern of the American public, and this shortage appears to be becoming greater. Two important purposes of both the American Nurses Association and the National League for Nursing are to recruit more people for a career in nursing and to discover ways to keep them actively employed in the field.

The writer feels that this study will be helpful to the Arkansas Nurses' Association and the Arkansas League for Nursing in that both organizations may have a better understanding of the perceptions from a sampling of the registered nurses in Pulaski County. As a result of the study, each organization can make definite plans toward recruiting student nurses and creating better working conditions so more will remain in nursing. Both the Arkansas Nurses' Association and the Arkansas League for Nursing have requested a summary of this study.

The writer believes that this study will be beneficial to nursing leaders in other states, for many of the sociological perceptions prevalent among the Pulaski County nurses should be similar to the perceptions of nurses in other states.

DEFINITION OF TERMS

In this study the following definitions of terms will be used:

1. Certain: This term pertains to definite or particular perceptions.

2. Sociological: This word refers to a " . . . perspective. It draws attention to social organizations and culture as these influence people."[8]

3. Perceptions: This word refers to the ways which things may be viewed, interpreted or regarded by the nurse.

4. Nurses and Nursing: These terms pertain to the registered nurse in her profession.

DELIMITATIONS OF THE STUDY

This study was delimited to active registered nurses currently working full-time or part-time in a hospital or nursing home located in Pulaski County, Arkansas.

SOURCES AND ANALYSIS OF THE DATA

The Arkansas State Board of Nurse Examiners supplied a random list of names and addresses of 250 registered nurses of Pulaski County who work in hospitals or nursing homes. These nurses were sent a questionnaire seeking information relating

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[8] Mumford and Skipper, op. cit., p. 13.

to certain sociological perceptions of nursing. The nurses were asked, in part, to check or indicate why they decided to become nurses, the area of nursing in which they are working, present position, salary, length of service in nursing, educational background, marital status, ethics of nurses, preferred dress while on duty, deficiencies noted in the new graduate, what keeps them in nursing, their family's influence upon their working, and their participation in community affairs.

In Chapter II the writer surveys the literature pertaining to the questions asked in the questionnaire to compare the views of various writers with those of the nurses who are sampled.

Chapter III consists of the findings from the questionnaire.

Chapter IV presents the conclusions and recommendations.

Appendix A contains a copy of the letter which was sent to each registered nurse stating the purpose of the questionnaire and asking her to assist with the study.

Appendix B contains a copy of the questionnaire used in this study.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this chapter was to review the literature pertaining to the areas included in the questionnaire.

Despite the number of other areas in which nurses practice, hospital and related institutions continue to employ over two-thirds of the professional nurses working in the United States. Almost two-fifths of all working nurses are general duty nurses in hospitals.[9] Unlike the self-employed physician, surgeon, or dentist, more than 85 percent of all practicing nurses are employees whose wages and working conditions are determined by their employers. For three-fourths of these nurses, the employer is a hospital.[10]

EDUCATION

Education for nurses must continue for it cannot be thought of as ending when adult life begins. Education for the nurse is a necessity, for the nurse's abilities must be sharpened and her knowledge and skills kept current.

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[9] Evelyn B. Moses, "Nursing's Economic Plight," American Journal of Nursing, January, 1965, p. 68.

[10] Judith G. Whitaker, "The Changing Role of the Professional Nurse in the Hospital," American Journal of Nursing, February, 1962, p. 68.

Education is a life-long process which applies to everyone, but particularly to nurses.[11]

The largest number of nurses employed in hospitals are graduates of hospital diploma programs. Many hospital diploma school graduates are enrolled in, or are seeking admission to, baccalaureate programs to prepare themselves to carry out their responsibilities in the hospitals.[12]

The New York State Nurses' Association believes the nature and complexity of health services today demand continuing education for all health personnel. For this reason the association has committed itself to encourage and direct all nurses to seek educational advancement.[13] Dr. Max R. Goodson feels that in the past the program of the professional school has been "parochial, reflecting the heavy influence of professional practitioners."[14] He feels there has not been enough scholarship; too much emphasis has been in the direction of practice, and the college or university should take on the responsibility for professional education.

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[11] Gretchen Gerds (ed.), "The Status of Women Today and Its Effects on Nursing," American Journal of Nursing, November, 1963, p. 71.

[12] "Transition in Nursing Education," American Journal of Nursing, June, 1967, pp. 1212-1213.

[13] Ibid., p. 1214.

[14] Goodson, op. cit., p. 800.

> Professional preparation programs usually are located in academic institutions and, more frequently than not, are associated with universities or colleges. . . . In general, the mission of professional education is to prepare young people intellectually, and by disposition to participate in the life and the work of the profession, and I would add, to participate critically, intelligently and creatively.[15]

In 1963 a study was made of the educational background of nurses in 10 Nebraska hospitals. The data revealed a lack of strong emphasis on education and training among nurses. Although one-half of the 98 nurses interviewed thought the best way to improve their occupation would be by requiring additional education, less than 20 percent had more than the minimum three-year diploma. Although opportunities for continued education were available, no strong emphasis on advanced education and training in nursing was apparent.[16]

A proponent of the hospital school of nursing is Dr. Douglas S. Samrosch of New York's Columbia-Presbyterian Medical Center. In 1968 he said, "Measured against the products of the new college and junior-college nursing programs, the hospital schools are overwhelmingly superior."[17] He believed that nursing leaders who favor college degrees over hospital diplomas are showing

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[15] Goodson, op. cit., p. 798-799.

[16] Richard A. Kurtz and Karl H. Flaming. "Professionalism: The Case of Nurses," American Journal of Nursing, January, 1963, p. 76.

[17] Roland H. Berg, "Where Did All the Nurses Go?" Look, January 23, 1968, p. 29.

> . . . blind and uncritical faith in a system that is replacing professional competence with a smattering of nursing skills, a smattering of liberal education and an academic degree.[18]

Many hospitals are recognizing that they do not have the essential resources for nursing education. By 1966, 58 percent of the hospital schools of nursing had purchased general education courses from colleges.[19]

In New York State, associate degree nursing programs have prepared nurses since 1952; their phenomenal growth has demonstrated the community response and support for this type of education.[20] Since 1952 these programs have steadily increased until in 1966 there were 218 in 42 states. The number of students enrolled in these programs has increased from 27 the first year to over 8,500 in 1966.[21] Since the length of the program is two years, graduates are produced at a faster rate than in the traditional hospital programs.

An unexpected finding in the literature was the interest shown by an older age group in nursing. Most of these were over 35 years of age, were married, and had families. Men have been admitted in somewhat larger numbers in this program than

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[18] Ibid.

[19] "Transition in Nursing Education," op. cit., p. 1213.

[20] Ibid.

[21] Facts about Nursing, A Statistical Summary, American Nurses' Association, 1967 Edition, New York, p. 92.

has been true of other programs.[22] The chief reasons given for choosing the associate degree nursing program have been "its location in a college, its length, and its easy accessibility."[23]

Trends in enrollments in schools of nursing and colleges and universities generally indicate that increased numbers of high school graduates are seeking college preparation. Whitaker found that the number of women attending college in 1959 was 69 percent greater than it was in 1950. Yet enrollment in schools of nursing for professional nurses in 1959 was hardly 20 percent above that in 1950.[24] The New York Hospital Association claims that students in associate degree programs primarily observe nursing procedures rather than practice them, and upon graduation from these schools they are not qualified to assume duties at the bedside of the patient.[25] Contrary to the New York Hospital Association's statement, the New York State Nurses' Association responded that "both associate degree and baccalaureate degree programs in nursing include direct clinical experience."[26]

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[22] Ibid., p. 102.

[23] Ibid.

[24] Whitaker, op. cit., p. 67.

[25] "Transition in Nursing Education," op. cit., p. 1212.

[26] Ibid., p. 1213.

At Houston's Methodist Hospital, Dr. Edward B. Diethrich shrugs off any claim of superiority for the nurses who work in operating rooms and intensive-care units. He said in 1968, "Both college girls and hospital-trained girls take to this special work like ducks to water. There is no difference."[27]

The following sums up the premise upon which the New York State Associate Degree Nursing Project was based:

> The constantly increasing discrepancy between the need for nursing service and the supply of nurses makes it imperative that more students be enrolled in schools that prepare for nursing. The burden which now falls so heavily upon hospital schools of nursing must be shared, and perhaps eventually reduced. This can be accomplished by the establishing of new programs in the new type of educational institutions in which an increasing proportion of the youth of America are enrolling, namely the junior or community college.[28]

Approximately 800 junior colleges are in the nation with just over 500 being supported as public community colleges. About 190 junior colleges are currently being established. By 1970 there will be more than 1,000 publicly supported community junior colleges. This also means that 100,000 additional teachers will be needed for these junior colleges. Universal educational opportunity for at least two years beyond high school will become a reality much sooner

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[27]Berg, op. cit., p. 29.

Robert E. Kinsinger, "Partnership for Junior College Programs," American Journal of Nursing, September, 1964, p. 104.

than many people anticipated. If this trend continues, one can anticipate a similar increase in the number of nursing programs in junior colleges. Such programs are high on the priority list of new junior colleges anxious to meet the needs and demands of their communities.[29]

The predictable health needs of people demand that the concept of nursing as merely a vocation be replaced with the concept of nursing as a learned profession. The traditional identification of nursing as only <u>doing</u> is being replaced by an understanding of nursing as being a body of knowledge rooted in the humanities, as well as in the biological, physical, and social sciences. An aggregate of theories exists which goes beyond the foundation and represents the core of nursing knowledge upon which professional practice in nursing depends. Thus nursing focuses on human beings, and the practice of nursing is directed toward helping man achieve maximum well-being.[30]

Goodson says the following about the professional student:

> Unsegregated from other students, with their own distinctive educational mission and professional goals, students of every profession should have a vital

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[29]Margaret Brown Harty, "Trends in Nursing Education," <u>American Journal of Nursing</u>, April, 1968, p. 769.

[30]Martha E. Rogers, "Building a Strong Educational Foundation," <u>American Journal of Nursing</u>, June, 1963, p. 95.

> experience in the liberal arts. The first step after high school in the preparation of a professional person is his transformation through the arts, the sciences, and the humanities. These pursuits should make a deep impression on his personal value system, his outlook upon life, and his understanding of the physical and social world. It should above all, prepare him for a continuous intellectual life.[31]

In building a strong educational basis for nurses, Rogers states that

> . . . the education of the professional practitioner in nursing demands a strong foundation in the humanities and sciences at both lower and upper division college levels . . . . Students majoring in nursing must possess knowledge in English, history, logic and philosophy, in foreign languages, mathematics, biology, physics, chemistry, in psychology and sociology, political science and economics. They must possess knowledge and understanding of the biophysical-psychosocial organism, gained through study in physiology, microbiology, genetics, embryology, histology, biophysics and biochemistry; in social psychology, anthropology, literature, history, philosophy, economics, and political science. They must know and understand the theoretical concepts of nursing--incomprehensible without a liberal and nonspecialized foundation.[32]

Smith feels that the science of communication is more pertinent to nursing than the science of disease or pathology. She says then that if this is true,

> . . . we need to systematize communication among nursing personnel themselves, between them and other members of the health team, and between nursing personnel and patients.[33]

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[31]Goodson, *op. cit.*, p. 800.

[32]Rogers, *op. cit.*

[33]Dorothy M. Smith, "Myth and Method in Nursing Practice," *American Journal of Nursing*, February, 1964, p. 70.

NURSING AS A CAREER

Historically nursing has been a women's profession. Less than 3 percent of all employed professional nurses are men. In the past two decades, career choices for women have expanded rapidly. Many less responsible occupations and non-professional ones requiring less physical and emotional commitment have employed women and promise greater financial rewards than does a career in nursing. Competition with other occupations and disciplines for women with the aptitudes and intelligence to pursue a professional education have never been keener than they are today.[34]

May tells why she became a nurse:

> Why did I become a nurse in the first place? For two reasons: I liked science and I wanted to help people. Nursing seemed to fulfill these two affinities very well. Nursing takes stamina, intelligence, a desire to help people, patience, and a strong regard for human life. Nursing is the most useful preparation for life that I can think of and, to me, nursing is the most wonderful profession there is.[35]

Studies show that young women choose nursing as a career "because they want to help people who are ill and to help people keep well."[36]

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[34] Whitaker, op. cit., p. 67.

[35] Karen H. May, "What Nursing Means to Me," American Journal of Nursing, January, 1964, p. 87.

[36] Whitaker, op. cit., p. 65.

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Many nurses have shown their professional identification by encouraging others to study nursing. Of over 200 student nurses interviewed in Kansas, nearly half stated that one reason for choosing nursing was the encouragement of relatives or friends who were nurses. In 1958 Hughes and Deutscher reported that 90 percent of the nurses questioned in Arkansas thought enough of their occupation to recommend it.[37] In a 1962 study by Kurtz and Flaming, a group of nurses was asked whether they would encourage qualified high school seniors to become nurses and if they would change from nursing to another occupation if the other would provide a higher income. Nearly 90 percent said they would encourage qualified seniors in high school to go into nursing, and slightly more than 10 percent said they would leave nursing for a better paying occupation.[38]

Much interest exists in nursing as a career. The problem and challenge are translating that interest into intelligent and realistic career exploration and planning. For each student, this means academic planning, financial planning, and personal planning. Many factors affect the educational and career decisions of young people: the

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[37]Everett C. Hughes, Helen MacGill Hughes, and Irwin Deutscher, Twenty Thousand Nurses Tell Their Story, (Philadelphia: J. B. Lippincott Co., 1958), p. 248.

[38]Kurtz and Flaming, op. cit., p. 78.

influences in the family, mass media, and students' peer groups.[39]

Scheinfeldt stressed an important point about career counselors. She reminded nurses that

> if some of us . . . are still wondering about the differences in curriculums and goals among the associate degree, diploma, and baccalaureate degree programs, how can persons outside the profession be expected to understand? Yet these are the very persons who are responsible for counseling people into appropriate careers.[40]

In 1963 one worker in three was a woman, three out of five women workers were married, and one-third of the married women worked part-time. In 1900 the average age of the working women was 26, and in 1950 the average age was 41. In 1963 more than half of all women in the age group from 45 to 54 were in paid employment and had a life as a mother and homemaker. When her family is older, she also has a working life of importance to our economy. This underlying concept of a working life for women means that they might choose to make this a nursing life.[41] Kelley who began studying nursing at the age of 42 stated:

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[39] Genevieve Fillmore, "When You Are Asked about Nursing," American Journal of Nursing, August, 1963, p. 76.

[40] Jean Scheinfeldt, "Opening Doors Wider in Nursing," American Journal of Nursing, July, 1967, p. 1462.

[41] Gerds, op. cit., p. 70.

> I discovered that my seniority was actually an advantage in developing rapport with staff nurses and doctors. They never talked down to me; they seemed to expect more from me. In my effort to live up to these expectations I changed very rapidly from a shaky new student to one who was anxious to know more and more. . . . After all, one doesn't live to the middle years of life without gaining some experience and understanding.[42]

Recruitment can be applied both to bringing individuals into schools of nursing and also to attracting graduates to places of employment. Just as crucial as recruitment is for nursing so is the matter of retention of nurses. The fantastic turnover of nursing staff is one of the greatest problems of hospital and nursing administrators. The problem of retention is not necessarily peculiar to just nursing, but it is a burden which nursing shares with other professions which are composed primarily of women. But the concept of women remaining in the home for the rest of their lives is fast becoming an old-fashioned idea.[43]

Roren, an eminent hospital administrative authority, stated in a 1967 issue of Hospital Management that the recruitment of nurses will increase when the public makes provision for additional pay, additional responsibilities, wider authority, and deeper self-realization by individual nurses.[44]

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[42]Rosanne D. Kelley, "Age Is No Handicap," American Journal of Nursing, September, 1967, p. 1861.

[43]Schutt, "Getting and Keeping Nurses," op. cit.

[44]Ibid.

SALARY

In the last few years, nurses have started to talk, loudly and clearly, asserting their demands for a decent salary. At the 1966 meeting of the American Nurses' Association Convention in San Francisco, the beginning salary goal of a nurse was set at $6,500. One of the most active current groups studying salaries is the Michigan State Nurses' Association. Its program suggested the following:

1. Starting salary of $8,000 to $10,000 a year, depending upon qualifications;
2. Eight-hour day, with pay for all time on call;
3. Shift differential of $5.00 a day;
4. Better vacation benefits;
5. Accumulated paid sick leave;
6. Pension programs; and
7. Paid accident, hospitalization, and life insurance programs.[45]

The American Nurses' Association Convention in Dallas during May, 1968, set new salary goals, and, for the first time, tied them to the kind of educational preparation a nurse has. The A.N.A. pronouncement stated that the entrance salary of registered nurses shall be a minimum of $7,500 for those with a diploma or associate degree in nursing, and

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[45]Allyn, Z. Baum, "Michigan's Nurses See E.S.P. in Their Future," RN, March, 1968, pp. 38-39.

$8,500 for those with a baccalaureate degree in nursing.[46]

Competitive salaries will attract young people into the profession who now bypass it because it is so easy to find other better rewarded outlets for dedicated service. Competitive salaries will force hospitals and other agencies to increase their efforts to automate and to cooperate with each other for much larger purposes than to keep nurses' salaries down. The most important result of competitive salaries for the nurses will eventually be the awakening of the American people to the idea that health care cannot be paid for in the haphazard manner it is now being done. Nurses cannot continue to subsidize the current inefficient system by accepting low salaries.[47]

PROFESSIONAL PARTICIPATION AND ETHICS

A code of ethics which specifically defines the behavior of nurses is relatively new. The possibility of a code was discussed as early as 1897. A preliminary code was completed in 1940, revised in 1950, and revised again in 1960. This code expresses the basic attitudes, ideals, values, and norms of the members of the group, emphasizes that behavior must exhibit a professional attitude, and defines the

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[46] "The A.N.A. at Dallas," RN, June, 1968, p. 51.

[47] Dorothy N. Kelly, "Equating the Nurse's Economic Rewards with the Service Given," American Journal of Nursing, August, 1967, p. 1644.

relationship between the practitioner and others. Implied in adherence to these norms was personal involvement with the discipline.[48]

Membership in the professional organization is considered one index of the individual's acceptance of the principles of the code. One of the concerns among nurses who are interested in the advancement of their profession is the relatively low rate of membership in the American Nurses' Association.[49]

Kurtz and Flaming stated that:

> A low membership rate has been reported in previous research and only 29 to 30 percent of the nurses interviewed were members of the American Nurses' Association. . . . A.N.A. is facing serious problems in its strain toward professionalism because of the apathy and lack of understanding among nurses. . . . In terms of the model of professionalism, these findings indicate that although personal involvement with the occupation is prevalent, nurses do not participate in organizational activities.[50]

The nursing profession has had difficulty pulling itself up the professional ladder where it would be able to enjoy more of the secondary characteristics, such as income, status, and prestige. The problems confronted have been related to trouble with the "third essential element of

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[48] Kurtz and Flaming, op. cit., p. 77.

[49] Ibid.

[50] Ibid., p. 78.

professionalism--strong identification with the profession."[51]

Crowin and Taves, as did Kurtz and Flaming, found a low percent of nurses who belong to the A.N.A.

> Nurses themselves seem to show a rather wide variation in the extent to which they manifest identification with their professional groups. For example, only about 40 percent of the nation's registered nurses are members of the American Nurses Association, their largest professional organization.[52]

When interviewed three months after completion of their program, nurses were virtually unanimous in expressing their conviction that employers should actively promote membership and participation in nursing organizations. A few said membership should be mandatory, but the majority objected to this.[53]

Professions characteristically keep more of their recruits than do occupations. One attribute of a profession is the relative stability of its membership.[54]

Kelly remarked that, as nurses,

> we can no longer as members of a professional association tolerate nurses who do not live up to professional standards. It is the prerogative and the obligation of a profession to set standards and to see that practitioners

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[51]Ronald B. Crowin and Marvin J. Taves, "Nursing and Other Health Professions," in Howard Freeman, Sol Levine and Leo G. Reeder (eds.), Handbook of Medical Sociology (Englewood Cliffs, N.J.: Prentice-Hall, 1963), p. 191.

[52]Ibid.

[53]Marlene Kramer, "The New Graduate Speaks," American Journal of Nursing, November, 1966, p. 2423.

> abide by them. This cannot be left to employing agencies; it must be done by the profession itself.[55]

If an organization is weak, the lay community is less likely to grant prestige and other privileges to members of the occupation. In turn, the members of the occupation would be able to perceive the lost prestige afforded them by the larger community.[56]

The goals of the Michigan State Nurses' Association are to convince their nurses they can achieve economic advances through their professional association rather than through labor unions. In 1967 about twenty of Michigan's nurses left the association to join the A.F.L.-C.I.O., but some of these have already indicated a desire to return to the Michigan Nurses' Association. Nurses should speak for nurses; labor leaders should not.[57]

The no-strike policy in effect since 1950 was repealed at the A.N.A. Convention in Dallas in May, 1968. The convention adopted a resolution to leave action up to each state association. This was supplemented by adoption of a resolution which stated that the A.N.A.

> supports the efforts of the state nurses' associations . . . in taking necessary steps to achieve these improved conditions, including concerted economic pressures which

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[55]Kelly, op. cit., p. 1645.

[56]Kurtz and Flaming, op. cit., p. 79.

[57]Baum, op. cit., p. 40.

are lawful and consistent with the nurses' professional responsibilities and with the public welfare.[58]

CHANGING ROLE OF THE NURSE

Traditionally, the doctor saw the nurse as his assistant, and the nurse saw herself in a similar capacity. Research findings indicate increasing conflict within the nurse as to her responsibilities to the doctor, the patient, and to the hospital. Changes in the functions of nurses and the ever-increasing number of court rulings which hold nurses accountable for their own actions (rather than under the protection of the physician) show the emergence of the nurse as a professional in her own right. This transition is not clearly seen by many practicing physicians today.[59]

Hughes points out in his report that these two groups can operate effectively on behalf of the patient only when the "expectations they have of each other are mutually shared."[60]

A fundamental agreement is present that nurses and doctors must communicate, coordinate plans, assist each other, and each perform his job well. The disagreement seems to be found in the methods of accomplishment. Physicians and nurses are so close to these problems on a day-to-day basis that it

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[58] "The A.N.A. at Dallas," op. cit., p. 51.

[59] Whitaker, op. cit., p. 67.

[60] Hughes, op. cit., p. 162.

is hard for them to look objectively where they have been and where they are, so it makes it even harder for them to be rational about where they are going. Knowledge of and respect for each other's plans, which do complement each other, are the bases of collaboration.[61]

For the past 50 years physicians and nurses have become increasingly a part of the bureaucratic life of the hospital, with an attendant loss of autonomy. Each avows an interest in the welfare of the patient but each from a different point of view.[62] Physicians have their roots in the physical sciences while the nurses recently have been more oriented to the social sciences. The physician's authority in the hospital has been declining during the same period that the nurse's has increased. Today the hospital is the domain of the nurse; she exercises informal controls over work in which the physician is highly dependent.[63]

Many problems between nurses and doctors in the hospital stem from the organizational structure of the hospital rather than from the personalities of the individuals

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[61]Barbara Bates and J. Sue Kern, "Doctor-Nurse Teamwork: What Helps? What Hinders?" American Journal of Nursing, October, 1967, p. 2070.

[62]Pellagrino, op. cit., p. 112.

[63]Crowin and Taves, op. cit., p. 192.

involved. Nurses often assert the latter.[64] Three selected aspects of hospital structure that are seen as sources of strain for nurses in their relationship with doctors are:

> 1. Doctors do not see themselves as full-fledged members of the hospital organization. While nurses, who do, feel bound by the operating rules of the hospital, doctors tend to operate as free agents.
>
> 2. The hospital has two lines of authority, administrative and medical, unlike most large-scale organizations which have only one. Nurses are in the former while doctors are in the latter hierarchy. The "influenced relationship" between nurses and doctors is largely unarticulated: informally "negotiated" patterns prevail. . . .
>
> 3. In the absence of a functioning health team nurses have assumed responsibility, without the requisite authority, for the coordination of patient care. Although this action is for the immediate benefit of patients, nurses should realize that it also tends to retard the development of needed organizational changes in the hospital.[65]

RACIAL DISCRIMINATION

Are nurses guilty of discrimination or are they equitable toward others? Little was found in the literature concerning this subject. Scheinfeldt put it aptly in these words:

> Nursing, perhaps because its practice has always been concerned with the individual himself, rather than with

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[64]Signe S. Cooper (ed.), "Nursing Practice: Expectations and Reality," The Nursing Clinics of North America, Vol. 3, No. 1, (Philadelphia: W. G. Saunders Co., March, 1968), pp. 125-126.

[65]Ibid.

> his race, creed, or color, has a distinguished record so far as human and civil rights are concerned. In most nursing services throughout the country the young Negro man or woman works side by side with his or her white colleague, with neither of them giving a thought to racial distinctions.[66]

Hegerty wrote that intolerance and racial discrimination toward the patient are not present:

> We are so intent on our corporal works of mercy, we usually see each patient only as a sick human being who needs a nurse, and this tends to erase any vestige of prejudice. . . . I read now of race riots and I think of all the white nurses . . . who have felt the same compassion and given the same care to colored patients as to white ones. Then I recall all of the wonderful Negro doctors, nurses, and aides with whom I have worked and I cannot single out one instance when their treatment of a white patient was marred by a difference of skin color. . . . To me, nursing is such a dedicated, humanitarian, life-and-death sort of profession, it seems almost blasphemous to speak of it in the same breath as intolerance.[67]

NURSING UNIFORMS

Today nurses ask if a uniform and cap are necessary in the role of the nurse? Particularly in psychiatric units, the uniform has been discarded in numerous hospitals and replaced by street clothes. One nurse who has worked in a psychiatric unit discussed the reaction of the patients to the student nurses who came in street clothes:

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[66] Scheinfeldt, op. cit., p. 1461.

[67] Genevieve Cowles Hagerty, "A White Nurse Probes Her Conscience," American Journal of Nursing, December, 1963, p. 104.

> It was a challenge to play the role of the nurse without status symbol of the uniform. They were treated like women and therapeutic agents not just nurses. The students found that they could not hide behind the stereotyped concept of the nurse. They were forced to give more of themselves and to relate actively to the patients. Somehow they felt closer to the patients as persons. The nurses' personalities as human beings emerged and for the first time they were actually "seen.". . . The patients felt freer to talk to the students who, in street clothes, were more like the individuals patients met in their outside environment. It helped them to prepare for possible experiences on the outside. Their resentment toward authority figures was eased. Personal hygiene and appearance received more attention; patients pressed their clothes and shaved more often.[68]

The head nurse on this same psychiatric unit found that when she wore a uniform it was not necessary to give as much of herself, and her communications were cut to a minimum. While in street clothes, she discovered that she communicated and related better in giving psychiatric nursing care to the patients. Personal attitudes became more important. The head nurse discovered that the uniform was not equated with tender loving care, understanding, and empathy. The total morale of the ward improved.[69]

The patients began to take more initiative in the care of their fellow patients and to participate to a greater degree in maintaining ward responsibilities. At the same time, the staff became representatives of the outside world in their

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[68] Frances Gold Brown, "Ritualism and Patient Reactions," American Journal of Nursing, October, 1967, p. 64.

[69] Ibid., p. 65.

street clothes, making the patients feel more at home. According to Brown, the only negative aspect expressed by staff members concerned the expenses involved in wearing street clothes.[70]

In the usual general hospital setting, many nurses prefer the traditional uniform stating that the public expects to see the nurse in white. Render stated it aptly when she reminded the nurses, "A point to keep in mind is that the nursing uniform is as much a protection to the patient as to you."[71]

A new graduate expressed her thoughts about the importance of the uniform, cap and pin in this manner:

> Look at it this way--the uniform, cap and pin are only outward symbols of the profession, but the professional organization is the symbol that really stands for the profession: standards, ethics, concern for the patient, commitment to self-improvement.[72]

DEATH AND THE DYING

Several factors have contributed to a psychological rebellion against a serious examination of the nurse's role in relation to the dying. These include the tremendous emphasis in our American society on youth, life and health;

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[70] Ibid.

[71] Helena Willis Render and M. Olga Weiss, Nurse-Patient Relationships (New York: McGraw-Hill Book Co., Inc. 1959), p. 97.

[72] Kramer, op. cit., p. 2423.

the ways we seek to insulate ourselves against the impact of tragedy and deny the reality of death; and the preoccupation of the medical community with saving and prolonging life.[73]

Teachers and students of nursing have found themselves in painful positions of having to reconsider long-established and culturally dependent values and attitudes as the teaching-learning processes have unfolded.[74]

Cultural taboos, hospital rituals, professional defense mechanisms have all operated to make withdrawal from the dying patient a common behavior for personnel.[75] Yet death is but one phase of life; one which each is destined to experience from birth. Nurses have become increasingly skilled in helping people discuss and meet all phases of life--birth, childhood, adolescence, adulthood, aging, but death--the next phase in the natural progression of life--is too often avoided in the conversation of the nurse.[76]

Baker and Sorensen felt that nurses do not have definite ideas or a philosophy about death:

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[73] Berniece M. Wagner, "Teaching Students to Work with the Dying," American Journal of Nursing, November, 1964, p. 129.

[74] Ibid.

[75] Carol Ren Kneisl, "Thoughtful Care for the Dying," American Journal of Nursing, March, 1958, p. 550.

[76] Joan M. Baker and Karen C. Sorensen, "A Patient's Concern with Death," American Journal of Nursing, July, 1963, p. 92.

> Maybe talking about death makes you feel sad and inadequate because you have not been able to face and explore your own past experiences related to death . . . . Many nurses have never pondered and formulated their own ideas about death before being confronted with a question similar to the one asked by the patient. . . . A person is likely to feel more at ease when he is allowed to explore the meaning that death has for him and to arrive eventually at his own philosophy.[77]

Folta suggested that persons with much anxiety about death tend to enter the healing professions in an attempt to make themselves invulnerable. She also felt this could be one reason why the average nurse finds it difficult to work with the elderly, for they are closer to death which the nurse actually wishes to avoid. At the same time, the nurse may unconsciously fear them since death is near them.[78]

Many dying patients are fearful. Fear of death is the most realistic and inescapable of all the fears faced by the living. Often nurses have become so involved in acknowledging their own fear of death that they forget that dying patients may be experiencing fear of loneliness, isolation, and abandonment.[79]

The dying patient deserved comfort, not isolation, support, not abandonment. When the nurse is faced with this dilemma, she must come to grips with her own attitudes toward death and dying. Only then can she provide the thoughtful

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[77] Ibid., p. 90.

[78] Jeanette R. Folta, "The Perception of Death," Nursing Research, Summer, 1965, p. 232.

[79] Kneisl, op. cit., p. 550.

care that dying patients have so desperately needed. Unless the meaning of the experience of death has been talked about, looked at, and studied, the nurse will be unable to meet the expectations in providing understanding, comfort, and support for the patient and his family.[80]

Kneisl has said that

> . . . the first step nurses must take in improving the care given to dying patients is to engage in introspection, to understand and perhaps alter their attitudes toward death and dying. But to do this, nurses need additional support from colleagues, from nursing educators, and nursing administrators. Introspection requires commitment for introspection is painful. . . . Nurses often are present during the second phase of mourning when crying takes place. Tears are a vital and important part of the mourning process, and nurses should not be afraid to see them shed. Nor should nurses feel guilty when they too cry.[81]

The obvious place to begin acquiring skills pertaining to care given dying patients is in the basic nursing programs. The University of Kansas School of Nursing has already recognized the need for more concentrated effort in teaching students how to care for the terminally ill. Their five reasons for more emphasis being placed upon this area are listed as follows:

1. A significant proportion of people in our society die in a hospital. It is imperative that students be prepared to respond to the needs of the dying as a part of their basic nursing preparation.

2. Dying is an experience which evokes an intense emotion associated with grief and anxiety, the nurse must learn to recognize, respect, and deal effectively with its

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[80] Ibid.

[81] Ibid., p. 553.

behavioral expressions.

3. It is human for an observer to feel fearful and helpless in the presence of the dying, but as the nurse finds meaning in the experience for herself and acquires skills and insight which are supportative to the dying person and his family these unpleasant feelings tend to dissipate.

4. The necessary insight and skills basic to compassionate care of the dying can be acquired only through prolonged, somewhat constant, yet intermittent, consideration of what the needs of the dying seem to be, and an imaginative projection of oneself into the role of a nurse privileged to respond.

5. The acquisition of the necessary insights and skills would need to be developed by a method, or methods, in which the student would assume the major responsibility of her own learning.[82]

THE NEW GRADUATE NURSE

Graduates of basic programs in nursing are prepared for the practice of nursing. Assignments as head nurses or charge nurses should require additional preparation with on-the-job training in the routines and methods employed by the particular patient care unit. Increasingly graduates of any program are inadequate in certain aspects of any position. Industry long has recognized the need for the orientation of new employees, but hospital administrators for a long time have implied that any beginning program in nursing should prepare for any eventuality of employment.[83]

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[82] Wagner, op. cit., p. 129.

[83] "Transition in Nursing Education," op. cit., p. 1214.

The amount of time the student of nursing spends in the clinical area has been severely criticized and viewed as the cause of limited skill in nursing practice upon employment. Appraisal of the criticism revealed that the new graduate does not know how to carry out routines in the employing hospital.[84] For example,

> . . . the hospital boils syringes and the new graduate received clinical experience in a hospital that used disposable syringes; or the employing agency assigns her to the obstetric service and expects her to immediately assume full responsibility for patients in labor when her education was in a hospital where residents assumed this responsibility. Hospital administrators evidently fail to recognize the significant differences that exist in hospitals of various sizes and types, and the influences these differences have on the practice of nursing.[85]

The hospitals expect graduates of any type of nursing program to assume immediate responsibility as head nurses, a position which the scope of responsibility and activities have depended upon knowledge of routines and procedures of that particular hospital.[86]

According to a survey made by Kramer of new graduates, 73 percent started working within one month after graduation. Three months after graduation from a basic program in nursing, 64 percent of these new nurses were assuming charge nurse responsibilities, defined as total nursing responsibility for

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[84] Ibid.

[85] Ibid.

[86] Ibid.

a ward unit for a given eight-hour period; 17 percent were relieving when head nurses took their days off.[87] The dissatisfaction of the new graduates with nursing in general was related to personnel policies pertaining to assignments, especially concerning floating--being taken from the assigned ward to work in another clinical area.[88] Several voiced a dislike of rotation, or of the assigned shift, but there were no complaints about unfair rotation policies.[89]

The Oregon Nurses' Association in 1967 began a professional nurse residency program. The purpose of the program was to give the beginning or returning practitioner an opportunity to develop competence in her performance, to provide the inservice education and supervision necessary to enable her to participate effectively, and to create a working climate which allows the nurse to progress at her own speed.[90]

> The nurse enters as a junior, intermediate, or senior resident. The junior resident is either a new graduate from a basic program--diploma, baccalaureate or associate in arts--or a nurse returning from an inactive status. The intermediate resident is a licensed professional nurse with a minimum of three months' experience in hospital nursing. The senior resident is a licensed

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[87] Kramer, op. cit., p. 2422.

[88] Ibid., p. 2421.

[89] Ibid.

[90] Lee Killam, "In Good Faith," American Journal of Nursing," September, 1967, p. 1184.

> professional nurse with a minimum of six months' prior experience. . . . A nurse may progress through the junior, intermediate, and senior phases in one year or less and omit any one phase if her ability and performance warrant this.[91]

Salary increments were not automatic, but were dependent upon ability, performance, and evidence of continued professional growth. Killam stated that the hospital where she worked was greatly alive with the excitement of experimenting with the professional nurse residency. Recent graduates from the Oregon schools were asked their opinion of the newly established resident program; they voiced their approval and wished there had been such a program for them upon their graduation from their school of nursing.[92]

BEDSIDE NURSING

Too many hospital nurses are entirely too dedicated to some old traditions that have no validity today and have too many misplaced loyalties. Nurses have to learn that patients and society have first claim on their dedication and their loyalty. They have to stop taking care of hospitals and doctors and give the best of themselves and their talents to patients and potential patients. Nurses want to take care of patients, but without the conviction that nursing is theirs, without the conviction that they have rights and

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[91] Ibid., pp. 1183-1184

[92] Ibid., p. 1185.

responsibilities on which no other group may impinge, they will not do much more than flounder. Nurses have begun to have these convictions, but by and large, they have not been prepared to fight adequately for them.[93]

Nurses have begun to demand not only their right to decent salaries, but more importantly, their right to assume their responsibilities for nursing care of patients. Nurses have come to a belated recognition that their long-standing refusal to speak for themselves and for their profession has reflected in what every nurse deplores--poor patient care.[94]

Two-thirds of the nurses questioned by Kurtz and Flaming indicated that some of the tasks now performed by nurses could be performed by other hospital personnel. One half of these indicated that certain tasks presently performed by others should be performed by nurses. When they were asked to name such tasks, there was little agreement; however, nurses did mention that bedside nursing care should be performed by nurses. These findings were interesting in view of the responses to another question which asked if there were traditional nursing procedures that should not have been relinquished. Those who responded positively mention bedside care the most often.[95]

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[93] Dorothy Kelly, "The Situation in Nursing," American Journal of Nursing, January, 1965, p. 78.

[94] Kelly, "Equating the Nurse's Economic Rewards with the Service Given," op. cit., p. 1644.

[95] Kurtz and Flaming, op. cit., p. 76.

Baum remarked in her study of Michigan nurses:

> We are striving not only for better salaries but for improved working conditions that will let R.N.'s do nursing. Right now, for example, hundreds of nurses in Michigan's hospitals spend as much time at clerical work as they do at nursing. Why shouldn't the hospitals hire ward managers for the nursing stations and let R.N.'s nurse?[96]

The long-held concept of general duty nursing as the beginning position in nursing practice must be replaced by the concept of clinical nursing practice as a continuing career according to Whitaker. She stated that economic incentives must be provided for the nurse to continue her professional education as a clinician and to improve her knowledge and skills as an expert in the planning, designing and giving of nursing care.[97] She has argued positively that

> . . . the present narrow span between the minimum and maximum salaries paid by hospitals gives no recognition to the length of experience or to additional education, either formal or informal, for those engaged in direct care of patients--the general duty nurses. This is an important factor in the mobility of nurses in this area of practice. . . . At present, the only way a nurse may progress economically in the hospital setting is by becoming a head nurse, then a supervisor, and then an assistant director or director of nursing service. The low economic position of the nursing profession has had a telling effect on recruitment, on the retention of nurses in hospital nursing, on attracting inactive nurses to return to practice, and on morale which affects both the quantity and quality of patient care.[98]

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[96] Baum, op. cit., p. 41

[97] Whitaker, op. cit., p. 67.

[98] Ibid.

In 1962 Zimmerman predicted that the decade ahead would see economic rewards for the nurse who finds satisfaction in nursing where administrative responsibilities are not a part of her job and who pursues continuing education to improve the quality of nursing care she gives to patients. Only when it has been made economically reasonable for the nurse to function in the clinical area as an excellent nurse will the people see any substantial number of nurses remaining at the bedside.[99]

THE PART-TIME AND INACTIVE NURSE

Approximately one-fifth of all nurses employed in 1962 worked on a part-time basis.[100] According to Reese, Seigel and Testoff the ratio of part-time to full-time nurses has risen, and expectations are that it will continue to rise. In 1964 the ratio stood at approximately one part-time nurse for every two full-time nurses. Part-time nurses contributed roughly one-fifth of the total nursing service available to short term general and allied special hospitals in the continental United States.[101] These observations about part-time nurses were noted:

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[99]Anne Zimmerman, "Economic Security in the Decade Ahead, American Journal of Nursing, December, 1962, p. 101.

[100]Mumford and Skipper, op. cit., p. 177.

[101]Dorothy E. Reese, Stanley E. Seigel and Arthur Testoff, "The Inactive Nurse," American Journal of Nursing, November, 1964, p. 124.

> Apparently, part-time nurses take considerable interest in maintaining contact with their profession . . . The primary reason for working is to maintain professional skills and to help alleviate the nursing shortage. . . . When asked why they worked part rather than full-time, 71 percent answered that family obligations did not permit full-time employment. . . . Marital status affects the number of days worked. . . . Divorced nurses worked considerably more than nurses in any other marital status group, single nurses came next. The greatest concentration of part-time nurses is in the 30-39 age bracket compared to 20-29 for all nurses, full-time and part-time, in hospitals or other institutions. If part-time work were not available, many of these nurses would not be in the nursing labor force at all. . . . Employment of large numbers of part-time nurses does create certain administrative problems.[102]

A director of nursing in Colorado has stated that three categories of nurses have been established in her particular hospital: part-time relief, which means the nurse works no more than two days a week whenever and wherever she is needed; permanent part-time, which means the nurse can work two to four days a week or full-time as a vacation relief, earning as much as 1,040 hours in one calendar year for which she is entitled to half of the fringe benefits; and full-time, which means the nurse works forty-hours a week and is entitled to full fringe benefits. If a part-time nurse averages three days per week over a year's period, she will receive half the benefits which the full-time nurses have received.[103]

Some directors of nursing have used part-time nurses only on the evening and night shifts and day off relief

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[102] Ibid., p. 89.

[103] Gladys McGregor, "The Realities of Staffing," American Journal of Nursing, November, 1962, p. 57.

which has improved the morale of the full-time nurses.[104]
One director stated the expectations of the part-time nurse in the following manner:

> We do expect per diem nurses to work every other week-end (or comparable time--all Saturdays or Sundays). We are firm about this and in many instances have had nurses to resign or not start to work because of this. However, in the end, we believe that full-time staff appreciate the fact that they are given the same privileges on week-ends as all nurses who are employed.[105]

A large proportion of the inactive nurses are married and in the younger age brackets. They cite home and family responsibilities as major reasons for not working. A salary of $4,500 a year cannot cover the cost of arrangements necessary to take care of the home and family responsibilities as well as provide additional income for the families of these nurses. Returning to work has not been considered financially attractive to inactive nurses.[106]

Reese, Seigel, and Testoff quoted four main reasons given by inactive nurses for not working:

1. I believe a mother should be in the home while her children are young.

2. I cannot make suitable arrangements for the care of my child or children.

3. My husband prefers that I do not work.

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[104] Ibid., p. 63.

[105] Ibid., p. 61.

[106] Moses, op. cit., p. 71

4. The salary I would get would not make it worthwhile.[107]

The study by Reese, Seigel, and Testoff also showed that 47 percent of the nurses who plan to return to work expressed an interest in working part-time. An earlier study by Reese, Seigel and Testoff showed that 23 percent of the nurses who began to work on a part-time basis following a refresher course later converted to full-time employment. The return of the inactive nurse to part-time may be the first step in returning to full-time employment.[108]

Statistics show that the longer a nurse is inactive the less likely she is to return to active status.[109] A refresher course has been the necessary requirement stipulated by the inactive nurses who are considering returning to work. Of the inactive nurses surveyed by Reese, Seigel and Testoff in 1964, 65 percent stated they would like a refresher course within the next twelve months, and more than 60 percent of the nurses who had been inactive less than 10 years wanted a refresher course.[110]

A sizeable number of inactive nurses replied that the reason they were not working was that, "Employers cannot

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[107] Reese, Seigel and Testoff, _op. cit._, p. 125.

[108] _Ibid._, p. 127.

[109] _Ibid._, p. 125.

[110] _Ibid._, p. 126.

utilize the working hours I could be available."[111] Changes in work schedules could be arranged to capitalize on the availability of these nurses. A day-care center near the health agency could be provided for adequate child care for preschool and school-age children if many of the inactive nurses indicated an inability of their part to make suitable arrangements for the care of their child or children.[112]

STAFFING

Major staffing difficulties which have confronted nursing administrators with staffing have been related to evening and night shifts, week-ends and summer months, finding general duty nurses, supervisory personnel, special units as obstetrics, pediatrics and the operating room.[113] In the past the solutions have resulted in two wide-spread practices in the use of part-time nurses and the increased use of practical nurses and auxiliary nursing personnel.[114] As a result of this, there has been increased paper work in keeping track of part-time personnel; continuity of patient care when large numbers of part-time nurses are employed must

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[111] Ibid.

[112] Ibid.

[113] McGregor, op. cit., p. 57.

[114] Ibid.

be maintained; and the increased need and lengthening of orientation programs, inservice education, and refresher courses for both part-time and full-time personnel.[115]

A director from New York said:

> Nurses do not seem to want to work these shifts (night and evening). . . . Some have commuting problems, but I think a great deal of the problem comes from the fact that as students nurses get very little experience on these shifts, and as graduates they feel insecure and reluctant to work these hours.[116]

A director from Pennsylvania said: "It has . . . become increasingly difficult for the young general duty nurse to be satisfied since she is working most evening and night tours of duty."[117] Another director of nursing mentioned that cooperation of the medical staff had helped; doctors had cut to a minimum their orders for medications and treatments on night shifts, eliminating the need for as much nursing personnel as was previously required.[118] Still another director of nursing mentioned that cooperation with the medical staff was extremely helpful in the reorganization of nursing care when an intensive care unit and a recovery room were set up.

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[115] Ibid.

[116] Ibid., p. 59.

[117] Ibid.

[118] Ibid.

Staffing those units was not a problem because they presented challenges to graduate nurses in giving good nursing care.[119] A Nebraska director of nursing remarked that "over half of our graduates are married within a year after graduation and nearly all are married within two or three years."[120]

Married nurses frequently work only part-time, or will not or cannot work evening and night shifts, holidays, or week-ends because of children or husbands. Some nurses leave during the summer months when their children are out of school.[121] Many directors of nursing cite marriage and home responsibilities as a partial cause for difficulties in finding professional nurses for supervisory positions.

> Many of the professional nurses who come to us for work, especially the younger ones, are not interested in a position which carries more than general duty responsibility. And this is understandable since many . . . are carrying a full load at home as housekeeper, mother, and wife since they cannot afford to pay someone to work for them.[122]

One director stated that her hospital did not rotate shifts, and she believed that was a reason they were able to secure professional personnel better. She had also staffed her positions in the following manner:

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[119] Ibid., pp. 59-60.

[120] Ibid., p. 58.

[121] Ibid.

[122] Ibid.

> We have twice as many registered nurses on days as we do on evenings and the ratio is even higher between days and nights. I believe that nurses are better able to manage their home responsibilities by remaining on one shift. As much work as possible is given to the 7-3 shift such as ordering of drugs, keeping up with the charts, and most housekeeping duties which are delegated to the nursing department. (We have non-nursing aides for these duties--clearing utility rooms, refrigerators, medicine rooms). This makes it possible to staff the unpopular hours with fewer personnel. . . . We have well-trained ward clerks at all nursing stations on both the day and evening shifts.[123]

To help relieve the nursing staff shortage, a New Jersey director said:

> As more . . . men nurses become available, I shall continue to employ them to alleviate the shortage of professional nurses, not because I consider them superior in performance, but because one does not encounter the same problems common to the female nurses--leaving because of marriage, pregnancy, and lack of baby sitters.[124]

McGregor concluded her study on the problems of staffing with this comment: "If there is a panacea to the staffing shortage, it lies, I am convinced, in better nursing administration."[125]

CLERICAL AND OTHER NON-NURSING DUTIES

In a 1962 study by Scott, data revealed that about one-fourth to one-third of the nursing staff's time was spent on activities that did not require nursing skills with only a little over half the time provided for nursing was spent on

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[123] Ibid., p. 60

[124] Ibid., p. 58.

[125] Ibid., p. 63.

patient care activities.[126] The time spent on non-nursing activities such as clerical, housekeeping and messenger type activities ranged from 30 to 40 percent of the time. Of the time spent on non-nursing activities, clerical duties ranked first in 211 cases; housekeeping and dietary services vied for second place.[127] A comparison of the morning and evening tour of duty showed that more time had been spent on nursing activities during the evening tour of duty than the morning. The head nurse group spent less time in activities in keeping with skill and judgment required for the job than did the other groups of personnel.[128]

When involved in activities other than nursing, the professional nurses tended to do clerical work; practical nurses and nursing aides did the dietary and housekeeping work. Hospital routines--administrative, managerial, operational details--were handled for the most part in the morning tour of duty. The nursing staff, particularly the professional nurses had spent a proportionately larger share of time in completing these non-nursing routines despite there being more nurses on duty. The aide had spent more time with the

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[126] Jessie M. Scott, "Seeing Nursing Activities As They Are," American Journal of Nursing, November, 1962, p. 70.

[127] Ibid.

[128] Ibid.

patient, talking with him and observing his need for care, than had any other person on the nursing staff. The aide's assignment tended to keep her with the patient, and the professional nurse's assignment tended to keep her away from the patient. The professional staff nurse spent more time--almost twice as much in getting ready to give care as in actually giving it. Much of the time spent in clerical activities seemed to have a direct relationship to the detail with which the hospital records, other than the patient's chart, were kept. A large proportion of the work was being done on the nursing unit, with or without clerical staff.[129]

The care of the patient's record seemed to be assigned almost exclusively to the head nurse; at least she has written in it more often than anyone else has done. What does she write? Usually what the others tell her. Why make the head nurse a secretary to nursing aides?[130]

Scott suggested two approaches to correct this problem:

> Two approaches are needed--one from hospital management and one from the nursing department. Advances can be made simultaneously or quite separately, or both. Part of the answer in returning the nurse to nursing lies with hospital administration, if the nurse is to be relieved of the strictly non-nursing activities now considered to be part of her assignment.

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[129] Ibid., pp. 70-71.

[130] Ibid., p. 71.

But this is only part of the picture. Only nursing can return the nurse to the patient.[131]

DeMarco listed eight activities of nurses which were unrelated to direct patient care. They were as follows:

1. Acquiring information
2. Recording
3. Transcribing or copying
4. Referencing
5. Exchanging information
6. Transmitting
7. Maintaining records
8. Conducting classes[132]

The most hopeful development which should become a reality to many hospitals in our country in the next decade will be the increased use of hospital information systems using computers. Nursing personnel time that can be devoted strictly to nursing duties should become a reality.[133]

Johnson, of the International Business Machines Corporation, predicted "that within the next decade, computers will be used by the nurses as frequently as thermometers and aspirin are today."[134]

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[131] Ibid.

[132] J. P. DeMarco, "Automating Nursing's Paper Work," American Journal of Nursing, September, 1965, p. 77.

[133] Rusk, op. cit.

[134] Ibid.

In 1965 DeMarco stated that automation of nursing notes can provide charts which are clear and helpful and will lead to the time when we will be able to tell what a certain nurse's notes mean in a hospital in Ohio and know that they mean the same thing in Colorado.[135]

Automation certainly promises to perform many tasks more efficiently than humans can. Further, the distinguishing characteristic of the professional is understanding of the principles underlying techniques and actions, not the technique itself.[136]

COMMUNITY ACTIVITIES

Little was found in the literature relating to the participation of nurses in the life of the community with reference to organizations to which they belong and in which they actively participate. Seemingly, nurses do not involve themselves in community leadership and activities as have other professional groups.[137]

Kelly stated in 1965:

> The criticism we receive today comes not from the public but from our own ranks and from hospital authorities. So far as the public is concerned, all that is wrong with nursing is that there aren't enough nurses. I believe that we have failed the public to

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[135]DeMarco, *op. cit.*

[136]Pellegrino, *op. cit.*, p. 112.

[137]Kelly, "The Situation in Nursing," *op. cit.*, p. 77.

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some extent but the failure has been in public leadership, rather than in public service.[138]

In his article, Goodson commented about nurses becoming more concerned with politics:

I believe that members of the nursing . . . profession need to become more concerned with politics and take on a much more effective role in influencing politics if they expect increased public recognition.[139]

SUMMARY

In this chapter the literature pertaining to certain sociological aspects of nurses throughout the United States was reviewed.

The professional education of the large majority of the nurses has been in diploma schools of nursing, but the newer trend is toward the preparation of nurses in colleges and universities with the emphasis upon theory and principles rather than upon actual proficiency of the techniques and skills as stressed by the diploma schools. The majority of the diploma schools of nursing have realized the need for general education courses from nearby colleges and universities and have purchased these courses for their students. The community two-year college is the latest development in the trend toward nursing on the college level in which an associate degree in nursing has been given since 1952. With

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[138] Ibid.

[139] Goodson, op. cit., p. 799.

its shorter program, being more accessible to the general public, having more appeal to the male student and the mature woman, and with the increased number of high school graduates who are now attending college, the two-year associate degree has expanded rapidly.

Women choose nursing primarily because they want to help people and have been encouraged by some specific person to go into nursing with the encouragement most often being given by a nurse. The working woman of today is not only accepted but our economy demands her. Retention of nurses in the profession is as great a problem as recruitment. Women and the elusive males (who comprise only 3 percent of all nurses) will come into nursing as provisions for adequate salary, additional responsibilities, more authority and greater self-realization become more obvious.

Only in the last few years have nurses spoken out and demanded decent salaries. Competitive salaries will attract young people who now by-pass the profession for an often less demanding but better-paying profession or occupation. The first nation-wide salary goal by the American Nurses' Association was in 1966 with a suggested beginning salary of $6,500. In 1968 this was raised to $7,500 for beginning nurses from diploma or associate degree programs and to $8,500 for beginning nurses with a bachelor's degree in nursing. This is the first time that differences in educational preparation have been spelled out in salary.

Studies reveal that at best only 40 percent of the nurses belong to the American Nurses' Association. Nursing has had a struggle in the past to pull itself up the professional ladder. This pull has been caused by a lack of interest and concern of so many nurses who fail to participate actively in their own professional organization. The lay community's acceptance of a profession is primarily dependent upon the strength of the professional group itself. Michigan State Nurses' Association has been a leader in trying to achieve nursing goals through its professional organization. The formulation of ethical standards has been talked about for more than sixty years, but only in the last twenty has a definite code of ethics become a reality.

As the nurse's role has rapidly changed in the past few years, the doctor-nurse relationship has shown signs of strain. The role of the nurse is not clearly understood by many practicing physicians, and some nurses are confused. Many problems between doctors and nurses stem from the organizational structure of the hospital. For the doctors and nurses to cooperate effectively on behalf of the patient, the expectations they have of each other must be mutually shared.

The literature has little to say regarding racial relations in the hospital among the nursing personnel or between the nurse and the patient. Because nursing has always been concerned with the individual himself rather than with his race, creed, or color, the great majority of nurses

are free from racial discrimination in their work.

The nursing uniforms and caps are no longer considered a must in certain areas of nursing. Studies have revealed that street clothes are more therapeutic for patients, particularly in psychiatric units. Nurses have found that when they wear street clothes, they have to give more of themselves to their patients than they do in the traditional uniforms. Some nurses feel more protection by being in white, but, at the same time, the uniform is also a protection for the patient.

Too little emphasis has been placed upon the nurse's forming a philosophy of death and upon her acquiring certain aspects of care for the dying in schools of nursing and in the hospitals. Attitudes need to be changed as death, the last phase in the natural physical progression of life, is too often avoided as a topic of conversation by the nurse. Nurses in general have been accused of not wanting to work with the elderly because they are closer to death, and the nurse wants to avoid dealing with death. The nurse should provide understanding, comfort, and support to the patient and his family. Before the nurse can provide this she must engage in introspection--which may be painful. The obvious place to begin acquiring basic skills toward care given the dying patient and his family is in the basic nursing program. The University of Kansas School of Nursing has recognized this need and has given more concentrated effort in teaching

students how to care for the terminally ill.

The new graduate nurse has been prepared for beginning positions in bedside nursing. Some programs have been severely criticized for lack of adequate clinical experience. Too many hospital administrators and nursing service administrators expect graduates of any type of nursing program to assume immediate responsibility as head nurses which depends not only on proficiency of skills, but also knowledge of routines and procedures of that particular hospital. Some new graduates were required to float (going from one clinical area to another to work). The Oregon State Nurses' Association in 1967 began a professional nurse residency program to give the new graduate or returning practitioner an opportunity to develop competency in her performance and to allow the nurse to progress at her own speed. Salary increments were not automatic but were dependent upon ability, performance, and evidence of continued professional growth by the nurses in the residency program. Many recent graduates voiced their approval and wished such a program had been established when they graduated.

Nurses have begun to demand not only their right to decent salaries, but more importantly, their right to assume their responsibilities for the nursing care of patients. Studies show that nurses have said most often that the traditional nursing procedure that should not have been relinquished by them was bedside care. The only way a nurse

has been able to progress economically in the hospital setting has been by becoming a head nurse, then a supervisor, then assistant or director of nursing service. Only when it becomes economically reasonable for the nurse to function in the clinical area as an excellent nurse will any substantial number of nurses remain at the bedside.

Part-time nurses contribute one-fifth of the total nursing services in hospitals. These nurses are interested and concerned in maintaining contact with their profession and in helping to alleviate the nursing shortage. Almost all part-time nurses are married and have children. The employment of large numbers of part-time nurses does create administrative problems in regard to staffing. Some hospitals have used part-time nurses on the 3-11 and 11-7 shifts and expect them to work every other week-end (or comparable time--Saturdays or Sundays). This has helped the morale of the full-time staff. A large proportion of inactive nurses is married and is in the younger age group. The four main reasons inactive nurses give for not working are: need to be with the child or children, unable to make suitable arrangements for the care of the child or children, husband prefers that she not work, and salary is not considered attractive enough for her to work. Statistics show that the longer a nurse is inactive the less likely she is to return to active status. The return of the inactive nurse to part-time work may be the first step in returning to full-time employment. A refresher

course is considered a necessary requirement by inactive nurses before returning to work.

The major staffing difficulties confronting nursing administrators have been related to evening and night shifts, rotation of shifts, week-ends and summer work, and lack of personnel in supervisory positions. Some directors of nursing service believe this problem has been caused because student nurses get little experience on the evening and night shifts, and as graduates they feel insecure and reluctant to work these hours. Some directors have helped solve this problem by getting doctors to cut orders for medications and treatments on the late shifts to a minimum thus eliminating the need for as much personnel. This made it possible to staff the unpopular hours with fewer personnel. Another director felt that the hospital was staffed better by nurses remaining on the same shift. Better nursing service administration can correct many of the problems dealing with staffing.

Studies reveal that one-fourth to one-third of the nursing staff's time has been spent on activities that do not require nursing skills. Only a little over half of the time provided for nursing was spent on patient care activities. Of the time spent on non-nursing activities, clerical ranked first, and housekeeping and dietary services vied for second. The professional nurse tended to do the clerical work while the practical nurse and nursing aides more often took care

of the dietary and housekeeping work. The use of well-trained ward clerks on the morning and evening shifts, and non-nursing aides for housekeeping duties has been helpful in relieving the nurse from a portion of the clerical work and other non-nursing duties. More time is spent on nursing activities during the evening tour of duty than the morning. The head nurse spent less time in activities in keeping with skill and judgment required for the job than did other groups of personnel. The professional staff nurse spent more time--almost twice as much in getting ready to give care as in actually giving it. The aide's assignment tended to keep her with the patient, and the professional nurse's assignment tended to keep her away from the patient. The most helpful development in the next decade to relieve the nurse of the clerical duties will be the increased use of computers.

Nurses do not involve themselves in community leadership and activities as do other professional groups. If less than 40 percent of the nurses actively participate in their own professional organization, it is understandable that the majority are not interested in other community activities. The failure of nurses in the past has not been in public service but in public leadership. Nurses have been urged to become more concerned with politics and to take a much more effective role in influencing politics if they expect public recognition.

CHAPTER III

FINDINGS OF THE STUDY

The purpose of this chapter was to discover certain sociological perceptions of nurses regarding their profession in Pulaski County, Arkansas.

PROCEDURE AND RESPONDENTS

With the help of the writer's sociology instructor and the Executive Director, Arkansas League for Nursing, and from ideas received from a survey of the literature pertaining to problems of nurses and nursing as a profession, the writer developed a questionnaire seeking certain sociological perceptions of a sampling of registered nurses in Pulaski County, Arkansas.

The study was limited to a sampling of 250 registered nurses currently working full-time or part-time in hospitals or nursing homes located in Pulaski County, Arkansas. Mrs. Nell Balkman, Executive Secretary, Arkansas League for Nursing, and a Member, Arkansas State Board of Nurse Examiners, chose at random the names of the nurses to be contacted. She had access to the records of the nurses in Pulaski County.

The questionnaire and a cover letter were mailed to each nurse. The cover letter asked that the questionnaire be checked and returned to the writer. A copy of this letter is

found in Appendix B.

COMPILATION OF RESPONSES

One hundred and fifty questionnaires were returned to the writer with the information completed. This represented a 60 percent return.

Information concerning the positions presently held by the respondents showed that 49 percent were staff nurses, 23 percent were head nurses, 15 percent were supervisors, and the remaining 13 percent were administrators, instructors, anesthetists, in-service educators, coordinators, and private duty nurses.

In relation to the number of years represented in nursing, 25 percent of the nurses had been in nursing from one to four years, 23 percent from five to ten years, 17 percent from eleven to seventeen years, 14 percent less than one year, 13 percent had from eighteen to twenty-five years, and 8 percent represented over twenty-six years of nursing. To put it another way, 38 percent of the respondents had been in nursing more than eleven years, or 62 percent had been in nursing ten years or less.

As to ages, 54 percent of the respondents were in the age group of twenty-one to thirty, 21 percent were between thirty-one and forty, 14 percent from forty-one to fifty, 7 percent from fifty-one to sixty, and 4 percent were in the range of sixty-one to sixty-five.

Regarding marital status, 70 percent of the respondents were married, 19 percent were single, 8 percent were divorced, 2 percent were widowed, and 1 percent were separated. Of the 70 percent who were married, 35 percent had no children, 26 percent had one child, 19 percent had two children, 10 percent had three children, 4 percent had four children, and 1 percent had more than four children. Five percent of the respondents replied that they were pregnant.

The respondents represented three religious groups: 79 percent were Protestants, 20 percent were Catholics, and 1 percent were Jehovah Witnesses.

EDUCATION

Eighty-six percent of the respondents completed their professional nursing from a diploma school; 13 percent had a bachelor's degree in nursing; and 1 percent of the respondents had a master's in a field of nursing. Sixteen percent of the respondents have less than two years of college, 3 percent have at least three years of college work, 4 percent have a bachelor's degree in a field other than nursing, and 1 percent have a master's degree in a field other than in nursing.

The question was asked: "If you had the opportunity to take more college courses, name the first three areas in which you feel you need more education." Eighty-eight percent of the respondents listed one or more courses they would be

interested in securing more education. Twelve percent of the respondents did not list any. The following table indicates the courses and the percentages of respondents who replied to the need for more education in that subject area:

Name of Course	Percent
Physical Sciences	44
Psychology	37
English	25
Social Sciences	17
Education	16
Mathematics	15
Sociology	14
Speech	4
Other	18

In the physical sciences, respondents listed the need for more chemistry and anatomy and physiology. In English, a request for a course in communications far exceeded any particular course in literature. History was the main area requested in the social sciences. Supervision and administration courses in education were the most often mentioned in that field. Other courses suggested were numerous with less than 2 percent for any one of the following: flying lessons, foreign languages, art, business, fine arts, music, law, philosophy, religion, ethics, humanities, equipment mechanics, business administration, and home economics. Some nurses listed less specific areas, such as general academic courses, liberal arts, a B.A. degree, or B.S. degree.

A low percentage of the respondents indicated they would like to have specific nursing courses on the academic level. The following table indicates these courses:

Name of Course	Percent
Coronary Care	6
Psychiatric	5
Pharmacology	5
Public Health	3
Medical	3
Surgical	2
Other	4

In "Other" were listed orthopedic care, medical research, neurology, pediatrics, and obstetrical nursing.

The question was asked: "How do you feel about the new two-year college program in nursing?" The respondents were asked to check one of the following: "Very good", "Do not know", "Opposed to it." Forty-three percent of the nurses stated they did not know, 37 percent were opposed to the program, and 20 percent stated they thought the new two-year college program would be very good. One nurse commented that she believed it "required the student to learn too much too fast." Another respondent stated she would "rather have the three-year programs with federal aid." Another said, "I hope they turn out better bedside nurses than the four-year programs." Another respondent, a supervisor, remarked:

> The associate program here in Arkansas is fairly new. I'm anxious to see some nurses from this program in action--after they graduate. This type program may meet the nursing shortage as to the number of nurses it turns out, but what type nurses result from this program remains to be seen. Will they be able to run a floor with a minor amount of supervision? Will they need help in organizing their work in caring for patients at the bedside? I don't believe they'll have enough clinical experience when they finish their two years--this included staff nursing and basic bedside care. A great deal of our time is going to be spent in giving them post-graduate clinical guidance and with the nursing shortage the way it is in Arkansas, is this really the answer? It remains to be seen!

Another supervisor said:

> I feel we should try more to retain our three-year diploma schools rather than make them four-year schools. We have the nurse's aides and licensed practical nurses. Changing to two-year schools all you have are glorified LPN's. If more help, financial-wise, was given to help nurses, we wouldn't have to reduce our standards to make a two-year graduate. In two years you cannot possibly give her the knowledge or the experience to call her a nurse. Speaking from my point of view as a supervisor in a hospital, you already have to use the three-year graduate to give the clinical experience to the four-year graduate; now they want to make a two-year graduate with fewer three-year schools all the time. What will we do ten years from now?

The question was asked of the respondents, "Do you think the new two-year college program will be effective in meeting the nursing shortage?" Forty-two percent replied, "No"; 35 percent stated they "Do not know"; 22 percent said "Yes"; and 1 percent said "Partially." Approximately 10 percent of the respondents made additional comments:

> I don't think we will ever have enough nurses.
>
> We need more four-year graduates.
>
> What about standards and quality of care?
>
> They are not really capable nurses.
>
> They lack basic training.
>
> Let them work while they are learning and quit babying them.
>
> The quality of nursing care will certainly not be improved.
>
> They will need much inservice education.
>
> They will not be ready for too much responsibility.
>
> Let them require a one-year internship.

Each married nurse was asked to compare her educational background with her spouse's. This comparison is shown below:

Spouse's Educational Background	Percent
Greater	35
Less	35
About the same	30

NURSING AS A CAREER

A question for the respondents to answer was "Why did you decide to become a nurse?" The following were the main reasons given in answering this question:

Reasons for Becoming a Nurse	Percent
Humanitarian desire to help the sick and be of service to those in pain	33
Influenced directly by someone else or group	14
Childhood ambition and desire	11
Inexpensive education to prepare for a profession	9
To meet own needs	8
Felt qualified for this type of work	6
Job security	5
Felt called of God for this work	5
Other	9

The respondents who were influenced directly by someone else stated that their mother, aunt, or older sister had been a nurse; their father had been a doctor; a science teacher in high school had influenced them; or a friend had

encouraged them. Groups which influenced the respondents were the American Red Cross, especially in its home nursing course, and sponsors of the Candy Stripers. In answer to the question, "Are you glad that you became a nurse?" 97 percent answered "Yes"; 2 percent replied "At times"; and 1 percent said "No."

Nine percent felt the nursing profession was a means of securing an inexpensive education. One nurse said:

> This was the only opportunity for education available to me. I wanted a professional career. I came from poor people, and the lack of funds prevented a college education; this education was not too expensive and was within the means of my family.

The 8 percent who entered nursing to meet their own needs replied they felt a great need to serve others and liked the feeling they got from helping others. One stated, "I feel nursing fulfills my strong desire to help people."

The 6 percent who said they felt qualified for this profession gave as the reasons for choosing this career their being interested in science in high school, being interested in the medical field, and having a natural talent for nursing.

Those respondents who entered the nursing profession for job security added the following comments:

> Nursing is an occupation enabling me to travel.
>
> There is always a need for nurses.
>
> It is a good profession for women.
>
> It is a vocation I can return to later in life if I need to work.

It is a rewarding profession.

For the 6 percent who entered nursing because they thought it would be an exciting and challenging job mentioned other adjectives and comments to describe their feelings about nursing as "fascinating"; "enjoyable"; "interesting"; "thought it would be fun"; and "glamorous."

The 5 percent who felt called of God for this type work believed this dedication to a career in nursing as a definite purpose for their lives. One stated that she started to nursing school with the idea of becoming a medical missionary.

The 9 percent included in "Other" reasons replied:

I do not know why I chose nursing.

No particular reason.

Do not remember.

Could not find any other field of interest.

Was not good in business, so I decided to try nursing.

Did not know much about other professions for women.

One nurse said, "Nursing was my second choice. I took pre-medical courses for three years and got cold feet before I was to enter medical school."

The married respondents were asked the question, "How does your spouse feel about your working?" Sixty-eight percent replied that their spouses "Approved"; 16 percent "Disapproved"; and 16 percent "Did not care" whether or not they worked.

The nurses were asked the question: "What keeps you in nursing?" They were permitted to check more than one reason. The following chart gives the reasons and percent for each:

Reasons for Staying in Nursing	Percent
Job satisfaction	68
Salary	31
Have to work	29
Nursing shortage	12
Helps to occupy my time	1
Obedience to Mother Superior	1

One nurse wrote:

> I returned to full-time staff work (my preference) when the youngest child started to the first grade. My nursing salary has never been included in our regular budget. It was used to help educate four children. Our oldest boy is now a fairly successful veterinarian. Our second son is a dentist on active duty with the Navy. Our youngest boy graduates from college this June with a marketing and advertising degree. Our daughter will receive her elementary teaching degree in June. Nursing made all this possible financially. I love my work. It was the answer to emotional problems during menopause and a definite help when I faced divorce after twenty-nine years of marriage. Nursing was not the cause for my divorce.

SALARY

The respondents were asked to check the salary range of their yearly salaries. In 1966 the American Nurses' Association stated a goal of $6,500 as the starting salary for beginning nurses. Listed below are the figures related to the respondents:

Yearly Salary	Percent
Above $10,000	3
$9,000 to $10,000	4
$8,000 to $9,000	9
$7,000 to $8,000	20
$6,000 to $7,000	8
$5,000 to $6,000	41
$4,000 to $5,000	5
Less than $4,000	10

All of the nurses who made less than $4,000 stated they worked part-time. The nurses who made $10,000 or above were administrators or anesthetists.

The married nurses were asked, "Do you make more money than your spouse?" Fifty-one percent answered, "No"; 25 percent replied, "Yes"; and 24 percent said, "About the same." Of those nurses who make more money than their spouses almost one-third of these commented that their husbands were students in college (medical, dental, pharmacy included) or had just been drafted into the Armed Forces.

PROFESSIONAL PARTICIPATION AND ETHICS

Of the 150 respondents, only 30 percent stated they belonged to the Arkansas State Nurses' Association. The nurses were asked to evaluate the ethics and morals of their nursing colleagues. The following results were obtained:

Ethics	Percent
Superior	7
Above average	43
Average	48
Below average	2

Morals	Percent
Superior	6
Above average	21
Average	52
Below average	1

One respondent said, "I believe they have omitted the teaching of ethics in today's nursing programs."

The nurses rated themselves as to how they felt the community and physicians evaluated their profession in their area. The following tabulations show the results:

Community	Percent
With great respect	27
With respect	70
Poorly	1
Other (specify)	3

Physicians	Percent
With great respect	19
With respect	73
Poorly	6
Other (specify)	2

The "Other" remarks submitted in regard to how the community and physicians evaluated the nursing profession included the same remarks of "Indifferent" or "As a necessity."

The nurses were asked, "If given the opportunity, would you join a union to organize nurses?" Sixty percent of the nurses said "No"; 33 percent said "Yes"; and 7 percent said "Do not know."

The question, "Could you justify your position (ethically) to strike if it means unsatisfactory care for your patients?" was answered by 74 percent of the nurses saying

"No", 21 percent saying "Yes", and 5 percent being "Undecided." One nurse commented that she felt that her hospital was "more than meeting the demands of its nurses."

Another nurse commented,

> Nursing no longer seems to be a profession in our area--a job or position, perhaps. The number of people with the title of nurse is great, but few seem to carry out my idea of good nurses. Few people seem to care enough to put forth the effort to be effective members of a very necessary team--making an additional hardship on those who do. Far too many put in their eight hours doing as little as possible because the pay is the same. We are, indeed, fortunate to have those few who continue to learn and to practice good nursing techniques. They belong to nursing organizations, attend meetings, seminary and lectures. These people are in the minority, but are the ones who attempt to see that the patient gets the best possible care.

RACIAL DISCRIMINATION

The nurses generally revealed no problem in regard to working with persons of other races or taking care of patients of another race. The question was asked: "How do you feel about working with other races?" Seventy-two percent stated that it "Makes no difference"; 27 percent said they "Enjoy it"; and 1 percent said they "Do not like this." Another question was: "How do you feel about taking care of patients of other races?" Seventy-nine percent said "Makes no difference"; 20 percent said they "Enjoy it"; and 1 percent said, "Do not like this." The last question in this area was, "How do you feel about someone of another race being in a higher position than you on the nursing team?" Ninety

percent said "Makes no difference"; and 10 percent said, "Do not like this." To the question no one said, "Prefer this." After checking "Makes no difference," a few of the nurses added the remark, "Provided they are qualified." One nurse added the following comment to this question, "It never occurred to me." No one checked that she would quit her job because someone of another race was in a higher position than she was.

NURSING UNIFORMS

Sixty-nine percent of the respondents favored the wearing of white uniforms in the hospital or nursing homes. Seventeen percent felt the pastel uniforms should be used in some areas, particularly pediatrics, and 10 percent stated that washable or street dresses should be worn in particular areas. Ten percent of those who checked "White uniform" also added remarks consisting of the following:

> Wearing white makes me feel secure.
>
> The white uniform with the cap is traditional.
>
> The white uniforms are probably good for adults, but not necessarily so in caring for children.
>
> To the adult, it is a symbol of help and, hopefully, respect.
>
> To the child, it is a reminder of past pain or hospital fear.
>
> Waitresses, beauticians, maids also wear white uniforms--there should be a distinction since the average layman thinks anyone in a white uniform is a nurse.

Pastels should be worn in pediatrics.

White except in pediatrics and psychiatry.

Washable dresses should be worn in psychiatric nursing.

Street clothes of any fabric should be worn in psychiatry.

Nursing service administration should wear the dress suitable for the job.

One nurse stated:

> I checked pastel uniforms and white because I feel both are appropriate. In some areas, I believe, pastel would be better than white. And, I think, even washable dresses may be the answer for some nurses in certain situations.

Another nurse made a prediction: "I believe we will see many changes in the future, and I anticipate comfortable, attractive slack outfits in the hospitals."

The second question related to dress was, "Do you think nurses should wear the cap?" Seventy percent preferred this, 17 percent said it did not make any difference to them whether they wore one or not, and 13 percent stated they had rather not have to wear the nurse's cap. One nurse felt that the cap was "a symbol to layman, and we should wear it with dignity." Another nurse replied, "It only gets in the way."

DEATH AND THE DYING

The respondents were asked to check as many of certain instances in which they felt at ease in talking to patients and their families. The following results were tabulated:

Instances Related to Death and Illness	Percent
Loss of a limb or limbs	49
Death	41
Terminal illness	39
Death of a newborn	31

Nineteen percent of the respondents failed to check any of the instances in which they felt at ease in talking with the patient or the family. One nurse stated, "While I do not enjoy talking to patients or relatives about these things, I do not necessarily find it too difficult."

THE NEW GRADUATE NURSE

The respondents were asked to check the apparent deficiencies of the new graduate nurse as she comes into a beginning position of nursing. No stipulation was made as to the number of areas that could be checked. The following tabulations were made:

Deficiencies of New Graduate	Percent
Unable to assume expected responsibility	50
Hospital expects too much of new graduate	37
Lacks clinical experience	32
Lacks good judgment	30
Are not placed in beginning positions of nursing	23
Lacks theory background	7

Only one nurse respondent did not check any deficiency. One nurse added:

> The diploma graduate from the majority of schools lacks theory background, but not clinical experience.

> The four-year graduate sometimes has limited clinical experience, but she can obtain this on-the-job.

Another nurse responded, "The nurses graduating today should not be allowed on the wards because of a lack of experience."

Other comments made by nurses in response to the deficiencies of the new graduate included the following:

> Insecure.
>
> Afraid to work.
>
> Are led around by one hand every minute of their training and are not taught to think and act on their own.
>
> Need more responsibility as students.
>
> Have little bedside nursing and understanding of people.
>
> Diploma graduates are more qualified than degree graduates.
>
> Not enough faith in their ability.
>
> Lack of technical skills.

BEDSIDE NURSING

In reply to the question, "What do you feel about the new trend in nursing of getting the nurse back to the bedside?" Eighty-four percent said they would prefer this, 13 percent said it did not matter to them, and 3 percent said they would not like to return to bedside nursing. Several remarked that although they would like to return to bedside nursing, they felt this could not be done until the nursing shortage had been eliminated. The answer most often given by the 3 percent

who said they would not like this was that they felt they should supervise and evaluate patient care. One nurse commented that she felt that "Too many RN's don't know what real nursing is all about."

PART-TIME AND INACTIVE NURSES

Ten percent of the respondents are now part-time employees. Since the literature stated that the majority of the inactive nurses and part-time nurses are young married women with children, the writer wanted to find out how many of the presently employed Arkansas nurses worked while their children were small.

The question was asked: "Did you stop nursing full-time when your children were small?" Sixty-nine percent said "Yes"; and 31 percent said "No." The respondents were then asked, "Did you work part-time when your children were small?" Forty-six percent said "Yes"; and 54 percent said "No." Fifty percent of the nurses felt they were neglecting their children when they worked.

The nurses were asked: "Do you feel that nursing helped you to be a better parent?" Seventy-three percent said "Yes"; 11 percent said "No"; and 16 percent replied they could not tell that a nursing career had made that much difference in their ability to be a parent. One nurse said, "I worry more about my children because I am a nurse."

The following list indicates the person or agency responsible for the care of the children of the nurses who work full-time or part-time:

Person or Agency	Percent
Baby sitter	22
Husband	19
Relative	16
Day Care Center or Day Nursery at the hospital	11
Children old enough to care for themselves	10
Housekeeper	8
Maid	8
Neighbor	5
Nursery school	1

STAFFING

To the question, "Are you working in the area of your preference?" 81 percent checked "Yes"; 17 percent checked "No"; and 3 percent said "At times."

The question was asked: "What area of nursing do you prefer to work and why?" The following chart tabulates the results of the respondents' answers:

Area of Preference	Percent
Surgery	11
Medical-surgical	9
Psychiatric	9
General Duty	9
Pediatrics	8
Surgical	7
Medical	7
Intensive Care	5
Obstetrics	5
Teaching	5
Labor and delivery	4
Geriatrics	3
Emergency room	3

Area of Preference (continued)	Percent
Newborn nursery	3
Administration	2
Office	2
Rehabilitation	2
Orthopedic	2
Inservice education	2
Recovery room	2

The nurses who preferred to work in surgery included the following reasons:

The work was interesting.

No desk work.

Things move faster.

Challenging work.

I do not like bedside nursing.

I enjoy the team work found in the operating room.

I get week-ends off.

Get to work the 7-3 shift.

Is a different type of nursing.

Husband prefers I work these hours.

The nurses who preferred medical-surgical nursing gave the following reasons:

There is a variety of patients.

I can keep abreast of the latest drugs and changes in medical and surgical procedures.

I prefer to remain at the bedside rather than in an entirely administrative capacity.

I learn about many illnesses.

I am not confined to a specialty.

The work is challenging.

I enjoy working with these patients and being a part in helping them get well.

The nurses who preferred to work in psychiatric nursing stated the following:

The work is more interesting.

The staff is more relaxed and is able to give total patient care.

Mental illness is intriguing.

I feel comfortable in this area.

I feel there are many opportunities to use one's own ingenuity.

I do not just follow doctor's orders.

I like the searching, challenging and rewarding feelings from working in this area.

I feel the need of research and understanding in human relationships that I can give in this setting.

The 9 percent included in general duty nursing all areas of the hospital which afforded numerous aspects of nursing where there was close contact with the patients. Some of these stated it was not the particular area of the hospital for which they had a preference, but they preferred general duty because it "afforded them more direct patient care than that of the head nurse or supervisor.

The 9 percent who preferred pediatrics stated:

I like children best.

I can give more of myself to children than I can to adults.

I enjoy working with children.

I have to keep on my toes more than I would in other areas.

> I have to use imagination and creativity constantly.
>
> My personality lends itself to this field.
>
> The demands and duties of this area fulfilled my needs.
>
> The beginning of life needs a lot of tender, loving care.
>
> The experiences are more varied here.
>
> I liked to teach and work with the families as well as with the children.
>
> It is exciting.
>
> I receive more self-satisfaction working in this area.
>
> It is challenging.

The 7 percent who chose surgical nursing gave the following comments:

> The majority of patients operated on get well and go home.
>
> More progress and results of care given can be seen more quickly.
>
> Excellent opportunity is here for teaching.
>
> There is a rapid change of patients.
>
> The work is challenging and rewarding.

The 7 percent who said medical nursing was their area of preference commented:

> The cases were more interesting.
>
> The job had more satisfaction.
>
> There is a variety of diseases and methods of care with new medicines and treatments all the time.
>
> I feel that I get to know the patients as individuals better and can do more actual bedside nursing.

The 5 percent who chose the intensive care unit as their preferred choice remarked:

It was most satisfying.

I feel I am needed.

It is very challenging.

I like the actual contact with the patient.

I get to work with all kinds of people and problems.

I feel good knowing I can help seriously and critically ill persons.

Obstetrics was chosen by 5 percent of the respondents as their preferred choice. Some reasons listed included:

It is a very happy place to work.

It usually concerns life and not death.

It presents a new challenge every day.

The 4 percent who preferred labor and delivery said:

This is one area where you have much contact with the patients.

I enjoy communicating with the patient and her family.

It is rarely a place with sad experiences.

I feel a sense of accomplishment in this area.

The patient has something to show for her pain.

The 3 percent who listed geriatrics as their choice area stated:

This is a very rewarding place to work.

I feel the last of life needs tender, loving care.

I prefer this area because it seems to be the most neglected.

I feel our senior citizens deserve more than they receive.

The area offers challenges in helping elderly patients improve.

This fulfills my desire to help someone who really needs me.

The 5 percent preferred the area of teaching because:

I enjoy teaching.

I feel that teachers have more professional respect and better working conditions.

I receive stimulation and increased knowledge and personal growth.

I enjoy working with young people.

I like to study.

I have a better working schedule.

The reason given by the 3 percent who preferred the emergency room was that there was "something new and different all the time."

The 3 percent who preferred the newborn nursery stated that they "liked small babies; it was challenging, and a happy place to work."

The 2 percent who listed administration as their choice gave no reasons for their preference.

The 2 percent who preferred office nursing listed the following reasons:

It is given more professional respect by the public.

It offers better working conditions and hours.

It presents a more challenging and enjoyable work.

The 2 percent who listed rehabilitation nursing as their preference stated it was most satisfying "to teach and aid patients to be independent to their fullest capacities."

The 2 percent who preferred orthopedic nursing gave the reason that it was "very interesting."

The 2 percent who preferred recovery room work stated they enjoyed working with a "variety of patients."

The 2 percent who preferred inservice education felt that the work was "challenging and different from day to day."

The respondents were asked to check three aspects of nursing they disliked the most. The following list with the percent indicates those aspects of nursing most disliked by the nurses:

Most Disliked Aspects of Nursing	Percent
Shift work	54
Desk work	53
Working week-ends	50
Charting	30
Salary	27
Attitude of doctors toward nurses	13
Supervising	10
Bedside nursing	1
Other (specify)	15

Of the 15 percent who marked "Other", the respondents specified certain disliked aspects of nursing:

A lack of qualified help.

Too much red tape before one can do things for patients.

Too many nurses as supervisors and not enough to give patient care.

Poor nursing service attitudes.

Unqualified people in supervisory positions.

Time spent in unnecessary meetings.

Lack of staff interest.

Call duty.

Lack of recognition and understanding.

No time for family.

Lack of proper orientation of new nurses to the hospital.

Insecurity (not knowing where the nurse with the diploma will fit in).

COMMUNITY ACTIVITIES

The respondents were asked to check those community activities in which they actively participate. The results are listed below:

Activities In Which Nurses Participate	Percent
Church	73
Sunday school or ladies organization of the church	35
Professional organization	30
Teach Sunday school class	13
P.T.A.	13
Bridge club	8
Serves as a leader for a children's organization (a church or civic group as scouts)	7
Music club	5
Garden club	4
Political organization	4
Other (specify)	20
None	4

Less than 2 percent of the respondents stated participation in any of the following organizations as the Business and Professional Women's Club, TOPS, AORN, Jaycettes, Audubon

Society, church choir, Medical Dames, Newcomers, Ladies Medical Auxiliary, Great Decisions Group, Faculty Wives, Hospital Auxiliary, Beta Sigma Phi Sorority, Vista, skiing club, Engineers Wives, Women's Club, and high school alumni association.

One of the nurses who failed to mark any activities remarked, "Are you kidding?" Another nurse replied: "I work from 2:30 p.m. to 11 p.m. and don't have time to participate." Another remarked: "I am going to school at night and cannot participate in community activities." Several nurses who worked irregular hours felt that with a family any active participation "was too much."

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

The problem of this study was to discover certain sociological perceptions of nurses in Pulaski County, Arkansas in regard to their profession. The questionnaire was submitted to a sampling of 250 registered nurses currently working full-time or part-time in a hospital or nursing home. One hundred and fifty nurses replied to the questionnaire.

CONCLUSIONS

Eighty-six percent of the nurses completed their professional work from a diploma school. Eighty-eight percent of the nurses felt the need for more education and knew specifically what course or courses they would take if they could go to college.

As a group, the nurses either did not know enough about the new two-year college program to feel it would be beneficial, or they were opposed to the program. Those in opposition to the program were the most verbal in their disapproval.

The nurses felt overwhelmingly that they were happy that they chose nursing as a profession. From a review of the literature, one saw that the reasons given by the respondents for going into nursing were similar to those found in other studies.

Of the 150 respondents to the questionnaire only one was a male nurse. He felt a lack of acceptance from women in nursing, and felt he was discriminated against by some of the nurses because of his sex. The salary of almost 50 percent of the nurse respondents was below the 1966 salary scale of $6,500 set up by the American Nurses' Association. The new salary goal adopted in May, 1968, with $7,500 as a starting salary for beginning nurses with a diploma or associate degree and $8,500 as a beginning salary for a nurse with a bachelor's degree in nursing, indicated that presently only about 26 percent of the Arkansas nurses questioned have reached just the beginning salary goal after many years of service. Already 27 percent of the Arkansas nurses stated disapproval of their salaries before the new salary goals were established.

Although 35 percent of the nurses had more education than their spouses and 30 percent stated their education and their husband's were about the same, 51 percent of the nurses stated that their husband's salary was greater than theirs. Of the 25 percent who said their salaries were greater than their husband's, about one-third mentioned that their husbands were in school or had just been drafted.

The Arkansas nurses felt their colleagues' ethics and morals were average or above average, and the community and the physicians with whom they worked looked upon the nursing profession with respect.

The majority of the respondents were not interested in joining a union; yet only 30 percent of these belonged to their professional organization. In May, 1968, at the American Nurses' Association Convention, the no strike policy was repealed, and a resolution was adopted to leave action up to the state associations. According to the respondents from Arkansas, 74 percent would not strike if they felt it meant unsatisfactory care for their patients.

From this study, apparently little if any friction was noted in regard to racial discrimination among workers in the nursing profession and in the treatment of patients of different races.

A definite indication was present that nurses needed more help and understanding in caring for the dying patient and in offering support to the families. Indications were found in the literature that this was too-much overlooked in the basic nursing program; throughout her professional career, the nurse has the tendency to stay away from the dying patient and his family instead of offering the support and help the patient and his family need so desperately.

The new graduate's greatest deficiency was considered to be a lack of clinical experience. Other deficiencies, such as being unable to assume expected responsibility and lacking good judgment, stemmed from the new nurse's not having the needed clinical experience. The other two additional deficiencies (the new nurse's not being placed in beginning

positions of nursing and the hospital's expecting too much of the new graduate) were caused by the unwritten policies of the hospital administration or nursing service administration to meet shortages in professional nursing. A review of the literature indicated that the Oregon State Nurses' Association had made progress in trying to solve this problem by requiring a residency program for the new nurse and the inactive nurse who wanted to return to part-time or full-time nursing. The nurses progressed at their own speed through the three-steps of junior, intermediate and senior residency. Salary increments depended upon ability, performance and continued professional growth by the nurse in the residency program.

An overwhelming majority of the nurses in Arkansas responded that they would prefer to do bedside nursing and would like to return to it. At the present, a nurse progresses economically in the hospital by becoming a head nurse, supervisor, assistant director and director. Until it becomes economically reasonable for nurses to remain at the bedside, little change will be seen in the number returning as clinical nurses.

Several findings about part-time and inactive Arkansas nurses were evident. One-tenth of the respondents were part-time nurses. Sixty-nine percent stopped working full-time when their children were small. Forty-six percent worked part-time when their children were small. Half of the group

felt they were neglecting their children when they worked. Home responsibilities created in the rearing of children, the inability to secure proper care for the children if she worked, her husband's not wanting her to work, and salary were the four main reasons given for nurses becoming inactive in the field.

In regard to staffing, 81 percent of the nurses stated they were working in the area of their preference; 3 percent more stated that they were able to work in their area of preference part of the time. A wide variety of preferences was present among the nurses indicating that area staffing was not a problem as was staffing for various shifts or for week-ends. For every preferred area mentioned, the nurses felt that that particular area was the most challenging or interesting to them.

Shift work and week-end work caused major problems. Fifty-four percent of the nurses disliked shift work, and 50 percent disliked working week-ends. Twenty-one percent of the nurses admitted they would quit or had quit work at one time because of shift work, having to work on week-ends, or poor salary. The literature revealed that the staffing of night shifts, evening shifts and week-ends was a major difficulty confronting nursing administrators. Part-time workers have helped, but nursing administrators have problems in using part-time workers so that full-time employees do not feel they have to work the unpopular shifts or the

week-ends most of the time. Part-time help had increased the need for and the lengthening of orientation programs, in-service education, and refresher courses for both part-time and full-time personnel.

More cooperation with the medical staff in reorganization of nursing care helped to cut down orders for medications and treatments on the night shift, and this eliminated the need for some nursing personnel. Allowing nurses to remain on one shift was suggested by the literature, and was found to help nurses manage their home responsibilities better. Since 7-3 is the popular shift, as much as possible should be done with more professional staff being employed for this shift. The 3-11 and 11-7 shifts could be handled by having fewer professional persons, by using more part-time help on these shifts or on the week-ends, and by securing nurses who prefer to work these hours. Additional increments should be great enough to encourage more nurses to want to work evenings and nights.

Desk work and charting were disliked by the Arkansas nurses. Fifty-three percent did not like the amount of desk work they had to perform as nurses, and 30 percent disliked the time they had to spend in charting. The use of unit or ward managers, unit secretaries, and the beginning use of computers appear to be the partial answer to relief of the nurse from non-nursing duties.

Of the respondents, 73 percent attend church. Thirty-five percent belong to a Sunday school class or ladies organization of the church. Thirty percent belong to the Arkansas State Nurses' Association. Thirteen percent belong to the P.T.A. and 13 percent teach a Sunday school class. The participation of nurses in other community activities is insignificant.

RECOMMENDATIONS

The findings in this study suggested some recommendations for the Arkansas State Nurses' Association and the Arkansas League for Nursing in improving the recruitment of students into nursing and creating better working conditions so that more will remain in nursing.

1. The nursing shortage will not be solved either by closing hospital schools or by blocking the modern trend toward higher education. Modern nursing needs both hospital schools and colleges. Hospital schools of nursing must be constantly improving their programs. Until the nursing profession competes successfully with other careers that demand college education, the hospital schools of nursing will be much in demand. The main problems forcing hospital schools to close are rising costs, inability to recruit applicants or qualified faculty, and the schools' inability to meet accreditation standards.

2. Nurses as individuals and nursing organizations must become more actively involved in the recruitment of high school students for a career in nursing. The elusive male and the socially and economically deprived persons of all races must be actively sought. Planned, on-going remedial programs must be initiated to prepare the culturally deprived persons for acceptance into nursing programs. Economic guarantees with occupational acceptance for males would bring more men into nursing programs.

3. The continuing demand for more and better health care means that nursing as a profession must be economically and professionally attractive enough to recruit and retain competent practitioners.

4. Nursing requires much planning to develop the stability of membership desired for its profession. Schools of nursing must place more emphasis on its professional organization, and the Arkansas State Nurses' Association should capitalize on the new graduates' enthusiasm by involving them immediately with their organization when their enthusiasm is at its height.

5. The Arkansas State Nurses' Association must become more verbal in its demands for better salaries for nurses. Many of the nurses are not now receiving the 1966 salary goal for the beginning practitioner as set up by the American Nurses' Association. If Arkansas wishes to keep qualified nurses it cannot lag behind any longer in trying to achieve

the new salary goals. The new salary goal should help to alleviate some of the inequities in salaries of nurses who have more education than their husbands but have been receiving lower salaries.

6. The clinical (bedside) nurse will be seen in substantial numbers when it has been made economically desirable for the nurse to remain at the bedside.

7. Arkansas student nurses need more basic teaching, discussion, and thinking about the formation of their philosophy of life and death and care for the dying, so they can give the support needed to the patient and his family. For nurses already involved in hospital or nursing home care, inservice programs should include this phase of nursing to help the nurses improve their abilities in caring for the dying patient and offer support to the families of the patient. The district and league meetings should focus more attention on programs to help nurses come to grips with this problem they often face in their daily professional life.

8. Partial fringe benefits should be set up for part-time nurses who work at least half-time.

9. Part-time nurses should be used more on the 3-11 and 11-7 shifts as feasible, and 7-3 part-time nurses should be expected to work every other week-end or a Saturday or Sunday of each week. These innovations should improve the morale of the full-time nurses.

10. Refresher courses should be sponsored by the district Nurses' Association twice a year to recruit the inactive nurse back into nursing.

11. During the latter part of the senior year, more opportunities should be offered seniors to spend eight hours on the 3-11 and 11-7 shifts. These students need to become familiar with the duties of these shifts so they will feel more confident when placed on these shifts after graduation.

12. Increments for working the 3-11 and 11-7 shifts and working any of the week-end shifts should be great enough that the nurses will not object to these hours or days.

13. Unit managers and ward clerks should assume the greater part of clerical duties and desk work. Non-professionals can assume a delegated portion of the charting for which they have been responsible for carrying out in the specific care of the patient.

14. Nurses must become more active participants in community activities, especially in their own professional organization. Community support manifests itself when nurses themselves stimulate it. One of the best means of stimulating interest in nursing is by individual nurses giving of themselves to community activities.

15. Much emphasis should be given to continuing education for practitioners and to the use of more modern

teaching methods, such as closed circuit television and programed learning.

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APPENDIXES

APPENDIX A

2304 Burma Hills Drive
Mobile, Alabama 36609
March 1, 1968

Dear Registered Nurse of Pulaski County:

The enclosed questionnaire is being sent to you with the request that you take a few moments to complete it and return to me as soon as possible.

I am doing a study entitled "Certain Sociological Perceptions of Nurses in Pulaski County, Arkansas," and I have chosen a sampling of 250 Registered Nurses in your county who are either employed in hospitals or nursing homes. While living in Arkadelphia, Arkansas for several years I completed my course work for my Master's at Ouachita Baptist University, and this questionnaire will be the main area for my thesis. I am very interested in nursing and if the questions asked on the questionnaire are answered by you then I can find out the thinking of the nurses in your county.

All of the questions may be answered by a check in the appropriate blank except for three questions which require short answers. If at any time you wish to add further information or a remark about a question or your answer, just list the number of the question on a blank area of the same page, write by the question, or use additional paper.

Your name or address is not needed, as your identity remains anonymous. I do hope that you will take the time to fill out this questionnaire and return it in the enclosed stamped envelope. Your interest and help will be greatly appreciated.

I feel sure that the findings will be of interest to you, and I plan to share this information with the nurses in Arkansas.

Sincerely,

(Mrs.) Mary Ann Todd, R.N.

APPENDIX B

QUESTIONNAIRE

I. Please give the following information by checking or circling the proper blank or number:

A. Age

Under 21 ___
21-30 ___
31-40 ___
41-50 ___
51-60 ___
61-65 ___
Over 65 ___

B. Salary

Less than $4,000 ___
$4,000 to $5,000 ___
$5,000 to $6,000 ___
$6,000 to $7,000 ___
$7,000 to $8,000 ___
$8,000 to $9,000 ___
Above $10,000 ___

C. Marital Status

Single ___
Married ___
Separated ___
Divorced ___
Widow ___

D. Religion

Protestant ___
Catholic ___
Jehovah Witnesses ___
Judaism ___
Mormon ___
Other (Specify) ___

E. Number of Children (Circle)

0 1 2 3 4 5

If more, specify number ___

F. School of Nursing Attended

Diploma ___
Associate Degree ___
Bachelor of Nursing ___
Master's in a nursing field ___

G. College (other than nursing)

Less than 2 years ___
Three years ___
Bachelor's degree ___
Master's degree ___
Doctorate ___

H. Number of Years in Nursing

Less than 1 year ___
1-4 years ___
5-10 years ___
11-17 years ___
18-25 years ___
Over 25 years ___

I. Position Presently Held

Administrator ___
Supervisor ___
Inservice Education ___
Coordinator ___
Instructor ___
Head Nurse ___
Staff Nurse ___
Private Duty Nurse ___
Other (Specify) ___

II. Complete the following blanks: (use back of sheet or blank paper if additional writing is needed).

A. Why did you decide to become a nurse? ______________

____

B. Are you glad that you became a nurse? Yes ___ No ___

C. What area of nursing do you prefer to work in and why? ______________________________

____

D. Are you working in this area? Yes ___ No ___

E. If you had the opportunity to take more college courses, name the first three areas or specific courses in which you feel you need more education.

(1) ________________ (2) ________________

(3) ________________

III. Check the appropriate blank:

A. How does your community evaluate the nursing profession?

With great respect ___
With respect ___
Poorly ___
Other (specify) ___

B. How do the physicians evaluate the nursing profession?

With great respect ___
With respect ___
Poorly ___
Other (specify) ___

C. How do you evaluate the ethics of your nursing colleagues?

Superior ___
Above average ___
Average ___
Below average ___

D. How do you evaluate the morals of your nursing colleagues?

Superior ___
Above average ___
Average ___
Below average ___

E. How do you feel about working with other races?

Enjoy it ___
Makes no difference ___
Do not like this ___

F. How do you feel about taking care of patients of other races?

Enjoy it ___
Makes no difference ___
Do not like this ___

G. How do you feel about some of another race being in a higher position than you on the nursing team?

Prefer this ____
Makes no difference ____
Do not like this ____
Would quit my job ____

H. How do you feel about nurses wearing uniforms other than the traditional white?

Should wear white ____
Should wear pastel uniforms ____
Should wear washable dresses ____
Other (specify) ____

I. How do you feel about the new two-year college program in nursing?

Very good ____
Do not know ____
Opposed to it ____

J. Do you think the new two-year college program will be effective in meeting the nursing shortage?

Yes ____
No ____
Do not know ____

K. Do you think nurses should wear a cap?

Prefer this ____
Makes no difference ____
Rather not wear one ____

L. If given the opportunity, would you join a union to organize nurses?

Yes ____
No ____
Do not know ____

M. Could you justify your position (ethically) to strike if it meant unsatisfactory care for your patient?

Yes ____
No ____

N. Check the following instances in which you feel at ease in talking to patients and their families.

Death ____
Terminal illness ____
Death of a newborn ____

A. What are the apparent deficiencies of the new RN graduate as they come into beginning positions of nursing?

Lack clinical experience ____
Lack theory background ____
Lack good judgment ____
Unable to assume responsibility expected ____
Hospitals expect too much of new graduate ____
Are not placed in beginning positions of nursing ____
Other (specify) ____

B. What keeps you in nursing?

Job satisfaction ____
Salary ____
Have to work ____
Nursing shortage ____
Other (specify) ____

C. How do you feel about the new trends in nursing of getting the RN back to the bedside?

Would prefer this ___
Does not matter ___
Would not like this ___

D. Check three of the following aspects of nursing you dislike most:

Working week-ends ___
Shift work ___
Salary ___
Charting ___
Desk work ___
Bedside nursing ___
Supervising ___
Attitude of doctors toward nurses ___
Other (specify) ___

E. Would you ever or have you ever quit nursing for any of the reasons listed in D?

Yes ___ No ___
If, yes, which reason ___

V. If you are married (or have ever been married), please complete the following:

A. Do you make more money than your husband? Yes ___ No ___ About the same ___.

B. How does your husband feel about your working?
Approves _____ Disapproves _____ Makes no difference ____

C. How does your educational background compare to that of your husband's?
His education is less _____
His education is greater _____
Both have about the same educational background _____
(this means no more than one year's difference)

VI. If you have children please fill out the following:

A. Did you stop nursing when your children were small?
Yes _____ No _____ Worked part-time _____

B. Did you or do you feel you were neglecting your children when you worked? Yes _____ No _____

C. Do you feel that nursing helped you to be a better mother? Yes _____ No _____ Could not tell that much difference _____

D. Who kept your children when you worked?

Relative ____
Husband ____
Housekeeper ____
Maid ____
Neighbor ____
Baby Sitter ____
Children old enough to stay by themselves ____
Other (specify) ____

VII. Check the following activities in which you actively participate in your community.

Church	___	Garden club	___
Sunday school or ladies organization of the church	___	Bridge club	___
Teach Sunday school class	___	Literary club	___
Serve as leader for a children's organization (church or civic group as scouts)	___	Music club	___
Professional organization	___	P.T.A.	___
Political organization	___	Other (specify)	___
B & PW or Pilot Club	___		

Additional Comments: