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AN APPLIED ANTHROPOLOGICAL STUDY
OF ROLE BEHAVIOR OF NURSES

AN APPLIED ANTHROPOLOGICAL STUDY
OF ROLE BEHAVIOR WITHIN THE
PROFESSION OF NURSING WITHIN THE
COMPLEX INSTITUTION OF THE HOSPITAL

By

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ABSTRACT

An examination of values and behavior of nurses within the institutional bureaucracy of a hospital is the subject matter of this thesis. In this study the structural characteristics of health provisioning in the hospital environment restrict the development of a unified body of nurse professionals, and these realities generate conflict between the value interests of nurses and those of the hospital. Conflict examined here refers specifically to the disparities between belief and action, and were analyzed by utilizing the distinctions drawn between cultural and social elements of life developed by the anthropologist Geertz.

An ethnographic study with the use of a questionnaire developed from the anthropological political role behavioral concepts of middleman, patron, and entrepreneur to investigate attitudes and beliefs about nursing behavior suggests that a critical paradox is emerging between the behavioral expression of nurses and professed institutional ideologies. Traditionally, the nursing profession has been oriented toward "otherness," that is, the interests of the patient and the physician stood above those of the nurse. The bureaucracy, with institutional goals, and the relative powerlessness of nurses vis-à-vis physicians, prevents the development and implementation of their own caring model of service. The fact that nursing models of care are being thwarted by organizational and physician interests creates stress

for the majority of nurses.

One major outcome of stress is that nurses are now beginning to alter their professional role behavior. The old value system is now being challenged by a younger generation of nurses, who see themselves as professionals seeking personal advancement and gain within the conditions of the hospital.

From an applied anthropological perspective, the ethnographic data were generated into a research hypothesis and questions related to value conflict and social behavior. A list of recommendations for change within nursing and the institutional bureaucracy is suggested.

Dedicated to
Donna Lianne Marie Mitchell
my friend, and support

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*Pseudonym: St. Francis' Hospital will be used throughout this study.

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CHAPTER I

INTRODUCTION

...The shapes of change
ai ai they take their time

asking what the dawn asks
giving the answers evening gives
till tomorrow moves in
saying to man the moon shooter,
"Now I am here--now read me--
give me a name,"

Carl Sandburg, "Man the Moon Shooter"

Anthropology is the study of human beings and its largest sub-field, cultural anthropology, is concerned with cultures human beings have created. The working definition of culture in this thesis is the acquired knowledge that people use to interpret experience and to generate social behavior (Goodenough 1975:5). The following study deals with the way in which nurses behave and with what they believe about their work within one complex institution where the delivery of health care services takes place within the greater cultural entity of Canada.

Transcultural Nursing

The development of the interrelationship between the fields of nursing and anthropology has been largely due to the efforts of Madeleine Leininger, the first nurse-anthropologist. Leininger (1977a:6) has described the new field as "transcultural nursing" which is:

the study of cultural differences and similarities regarding the caring components of nursing practices, but with the emphases upon the systematic comparative study of values, beliefs, and patterns of caring behaviors.

The concept of care and caring behavior is, therefore, an important aspect of transcultural studies relating to health care. Most studies in the subfield of medical anthropology have been concerned with curative aspects, and they have generally been interpreted from a medical (disease-illness) orientation both in Western and non-Western cultures. Transcultural health care is more all encompassing, in the sense that it suggests study and work by all health disciplines--their roles, functions, and activities in different contexts (Leininger 1975:5).

This study will focus primarily on the roles, functions, and activities of nurses; however, other health care professionals will of necessity enter into the study.

Purpose of the Study

Though anthropologists have been describing, analyzing, and interpreting cultures throughout the history of the discipline, nursing has, only recently, been examined as a cultural subset. From theoretical and research perspectives, its central focus, "caring," is now receiving explicit attention. Nurses and other health care professionals, as well as health care institutions, have been studied extensively by behavioral and social scientists. However, only in the past decade have nurses begun to study the components of nursing, seeking to bring forth the dimensions of care and caring behaviors exhibited by nurses themselves.

The purpose of this study is the exploration of nurse role

behavior within one institution. In the process of organizational socialization, the implications for nurses and their patients have important theoretical questions in terms of political-bureaucratic goals versus professional "caring" values and behaviors.

Objectives of the Study

A number of objectives were developed to guide the investigator during the course of the research development. As an integrative discipline, nursing has adapted and combined knowledge from many fields of study in its attempt to understand the health and role behavior of individuals to improve the practice of nursing. Anthropology continues to gain insights about human behavior drawn from all parts of the world through a long span of time. As such, anthropology may be considered the most integrative discipline of all the social sciences. Nursing is, also, an integrative discipline and shares knowledge from various fields while developing its own science. Anthropology has and is having a definite impact upon the theoretical developments of nursing to effect growth and change in the "practice" arena. Thus, the first objective in this study was the use of anthropological and social science research methods (interviewing techniques, participant observation, and a questionnaire) to gain insights into nursing values and behaviors.

"Applied Anthropology" provided an important function in this investigation. Included were the notions of the theoretical components and the production of practical data in the form of information, ideas, knowledge, understanding, and hypothesis formation for the purposes of

their contribution to the solution of problems of interest and concern to professional bodies and organizations. Foster (1976:29) explains that "applied anthropology" is a phrase commonly used by anthropologists to describe professional activities in programs that have as primary goals changes in human behavior believed to assist in the amelioration of contemporary social, economic, and technological problems, rather than the development of social and cultural theory. However, theories may, incidentally, develop from the research itself.

At the outset of this study specific objectives were chosen over a particular theory, or conceptual framework, as the guide to data collection. Schatzman and Strauss (1973:12) indicate that without specific theory as a guide, the researcher may relinquish some measure of control over the inquiry, but probably will make the relation to it more flexible and, hopefully, thereby generate new theory. Moving toward problem solving goals was one of the functions of this research, but the theory advanced by the anthropologist, Geertz, provided a direction in the analysis of the distinctions made between social and cultural elements of life and the social behavior of nurses.

Concepts described in political anthropology, specifically those related to role characteristics of middleman, patron, and entrepreneur (see Appendix A) facilitated development of the questionnaire designed to unfold knowledge about nurses' attitudes and values regarding professional role behavior.

The second of the major objectives was related to the impact of the structural characteristics of complex organizations on nursing values and the consequences for nursing practice. The third objective

was directed at the development of awareness of the cultural norms, some rituals and myths of nursing practice which influence, positively or negatively, the caring process of nursing. Leininger (1970) has perceived and described nursing as a culture by examining the values, beliefs, and ritual practices of nurses. She has illuminated the myths which have been perpetuated by nurses themselves, by bureaucratic structures where "practice" takes place, and by the power and authority vested in members of the medical profession. These ideas, incorporated into the analysis of the results, served as a foundation in the formulation of a research hypothesis, and questions arising out of the research itself.

Objective four was designed to elicit information leading to an understanding of the inter-intra-professional decision-making patterns. In terms of the group interaction, the notion of political role behavior was reinforced within the complex organization. Characteristics regarding the power base structure within the bureaucracy and the inter-hierarchical occupational groupings led to ways in which ideologies were introduced, transmitted, and/or maintained. As an example, and to be discussed in detail later, is the relationship between physicians and nurses with the resultant "powerlessness" of nurses in the development of new models of "care."

The fifth objective was to gain insight into the fundamental link between anthropology and nursing. The scope of the problems of this study addressed one central, recurrent theme. A critical paradox and implicit contradiction is emerging between the day-to-day behavioral expression, nurses' values and attitudes, and institutional

ideologies. Disparities and philosophical inconsistencies between belief and action created a number of problems for the nurses in the role of care-provider and for their primary responsibility--the care-recipients.

The problem identified and examined in this study was conflict within the context of political/organizational goal formation, cultural and institutional ideologies, and the consequential effects on professional nurse values and the delivery of health care itself.

From the interpretive analysis of this study, potential resolutions to the conflicting values and behavior are presented later in the thesis in the form of recommendations for change. Group interaction was discussed as an avenue to facilitate the implementation of the planned change.

A critical aspect of the study was stress. As a result of the stress, nurses were beginning to alter their professional role behavior. The old value system related to "otherness," that is, the interests of the patient and the physician, was now being challenged by a younger generation of nurses who see themselves as professionals seeking personal advancement and gain within the conditions of the hospital. This raises a number of questions in terms of the constitution of care itself. If nurses are no longer willing to engage in patterns of self-denial or extended, personalized care, what goals are realistic for the nurses? What models of care are imperative to meet the health needs of patients and the personal needs of care-givers in the social context of the hospital environment today?

Background Information

In carrying out a study of role behavior within an industrial city in Ontario, Canada, a knowledge of some of the highly specialized notions and concepts within the profession of nursing and the prevailing Canadian health care system is necessary. Additional information regarding specific glossary and other supportive data used within the context of this thesis appear in the appendices and will be so stated when indicated.

The Canadian Health Care System

The National Health Insurance Program in Canada is based upon the established policy that every citizen has the right to adequate health care and it is the government's responsibility to assure that right. The four basic principles of the program are: universal coverage, comprehensive benefits, portability of benefits, and public administration and accountability (Andreopoulous 1975:xxi).

The Canadian personal health care system has been successful particularly in the treatment of disease. Canadians are prepared to spend a large portion of their national income on personal health care services (Lalonde 1974:65). The Government of Canada, as set forth by the Ministry of Health (Lalonde 1974:11-67), has as its intention the maintenance of a high level of services and support provided through its present activities in health protection, research, and the financing of personal health care. To these will be added specific measures directed at the reduction of particular national health problems such as social-stress conditions leading to deaths from suicide and accidents; environ-

mental-ecological conditions leading to increased incidences of cancer and other diseases; social and cultural conditions leading to chronic diseases and social alienation problems of the aged. The two broad objectives proposed by Lalonde (1974:66) are:

1. to reduce mental and physical health hazards to populations of Canadians at risk
2. to improve the accessibility of good mental and physical health care for those whose present access to care is unsatisfactory.

The "health field concept" has evolved as the new scientific and research approach to fulfilling the goals listed above. Lalonde (1974:55) has described four categories for health research by which answers to health problems will be sought. They are:

1. human biology
2. environment
3. lifestyle
4. health care organization

In providing universal coverage, the health care system is a human concern rather than purely an organizational concern. The purpose of the program is to remove barriers to health care. Canadians now take for granted that illness should no longer be associated with fears of destitution. The National Health Insurance Program has improved access to protection against financial catastrophe (Marmor 1975:243).

The ideas presented here provide background data for the understanding of a number of the problems raised in this study relative to health versus medical care; medical models (disease-illness) of care versus nursing care; cure versus care; care versus caring; organizational systems, such as active treatment hospitals versus aged-chronic care institutions.

Regulating Organizations in Nursing

Since nurses are primarily employed in hospitals, economic control is largely under the direction of hospital administrators, the Ministry of Health budgetary appropriations, economists, and/or physician directors. Management of nursing services is controlled by Directors of Nursing who are responsible to hospital administrators. Nursing supervisors or coordinators and head nurses, also a part of the nursing management staff, are responsible to the Director of Nursing (see Appendix B, Nursing Organization Chart). Nurses in direct care to the patients function in the roles of team leader, charge nurse, and/or staff nurse and, though responsible to the Director of Nursing, are union members.

In October of 1973, the Ontario Nurses' Association (the nurses' union) which evolved from the Registered Nurses' Association of Ontario (the professional organization), as the bargaining agent, was certified through the use of successor rights to bargain for nurses (Ontario Nurses' Association 1977). From that time until the present, collective agreements between hospital administrators and staff nurses have been directed toward the improvement of salaries. Working conditions, although imperative, have received some attention, but references to quality nursing care are still in the process of discussion and negotiation. Arbitration procedures and processes regarding factors about the quality of care will be a major consideration and step toward the control nurses would have over their professional commitments and practices within bureaucratic structures.

The Health Disciplines Act of Ontario (1974) which is composed

of rules regulating the disciplines of nursing, medicine, dentistry, optometry, and pharmacy ensures that the activities of health disciplines are effectively regulated and coordinated in the public interest. Each discipline has a regulating body; for example, in nursing it is the College of Nurses of Ontario. Standards of practice are to be maintained. The Colleges ensure that the rights of individuals to the services provided by health disciplines of their choice are also maintained. In nursing, an annual Certificate of Competence is issued upon knowledge of professional conduct within the standards developed by the College of Nurses of Ontario. A set monetary fee is required. In addition, in the near future, proof regarding numbers of hours engaged in nursing practice and continuing education will be necessary prerequisites for annual licensure. One of the objectives of each group within the Colleges is the establishment, maintenance, and development of standards of knowledge and skill (The Health Disciplines Act, Government of Ontario 1974:1-11).

Information Contributing to the Development of the Study

Hospitals

Most studies of hospitals have been conducted in psychiatric institutions from sociological perspectives. Emphases on a variety of points of view including social organization, managerial control, processes, systems, human resources, economic considerations, professionals (nurses and physicians), and patients and patient care have been recorded in the literature (Mauksch 1973:817-830). Strauss and his associates (1964) provided a framework called "negotiated order" for

understanding and conceptualizing the hospital as a functioning organization. Interaction in the hospital involved negotiation between occupants of positions, work roles, and between subgroups within the hospital system. The overall research model for other sociological studies has been adapted and modified from the work of Strauss, et al.

Few studies have examined the hospital as a cultural entity. Byerly (1970) conducted research in a general hospital in the United States where she studied registered nurse role behavior by means of a "systems" approach. She concluded that the social and cultural variables in organizational functioning were frequently overlooked by social scientists. Her conclusions provided a knowledge of the variables, insights into nursing problems, and recommendations for change, thus giving rise to the need for more specific research studies for the improvement of nursing practice.

Leininger (1970) has described nursing in terms of the "old" and the "new" cultures based upon the changes in the education of nurses from hospital schools of nursing to university education systems. She has elucidated ideas about authoritarian and democratic leadership styles of nurses and physicians, and the social organization of hospitals. A primary feature of Leininger's work was the conceptual schema for understanding the relationship between the disciplines of anthropology and nursing, and how each field can contribute to the growth and development of the other.

Medical Anthropology

In terms of the anthropology of health and illness, Dunn (1976: 137) has expressed the fact that ninety-five percent of the ethnographic

literature on health-enhancing behavior and on the values and beliefs that understand such behavior is concerned with curing. Within the concept of "medical" anthropology, theoretical orientations have been discussed and advanced as empirical generalizations (Wellin 1978:38-39).

They are:

1. the universality of disease as a part of the human condition
2. the fact that all human groups develop methods and roles for coping with disease, and
3. the fact that all human groups develop beliefs and perceptions for cognizing disease

The last two statements recognize the social and cultural dimensions; however, the theoretical postulations support a "medical" (disease-illness) position rather than a total health care (health prevention, promotion, maintenance) model.

A Model of "Caring"

The wider conceptual framework which reaches beyond the "curing" focus of medical models is that of nursing which is based upon "caring." Leininger (1977:2 & 14) conducted research of seventeen cultures and has developed constructs relating to "caring" phenomena. They include comfort/support measures, compassion/empathy acts, coping assistance, stress alleviation, nurturant/succorance acts, surveillance measures, and health instructive acts and maintenance assistance. These cross-cultural "caring" constructs have been described as the behaviors which comprise the model of ethnonursing within the transcultural nursing framework.

Nursing and Political Behavior

An examination of political behavior in nursing has been largely

confined to leadership and leadership styles. Currently, there is an emphasis on power, authority, and influence from research and educational perspectives. Claus and Bailey (1977) have described a new approach to leadership by the development of personal and organizational power bases and how its translation into influence can alter the system of health care in bureaucracies.

Leininger (1974:28-34) has analyzed subordination and servitude as cultural images of the female nurses in the society. She suggested that nursing administrators and leaders need to become politically astute and learn to select different power strategies to solve administrative problems in nursing. In another publication on health care practices, Leininger (1975:83-94) has pointed to the fact that, from an anthropological perspective, few cultures in the world have been so tightly regulated and socially sanctioned by one group--the physicians, who control and dominate all aspects of the field of health care.

Deloughery and Gebbie (1973) have examined many factors of the governmental political dynamics in terms of nursing. They described problems of the political system of the United States, power and its relationship to nursing, guidelines for preparation for political action, and proposed changes in nursing political goals and outlook.

Political Anthropology and Values: Their Relationship to Nursing

The utilization of data from political anthropology contains viable concepts and theories which can be applied to nursing. In political anthropology, researchers have described and interpreted the events of a political nature from cross-cultural perspectives. In nursing,

politics and political behavior in the form of power and influence have been identified as some of the greatest challenges in the movement toward professional control over practice conditions. The inter-relationship of political anthropology to nursing may serve as a direct resource for analytical problem solving and planned change.

To add to the "political" behavioral framework, Leininger (1970) has identified the professional and cultural value systems of nursing, the relationship of nurses to patients and physicians, and the patterns of communication within structured organizational settings. From selected ethnographic case studies and research findings of health-selecting behaviors of particular groups, her analyses have led to increased understanding of cross-cultural health care realities.

A variety of ideas related to the concept of particular role behavior in different cultures can be applied in the role identification of political attitudes/behavior of nurses when viewed as a cultural subset. In the nursing profession the caring role is closely bound to the hierarchical structure of roles within complex organizations, primarily hospitals. Although caring behavior and political behavior might appear to be at opposite poles of a semantic axis, there is an intrinsic link between them. The political anthropologist, Swartz (1968a:1) describes politics as:

the events which are involved in the determination and implementation of public goals and/or the differential distribution and use of power within a group or groups concerned with the goals being considered.

This statement has implications for nursing. By viewing nursing as having a political basis, the events relative to the determination and implementation of public goals are the nursing care services them-

selves. The use of power relates to the authority figures (nurse and hospital administrators, and physicians) who institute and initiate organizational policy which affects those groups (practitioners, nursing care coordinators, head nurses, and team leaders) concerned with the direct implementation of nursing care services to patients.

Political anthropological literature has a rich source of data for methodological and interpretative analyses in nursing. An attempt to critically review the theoretical underpinnings and construction of all the political anthropological data found in the literature was not undertaken by this author. But selected data, especially from the literature related to the role concepts of middleman (Swartz 1968:a,b; Denis 1973; Bailey 1970; Gluckman 1968; Löffler 1971; Attwood 1974; Fallers 1955; Rodman 1977) were used as a conceptual framework for the development of a questionnaire. Two other role concepts, patron and entrepreneur, were included to assist in the design of the questionnaire items (see Appendix A and Appendix C). The behavior described in these roles parallels a variety of behaviors present when nurses are situated in particular organizational structures, like hospitals.

The questionnaire items were translated from specific political anthropological data into the current terminology of health care professionals and hospital organizational processes and policies. The questionnaire, Current Nursing Trends (see Appendix C), was chosen as a methodological tool for the purposes of arriving at discriminating types of information. Its main use in this study was directed at a hypothesized, internalized symbolic system of values. According to Kluckhohn et al. (1951:388-399):

Values are ideas formulating action commitments. The ideas are instigators of behavior within the individual, that is, values and motivation are linked, but rarely do they coincide completely.

Kluckhohn (1951:421-422) describes "value" further by stating that it is:

A selective orientation toward experience, characteristic of an individual and/or group, which influences the choice between possible alternatives in behavior.

The ideas of Kluckhohn are closely linked to the definition of culture which was presented at the outset of the study--that is, the acquired knowledge that people use to interpret experience and generate social behavior (Goodenough 1975:5). The cultural subset of nursing has value orientations linked to roles, organizations, and generally to the "caring" phenomena of nursing itself. The use of the questionnaire, therefore, elicited data for the interpretation of the relationship between nursing values and social action. A more complete analysis and explanation will appear in Chapters IV and V, respectively.

A research study conducted by Ray (1976) investigated political role behavior of nurses with the use of the questionnaire, Current Nursing Trends (see Appendix C), as a tool to test its reliability in examining attitudes toward nursing. Role behavior concepts (middleman, entrepreneur, and patron) as characterized in political anthropology were applied to three groups of nurses--staff nurses, nurse practitioners, and office nurses (see Appendix A). Data were subjected to statistical analysis whereby the results showed evidence to support overlapping role behavior as the dominant style in two of the groups. In ethnographic studies done by Swartz (1968a:199-204) and Rodman (1977: 525-537) overlapping role behaviors were identified when the structural

role positioning of middlemen was interpreted within their particular culture groups. Thus, the conclusions reached were consistent with those reached by Ray (1976) in her study of political role behavior of nurses.

Summary

The foregoing chapter has provided the background information for the exploration of nurse role behavior with the complex institution of the hospital within the larger cultural entity of Canada. A description of some important elements in the discipline of anthropology integrated into the discipline of nursing illuminated a variety of social and cultural phenomena in nursing and nursing care. A small number of nurses have become anthropologists, and their work has contributed to the understanding of transcultural health care and health-seeking behavior of particular culture groups. The field of transcultural nursing as advanced by Leininger is a new subfield within nursing which studies cultural similarities and differences of caring components within nursing practice. Social science studies have largely concentrated on role behavior of nurses with emphases upon the therapeutic milieu that will facilitate the "cure" functions. Little has been done regarding the analysis of "caring." It is considered the "art" of nursing. Descriptions of some major constructs of care from cross-cultural research have helped to classify what this "art" is, thus preparing the way for scientific investigation.

Five objectives were developed to use as a methodological tool for investigating the nurses' ideology and social behavior. Studies

done on political role behavior as related to the concepts of middleman, entrepreneur, and patron were used to design a questionnaire to examine nurse values. A previous study tested its reliability with three nurse groups. The use of other social science research methods--the interview and participant observation techniques--were employed to secure behavioral data.

Structural characteristics of the hospital, inter-intra-hierarchical role positioning, communication, and decision-making patterns were a part of the investigative procedure to examine power as a political force in the hospital.

Caring, in the form of therapeutic and non-therapeutic rituals and myths which affect nurses and care-recipients, was a way of linking the anthropological and nursing data which Leininger described in her analysis of nursing as a culture. The integration of the two disciplines assists in problem-identification and understanding. In this study the critical paradox between professed institutional ideologies and the conflict of the professional value interests of nurses became the dominant theme which manifested itself in stress-related behaviors.

An explanation of the Canadian Health Care System in this study exemplified the conflict of ideologies of the philosophies of the federal and provincial Ministries of Health and the existing relationship to the problems associated with economic constraints, conflicting bureaucratic goals, and the power the medical profession has over the whole system of health care delivery.

Regulating bodies in nursing, such as the Ontario Nurses' Association and the College of Nurses, seek to support and maintain stan-

dards of practice in favor of the nurses' and patients'/clients' welfare.

Information regarding political behavior, political anthropology, and its relationship to nursing set the stage for understanding how and why conflict became the dominant theme in the study. Theoretically, the ideas from the political anthropological literature provided a framework for classifying political role behavior in nursing. Distinctions made by Geertz, relative to culture and social behavior, were selected as a means of analysis for the relationship of culture value conflict and action systems.

A few studies served to illustrate that there is a paucity of information about the social and cultural milieu of the hospital from the standpoint of nursing, thus demonstrating the need for nursing research from an "applied" anthropological perspective.

The following chapters will describe in detail the methodology, results, and interpretation briefly outlined in the Introduction. The final chapter will include the Summary, Conclusion, and a number of plausible Recommendations in the wake of changing professional and personal interests within the institutional bureaucracy and the culture of nursing.

CHAPTER II

RESEARCH DESIGN AND METHODOLOGY

In this chapter, the author shall discuss the role of the nurse researcher as a participant observer in a study of the members of her own profession. Also described is the selection of the setting for the study, the presentation of a research proposal to groups within St. Francis' Hospital, the research procedure, and the limitations of the study.

Role of the Nurse Researcher in the Study of Nursing Phenomena

Byerly (1976:143-162), a nurse-anthropologist, describes participation observation as a role, a technique, and a methodology. Although there is a problem of bias in the examination of one's own professional group, Byerly emphasizes that the process of participant-observation involves the sensitive awareness of behaviors of the persons being observed and similar insight into the researcher's own actions and reactions. The use of careful and complete recording of events, generation of a hypothesis from quantitative and qualitative data, and retrospective evaluation and analysis, all provide the nurse-researcher with a broad data base, thus allowing for the maintenance of objectivity and integrity while investigating members of the nursing profession. Complete eradication of subjective bias is virtually impossible and probably not even desirable. The subjective process is a valuable part of anthro-

pology and nursing because of the empathetic involvement of the researcher with the people.

As a nurse-researcher, the author found herself on several occasions in a conflict of values about certain practices within the hospital. It was difficult not to intervene and actually explain to the nurses why a particular action would, either positively or negatively, influence or assist in changing the behavioral responses of some patients. For example, in the coronary care unit, the researcher was sure that some patients would benefit from increased nurse interaction and counseling about their anxieties related to coronary by-pass surgery based upon what the nurses had explained regarding their hospital experiences. But, in view of the fact that the information would potentially bias the conclusions, this action was not taken. The study, however, was developed for the purposes of eliciting problems which could result in planned change at a later date. Planned change, according to Bennis (1969:62-78), is defined as a deliberate and collaborative process that 1) involves mutual goal setting between a change agent and a client system and, 2) is undertaken to resolve a problem or attain an improved state of functioning.

The author was unable to assess the extent to which her status as a nurse influenced the data collection. Because the researcher was engaged in work as a clinical practitioner in another hospital on the weekends, the staff regarded all intentions to accomplish a study in nursing as fixed in reality and not just in the "ivory tower." This is important for nurses are action- and practice-oriented and are critical of other nurses who speak only from the positions of educators or mana-

gers. Very little nursing research is conducted. Therefore, the hospital nurses could have been reluctant to give information, but this was not experienced. There were no refusals on the part of any nurse to participate in the study. One nurse, however, did ask to whom this research would be of benefit. With an honest appraisal, the author stated it would benefit both the hospital and herself. There were more positive effects of the dual role of nurse and researcher than negative ones. In fact, the quality and quantity of the research were, no doubt, enhanced by the dual role.

Selection of the Setting for the Study

The Hospital

This field study was conducted in a hospital setting located close to the core of a city with a population of approximately 330,000 which services a wide variety of the citizens of an industrial complex situated just east of it. The community of the core city is represented by a large number of "ethnic" groups besides the Anglo-Canadian. Many are newly arrived immigrants such as the Portuguese. Other ethnic peoples are East and West Indians, Africans, Chinese, East and West Europeans, Italians, and urban North American Indians.

The hospital is designated as an active treatment hospital (in contrast to a chronic or aged care hospital) which has its major facilities open for over six hundred beds (including bassinettes). Since the health care system in Ontario is moving toward regionalization, major specialty areas are designed for specific centers. For example, this hospital is the major center for renal (kidney) problems, kidney organ

transplant surgery, and peritoneal and hemodialysis procedures for the region. Health councils are designed to delineate the kinds and types of services available in the various hospitals for efficient use of resources. The Executive Director of St. Francis Hospital, initiator of the first district health council in Ontario, was instrumental in developing an effective assessment and placement service for the chronically ill and aged, a district laboratory medicine service, a coordinated health library service, an inter-institutional transport service, as well as the development of comprehensive district programs of health services.

The hospital has "lay" administrators but is also administrated by a religious community of nuns within the Catholic Church, who had the full jurisdiction of managing St. Francis' Hospital before the government's intervention in the health care system.

The setting was selected for study, primarily because of the encouragement and support from the Director of Nursing, in consultation with the Intensive Care Unit clinical specialist. The author explained the type of research which would be involved and, collectively, they felt that "applied" anthropological research was important for identifying both management and clinical nursing problems.

Participants Selected for the Study

Upon the recommendation of the Director of Nursing, the primary group chosen for the structured interviews and the questionnaire administration were the nursing coordinators because of their long-term employment in the hospital. Nurse clinicians, clinical specialists, and head nurses were asked to complete the questionnaire as well.

For the non-structured interviews, the above groups and the general staff nurses participated with this researcher to develop the data base from which to examine bureaucratic and professional nursing problems.

Refer to Appendix A for a working definition of the job description and/or responsibilities of the above listed occupational roles of nursing within the hospital. The Nursing Organization Chart (see Appendix B) explains the intrahierarchical structuring of these various occupational roles according to the management positions.

Wards/Units Selected for the Study

The wards/units (see Appendix A) selected for participant observation with head nurses and staff nurses were all but three units in the hospital: one Surgical Ward, the Emergency Psychiatric Unit (a crisis intervention center), and the Liaison Ward (a drug detoxification and/or suicidology unit).

The Presentation of the Research Proposal to the Hospital Research Committee

The author was requested to prepare and present a research proposal (see Appendix B) to the Hospital Research Committee which consisted of eleven physicians, one director of nursing, one board member, and one director of medical services (non-physician). Social science research conducted by a nurse had never been the subject of a presentation to the committee in the past. Because there was little knowledge of the goals and objectives of anthropological research, ample time had to be taken for explanation. There was some dismay rendered by the

physicians as the qualitative aspects of the research and, especially, the role of a nurse as participant-observer. Although the research objectives were primarily concerned with nursing care and nurse interaction, some of them referred to interhierarchical role structuring, decision-making, and communication patterns which appeared to arouse apprehension among a number of the physicians. One can surmise that the apprehensions were related to the fact that interactions within the hospital do not occur in a vacuum. Thus, investigations into behavioral patterns could reveal threatening events of a "political" nature or the delivery of medical care (in contrast to nursing care) among competing individuals or groups of physicians.

The use of the questionnaire was acceptable as an investigative tool. However, considerable discussion was required regarding the use of political anthropological terminology as its conceptual framework. One physician thought that the author was going to undertake "subversive activities" of a political nature within the hospital. New symbolic formulations of political anthropology caused confusion within the physician group relative to their political knowledge of existing Canadian governmental systems.

A discussion evolved around the issue of "informed consent" which is of major concern in research studies today. One physician raised the point that persons engaged in the study should be aware of the subject matter and sign "consent forms." But, in terms of descriptive research, it would be almost impossible to inform and receive consent from all the professional and non-professional staff, as well as the patients. The Director of Nursing expressed her opinion that the

use of the formal procedure would not be a problem in nursing research. The researcher reassured the Committee members that the ethical considerations regarding protection of names and delicate information would be guarded and extreme respect maintained. Nurses and physicians have acute senses of responsibility in the area of ethics where many facets of health care and personal information must be safeguarded.

Arrangements for office space were discussed, and the cost factors were delineated.

Unanimity of agreement took place only after persuasive leadership techniques were employed by the Executive Director of the hospital who stressed the fact that a research study of this kind would be a step forward in the advancement of nursing and hospital management knowledge.

Presentation of the Research Proposal to the Coordinators

The meeting with the coordinators was vital. If the relationships were not established with this group, the project would have failed. The proposal and the questionnaire had been previously circulated. It was important to explain all the developments which led to the idea of nursing research. The study was overwhelmingly supported after a discussion about the methodology and the outcome benefits to nursing and the hospital. The Director of Nursing gave her full consent to the propositions; and, by her enthusiasm and that of the researcher, the study was fully accepted.

Research Procedure

As outlined in the Introduction, this study evolved around a set of research objectives to investigate the role behavior of nurses. To synthesize, the objectives are as follows:

1. To gain insights into nursing behaviors during delivery of care to patients by utilizing anthropological and social science research methods
2. To become knowledgeable about the impact of the structural characteristics of complex organizations on nursing values and their consequences for nursing practice
3. To develop awareness of the cultural norms, rituals, myths of nursing practice which influence, positively or negatively, the "practice" of nursing--for example, effective care to patients
4. To understand the intra- and inter-professional communication- and decision-making patterns within the hospital
5. To recognize some of the fundamental and important relationships between the fields of anthropology and nursing which have a bearing on the health/illness patterns of patient and nursing behaviors

The "field" method process of discovery was used to lead the researcher to problems within the complex cultural framework of the hospital. According to Schatzman and Strauss (1973:1-13), the field researcher understands that the field is continuous with other fields and bound up with them in various ways; therefore, by this method, the researcher is free to think of any or all pertinent theories and assump-

tions about the subject.

Using the objectives of the study as one of the guides to discovery was the mode of entry into the formulation of the data base of this descriptive study. Description is an important phase of anthropological research which can subsequently lead to the formulation of hypothesis/es. The hypotheses may then be tested experimentally, if feasible.

Structured interviews with the nursing coordinators and the two assistant directors of nursing were audio-taped, and the individual sessions were about one to one and one-half hours in length. The tapes were used only by the researcher for the purposes of understanding the information necessary for the thesis development.

Participant observation on each of the units (with the exclusion of the three previously stated) was a methodological tool for interacting with the nurses who were in management positions and direct patient care services. There were opportunities to witness the events of the professional life-ways of the people.

A data gathering instrument, Current Nursing Trends Questionnaire (see Appendix C) was used to understand the values, beliefs, and attitudes of nurses within the bureaucratic structure. The items on the questionnaire were developed from a variety of notions about political role behavior--middleman, entrepreneur, and patron--characterized in political anthropology and adapted to nursing.

The questionnaire had been, previously, designed for a pilot study of political role behavior of nurses from an applied anthropological perspective (Ray 1976). There were two main purposes of the

pilot study: the use of the questionnaire as an investigative tool into the study of the role of the nurse as middleman; and whether or not there was a demonstrated link between the nurses' beliefs and their expressed behavior.

Major strengths of the pilot study were as follows:

1. The questionnaire, as a research tool, did provide information about the political role behavior of nurses in the study
2. The results of the study revealed that overlapping political roles were the dominant styles of behavior of the nurses
3. Usable concepts and theories from political anthropology can be adapted to the study of a particular professional group in a modern, complex society
4. The questionnaire tool is an important method for examining selected types of data
5. Results provided knowledge about disparities between belief and action
6. Process of the study is adaptable to another system

The limitations of the study were as follows:

1. The study was not a representative sample
2. An item analysis of the statements on the questionnaire of the pilot study was not undertaken; therefore, the author was unable to discern which items discriminated between groups and whether or not there was considerable variation within groups

3. There were possible observer-bias and interaction effects
4. There could be sources of external invalidity--specifically, it is ungeneralizable
5. The study is unreplicable within the context of the study design

Administration of the Questionnaire

The same questionnaire from the pilot study was administered to the selected nurses within this present study (see Chapter IV). The questionnaire was distributed by the office staff of the Director of Nursing via inter-office mail. No interviews or participant observation had taken place before distribution. The participants were given a choice as to anonymity; however, a series of job inquiry questions were a part of the cover page of the questionnaire. The groups were given a two-week deadline to complete the questionnaire which had to be moved forward one time only. Via inter-office mail, the questionnaires were returned to the researcher's office by the secretaries. The nurses were unaware of the conceptual framework of the questionnaire as regarding political role characteristics in the analysis of values/attitudes. They were aware of the fact that current trends in nursing were under investigation. A complete computerized, statistical analysis was not undertaken until after all the observations and interviews had been made.

Other sources of data were spontaneous discussions which occurred in various locations in the hospital: the corridors, nurses' stations, patients' rooms, the cafeteria, conference or meeting rooms, or the nursing offices. Some of the interviews were focused, but often

they were open discussions about nursing, hospital, or organization problems.

The author was invited to a number of administrative meetings either for the purposes of patients, personnel, or both. In these meetings, the author was accepted as a partial participant by both administrative and staff personnel.

Additional sources of information were written materials. These included patient charts, patient kardexes (nursing care and diagnostic guides), administrative announcements, policy and procedure books, nursing organization charts, the monthly hospital publication, and a statement of the nursing philosophy and objectives. Job descriptions, personnel policies, "union" policies, published hospital write-ups of special projects were also reviewed.

Field Notes

The field notes provided a record of the author's observations during the time of the study. They served as accounts of the stated values of the nurses and the author's observations of the social and cultural setting within which the nurses' activities took place.

Some notes were recorded at the time the activity took place; others were recorded shortly after leaving the scene. Discretion had to be used in terms of when it was appropriate to take notes at the place of activity.

The field notes served as part of a data base from which to generate a hypothesis and analytical statements. They centered around information leading to a knowledge of the conflict between professed ideologies and bureaucratic goals. Recurring themes and patterns of

behavior suggested that nursing models of care are being thwarted by institutional interests which create stress for the majority of nurses and, consequently, nurses are now beginning to alter their role behavior.

Time Frame of the Study

The total study was estimated to require a three-month time period from mid-March to June 1977. All investigations took place during that time and from Mondays to Fridays. Most observations took place during the hours of 0700-1600; but some observations were important to make between the hours of 1600 and 2300 and 2300 and 0700, the evening and the night shifts, respectively. During the month of July 1977, the researcher attended an Administrative Management meeting and the Head Nurses' Meeting to give feedback regarding the analysis and results of the study. All groups expressed interest and support of the research. A tape recording was made of the researcher's presentation to the Head Nurses' meeting and transcribed as Appendix H.

The computerized statistical analysis for the purposes of evaluating the results of the questionnaire occurred during selected periods in July and August 1977.

Limitations of the Study

An anthropologist studying the lives of a people recognizes both the uniqueness of individuals and the recurring patterns of behavior of those individuals under study. The major limitation of this study was the fact that there was not a multi-disciplinary team of researchers from which to analyze and interpret phenomena to obtain

an integrative perspective. Hospital activity is multi-faceted and guided by various ideologies. It includes numerous goals to be accomplished by a number of professional and non-professional personnel.

There is a potential for observer-bias in the sense that the researcher is a nurse investigating the role behavior of members of her own profession and returning to a hospital where she had formerly worked.

Another limitation involved the use of the questionnaire. Nurse administrators were chosen as the primary participants for administration of the questionnaire. A more representative sample would have included all the nurses of the hospital, thus increasing the factor of external validity.

Summary

This chapter has illuminated the various considerations imperative in the development of a research study. First of all, there is the researcher herself. Within the study context, the researcher is a nurse examining the rôle behavior of nurses. Some major problems outlined were in relation to observer-bias, the acceptance of the nurse as an investigator within the hospital, and the conflict of values in terms of withholding professional advice in nursing care situations.

St. Francis' Hospital was selected as the base for the field study because there was a willingness on the part of the Director of Nursing to encourage and support nursing research from an "applied" anthropological perspective. Since social science research had not been conducted in the hospital, there was need of a personal presenta-

tion to the Hospital Research Committee. After much discussion, formal permission was granted for the initiation of the study.

A proposal was also made to the nursing management staff whereby collective interest and support allowed for a favorable climate for development of the research.

A discussion about the ethics of research involving health professionals and patients elucidated problems related to "informed consent," which was not considered a prerequisite for the conduction of anthropological research in St. Francis' Hospital.

The research procedure included the administration of a questionnaire which was designed initially as a method by which political role characteristics of nurses could be examined. The questionnaire had been the source of a pilot study whereby its reliability and validity as a research tool was tested. There were a number of strengths and limitations to the pilot study; however, its most positive element suggested that, overall, political role characteristics are important variables for investigation in nursing.

Primary participants in the study included the nursing management staff--assistant directors of nursing, the coordinators, head nurses, nurse clinicians, and clinical specialists. The general staff nurses made informal but valuable contributions to the research.

Participant observation, structured and non-structured interviews, as well as a host of other modes of resources within the hospital, provided the descriptive information necessary for the data base foundation.

Rather than using a specific theoretical framework, a set of

objectives was chosen as the guide to elicit data regarding roles, role relationships, nursing ideologies, and behaviors. A political anthropological conceptual framework was utilized in the design of the questionnaire and gave substance to the formulation of some of the objectives. Geertz's notions regarding distinctions between culture and social action were chosen for the analysis.

There are limitations to studies conducted with health professionals within organizational bureaucracies such as hospitals, and the most obvious is the complicating factor of the multidisciplinary groups represented. A team research approach might have identified other variables which, when analyzed, might have revealed new and different sets of data.

The following chapter will describe the social and cultural milieu of nursing which will provide an understanding and insight into the present status of nurse ideologies and behavioral expressions within the hospital.

CHAPTER III

SOCIAL AND CULTURAL MILIEU OF NURSING

The following chapter is an ethnography of the social and cultural milieu of nursing within St. Francis' Hospital. Included is a description of the socialization into nursing roles with a summary of the trends in nursing education; the hospital with its varying frames of reference; the hospital roles and relationships--nurses, patients, and physicians with their varied values, perceptions, and expressed behaviors.

At some points, the author will provide background information to clarify important and/or controversial subject matters within nursing.

Socialization into Nursing Roles

Trends in Nursing Education: Background Information

A key to the socialization process within nursing lies in a knowledge of the problems continuously encountered with the varying patterns of educational preparation for the registered nurse. The main reason for these problems centers around the fact that standardized systems of education have not been established for entry into practice as a "professional" nurse, thus causing public and professional confusion. In the past, the primary mode of education was apprenticeship

programs designed within hospitals for a period of three years. This nurse-training system was more an apprenticeship to hospitals and physicians which might explain why nurses have developed beliefs in the direction of administrative and/or medical technical duties (in contrast to nursing care responsibilities). Very few nurses are ever apprenticed to master nurse-clinicians in an organized, consistent way (Smith 1965:416-417). The beliefs expressed here reflect the interpretation of nurse values having roots in hospital and physician-centered goal orientations. It is important to note that at St. Francis' Hospital, the majority of those nurses educated in the apprenticeship system report that nursing presently is less patient-oriented than ever before. These conflicting ideas have valuable implications for understanding changes in values and generally altered role behavior within the context of this study.

In the decade of the 1960's, hospital schools of nursing began a phasing out system because of complex decision-making of nurse educators and governmental ministries. The movement away from hospital-controlled practical based programs sought to secure a more uniform nursing educational program developed with emphases upon theoretical foundations for nursing practice. Thus, the dominant mode of education was to become the two-year community college program.

Nursing has had university-based programs from as early as the first decade of this century. However, attempts to mobilize nursing toward a strong academic base for the profession has resulted in disunity among nurses. Hospital administrators, physicians, as well as "hospital educated" nurses encouraged this disunity for their own

advantages. Hospitals and physicians were reluctant to give up control over major portions of the education and practice of nursing which can still be seen today. Instead of serving society as the main goal of nursing, nurses, usually, were serving other nurses, physicians, and administrators. University-based education versus community college preparation remains a source of conflict and controversy among members of the profession. Although nursing is moving toward occupational professionalization by trying to standardize education at the university level, community colleges still produce the highest number of nurses for practice in complex health care organizations--mainly hospitals. (Nurses with university degrees usually enter into education or public health service.) The total length of educational preparation at the community college is, on the average, twenty-two months, which is one cause of the surplus of nurses. Other factors, such as the heightened increase in nurse recruitment of the 1960s; the relatively high pay in Ontario, approximately \$12,000 per annum (Collective Agreement, Full-Time Nurses, St. Frances' Hospital, 1977); the changing roles of women, with subsequent changes in child care arrangements; and shortened maternity leaves have also contributed to the present surplus.

Confusion thus prevails in the practice arena. A nurse is not usually distinguished by her/his length or type of education. The old adage, "A nurse, is a nurse, is a nurse," is a truism in most health care institutions.

As a result of the educational confusion in nursing, many nurse educators question whether or not a "professional" commitment in terms of accountability and responsibility for "holistic" nursing care can

be attained by the majority of young nurses prepared with such a minimum level of education. For the purpose of this thesis, "holistic" nursing care is defined as: the ability to assess and/or determine the appropriate human and/or technical resources necessary to meet the physical, psychological, social, cultural, and spiritual needs of patients.

Some former educators and coordinators at St. Francis' Hospital exemplified the confusion in nursing education and practice. A coordinator explained:

Nursing education is different today. Nursing is more technical. The old way, we were trained to give total care, no matter what or when. We had discipline with our feelings. In Intensive Care, some patients don't get their feet washed for over 24 hours. If a nurse doesn't like a patient--she won't care for him--say, like a person who had a gun-shot wound. They don't like problem patients--like alcoholics. The patient in the other bed may get excellent care. Those nurses are contradictory--the new ones preach love and indulgence, but they don't practice it. There is less discipline now--less expectations. Students are not made accountable.

Another nurse retorted:

Nurses forget about nursing care--they give a pain medication. They don't change the sheet, or fluff a pillow. Over the intercom, they ask a patient what type of pain medication they want and don't find out first of all where the pain is. When Nursing Arts was taken out of nursing--caring went down. But patients have changed too. They want their \$170.00 worth even though OHIP is paying. "Give it to me," or they are ready to sue. There are clashes between the patients and nurses. Nurses don't talk to patients to calm them. They have more Psychology and Sociology in school, but don't use it.

A coordinator stated:

Nurses are knowledgeable to use machines today. Nursing is easier because of technology. It takes the anxiety from the nurse. But there is an overuse of equipment.

Nurses of old lacked theory. They did all the housekeeping, dietary, and repetitive treatments. I think the student is geared to learn care for the patient, and learn at her own

speed. The new theoretical knowledge is good. They can pick up experience, judgment, and priority setting when they work. It would be better if their education was longer because they overload the nurses who are already working. The university graduates are skillful nurses--qualified as decision-makers. Nursing has improved skills and knowledge.

A management nurse said:

Nursing has changed in ten years. There is more independent learning. We lacked theory in the old three-year schools. The new programs should be longer.

A coordinator expressed:

Nursing is not nursing from the whole person. It is procedural and technical. Nurses don't discuss or talk to patients. Hospitals contribute either to the growth or deterioration of nursing. It's a job, but there is freedom to give better care. Students and graduates must be accountable from within. I ache for patients sometimes!

The Socialization Process at St. Francis' Hospital

Recruitment and socialization into nursing roles (refer to Appendix A for definitions of the major occupational roles within the nursing hierarchy) at the hospital occur on several levels: 1) the hospital, 2) the nursing department, and 3) the nursing unit. Socialization is both formal and informal. A formal orientation program is designed to acquaint new personnel with the Philosophy and Objectives of Nursing Service (see Appendix E), and to introduce nurses to the bureaucratic systems of operation as well as to the standards of nursing care in the hospital. In one orientation program, the researcher was involved as an active participant. The interactions focused on standards of care and the nursing process as a problem-solving tool. Some of the management personnel encouraged the author to take part in the interaction which led to a discussion about humanistic trends in

nursing (see Appendix A for the definition of Ethnonursing). These ideas about "caring" eluded many of the new personnel. One staff member angrily commented by stating, "That wasn't the way it should have gone. They were supposed to learn about the forms. Now, how are they going to learn about them?" Hence, one is led to a number of questions. What does nursing really mean? Who does nursing really serve?

Informally, nurses are socialized through their own values and by their peer group, whom they may imitate. The nursing values are the abstractions of socialization, while the concrete processes are the actions. Previous socialization and enculturation by virtue of education and experience, by family and community, all serve to influence nurse role behavior within the context of the hospital. Nurses are recruited on the bases of their experience and job openings on different units. At St. Francis,⁴ efforts are being made to grant nurses, who have completed a university program of study, increased pay for service and placement in clinical and management leadership positions.

The Nursing Administration budget is the direct responsibility of the Director of Nursing. The monies are allocated to the Nursing Units for which the head nurses are accountable. The Staffing Coordinator (see Appendix B, Nursing Organization Chart) is responsible for monitoring the budget on a day-to-day basis and assigning the staff to the units where needed and when necessary. To date, St. Francis' Hospital has not experienced staff cut-backs (budget-wise). In recent years, the ratio of professional to non-professional nursing staff has, in fact, increased according to statements made by the Executive Director and the Director of Nurses. Conversely, many staff nurses

reported that they were hired for specific units within the hospital where their expertise or experience was needed, but because of shortages of staff were reallocated to other units where they felt they had less knowledge and skill.

As examples, accounts of the fears of reallocation to other units and time constraint problems were given by a number of nurses. A young nurse stated:

I dread having to work on another floor. I will call in sick if I have a split weekend because I know that I will be reallocated. I can't cope. I don't know the patients. A surgical floor is so much heavier than maternity.

Another nurse reported:

All I do is whip in and out of rooms, making beds. I'd like to get involved, especially with new mothers, but there is not enough time to talk to patients about their problems.

A coordinator stated:

Nurses don't take time to care for patients. For example, if a patient wants a drink in the night, the nurse will tell the patient to get it herself. Nurses believe in this idea of "self-care," and patients shouldn't need help. Patients are lonely, and nurses don't know how to cope, or don't want to cope with fears of patients.

Nursing has changed over the years. It is worse now--holding the status quo. It is the same as an outside group--money, job. Parents give too much to their kids.

A staff nurse commented:

We are told we are not to tell patients we are short-staffed--the public shouldn't be aware of the situation. I want to and do tell patients why there is a delay in their nursing care.

A head nurse expressed:

Nurses are very unhappy, and it is reflected from them to patients. Patients ask me why they are so unhappy. Why do nurses "fly" in and out of rooms and never have time to talk?

Practitioners of nursing experience the shortage of staff or

are they unwilling to work very hard? Is there a "real" surplus of nurses? Is the budget for nursing care and nursing service fairly distributed in the hospital? Who controls nursing care?

In terms of the overall socialization of nurses, one stark reality to this supposed surplus in nursing is the movement of nurses to the United States. Educated in Canada, at the expense of the people of Ontario, new graduates are actively recruited to Texas and California. Some nurses who choose to remain in Ontario and Canada take jobs in other fields, thus failing to develop their nursing skills which, upon reapplication to nursing positions, create increased responsibility for assessment of competency by the hospital management staff, the nurses themselves, and the licensing body, the College of Nurses.

Another important phase of socialization at St. Francis' Hospital is membership in the Ontario Nurses' Association (the official union) which is the collective bargaining agent for nurses in Ontario. Nurses are interviewed by the Staffing Coordinator, whereby the Collective Agreement of the Association is explained to the new recruits. Nurses are able to present formal grievances to the hospital management staff by way of the union representatives. Staffing problems remain a problem in terms of the fact that Standards of Nursing Care for "safe" practice are just being developed and will be subject to varied interpretations in union negotiations. Membership in the professional organization (The Registered Nurses' Association of Ontario) is voluntary. Hospital nurses usually favor union membership because of the cost and that they are more or less guaranteed their job security. Nurses fall under compulsory arbitration in the hospital

context because they are considered essential workers by the Ministry of Labor of Ontario (Ontario Nurses' Association 1977).

St. Francis' Hospital

In a complex society such as ours, the care of the sick is primarily carried out in hospitals (see Appendix A). St. Francis' Hospital is designated as an active treatment facility whereby sophisticated medical, obstetrical, pediatric and surgical techniques, procedures, and medical and nursing care are rendered to patients.

"Active treatment" usually refers to the fact the patients are in need of immediate care; it is given; and patients soon return to their homes and communities. Lately, long-term health problems, such as rehabilitation from neurological disorders or accidents, mental illnesses, cardiac illnesses and strokes, are increasing. Medical units (in contrast to surgical units) are becoming "homes" for a large number of patients when assessment and placement services to chronic or aged care hospitals fall short of their goals. Lack of available nursing home beds is currently the norm as many patients are in St. Francis' well over six months to a year, or more. These changes in the hospital patient population reflect a variety of changes within society. People are living longer by virtue of the improvement of many medical techniques and nutrition. This increases the numbers of chronically ill and aged people. Many families no longer have the interest, time, will, belief, or coping ability to give care to the elderly in their homes; thus they seek hospitalization as a "home" for their relatives. Since the health care system has not made provisions for the changing health-care popu-

lation, there is a scarcity of beds for patients requiring extended care for chronic illness (Lalonde 1974:60).

A nursing coordinator exemplified the problem by stating:

Hospitals aren't built for the geriatric patient. There are so many old people now. Relatives "dump" people in the hospital. They can't be bothered with them. The same is true of doctors. They don't talk to the old patients. They don't know them. Since OHIP (Ontario Hospital Insurance Plan), people do abuse the system, especially the old folks. There is no place for them. The Ministry of Health--I don't understand their reasoning. The system isn't serving the patients. It's serving education. Those health care costs are up--why don't they just let patients die when they are ready instead of puncturing them so often? Doctors are afraid to make decisions. They aren't taught evaluation and assessment or they wouldn't be so afraid. They want to be heroic!

Another management nurse reported:

The aged--there is no recourse but to keep them in the hospital. People and agencies try though. They are here 6-7 months or 1 year. Patients get worse with their long stay. We aren't meeting their needs or other people's needs who care for them in the community. The problem is monumental.

A head nurse expressed:

The average age of patients is 50-55 years. On one team they are 75-96 years with lots of complications. The nursing homes hold their beds for only 72 hours. If a family doesn't pay, they release the bed; therefore the patients have to stay in the hospital because there is no place for them to go. Their families don't cope with them. Nurses can't handle the work load. They are tired, disgruntled after long, hard days, of so many in a row. They are worried about back injuries--lifting the patients. I have 2 out on Workman's Compensation.

We feed the patients at the desk. It is easier. Nurses would have to walk back and forth, from place to place, and they get too tired. Long-stay patients demand--their relatives think it is the Royal Connaught Hotel. The loudest patients often get the care, and there is no time for nursing care conferences--we just barely get the work done.

The social worker reported:

The beds in the nursing home are held for 72 hours because the government won't pay. The bed then is released. Some families

will pay to keep a bed. It's political--money. A wealthy patient can get back to a nursing home.

St. Francis' Hospital has a long and successful tradition of caring for the sick. The hospital has a religious foundation administered by an order of Catholic nuns whose history dates back one hundred years in the community. Over the years there have been extensive building and modernization efforts.

Two nurses' residences remain. When hospital schools of nursing closed, nurses no longer were housed in residences provided by the hospital. Thus, they became offices for different interest groups servicing patients. The newer nurses' residence is the home of social services and other administrative offices. The original nurses' residence is the center for the Nursing Service Department, a lengthy geographical distance from other administrative jurisdictions within the hospital. Nursing usually has the task of competition with the medical staff for suitable places from which to exercise administrative responsibilities. In most instances, nursing requests for change are not so highly valued or recognized. However, since the hospital is in need of increased parking facilities, there are plans to demolish the nurses' residence; thus changes are forthcoming. The Nursing Service Department has been designated for relocation, and the Director of Nursing is prepared to wait until she is assured of suitable quarters from which to fulfill the goals of the management of nursing care and personnel.

Parking Facilities

Most employees use the parking lots around the hospital. Staff nurses complained bitterly about the cost and the lack of convenient

parking spaces for use, especially during the 1500-2300 hour shift, when there is a heavy influx of patient visitors who utilize the parking lot. Nurses also revealed that it was dangerous for them to leave or come to the hospital at 2300 hours. Guards are not available to escort or protect nurses on entrance to or exit from the hospital, and most are fearful of attack. Since the hospital is located in the central city area, nurses are alarmed that no priority is given to them regarding parking lot safety.

The Physical Lay-out of the Hospital

The first floor of the hospital houses the administrative offices (except nursing), business offices, admitting offices, telephone switchboard, the large board room, volunteers' gift shop, the outpatient and emergency departments, the intensive care unit, the operating and recovery rooms, and the pharmacy. Housekeeping, maintenance, and laboratories are located in other areas of the hospital.

In-patient areas are located in both the old and new sections of the hospital, with a women's wing which has maternity, nursery, gynecological, and delivery room areas. In-patient services consist of medicine, surgery, pediatrics, psychiatry, orthopedics, renal transplant, peritoneal and renal dialysis units, head and neck unit, ophthalmology, and intensive and coronary care units. The out-patient department has a schedule of patients who need varied care for short periods of time. "Short stay" surgical patients (those admitted for the day only) are also scheduled through the out-patient department. There is also a "crisis" center for psychiatric patient care problems.

The Sisters who service the hospital live on the top floor of

the institution.

Research and Education

Medical research plays a major role in the hospital service to the local university, urban, and provincial communities. Nursing research is just developing. This study was the first nursing-social science research project to begin in the hospital. There are proposals of clinical nursing research now pending.

Nursing schools (community college and university) utilize the hospital facilities as a clinical base. Medical education is very dominant in every phase of clinical practice within the hospital and includes medical students and residents. Hospital administrators, although few in number, may have residency placements within the hospital for the purposes of administrative research.

Some of the nurses reported that the educational goals of physicians have taken priority over the goals of patient care. Medical students are thought to have caused some disruption of nursing by admitting patients late in the day, writing numerous physicians' orders, and by requesting excessive numbers of laboratory tests (in order to satisfy their teacher examiners regarding diagnosis and management). In the Intensive Care Unit, the dying patient is used from time to time for the physician's own practical advantages for learning procedures or "curing" functions. For example, an old man of 87 years was subjected to six blood cultures (insertion of a needle into his vein) for the express purpose of the learning convenience of the doctor. Nurses often must become involved as patient advocates in order to protect patient rights when they are hospitalized. The stresses of

the caring versus the curing models used in the delivery of health care services have always been a source of potential conflict between physicians and nurses. These conflicts are increased with the medical education influx and the excessive use of technological equipment introduced into hospital/health services.

Nursing Units/Wards

Each regular ward/unit averages 40-70 beds. The larger wards are divided into sections and managed with specific teams with one or two head nurses, team leaders who are registered nurses and team members who are registered nurses and/or registered nursing assistants (see Appendix A).

The head nurses have a special room where various administrative and personnel tasks are undertaken.

All patient care units have both registered nurses and registered nursing assistants, as well as a host of supportive staff to carry out the specific nursing duties and responsibilities. Each unit has one or two head nurses who are responsible for the assessment of staffing, particular patients', and health care administrative problems. They are in close contact with the coordinators, assistant directors, and the director of nursing.

Observations for the study were conducted in all in-patient units with the exception of the Liaison Unit (Suicidology), the Emergency Psychiatric Unit, and one of the Surgical Units. The out-patient and emergency rooms were also used for observation.

Architecturally, the most recent structure of the hospital was designed for effective utilization of nursing staff; however, the long

corridors make it difficult to carry out nursing functions with ease. The hospital units all have nursing stations which are central to the existing patient rooms. Major activities center around the nursing stations where nurses, physicians, and other personnel meet, plan, decide, and activate the treatments and care of the patients entrusted to them.

Organization of Nursing Service Within the Hospital

The organization of nursing service administration is arranged in a hierarchical scheme whereby the Board of Trustees, the Executive Director (a physician), the Director of Nursing, three Assistant Directors, and nine Day Nursing Coordinators are represented (see Appendix B, Nursing Organizational Chart). The evening and night hours are staffed by four full-time and seven part-time evening and night coordinators, whose responsibilities vary according to the type of administrative functions they exercise and the types of clinical areas they supervise. They are designated as representatives to various types of committees ranging from research, budget, education, clinical, and so forth. There are three clinical specialists and three nurse clinicians who, with advanced education, are responsible for clinical teaching and research. This group (with the exception of the clinicians and specialists) and the head nurses constitute the management staff.

There is an official body of executives which is accountable for the patient care, the physicians and house staff, the students and the budget. Interaction between this group and nursing is effected

through representation on various committees. The voice of nursing is strong because of the efforts of the Director of Nursing who is a forceful advocate for nurses in the practice of their clinical responsibilities.

The Religious Influences of St. Francis Hospital

The institution is a Catholic hospital. Its symbols are still very visible--Christ on the Cross being the most significant. These are displayed in each patient room and office. There has been a change from some of the religious symbolism of the past. There are fewer sisters, and their religious clothing has changed and is less noticeable. Sisters do not always become supervisors or head nurses as they usually did in the past. Also, the morning and evening prayers which used to be said by all nursing personnel from strategic points in the hallways are now read by ward clerks over the inter-com system. The chapel, a source of repose and strength, is available for meditation by the patients, visitors, and staff.

Many of these changes in a Catholic hospital reflect present-day attitudes. Overt symbolism has given way to more subtle religious practices because of government intervention in health care services, the transition to a teaching hospital, the ecumenical religious movement, fewer women entering religious life, general philosophical changes in a technological age, and many values rooted in material culture. Previously, the school of nursing values emanated from the values of the religious order. With the closure of the hospital school of nursing, the sisters no longer have formal access to students, and

there is a reduction in traditional Christian, Catholic philosophy. With these alterations, commitments relating to the extension of one's self to others in a "Christ-like" sense also changed. For example, this value can be symbolized through a portion of the New Testament reading according to Matthew 26:40: "I assure you as often as you did it for one of the least of my brothers, you did it for me." This value of "Christ-centeredness" is no longer the prevailing belief as it once was.

One of the coordinators stated:

The ethics now are utilitarian. The hospital is secular. There is a decrease in the number of nuns. There is a wider acceptance and tolerance of all religions and a decreased emphasis on Catholic ceremonies. But, before these changes and the "machines," the dying patient had the privilege of prayer. We used to put out the "communion" table, light candles, and pray with the family and the patient.

One of the sisters reported:

Now students do not have time to internalize a "caring" philosophy because of the type of nursing educational preparation in the community colleges. Teachers in community colleges have a different set of values and appear to be more committed to their "time-off." Nursing is now considered only a "job" rather than a vocation. There could be a "priesthood of the laity" whereby Christian people could be capable of transmitting patient care which reflects a respect for life and which will enhance the quality of life.

One of the sisters stated that a significant change in the past ten years has been in the attitudes and in the positions of physicians. Doctors from different cultures, for example Japan, India, and Britain, in executive positions, reflect a value system which varies regarding the care of the terminally ill, the use of technological equipment, and the implementation of organ transplant surgery. Generally, the respect for "individual" life and responses to "individual" concerns, have

given way to the "collective" value of "curing" by technological interventions as answers to many medical problems.

The Medical-Moral Committee, composed of two physicians, two theologians, and two sisters, has the responsibility of evaluating concerns regarding problems of a moral nature such as the Natural Death Act, sterilization, Badgley Report (which refers to abortion). Abortion is not an acceptable practice within the framework of Christian, Catholic philosophy and teaching; therefore, the procedure is not performed in the hospital.

Hospital Roles and Relationships

Hospitals are organized to benefit patients, and the society has specific roles for the diagnosis and care of the sick. In complex structures, a great number of interacting roles are needed to fulfill the professional and institutional goals. Role behavior analysis of the people directly responsible for the health and welfare of the sick is crucial to an understanding of factors which bear upon the perceptions of illness and health by both patients and professionals. The author will discuss the perceptions and attitudes of the nurses with respect to their relationship with patients and physicians at St. Francis' Hospital. This ethnography focuses upon the coordinators of nursing service as the key informants. Communication with the general staff and head nurses, including direct observation, provided the researcher with insights into the study of complexities of the relationships in modern bureaucratic structures.

This author entered into these interactions with the people of her profession with intense interest, especially discussions around the

changes in "practice" behaviors and beliefs about nursing and health care.

One interview with a coordinator who had been involved in the process of care for over ten years revealed changes about nursing.

She stated:

Change, yes! The old organizational pattern was such that nurses didn't have a say. Now nurses won't put up with that any more. Nurses want to be involved in the decision making. Head nurses used to guard what they knew, instead of sharing. Doctors liked the old way of going to the head nurse because she spoiled and babied them. There is more freedom now, but nurses don't monitor problems of care, or communication problems. There is a lot of intergroup conflict about who has charge of the patient. There have to be meetings, often psychological counseling, to get people to talk. There have been good things happening, though--my unit is more humane. Clinical nursing specialists have increased the quality of care by interest in teaching and, of course, by knowledge.

Herein are additional accounts of some significant historical changes in organizational policy, and its influences on nursing care.

A coordinator exclaimed:

There used to be only one way of handling problems--from the top down. Nurses couldn't express themselves freely. There was one way of learning. But somehow nurses of today--they are different. You can't see them. Those motel-like rooms--patients ask, "Where is the nurse?" There is a decrease in organization and management of patient care. Nurses know more about disease and psychology. Nurses don't give over and above--backsliding often. They don't pull their weight. Young nurses don't know the patient. They don't observe. Eyes are important! They give peace, comfort--they tell what you are. Attitude of the nurses is poor toward old people. They encourage self-care.

The Director has tried to improve the Department of Nursing. Doctors know and respect her. She controls nursing. There is always nursing input because there is always a nurse in a group. Nurses are encouraged to get involved. They have more "say" in committee meetings. In the past, the doctor "was always right." Doctors have their own internal problems.

Since this hospital became a teaching hospital, it serves education, not patients. There is not enough coordination.

Our main problem in nursing is not enough leaders. We don't have enough say. We don't have enough nurses who want to care!

A coordinator who had a long employment tenure in the hospital expressed these ideas:

We used to have 12-hour shifts. We would be with the patient longer. There were limited visiting hours, and we had more hours for patient care. We were made to feel responsible. The sister supervisor--we could ask her questions about basic care, medications, special care. She knew the patients so well. But there are a lot of differences in care now--advanced numbers of medications and diagnostic tests. There are more demands for the nurse. All these demands disturb nursing care. The function of the hospital should be care, first, teaching, second.

Perceptions of Role Relationships

The Physicians

Doctors historically have viewed the nursing role as subservient to their own role. With an aggressive movement in nursing occurring by virtue of the changing role of women more generally, and through overall change in the philosophy and goals of nursing and nurses, there appears to be a state of confusion in the perception of nurses by doctors. For the most part, doctors respect nurses who will speak up about incidents relative to patient care problems, and who are knowledgeable about their subject matter. Young physicians generally do not like to accept the decisions of nurses because they feel that they cannot fully trust them. This may be due to their own insecurity in diagnoses and treatment.

A nurse coordinator remarked:

In the olden times, doctors were like "holy" persons. Nurses followed orders. It was like blind experience. Nurses will question an order now. They won't carry out an order if they think it is wrong. Doctors no longer write nursing orders. Nurses use their judgement. Doctors and nurses consult more--

share the care of the patient. Doctors are more willing to listen except for the young ones. They say, "Who is she to tell me what to do?"

Even though there is a national commitment to holistic health care, physicians still dominate the field of health because of their slow departure from the curing or medical model which is oriented toward the disease process itself, and/or physical symptomatic care. The physicians' orders reflect this type of treatment modality. Doctors generally do not perceive nurses as having any specific body of knowledge, or theories of nursing care. "Care" to physicians is an extension of the model of illness; that is, it is oriented to the symptomatic treatment model. For example, this can be witnessed by the Physicians' Order Sheet. Doctors list various "orders" relative to particular symptoms so that nurses may carry them out for the purposes of an improved health status of the patients. Although physicians previously (and many still do) wrote the nursing care orders, the majority may know, but do not acknowledge, that "caring" actions are an integral part of the overall treatment plan and is, indeed, unique. Lalonde (1974:41), the former federal Minister of Health, stated that "care" would have to be raised to the same level of importance as "cure" before sufficient attention would be paid to its vital significance in the delivery of health care.

The Team

The concept of team nursing was introduced into the organizational scheme in the 1960s. The professional organization inferred that all registered nurses must be team leaders. To manage a group of patients and staff--both from health care and bureaucratic organiza-

tional points of view--was challenging to some and frustrating to many. When head nurses relinquished their total control to other nurses, physicians had a difficult time with the concept of a team approach to patient care. One coordinator remarked:

The doctors (especially the older ones) felt confused and dis-oriented in the hospital when we switched to team nursing. They had to track down the team leader who was in charge of a group of patients, rather than be greeted by the head nurse who knew all the patients' concerns, and who would cater to the physicians' needs.

A night coordinator stated:

We aren't any closer to "team" than we were 20 years ago. Nobody helps each other or works as a team. It isn't the answer. Nurses will walk by a flashing light if it is a patient on another team.

Often physicians are unable to share leadership responsibilities. They have always had the position as "head of the team" and when sharing is required, there remains the tendency toward domination and control. Partly, the problem is due to their beliefs about their accountability in life-death decisions and the potential legal consequences of such decisions. Nurses' caring models become relatively powerless under this value.

Holistic health care is committed to decision making at all levels of care--biological, psychological, sociological, cultural, and spiritual. It is designed so that shared health care responsibility can take place. When a medical model is preferred to the total caring model, the commitment to holism is lost in the attempts to find cures. The "holistic" model includes persons from other health disciplines who can provide input from other fields of knowledge and experience from which to improve the therapeutic regimen of patients. The medical

model can be exemplified by observation with nurses on the Coronary Care Unit. Nurses stated that many cardiac patients were repeatedly back in the hospitals. They said the patients were fearful of cardiac arrest. One nurse revealed that she would never get on a personal level to explore patients' expressions of fear. But she said she knows that the patients are afraid they might have "an arrest" at home, and because there may be no one there to revive them, they come to the hospital where they can feel secure. Instead of utilizing the psychosocial parameters of assessment of problems, or engaging resource persons from other disciplines, medication in the forms of sedatives or analgesics usually becomes the treatment modality used by both physicians and nurses. Nurses attend to the technology by spending a great deal of time reading cardiac monitors--really assisting the physician rather than encountering, by interaction, the patient and his/her emotional needs. This amounts to reinforcing the curing process rather than identifying and managing the underlying problems which the patient is experiencing. The physical pain of cardiac disease may be legitimate, but so is the anxiety, which makes it a recurrent problem. Nurses, although able to recognize that patients are anxious about their cardiac problems, do not become involved. They may reinforce the factor of reacting only to the physical symptomatology which is so much a part of medical specialization.

One coronary care nurse expressed:

Many of our coronary by-pass patients are addicted to narcotics. They say they have a lot of pain, so we give them Demerol. Usually, the surgical procedure clogs in two years, so they worry all the time. Men won't discuss their fears anyway. They want medication.

With attention to the physical symptoms, and the relief of pain only through medications, psychological and sociological care have little priority in the assessment of health problems and/or needs. Nurses and doctors contribute to yet another problem, that of "addiction," which is likened to what is referred to as "clinical iatrogenesis"--clinical conditions for which remedies, physicians [nurses], hospitals are the pathogens or "sickening agents" (Illich 1975:22).

From the field observations in the Hemo-Dialysis Specialty area, nurses who have been selected and trained by physicians in physical assessment of patients, see the nurses as able to be an extension of them by taking over their functions. Other nurses reported that the "primary care nurses" have withdrawn from their nursing role and are placing themselves "above" nursing by considering that the "doctoring" is more important than the nursing. Here, again, care has been subsumed by symptomatic care; and nurses permit this to happen!

Power of physicians vis-à-vis nurses begins early in their socialization to hospitals. In one instance, the author noticed a situation where a group of nurses was having a conference on one of the units. Some medical students left their coats and books in the conference room. They went ahead and barged into the room, apparently without respect for the content and context of the process of interaction, in order to pick up their articles. If the reversal were true, doctors would indeed react negatively. This incident involved only medical students--not fully trained physicians. The respect expected is reciprocal but not honored, and nurses do not insist that it should be. These incidents thus show the weak position of nurses and nursing with

respect to physicians and medicine.

Communication is an important base to social power and is the key interpersonal skill upon which a nurse leader can build a power base in interacting with colleagues (Claus and Bailey 1977:135). The field observations generally show that this vital process of communication is valued, but not operationalized. Increased amounts of data in circulation, more telephone interaction, more conferences and meetings do not appear to have improved the relationships of doctors, nurses, and administrators to any effective level. Is "interpersonal care," also preempted by the familiar "symptomatic cure" modalities in professional communication?

The Nurses

Nurses perceived the registered nurse role in a variety of ways. The coordinators had mixed impressions about the concept of nursing today. Because many of the coordinators historically came from 3-year hospital-based diploma programs, they viewed the registered nurse from the community college system as having a stronger theoretical base but little skill in organization and management of patient care. They saw this as a detriment to nursing because the majority of young nurses were unable to handle a large volume of patient care and management responsibilities which put the units into chaos from time to time.

A coordinator expressed:

Nurses coming out of school today need a lot of teaching. If something isn't ordered they won't do it; for example, if a patient has pneumonia, they won't take the temperature every four hours.

Another coordinator revealed:

Today there is more emphasis on rights than commitment. There are a lot of gripes about decreased staffing. But the nurses can't reorganize and develop a different pattern. They have a very self-centered attitude. Their personal needs are greater. I see the slow evolution of the affluent society--new-found money for social life and travelling. It has brought freedom, but insecurity. The job is a means to an end--money for outside activities. It has led to selfishness. So, there is affluence in the midst of constraint--decreased budget and increased demands.

The staff nurses unanimously complained about the coordinators and the "Nursing Office" as being uncaring, unfeeling, and not understanding about the heavy work load, responsibilities for patients and their general individual needs related to time off, shorter time spans for working, vacations, and illness of themselves or a family member.

One staff nurse said:

This scheduling system--7 days in a row. I'm too tired, not friendly, and it's unsafe.

Staff nurses, generally, complained about the decrease in staffing since the Ministry of Health budget cuts. They exclaimed that their workload and responsibilities were simply too great. One thing they overwhelmingly disliked was being constantly sent to other units to work. They felt they were just a "body" and not cared about as a person. Many of the young nurses remarked how terrified they were of working in unfamiliar places and with unfamiliar people. The majority disliked going to the medical wards where all the old people stayed because the work assignments were too heavy and exhausting.

A pediatric nurse expressed:

I hate reallocation. I just can't cope. I feel I don't know where anything is--the routines are unfamiliar. I fear something I don't know.

Another new graduate reported:

As a student I was trained for total patient care. I had only 2-4 patients. Now I have double loads. I can't cope with the constant frustrations. Why haven't they better staffing?

A staff nurse said:

That Nursing Service won't bend. There is no individualism--no fair return for service. You get hell--get in trouble for being sick. I'm married--my kids get sick. What would you do if your child got sick, and you had to work, too?

On a medical ward a nurse said:

The work is just too heavy. I feel like a machine--just shove the food in at mealtime--going from one old person to the next.

The budget cuts, according to the staffing coordinator, made it necessary for an excess of nursing staff on one unit to be transferred to a patient care unit in need. Nurses are expected to be flexible and willing to be reallocated to other areas when the need arises. The staffing department does, when possible, take into consideration the relative expertise of nurses; however, it is often not done because the specific patient care and bureaucratic needs overrule individual needs of nurses.

The nurse-patient ratio varies depending upon the type of ward classification. Intensive Care and other specialty units have a high nurse-patient ratio. In the Kidney Dialysis Unit, the nurses remarked that the unit is "like a factory." There are so many patients who need the treatment that many patients are not able to have their needs met effectively. The patients become very demanding, too. A nurse from the unit explained:

Patients are demanding here. The hospital becomes their home. They are here three times a week. They feel safe, fed, cared for. They sometimes "fall in love with their nurse," and want

the same one all the time. Patients want their own territory-- the same bed, the same nurse, and the same friend to be in the next bed. It's always a problem for us to meet all their needs.

Values, Beliefs, and Attitudes

The stated and written philosophy and objectives of nursing service (see Appendix E) reflect goals and norms of nursing, and the people within the institution from the point of view of nursing management. Interview with the coordinators revealed goals and norms which supported the organizational perspectives as well as statements which supported the "patron-like" attitudinal style or independent professional value positions. Management personnel were openly concerned with the discontent of the staff nurses but recognized the need to support the organization. The union did play a large role in causing the coordinators to express dismay about the heavy emphasis on the economic conditions, the need for over-time pay, and the working-hour discontent.

General staff nurses almost become an entity unto themselves in the hospital. Many of the changes which have evolved since "unionization" of the staff nurses have subsequently resulted in a "we-they" phenomenon between the management group and the staff-nurse group. Although benefits arise in terms of safeguarding the economic and social welfare of nurses, the relationship of the nurse-professionals to each other within the bureaucracy is jeopardized. Unionization appears to put a deeper cleavage and a dualistic perspective to the "nurse-professionals" working within the institution. In other labor relations contexts, "professionals" within organizations are not split between management and labor, perhaps with the exception of the teach-

ing profession in Ontario.

The value "professionalism" has many and different meanings for nurses. Professionalism refers to length of education preparation, a type or way of behaving, a set of skills, a body of knowledge and legal accountability and responsibility. Few are sure of the definition of "professional," but there is an intuitive sense about its connotation when translated into behavior. Many coordinators believe that a 22-month educational program is too short to internalize value of commitment to care and caring in the nursing profession. Many of the younger nurses have definite beliefs about what gains they should have regarding their employment status within the institution. Most of these beliefs revolve around adequate time off, working conditions which are more anxiety free, salary guarantees, and job security. From observations, nurses at the clinical level reported very few rewards from direct patient care. There is an ideal belief in rendering the best care possible, but most revealed that it was impossible because of the heavy work load and shortage of staff. The staff nurses also stated they could not change jobs if they were dissatisfied because jobs were difficult to get. Nurses stated that many part-time nurses employed caused a problem in the continuity and the quality of care of groups of patients within the units. They are considered a back-up pool of nurses who can be placed where help is most needed. They are called upon frequently; but if the budget is tight, the help is reallocated from the other units for the various shifts. There is a different Collective Agreement (Ontario Nurses' Association-Union) for part-time nurses than there is for full-time nurses. Differences are, for exam-

ple, in the areas of pay status, pay for experience, vacation and sick time, and statutory holiday time.

Nurses are expected to be accountable for their professional actions, but many of the coordinators felt that the staff nurses were not "professional" enough, thus unable to recognize what the true meaning of accountability was. For example, staff nurses would call in sick when they had split days off so as to give them a longer span of "off" time. Nurses at the clinical level did admit to the fact that they would take a sick day when they were tired, and felt that the "Nursing Office" did not care about them as people; therefore, they felt entitled to take time off without sanction. They mentioned repeatedly how "fed-up" they were with the excessive transfers to other units to carry out nursing care when units were short of help. The frequency of this practice made them frustrated and angry, and they felt they had little control over their professional lives.

The religious values were important to the coordinator group, partly because they were from the "old school," but most of all, because they felt that spirituality was a vital aspect of patient care and vital to their own humanity. This value was not shared by the young nurses, however. Religion only was discussed in terms of how some practices interfered with their work. For example, some nurses remarked that the coordinators interfered in cardiac arrest procedures by trying to find out what religion the patient was, and if he/she had been anointed (given the Sacrament of the Sick in the Roman Catholic Church, and an integral part of a Catholic person's belief system).

Hospitalized patients from a variety of culture groups were

mainly addressed by nurses from the perspective of the time it took to care for them. Demands on time, especially by the Italian groups, bothered most nurses. They generally could not internalize the needs of these patients with respect to the roles of the female within the Italian culture, the strong kin-ties, and the emotional expressions related to pain and anxiety. Nursing care plans, when existent, were not designed to meet specific needs of different culture groups and, generally, cultural factors have not been included as a nursing value in the practice arena.

The value of acute care carried the highest weight in terms of nurse preference. The fact that many patients are elderly and chronically ill produced a certain negative reaction. Reallocation to care for patients on the medical floors where there were high numbers of elderly with chronic problems made the nurses upset. They were tired of heavy assignments. Nurses reported that feeding the elderly was like an assembly line production. They stated they didn't have enough time or manpower to feel satisfied about the way in which they cared for the aged. Most of the elderly are in rooms alone or with one other patient. When they are helped to get up in a chair, they are tied in, left only to look at a bare wall. One can observe this phenomenon on the hospital units as one passes from one room to the other. A physician reported that visitors were upset when they witnessed a group of aged patients having their dinner at the nurses' station on one of the wards. The visitors said it didn't look right. The patients, however, were in each other's company and enjoying the communication and sharing with people.

The value of acute over chronic care presents problems in hospitalization in an active-treatment hospital. There is an increase in chronic care and aged persons because of the advances in technology and pharmacological agents, but these patients have low priority status in the active-treatment hospitals such as St. Francis'. Many aged are placed in hospitals to be held only while waiting for a transfer to a nursing home. Many nurses and social workers reported about the length of time the aged and chronically ill are housed in the hospital itself. There are some aged patients who have been hospitalized at St. Francis' for over a year. Within the institution, the Discharge Planning Service works to facilitate the transfer of patients to nursing homes. Due to the short supply of nursing home beds, problems exist within the regional health care system, but there is a higher value placed on the care of the aged within the local District Health Council than within many other provincial regions. Nursing homes are still a part of the private enterprise system; however, they do have some government support. Another factor which prevents an effective delivery system in the case of the aged is related to the economics of salaries of physicians. The Director of Medical Services stated that more income is generated by way of patients occupying active treatment beds than by occupation of nursing home beds, according to Ministry of Health of Ontario figures. Thus, there is the value of economics over effective distribution and utilization of beds for the needs of patients and patient care.

The values associated with the care of the chronically ill become a problem when there is an emphasis on the "curing" regime

rather than "holistic" care. For example, nurses in the Intensive Care Unit reported that many patients with a diagnosis of congestive heart failure are admitted directly from the nursing home to the unit and, when treated, are discharged back to the nursing home. There is a number of repeated admissions. One reason for this is the fact that health education is not a priority. If instruction were given to nursing home staff about the proper amount and types of medication to control congestive heart failure, and patients were supervised, the number of patients readmitted for a chronic problem could effectively be reduced. This practice has had excellent results by the local Visiting Nurses' group (Milne, 1977). There is indeed a value and goal for active treatment, short-stay patients; however, there is the evidence to show a preponderance and increase in chronic and long-term care, especially for the aged. The ill-elderly must be "cared for" (the goal of nursing), but certainly cannot be "cured" because of their age and chronic illness state (the preferred mode of treatment of physicians).

Other Role Difficulties

Role difficulties were manifested in other patterns of behavior:

1. The author observed that nurses took extended coffee and lunch breaks even though they bitterly complained about the excessive work load. The nurses most often did receive both coffee and lunch breaks during the day. Not once did the author observe a relinquishment of time allocated to breaks for the benefit of the patient
2. There were numbers of nurses who avoided patient contact and who relied upon medication to comfort the patient--a substitute for their active presence with patients

3. Nursing education was criticized in a variety of ways--from the coordinators, especially the night group--which discussed the "good old days" as providing a better type of caring than today

4. Shift rotation problems irritated nurses, especially if they had a number of different shifts within a few weeks. Research studies on "Circadian rhythms," affected by alteration in work routines (Nelson 1978) give evidence to support reasons why more attention should be paid to nurses who have to rotate shifts frequently

5. Lack of economic reward for long-term employment served to frustrate some nurses. The union policies, however, are responsible for the narrow range between the relatively good starting salary of approximately \$12,000 per annum, and the maximum salary level of about \$15,000 for the average staff nurse

6. Most nurses stated that their need for praise with respect to their contributions to patient care within the hospital were not recognized sufficiently enough by the Administration

7. Uniform policy rules and regulations, especially those related to the wearing of nurses' caps, were a source of role conflict. Some local hospitals have permitted options to the strict professional dress code of the past, and many nurses desired the autonomy of choice. Pastel colored uniforms, dresses, or pant suits are acceptable modes of dress in St. Francis' Hospital

Summary

This ethnography of the social and cultural milieu of nursing within St. Francis' Hospital has raised many extremely interesting

points about the role behavior, the goals and the values of the professionals, and the institutional bureaucracy.

The socialization process in nursing with respect to education, the socialization of nurses within St. Francis' Hospital, a description of the hospital itself, and the role relationships among physicians, nurses, and patients was discussed.

Educational variation within nursing has proved to be a source of conflict and disunity among nurses. In the transitional period of the 1960s, there arose patterns of change which had an influential impact on nurses, nursing education, and nursing practice. Education in the hospital schools of nursing transferred control to the community colleges, thus freeing students from apprenticeship programs which were designed to fulfill hospital goals as a part of the educational process, as a general rule. Students were exposed to more theoretical and technical knowledge and skill which contributed to increased freedom of thought and expression. When new graduate nurses translated their knowledge to the practice arena, conflict erupted between the personal values and professional goals and between professional values and bureaucratic goals. Generally the differences were manifested in hostile complaints about the management policies regarding working conditions such as patient load, numbers of days worked in succession, and problems of reallocation to other units to help with staffing shortages. Values relating to need for personal leisure time caused conflicts with those who were more committed to a "patient-centered" value orientation, even though, historically, nurses from the "old school" were considered more hospital-directed. The modern nurse of today, beset by

recent economic constraints set forth by the provincial Ministry of Health, is caught among values of freedom, affluence, and personal satisfaction and need, and the tight rules and regulatory activities of professional behavior within the bureaucratic structure. Forms of altered role behavior have emerged although the ideological system is rooted in the commitment to holistic care to patients. Many of the coordinator group interpret the nurse behavior as lack of concern and care for patients. Nurses, however, not only have to cope with the nursing demands but, also, are in conflict with physician demands as well. Traditional "curing" functions prevail as the dominant health service when many of the patient population pressures such as the aged and chronically ill demand new modes of "caring" activities. Because of these overall conflicts, nurses are relatively powerless vis-à-vis physicians; thus needs of patients become secondary to the existing professional, educational, and bureaucratic goals- (economic and political) within the hospital.

The following chapter is an account of the quantitative data analysis relative to the questionnaire results to which the management group, and nurse clinicians, and the clinical nurse specialists responded at the outset of the study.

CHAPTER IV

QUANTITATIVE DATA ANALYSIS

Background Information

The questionnaire Current Nursing Trends was distributed to the management staff (excluding the Director of Nursing), clinical nurse specialists, and nurse clinicians--a total sample of 44 out of 45 nurses. There was 100 percent compliance from the groups.

As stated earlier in this study, the questionnaire was designed to elucidate role behavior adapted from political anthropological and ethnographic research data. The rationale for developing a questionnaire of this nature was, primarily, because it was thought that political behavior is a crucial issue in nursing. Nurses are constantly being reminded of their lack of strength in the political "arena," namely, their competitiveness with doctors, administrators, and the Ministry of Health for economic and human public resources. The questionnaire, originally distributed to three groups of professional, clinical nurses, was tested as to its reliability as a tool in the recognition of nurse political behavior. The concepts evolved out of an examination and interpretation of the characteristics of roles of oppressed groups in developing countries living under colonial rule. The idea is likened to an oppression which nurses have felt, recognized, and discussed relative to their relationship with their medical colleagues and/or institutional bureaucracies, hospitals and government.

The roles of middleman, entrepreneur, and patron were selected because the definitions from the political anthropological literature appeared to parallel and characterize role concepts in nursing. The nursing definitions of these roles are as follows:

1. Middleman (a term adapted from political anthropology and translated into a nurse role behavioral term) is defined as a professional clinical nurse who occupies a hierarchical, structural role, and is the link between the physician and patient, the bridge between the culture of the hospital/institution and the patient group, and has assigned duties to mediate. In this study, the term middleman will be used without reference to the gender (Ray 1976)
2. Entrepreneur (a term adapted from political anthropology and translated into a nurse role behavioral term) is defined as a professional clinical nurse who is a kind of middleman where new ideas are implemented, where risks (especially in the decision making regarding clinical diagnosis and treatment) from traditional professional norms are taken, and where profit in terms of extra professional rewards (praise/economic) is gained (Ray 1976). For an example of an entrepreneurial role, see Appendix A for the definition of the Nurse Practitioner
3. Patron (a term adapted from political anthropology and translated into a nurse role behavioral term) is defined as a professional clinical nurse who is selecting values of his/her own choosing in response to clinical decision making and is capable of delivering first-order resources in the process of care to patients (Ray 1976).

The importance of primary data is extremely important for obtaining an accurate picture of the way of life of a group. Because the author is a professional nurse with strong clinical and educational backgrounds in nursing, the ideas developed for political roles are also grounded in actual experiences.

According to Pelto (1970:105), questionnaire responses involving complex statistical analysis are suspect because of the non-random character of the sample. However, Pelto (1970:106) also states that where statistical analysis of materials is secondary to the gathering

of general descriptive information, questionnaires can be quite useful in that anthropologists can systematically explore finite domains of cultural and social behavior. For the purposes of this study, the particular domains are the attitudes which nurses develop and maintain about social interaction relative to their own "culture," professional values, inter-professional values, and patient/client beliefs. The items of the questionnaire address themselves to beliefs currently held within the professional context of nursing. Because the items have been developed to arrive at select information, that is, behavior related to three types of political roles, one is able to understand the affiliation which nurse behavior has to power and influence in the delivery of health care services.

As indicated earlier in this thesis, nurses' educational levels are varied. Nurses traditionally have come from three-year hospital diploma programs. In the last ten years in Ontario, hospital schools of nursing have closed and educational programs have been developed in the community colleges. These programs are two academic years, averaging twenty-two months in length, and are considered terminal, technical programs. Usually, nurses have to restart a university program if they should choose a Bachelor of Science degree in Nursing. The university schools of nursing are four years in length after Grade XIII in Ontario. Nurses who complete any one of these two existing programs are eligible to take their Certificate of Competence examinations for Registered Nurse licensure issued by the College of Nurses of Ontario--the legislative and regulating body of nursing. All prospective nurses are given the same set of examinations. They are not differentiated

according to the type of educational preparation in nursing. As was elucidated earlier in this study and shall be demonstrated later in the analysis of quantitative and qualitative data, this is an important professional problem in nursing. In Ontario in 1976, the total number of nurses who sat for the first writing (with no repeats) of the nurse registration examination was 4,394 (College of Nurses of Ontario, Annual Report 1976). Approximately 11.5 percent of the total group were nurses who had graduated with a Bachelor of Science degree in Nursing. Thus, the ratio of university-prepared nurses is decidedly lower than those nurses prepared at the community college level.

Master of Science, Master of Health Sciences, and Doctor of Philosophy degrees in Nursing provide backgrounds for teaching, clinical specialization, clinical/educational research and administration. There are few Masters-prepared nurses in hospitals. However, at St. Francis', there are three clinical nurse specialists with Master of Science degrees; but there are no doctorally prepared nurses employed.

In the hospital structure, the intrahierarchical roles are important in terms of delineating management versus staff nurse levels. The Director of Nursing, Assistant Directors of Nursing, Nursing Coordinators (supervisors), and head nurses are the management group. Clinical nurse specialists and nurse clinicians are not considered in a management role but do have leadership positions as educators, researchers, or practitioners. Their ideas represent varied ways in which standards of nursing practice, hospital policies, rules and regulations, and nursing philosophy and objectives are implemented. Nurse clinicians and specialists are more involved with patient/client and

staff education and interaction, while the management group is involved with hospital organizational policy implementation and staff interaction and reaction.

The foregoing has been a brief introductory summary for the purposes of understanding the following statistical analysis.

Analysis of the Data

The following are results from the questionnaire Current Nursing Trends. The questionnaire consisted of 56 statements. Each statement was scored on a five-point scale ranging from (1) = disagree strongly; (2) = disagree; (3) = no opinion; (4) = agree; (5) = agree strongly.

Forty-four of the total distribution to the nurses of the management, and nurse clinician and specialists' groups of St. Francis' Hospital received and completed the questionnaire.

The number in specific positions are as follows:

	<u>Sample Total</u>	<u>Hospital Total</u>
Head Nurse	28	28
Nurse Clinician	3	3
Clinical Nurse Specialist	3	3
Nursing Coordinators	8	9
Assistant Directors of Nursing	<u>2</u>	<u>2</u>
Total N	44	45

For each subscale, middleman, entrepreneur, and patron, respective items were totalled, then averaged. Each item was given

equal weighting.

TABLE I
Mean Scores on Computed Variables for
Nursing Top Level Staff

Total Sample	Middleman	Entrepreneur	Patron
N = 44	2.912	3.956	4.205
Maximum = 5			
Minimum = 1			

Table I displays the mean scores for the total sample. The top level nursing group sample tended to agree most highly with those items that described the patron style, that is:

...a professional clinical nurse who is selecting values of his/her own choosing in response to clinical decision making, and is capable of delivering first order resources in the process of care to patients (Ray 1976).

They also tended to agree with items on the entrepreneurial scale, that is:

...a professional clinical nurse who is a kind of middleman where ideas are implemented, where risks from traditional professional norms are taken (independent decision making regarding diagnosis), and where profit in terms of extra professional rewards (praise or economic) is gained (Ray 1976).

Further analysis was done according to the nurses' educational background, length in present position, and length of time in nursing.

Table II presents the analysis of the questionnaire by the nurses' educational backgrounds.

Diploma nurses were significantly different on entrepreneurial attitudes than B.Sc.N. nurses but did not differ from nurses with an

TABLE II
Analysis by Education

Total - N = 44	Middleman	Entrepreneur	Patron
[†] Diploma (n = 31)	3.06	3.83	4.05
	**	*	*
[‡] B.Sc.N. (n = 10)	2.67	4.17	4.42
Diploma	3.06	3.83	4.05
	*	n.s.	*
[§] M.S. (n = 3)	2.40	3.86	4.41
B.Sc.N.	2.67	4.17	4.42
	n.s.	n.s.	n.s.
M.S.	2.40	3.86	4.41

* = $p < .05$

** = $p < .01$

n.s. = not significant

T-tests - 2 tailed T-test were performed on the data.

Findings: Diploma nurses differed significantly on the Middleman role than B.Sc.N. nurses or nurses who had a Master's degree. No difference noted between B.Sc.N. and M.Sc.

[†]Diploma nurses are those who are educated either in a 3-year hospital school of nursing or a 2-year community college program.

[‡]B.Sc.N. is a Bachelor of Science degree in nursing from a 4-year university program of study.

[§]M.S. is a Master of Science degree from an 18-24 month university educational program.

M.S. Similarly, diploma nurses were significantly different on patron-like attitudes than the B.Sc.N. and M.S. nurses.

Although caution must be exercised in extrapolating from this small sample, the results suggest that there is a consistent trend whereby management nurses, clinicians, and specialists in this hospital appear to have differing political roles (expectations) varying with their highest level of education. Diploma nurses appeared to have more beliefs which coincided with the middleman role than nurses whose highest level of education was B.Sc.N. and/or M.S., and lower agreement with beliefs consistent with an entrepreneurial or patron role.

There were no differences between the nurses and the length of time in their present positions or lengths of time in nursing. In summary, the results of the questionnaire project indicate a stronger relationship exists between political role beliefs and previous educational level but no relationship between political role beliefs and length of time in one's present position.

Interpretation of the Findings

It appears that the predominant style in this sample is patron on the mean scores on computed variables for the Nursing Top Level Staff suggests that the group values professional independence. In the sense that the patron style is defined as a purveyor of first order resources, then these nurses see themselves as persons who are in command of their own professional decision making and social interaction. Nurses have historically been seen as subservient and controlled by physicians. Therefore, in a highly organizational setting (see Appendix B--Nursing Organizational Chart), it is interesting to note that

there is a trend toward more independent professionalism taking place. This top level nurse group is not always in direct patient contact nor under the direct supervision of physicians. These nurses, nevertheless, do influence and set policy for the staff nurses to implement, and this latter group is in direct contact with patients and in close clinical interaction with physicians. Relative to the descriptive data, the staff nurses exhibit differing role behaviors to that of the patron role manifested from and through the questionnaire.

Education, as one might suspect, appears to make a difference in terms of role behavior. In this analysis, there is a significant difference with respect to educational levels of preparation. As one might anticipate, the middleman role, which is closely associated with behaviors linked to organizational parameters, is favored by the Diploma Nurse Group (3-year hospital prepared). They scored significantly higher than B.Sc.N. or M.S. prepared nurses. Diploma nurses also scored lower both on entrepreneurial and patron-like attitudes than university prepared nurses. This suggests that the more innovative and independent professional role behaviors are more in line with ideas advanced through university education. Political role beliefs and previous educational level, rather than the hospital position or length of experience, are important variables. They suggest that there is a value in advanced education leading to the production of more innovation within the profession. These innovators are the risk-takers for change and ultimate growth in the caring behavior of nurses. Risk-taking activity in nursing refers to the nurses' ability, primarily, as an effective decision maker, independent or interdependent in the

assessment and management of patient care problems. For example, rather than having to summon a physician immediately upon encountering a patient with a complex clinical problem, the nurse will exert knowledgeable, professional, clinical judgment to decide the correct course of action.

With the use of a questionnaire to examine attitudes/beliefs about nursing behaviors, one is able to gather insight into the ideological system of the nurse group under study. How do the values of the sample group influence other members of the professional groups and their behavior? These answers will follow in the analytical interpretation of the descriptive data.

Summary

This chapter discussed the background information relating to the questionnaire, Current Nursing Trends, that is, the reason for its design and development of the 56 items. Definitions of the terms middleman, entrepreneur, and patron provided a means of explaining how the concepts from the role characteristics in political anthropology were translated into nursing and health care terminology.

Ideas regarding the wide educational variation in nursing were reemphasized within the context of quantitative analysis of this study. Nurses employed in hospitals are, generally, graduates of the community colleges or the hospital schools of nursing in the past. Few nurses in hospital bureaucracies have Bachelor or Master of Science degrees. Those who do are usually in positions of organizational management such as coordinators, directors of nursing or clinical specialists who are

engaged in research or patient/nurse education.

An analysis of the data revealed that the mean scores of the sample group tended to agree with those items that described the patron style which is considered to manifest the nurses' role as a purveyor of their own resources, thus in command of their own clinical decision making.

Regarding the analysis of the data by education, diploma nurses (from hospital-based or community college schools) were significantly lower on entrepreneurial or patron-like attitudes than either B.Sc.N. or M.S. nurses. The results of the questionnaire indicate that there is a stronger relationship between political role beliefs and previous educational level, but no relationship between political role beliefs and length of time in one's present position. The attitudinal trend in the interpretation of the results tends to be more in the direction of independent professionalism; and the educational level appears to explain the significant difference. In this study, the majority of nurses had educational preparation in hospital schools of nursing. But, one can hypothesize that as the educational level increases so do the beliefs regarding professional autonomy. Hence, education is an important variable in professional control and management. An interesting aside is the fact that only one male was represented in this study. It has been predicted that as nursing includes more men in the professional ranks, the more it will grow in line with other professions, namely teaching, where new leadership strategies are producing effective economic and political results. In conclusion, therefore, one can predict that the variables of increased educational preparation

and the increased male nursing population may well represent a new era for the nursing profession.

The following chapter will be an interpretation and analysis of the "culture" of nursing within St. Francis' Hospital. The interpretative data will be explained using Geertz's distinctions between culture and social behavior, that is, through the flow of behavior, cultural forms find expression. A number of research questions and statements with a summary will complete the chapter.

CHAPTER V

INTERPRETATION OF THE CULTURE OF NURSING AT ST. FRANCIS' HOSPITAL

Concerning the interpretation of anthropological data, Geertz has made some distinctive remarks. Geertz (1973:17-19) has emphasized the fact that behavior must be considered with some exactness because it is through the flow of behavior or, more precisely, social action, that cultural forms find expression. Anthropological interpretation consists of the tracing of the course of social discourse and "fixing it" in a form which can be inspected. The following chapter will consist of an explanation of the ethnographic data and, from the analysis, will conclude with the generation of a research hypothesis and research questions. In this study, nursing behavior was observed within one institutional complex--the hospital. Within the framework of the social and cultural milieu, an attempt will be made to place the data into a meaningful context by trying to understand the conceptualization of the elements of values on one hand and social action on the other.

The Strategy for Analysis

Schatzman and Strauss (1973:108-113) state that qualitative data vary in levels of abstraction, in frequency of occurrence, and in relevance to central questions [or objectives] of the research. The working of thought processes in analytic thinking is complex, logical,

and purposeful. It is thinking which is self-conscious, organized, systematic, and instrumental. Therefore, by the use of the objectives of the study (including the questionnaire data) as the guideline, certain patterns of behavior for determining the significance of the data were found, and will be, subsequently, discussed. To restate, the objectives of this study are as follows:

1. To gain insights into nursing behaviors during the delivery of care to patients by utilizing anthropological and social science research methods
2. To become knowledgeable about the impact of the structural characteristics of complex organizations on nursing values and the consequences for nursing practice
3. To develop awareness of the cultural norms, rituals, myths of nursing practice which influence, positively or negatively, the "practice" of nursing--for example, effective care to patients
4. To understand the intra- and inter-professional communication and decision-making patterns within the hospital
5. To recognize some of the fundamental and important relationships between the fields of anthropology and nursing which have effects on the health/illness patterns of patient and nursing behaviors

The objectives served as a guide for eliciting data. By means of structured interviews using the tape recorder with the "day" coordinators, and non-structured interviews and participant observation with the "night" and "evening" coordinators and staff nurses, data were secured.

Theoretical constructs arising out of the field research methodology of participant observation, key informant interviewing, non-structured interviews, and the use of the questionnaire are central to the analysis. The main "cultural" element and theoretical construct identified throughout the course of study was conflict. Elements con-

tributing to nurse conflict behaviors contingent upon the goals of the bureaucracy were institutional ideologies such as the philosophy and objectives of Nursing Service; the rules, policies, and regulations; the model of health-provisioning--the "medical" model; the inter-/intra-hierarchical role structuring; and patient population shift to the aged and chronically ill. Those elements directly nurse-related are reactant stress behaviors because of the varying ideologies about the "care-orientation" in terms of "otherness" and "self"; powerlessness of nurses vis-à-vis physicians; manifestations of "caring" behavior; the variety of educational programs for nurse preparation; the "union"; leisure time and economic factors; "self-actualization" precepts and self-determination.

Most units within the entire hospital were surveyed with the exception of the Liaison (suicidology and drug detoxification) Unit, the Emergency Psychiatric Unit, and one Surgical Unit. The Physiotherapy Department was not included in the study because nurse interactions with physiotherapists generally took place on the patient units. The Pharmacy Department was included only with reference to its direct involvement with the nursing role inasmuch as the evening and night coordinators are responsible for the dispensing of medication after 2030 hours. (This practice of taking on the role of pharmacist is not unlike the nurse taking on the role of the physician when time, economic factors, or the geographical location is inconvenient for physicians. For example, the nurse decision-making role increases during the evening and night hours.) Nurses assume the role of pharmacists after 2030 hours because they have traditionally carried out this

practice, and it is less expensive for the hospital not to employ 24-hour pharmacists.

Interviews with the coordinator group revealed its expressed beliefs to be consistent--that is, their deep concern for the negative changes in nursing care and in health care, in general, and precisely, less care directed toward "others." Their institutional beliefs were also consistent; that is, their expressed loyalty to the hospital's organizational goals. The majority of these nurses had their educational roots in hospital schools of nursing. According to Leininger (1970:63-67), this type of education was largely guided by the norms of an outside reference group--the medical profession.

The questionnaire results on the analysis of education revealed that diploma nurses (hospital/community college educated) scored significantly higher on middleman scores, which is linked with loyalty and value patterns related to institutional policy and physician-guided decisions. On the other hand, the total mean (average) scores revealed that the top level management group beliefs and attitudes tended to agree most highly with both patron-like and entrepreneurial characteristics which suggest a more resourceful risk taker and self-determined, professional decision maker.

These differences may be related to a number of factors and are enumerated as follows:

1. The total sample included the head nurses, the clinical specialists, and nurse clinicians
2. The clinical specialists and nurse clinicians have advanced university education
3. Three of the coordinators had advanced university education after their hospital training

4. The attitudes of nurses and women are changing toward increased assertive behaviors
5. Written responses may differ from manifest behaviors or expressed beliefs

In summary, the coordinator group profile generally revealed the value of concern for others, concerns regarding changing professional values, loyalty to the institution, questionnaire results which suggested professional self-determination and resourcefulness. When the questionnaire results were analyzed using education as the variable, however, their attitudes were more consistent with middleman characteristics.

In contrast, while participating with the general staff nurses, the ideas and attitudes generated led the researcher to believe that there was a high degree of emphasis on the "self." Questions relative to patient care processes had to be directed. Spontaneous remarks about rigidity of institutional policies about fixed working hour schedules, the number of nurses assigned to a unit, the overwork, increased responsibility, and the problem of reallocation to other units were commonplace sources of complaints. Most nurses commented that they had to work too hard. The assignments were regarded as being too "heavy." When they had a team leading and medication responsibilities, they felt that they should have a sharp reduction in patient care responsibilities. Many nurses commented on the fact that they never had a chance to get any "light" days because as soon as there was a patient number reduction on the ward, some member of the team was reallocated to another unit. Nurses said they "hated" to be reassigned to another ward. Adjustments had to be made for the new team members when

reallocated. They felt they were treated poorly--"like dirt" was a common comment; and they felt their assignments were too heavy because they generally had to work on a medical floor or the surgical floor, which housed most of the old people. Nurses agreed that they just barely got the routine done--baths, bed making, feeding, and getting patients out of bed. Extra care or care of the patients' psychosocial and educational needs were minimal.

Organizational expectations regarding written plans of patient care and nurse activities were not accomplished except occasionally for long-term problem-type patients where special surgical dressing techniques, feeding requirements, and psychological counseling behaviors were deemed as important. For example, the Coronary Care Unit Kardexes (written nursing care plan guides) contained data related only to electro-cardiograph monitoring needs. Other patient needs, especially psychological, were not priorities for consistent, coordinated, organized care. "Caring behaviors" such as empathy, support, health education, stress alleviation, and comfort were observed as provisions only to meet the immediate functional need. No "extra" caring practices were observed in this unit.

The philosophy and objectives of nursing service of the hospital are designed primarily as the guiding force to care, that is, to care for others (see Appendix E). Nurses, who are supposed to be committed, dedicated, and patient centered, are continually faced with the reality that the bureaucracy and its organizational goals and policies provide a continuous level of frustration for the general staff nurses. In nursing education there has been an increased degree of emphasis

placed upon autonomy and self-directed learning. Today's nurse also comes from a culture which has had a great degree of emphasis on materialism and economic gain, self-actualization, and assertiveness training for women. These cultural changes may be indeed responsible in part for many of the changes witnessed in the study in terms of the alteration of caring behaviors and the hostilities rendered against the institution for failing to provide more time for leisure or comfort.

In the analysis from a positive perspective, the effect of self-emphasis demonstrates that the necessity of caring for others equally implies a caring for self. Where the fulcrum point lies which produces a balance along the axis of belief and action has yet to be developed and evaluated by nurses as a group, although individuals make this decision to themselves.

From the point of view of economic and social gain, the answer as to how these new values for nurses will be interwoven into the complex philosophy of patient and hospitals systems has yet to be unveiled. In essence, there is evidence to propose a two-fold professional and social need for growth and development. The "leisure" ethic is replacing the "work" ethic, and nurses, as a part of the post-industrial/technological age of mankind, are also a part of this shift. Daniel Bell (1973) has forecast a number of problems which derive from historical factors. In his book, The Coming of Post-Industrial Society, Bell discusses at length the dangers of a technocratic society in the sense that a post-industrial society cannot provide a transcendent ethic. He states that the lack of a rooted moral belief system is the cultural contradiction of society and the deepest challenge to its sur-

vival (Bell 1973:480). Anderson (1974) also forecasts a similar future. He states that the future of leisure depends, not surprisingly, upon the future of work which will be influenced by industrial change and other factors such as population, natural resource availability, and so forth. He does not predict, however, in what direction and at what rate the social values and norms will be changed (Anderson 1974:129-139). Both of these authors suggest that values and norms are important for growth and development. Since nurses as care providers and hospitals as caring institutions are a part of the fabric of human culture, where and how they will function in the post-industrial age is of great concern. This study connotes that thoughtful analyses of the present and future circumstances will be imperatives if we accept the guises of a moral belief system as our challenge for survival.

The hospital's cultural norms reflect care of the acutely ill. When a set of beliefs are established, a set of assumptions and ultimate outcomes guide the way in which behavior in institutions is operationalized. From participant observation, the author became aware of the fact that the units of St. Francis' Hospital were increasingly housing patients who were chronically ill, especially chronicity with aging. But, "active treatment" was often rendered because these patients were usually admitted under an active, rather than chronic, diagnostic problem label. With groups of aged patients, there is a number of diagnostic problems superimposed upon the factor of age. The problem is, of course, larger than just the institutional setting. The demographic profile of Canada suggests the same. Population shifts are in the direction of the aged, and the society is not prepared to meet

the specific challenges of the care of the aged. There may be, in fact, a general denial of this shift. The television medium carries programs and advertisements which emphasize youthfulness. Within family relationships, aged parents and grandparents do not remain with the nuclear family, nor is there much encouragement or support to do so. Coping with aging and the aged often places stress on the individuals, especially family members. Thus, there is a growing need for more nursing home/chronic care beds. However, these beds are sparse, and with so many restrictions on their use, the only place left for many elderly is often the hospital. And yet, another set of problems arises: hospital policies do not reflect care of the aged as a high priority item; nurses can't cope and doctors virtually abandon them as hopeless. Few health care providers choose to specialize in gerontology. When a hospital operates under an inappropriate set of assumptions, the outcome goals are inconsistent with actual problems. Therefore, in light of the social, economic, and humanistic problems of aging and the aged, the hospital philosophy should reflect the beliefs of a shifting population group. For example, the Population Projections for Canada and the Provinces 1972-2001 shows that the old-age segment of the Canadian population, those aged 65 or older, is expected to grow from its 1971 level of 1.7 million to approximately 2.6 million in 1986, or an increase of 48% (Statistics Canada, June 1974:86).

Future population movements are likely to be dominated by an upward shift in age structure, an overall aging population, a slow increase or even decline of groups in the formative ages, and a sizable increase in the number of elderly people (Statistics Canada 1974:89).

Concerning the problem of chronic illness in hospitals, many chronic diseases are a consequence of aging; and as the numbers of survivors into old age increase, so do the cases of chronic diseases (Lalonde 1974:59). By virtue of the present situation of the aged and chronically ill in hospitals and the projected growing numbers of aged in the population, both clinical and administrative nurses, in collaboration with the Ministry of Health and the Directors of the Hospital, should examine this critical problem with the end goal of planned policy changes. Although the Assessment and Placement Service evaluates the problem of the numbers of chronic/aged within the hospital, planning for increasingly greater numbers has not been thoroughly appraised. For example, on one medical unit, the researcher observed that there were 16 patients waiting for placements to nursing homes or rehabilitation units. The total unit contained 33 patients, out of an average of 50, between the ages of 57-88 years with chronic problems such as cerebral vascular accidents (strokes), arteriosclerosis, Huntington's Chorea, leukemia, hemiplegia, asthma, gastro-intestinal carcinoma, chronic emphysema, and so forth. With these chronic health problems, alterations in staffing patterns relative to the necessary modes of care would be an example of a major policy change to reflect alterations in the hospital patient population.

Communication and decision-making patterns revealed problems between management and general staff nurses. The phenomenon of a "we/they" relationship existed on both sides. In interpreting the general staff nurses' remarks, the majority thought that the management and its goals were a road-block to their need for satisfaction, especially

those needs related to comfort and leisure such as time off. "They just don't understand," was a common phrase directed at the coordinator group by the general staff nurses.

Another major problem is the staffing situation within the hospital. Although the director and coordinators believed that staffing patterns were adequate according to numbers of nurses relative to patient volume, nurses involved in direct care negatively discussed their experiences regarding shortages. The fact that they were continually reallocated to other units was an indication to them that there were staff cut-backs. Many coordinators judged their complaints about reallocation and increased work loads from the perspective of a lack of commitment and willingness to "care" for others, while some recognized the increased complexities of health care organization within teaching hospitals.

Much of the communication dialogue between management and the general staff nurses was expressed via union grievance discussions. If nurses felt that they had a legitimate problem relative to the terms of the Collective Agreement within the hospital, the union representative could act on their behalf in negotiation with management. The official union (Ontario Nurses' Association), although imperative in improving economic and social conditions for nurses, has contributed to the "we/they" phenomenon or split between management (administrative nurses) and labor (staff nurses). Because of the intrahierarchical role structuring of nurse occupational groups, nurses historically have had a built-in factor contributing to the split. By the natural institutional division of labor and now, with the union, a greater separation

of nurses appears to be evolving. With the energy required for overt conflict resolution, there is equally as much required for the covert conflicts which generally continue and cause reduction in the energy needed to assess and implement effective nursing care to patients.

A problem in expectation in terms of communication exists among the following: the goals of the Nursing Service (see Appendix F) which are founded on idealistic and Christian principles of dedication and commitment to the patient; the newer, comprehensive, holistic care goals; and the changing values of nurses which are, to some extent, out of line with their educational preparation. Since the majority of nurses are prepared at the community college level, the educational time span is limited. The nursing management group is promoting concepts which should elicit behaviors in nurses which emphasize the "problem solving" process in the assessment of the biological, psychological, sociological, cultural, and spiritual needs of patients. Graduates come from an educational preparation which is practically and technically oriented with only limited education in theoretical concepts. For example, in the community college curriculum a student reported that care of the aged in terms of theoretical developments is not a high priority. Thus, new graduates are not prepared educationally to handle the assessment process of their aged patients. Many experienced nurses have not had (nor have taken) the opportunity for continuing education. The end point to all of this is reflected in inadequate patient care. Again, nursing care planning and total patient needs are not adequately met. Professional goals which are commensurate with the goals of comprehensive nursing care are in conflict with

technical goals--the end product of community college educational programs.

The inter-/intra-hierarchical role structure predominates even though a concept of "team" is a highly valued goal. The team concept produces difficulty for team membership because of the institutional system of social stratification. Physicians have most often enjoyed the position of head of the team. Inter-hierarchically, the structural position of nurses has been as the lowest member of the superordinate group and, intra-hierarchically, as the highest member of the subordinate group. This concept, however bothersome to nursing educators, administrators, and the practitioners, still exists and can be linked to the middleman role (see Appendix A). Although team concepts continue to be developed, the hierarchical organizational schema contributes to the confusion of implementing the team approach to care in the highly structured hospital environment. Perhaps this system of management is the only useful way of the organization of health provisioning. It is governed by the traditional medical model; and because there is a tight bureaucratic chain of command, changes have a slow, often painful, evolution.

The "curing" function of the medical model continues to be the model of service to be emulated. For example, on one medical unit the elderly patients are placed in special corridors and are not construed by student physicians or their professors as a teaching value. Thus, patients who cannot serve the purpose of the primary curing mode of medical education in a teaching-learning environment are forsaken. The health care model, which includes health maintenance and health promo-

tion with a high priority on education, is not realized. The nurse who is not professionally able to define the educational role as his or her function of caring adopts the medical model's curative role with emphasis on physical symptomatic treatment measures.

Problems in health provisioning can be traced to the inter-/intra-hierarchical role structure, the educational system and preparation, the institutional philosophy, and the budgetary constraints expounded by the Ontario Ministry of Health. Insured Ontario health spending more than doubled from 1.23 billion dollars in 1970-1971 to 2.47 billion dollars in 1975-1976. Ontario's health care bill is expected to reach 3.8 billion in 1977-1978 (The Toronto Star, Saturday, January 14:1978:A2). These monumental increases affect nursing care in hospitals. When the Ministry of Health decides upon the health budget restriction, hospitals become the target. Hospitals are allocated budgets for which a portion of the health care dollar goes toward the staffing patterns of nurses and their salaries. When those specific funds are depleted, so ends the requests for nursing staff, which affect care.

The important relationships between the fields of anthropology and nursing, which have a bearing on the health/illness patterns of patients and nursing behaviors, are analyzed in terms of the conflict of values and social behavior in this study.

Values and Social Behavior: An Analysis

Clifford Geertz (1973:144-145) points out that Parsons and Shils have given a useful way of distinguishing between culture and social system. They state that culture can be seen as an ordered sys-

tem of meaning and of symbol, in terms of which social interaction takes place; and the social system can be seen as the pattern of social interaction itself. Geertz adds that on the one level there is the framework of beliefs, expressive symbols, and values in terms of which individuals define their world, express their feelings, and make judgments; on the other level there is the ongoing process of interactive behavior, whose persistent form is called social structure. Culture is the fabric of meaning in terms of which human beings interpret their experience and guide their action; social structure is the form that actions take--the actually existing network of social relations.

The values in conflict within the "culture" of nursing in St. Francis' Hospital center around those values which guide behavior. There is a marked difference in beliefs about the values which serve as guides to nursing practice between the management group and the general staff nurses. The value differential may be due, in part, to the intra-hierarchical role positioning of nurses and to the advent of unionization. These structural realities have served to contribute to a restriction of the development of a unified body of professionals. Among the nurses within the hospital, a paradox is emerging among their ideologies: bureaucratic ideologies versus professed staff nurse ideologies. Traditionally, the nursing profession has been oriented toward "otherness"; that is, the interests of the patient and also of the doctor stood above those of the nurse. In the past, and still to a large extent today, nurses were enculturated into a value system that stressed their role as care-giver in terms of "others," which contrasts to the doctors' "cure" orientation. Although the nurses as a total

group in the hospital are still committed ideologically to comprehensive, holistic care, this ideal is becoming increasingly difficult to implement. In practice, models of caring are preempted by time constraints, limited human resources, economic limitations related to budgetary constraints for nursing, ineffective nurse-physician decision making, and occupational power conflicts. The hospital, with its values of efficient and effective use of time, energy, and resources, seeks to advance bureaucratic goal interests above those of the patients it serves, especially with respect to the care of the aged and chronically ill.

Since nurses are relatively powerless in their role vis-à-vis physicians, they are unable to prevent their own caring models of service from being overridden by the traditional medical curing models. The fact that nursing models of care have been thwarted by conflicts of the values of the bureaucratic goal interests creates stress for the majority of general staff nurses. The management group, which represents values rooted in the bureaucratic structures, differs to a degree from the staff nurses.

One major outcome of this stress is that the staff nurses are now beginning to alter their professional role behavior. The old value system committed to "otherness," which is still professed by many of the nurses of St. Francis' Hospital and certainly within many schools of nursing, is now being challenged by the younger generation of nurses who see themselves as professionals seeking advancement and personal benefit within the conditions defined by the hospital bureaucracy. Increasingly, this younger generation of nurses is moving away from

their emphasis on responsibility to others and becoming more concerned with self-interests (stress alleviation by taking time off without permission, increased considerations for work-load responsibilities, shorter work weeks, overtime pay, and so forth). The general staff nurses are no longer willing to engage in patterns of self-denial or extended, personalized care in the interests of patients or the hospital. The "care-orientation" appears to be undermined by the staff nurses themselves in response to many of the constraints imposed by the bureaucratic structural value system, by their educational limitations, and by the newer values related to material comfort and leisure within the dominant culture of Canada.

An analysis of the value of self-actualization and nursing deserves consideration because of the emphasis the concept has received in nursing curricula.

Researchers recently have been examining this concept and have postulated a number of core assumptions about the emergent world view, which may attempt to explain some of the alterations in nurse behaviors. Robertson and Cochrane (1976:80-82; 1977) postulate the following:

1. The new consciousness is a belief that all human beings are endowed with a set of innate "potentials," which is the purpose of life to express--that is, "self-actualization" and "self-realization."
2. The extent to which the individual is able to express or fulfill these potentials is dependent upon the social and physical environment within which he finds himself.
3. The responsibility for providing the means for expressing and satisfying these potentials is held to lie in society rather than the individual.
4. The former value-systems were based on the principles of self-reliance and self-denial and on the belief that the indivi-

dual as an independent agent, is responsible for his actions and his current situation. The gratification of a person's wants was previously regarded as a personal, rather than a social, responsibility.

5. The young, guided by the new consciousness, will react with hostility to what they see as the failure of society to make adequate provision for their complete personal development.

Although their research centered around deviant behavior, the basic idea as to why there may be increasing stressors and stresses as a result of conflicting values, points to very realistic problems of culture change and cultures which are in transition.

In the situation of nursing, the "culture" transition of changes in caring patterns has become evident in this study. There is a degree of emphasis on patient self-care and independence. This can be interpreted as care which would be beneficial for the patient or interpreted simply as non-care. When one sees patients alone, lonely, and forsaken, questions about care and its meaning must be addressed. If one accepts the premise that the new world view is one whereby society (in this case, the hospital and nursing administration) accepts the responsibility for the satisfaction of individual potential, it is of little wonder that stress-related hostility has evolved among the young nurses. Their needs are not adequately being met. Hostility regarding "work-load" responsibilities and "time-off" scheduling are some main issues. The amount of deviance which can be tolerated relative to many issues creates problems and seriously violates the principles which guide the people of the more traditional value system, the management nurses. The bond of caring, the essential element in nursing practice, is not the bond which holds the "culture" of nursing together. The divergent beliefs between bureaucratic values and the

old value system of "otherness" has produced two modes of behavior. Thus, central questions arise. Can the norms of the social organization be changed to fit the new world view, or should the adaptation to the social organization take place in the individuals who are a part of and are shaping the new culture of nursing? Murphy (1971:57) points to the fact that culture institutionalizes the role system, and it becomes internalized within the personality. Culture is also the principal source of change in the social system. The cultural system is subject to the vagaries of the meanings and rules of the ideational realm. In nursing's ideational realm there is the conflict of what type of commitment is important in "caring." With the new "culture" of nursing, caring may, in fact, be taking on a different meaning. Murphy (1971: 218) stresses that values may be incongruent with actions but never are irrelevant to them.

Therefore, one significant conclusion can be drawn from the analysis of self-actualization and the "culture" of nursing within the hospital. With an increased emphasis on self-actualizing precepts, those values which do have meaning in the ideational order of staff nurses have contributed to changes in their caring behaviors.

Other behavioral changes will be subsequently explained in the form of a research hypothesis and questions based upon the observational methodological process.

The participant observation method has provided the primary means by which data regarding the conflict between values and social action were elicited and could be analyzed. A secondary data source was derived by means of the questionnaire.

As has been stated, the central theme in this study is conflict in a variety of forms. The observations and discussions with the groups of nurses have revealed that problems exist within the bureaucratic system of hospitals with differing policies or rules relating to time constraints, limited nurse resources, increased aging and chronic patient populations within the active treatment or acute care facility, the priority of medical curing models of health provisioning, the inter-/intra-hierarchical role positioning of health professionals versus the value of "team," in contrast to the value system of the new generation of nurses whose interests are directed toward the development of social and personal enrichment, economic responsibilities as wives and mothers as well as professional responsibilities, conflicts in technical, educational preparation versus institutional goal expectations of comprehensive, holistic care and the "union" collective agreements. These conflicts between the bureaucratic value interests and the ideological commitments of nurses have contributed to a separation among the professional groups and serious stress-related activities, especially alterations in caring behavior.

A major hypothesis can be proposed from the framework of analysis.

In a hospital, alterations in caring behaviors are an expression of conflicts relating to changing economic, social, political, and ideological factors of the dominant Canadian culture (or in any other culture).

An explanation of this hypothesis can be explained by the following research questions:

1. Do the rules, policies, and regulations of the hospital serve to thwart the professional commitment of nurses to

- comprehensive holistic care?
2. Can professional values be congruent with bureaucratic values?
 3. Does conflict serve to advance or impede professional growth and development?
 4. Are the responsibilities of a primary care taker in the home incongruent with professional care-taking responsibilities for nurses in the hospital?
 5. Is the institution prepared to meet the demands of nurses who choose to realize personal self interests within the bureaucratic structure?
 6. Has the value of "caring" taken on a different meaning for the new generation of nurses?
 7. How and why does the union serve to perpetuate a "we/they" split between management and labor within the professional nurse ranks?
 8. How does the stress resulting from conflict between bureaucratic and professional/personal goals of nurses alter caring behavior?
 9. Why is stress expressed as hostility within professional behavior?
 10. What types of educational preparation are needed for nurses employed in complex organizations?
 11. Can medical "curing" models be altered to include nursing "caring" models for all patients?
 12. Can the hospital's designated label of "active treatment"

- be altered to meet the needs of a changing chronic-aged population?
13. Is hierarchical role positioning the most effective professional social stratification model within the hospital?
 14. Do conflicts vary with the age of nurses?
 15. Do the conflicts vary with the types of educational preparation of nurses?
 16. Have the economic factors in health care delivery served to thwart, not only the nurse professional interests, but also the organizational goals of the hospital?
 17. What are the priorities across personal goals and professional goals?
 18. Do nurses select different kinds of caring behaviors based upon the age of the patient population or the degree of chronicity of the patient?

This observational process has proved to be a valuable method for engaging in the study of conflict within hospitals and could be applicable within other hospital environments in North American culture. Thus, hospitals become a valid place in which to study culture.

Summary

This chapter has included the interpretation and the analysis of the results of the interviews, participant observation, and the questionnaire in the study of nurse role behavior within St. Francis' Hospital. By using the distinctions drawn by the anthropologist Geertz regarding culture and social action, the following conclusions were

made regarding how cultural forms find expression through social action. By using the objectives as a methodological framework to examine the "culture" of nursing within the hospital, the central construct of conflict was identified as the cultural element to which numbers of stress-related problems were linked. The bureaucratic system goals and nurse value systems were producing the wide disparities between belief and action. As has been outlined, those values of the institution are firmly rooted in operational management and are more closely aligned with fulfilling the goals of efficiency and effectiveness based upon an outdated set of assumptions. On the one hand, management nurses who come from the more traditional orientation in nursing are committed to the old value system of "otherness" and to the goals of the institution. On the other hand, the newer generation of staff nurses are not only in conflict with their care orientation to others but are seeking to advance themselves professionally and personally within the conditions of the hospitals. Generally, this stress has produced an alteration in caring behavior and is most evidenced in a decreased value toward care of the aged and chronically ill. The fact that the patient population of the aged has increased in hospitals, both health care professionals and management groups are not prepared to meet the challenge.

A variety of other problems which produce conflict are related to intra-/inter-hierarchical role structuring. Both physician and nurse groups are affected by the division of labor which gives priority to physicians and medical "curing" models.

Anthropological methods have provided a very useful way of

analyzing and viewing the hospital as a valuable place from which to examine culture as a whole. The central research hypothesis related to the alterations of care behaviors of nurses serves to contribute to the explanation of many economic, political, social, and ideological changes in the dominant culture of Canada. In the hospital, the research questions regarding these changes may help to further advance the knowledge base from which nurses, other health professionals, and executive management groups may consider planned policy changes for the growth and development of patients and health providers.

The following chapter contains the summary, conclusions, and finally a list of recommendations which will help in the implementation of future research proposals and planned policy changes based upon population, fiscal, and new value considerations.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The final chapter discusses the summary and conclusions; a list of recommendations arising from the data analysis is presented. Appendices G and H are discussions of reports which were given to two administrative groups within St. Francis' Hospital at the closure of the research study.

Hospitals and nursing homes are the primary social institutions where care is provided to those persons who are unable to care for themselves. Nurses are one professional group which is publically responsible for care provisioning. This study of nurse beliefs and role behavior within one hospital complex has revealed knowledge about the interrelationship of their values and social action.

The relationship between the conflict of values and social behavior has been explicated by the anthropologist Clifford Geertz (1973:144-145). At one level, culture is the ordered system where there is the framework of beliefs, expressive symbols and values in terms of which individuals define their world, express their feelings, and make judgements. At another level, the social system is the ongoing process of interactive behavior whose persistent form is called social structure. Therefore, culture is the fabric of meaning by which human beings interpret their experiences and guide their actions; social structure is the form that action takes, the actually existing

network of social relations. The author used the analytical framework of Geertz in her analysis of the conflict of values between nurses' beliefs and action, as well as recent social science data described by other researchers.

Summary

Applied Anthropology and Nursing: The Methods of Research

The anthropological description of nursing as a cultural subset has only recently been identified (Leininger 1970). Transcultural nursing, which is the study of cultural differences and similarities regarding the caring components of nursing practice, emphasizing the study of values, beliefs, and patterns of caring, is a new field utilizing the knowledge and research methodologies developed from the interdigitation of the disciplines of nursing and anthropology (Leininger 1977:6). Empirically based ethnographic studies as the foregoing are important to the nursing discipline in terms of understanding the nature of nurse behaviors and for the guidance of nursing practice.

Five objectives were employed (including one relating to research methodologies) to investigate nurse role behavior: the structural characteristics of the bureaucratic organization of the hospital; the "cultural" norms (including education) of nursing which influence nursing practice; the intra-/inter-hierarchical role structure; and the relationships between nursing and anthropology. Anthropological research methods are a useful way of providing insights into nursing within its professional "cultural" context. How nurse behavior was described, analyzed, and interpreted conveyed an understanding of the

patterns of nursing "culture," the styles of caring behavior and a basis from which cross-cultural comparisons of caring phenomena can be made. The methods of anthropology and the secondary source, the questionnaire, employed in this study helped to determine the kinds of facts which in turn led to the development of a number of the pertinent theoretical constructs, a hypothesis, and research questions.

The method of participant observation as a technique demonstrated that the hospital was not only valuable for the study of nurse role behavior but, also, for the culture itself.

Conclusions

The scope of the problems elicited by this ethnographic study with the use of a questionnaire developed from the anthropological political role behavioral concepts of middleman, entrepreneur, and patron to investigate attitudes and beliefs about nursing behavior, suggests that a critical paradox is emerging between the behavioral expression of nurses and professed institutional ideologies.

The general philosophy of nursing at St. Francis' Hospital has, traditionally, been oriented toward "otherness," that is, the interests of the patient, the doctor, and the hospital stood above those of the nurse. This is not a new phenomenon in the history of nursing, however. For example, in Canada the woman's role as healer, the sisters and the ecclesiastical character of nursing from France to "New France," the strict socialization in the Florence Nightingale school traditions from Britain, and the changes in the status of physicians in the wake of the turn of the century developments in medical science, all served

to reinforce the strong female traditions of subservience, sacrifice, and subjugation to authority. The motto of the first school of nursing in Ontario, in the attempt to socialize a quality of passivity in new nurses, was "I see and am silent," (Coburn 1974:127-140). Nurses are now moving away from the subservient role to one of assertiveness. This new value, however, has produced a dichotomy between the goal orientation of nursing as "other" oriented care providers, and nurses, who demand self-satisfaction of personal, professional, and social needs.

From the past and, to a large extent today, nurses are enculturated into the value system that stresses their role as care-giver, which contrasts to the physician's cure orientation. Historically, with the advent of medical education in universities, "curing" received a prestigious title; and "caring," often associated with domestic work, was relegated to the lower ranks of importance in health provisioning to patients, both inside and outside the large bureaucracy of the hospital. Although the term "care" conveys meaning in terms of what nurses, physicians, and other health professionals do, "caring" as it is meant in nursing has had little attention in terms of research into the actual processes. Those key constructs identified and described by Leininger (1977b:14) such as comfort, touch, trust, empathy, support, compassion, stress alleviation, and so forth are caring functions and crucial to the health and welfare of human beings. Why have nurses not been successful in raising the "care" process to the prestigious level of "cure"?

The central problem at St. Francis' Hospital is contingent upon many factors within the bureaucratic value system and changes within

the professional and personal value system of nurses.

First of all, a questionnaire, Current Nursing Trends, designed to elicit attitudinal styles about nurse political role behavior of nurses was distributed to the top-level management nurses. Generally, this questionnaire demonstrated that the political style within this total group was patron (see Appendix A). However, when the education variable was tested, nurses as a whole demonstrated the significance of the middleman style (see Appendix A). It should be reemphasized that the majority of the nurses in top-management positions were initially educated in three-year hospital diploma programs where hospital and physician needs were highly valued goals; therefore, it is not surprising that the middleman style was dominant when the education variable was introduced. What does this mean? In answer, top-level management nurses believed that they were professionally self-determined and innovative in terms of the patron style. The middleman style is also considered to be a complex role from an anthropological perspective. For example, Swartz (1968a:203) describes a "political middleman as a character who wears not two or four masks, but must understand and manipulate dozens of colors and fibers from which he fashions subtly distinct and variously composite masks and guises." For as long as nurses will be employed in institutions to facilitate their role function of caring, the complexities of the role of middleman are inherent. The role can be viewed as vital to the care of patients. Rodman (1977) states that anthropologists tend to define middlemen as entrepreneurs who have bridged the gap in communication between individuals, groups, structures, or cultures. Rodman believes, however, that not all mid-

dlemen are entrepreneurs. This idea can be linked to nursing in the sense that, although nurses are in structural role positions, they all do not exhibit innovative, risk-taking behaviors.

The questionnaire generally has provided an understanding of the expression of the beliefs of the top management level nurses from which a distinction could be drawn between the nursing "culture" relative to social interactive behavior.

From the analysis of the professed ideologies and social interactive behavior of nurses, stress emerged as the major outcome of the conflict of values which was manifest in the alteration of professional caring behaviors of general staff nurses. Stress is a multi-complex phenomenon in hospital nursing practice. Increased technological and bureaucratic changes have added to the problems of "care." Technological equipment and pharmacologic agents have placed "caring" in a competitive, secondary role equal to the competition related to the dominant curing role within the physician group of the hospital. Selye, the most prominent researcher on stress-related psychophysiological systems, reminds us that the stress of frustration is particularly harmful, and nothing paralyzes efficiency more than frustration (Selye 1974:134-135). Stress, too, results in hostility and depressed behavior. The general staff nurses demonstrated that they had a high level of frustration and subsequent anger toward the management group and, also, toward some of their patients.

An examination of related bureaucratic contingencies can best elucidate the frustrations experienced by the nurses.

Ideologically, nurses may be committed to comprehensive, holis-

tic care, but this ideal is becoming increasingly difficult to implement. One occupational power problem rests with the physicians. Since nurses are relatively powerless in their role vis-à-vis physicians, caring models of service are consistently overridden by traditional curing models. The curing model seeks to facilitate the use of all available diagnostic, technological, surgical, and pharmacological techniques. These, in themselves, are not wrong; but when they are disproportionately or indiscriminately prescribed, or proscribed, patients and nurses become the victims. Nurses carry out the orders to patients who, too, become powerless in their patient role. Examples of these problems can be observed in the Coronary Care Unit at the hospital. Values within the hospital place emphasis on physician-dominated curing models with ineffective use of nurse resources. This leads to inaccurate and incomplete assumptions about what the health provisioning needs actually are within the hospital, which is also so evident in care of the aged. This problem of "curing," however, is not solely a physician-related problem. Nurses are usually educated by the terms of the medical model--that is, symptomatic care. Health care and symptomatic care are generally misunderstood in systems which adopt the medical model as the social organization of health care. On the one hand, symptomatic care is based on disease or physical-psychological system problems where the "cure" is to be initiated. On the other hand, health care involves the social context of health where education for health prevention, maintenance, and promotion are the motivating factors. Since the hospitals and many nursing education programs follow the symptomatic cure model, nurses as well as physicians and admin-

istrators fail in their recognition and implementation of the health care model as idealized by the Canadian Federal Ministry of Health (Lalonde 1974).

The community college educational system for nurses, moreover, allows little time to generate the internalized professional "caring" role in terms of the unique problem-solving skills of nurses. The St. Francis' Hospital Department of Nursing desires well-developed, educationally prepared professional nurses and, indeed, has organized its philosophy around professional "caring" goals. But, in reality, the technically prepared nurse is not adequately prepared to fulfill those goals, thus causing both stress and frustration for the two groups of nurses--management and general staff nurses. This leads to a second occupational power conflict. The hierarchical organization of nursing has traditionally resulted in a rank-ordering of personnel causing a split between the top management groups and the staff nurses. Though the idea of team leadership was thought to improve communication and decision-making patterns within the hospital, it is a difficult concept because of the overriding hierarchical management system of organization. Team ideas are preferred, but operationally weak, thus a source of conflict for the nurses.

The unionization of staff nurses has added another factor to the traditional split between top management and nurses in direct care to patients. The "union" has contributed to weakening the professional unity of nurses. On the one hand, the union purposes seek to advance the social and economic welfare of nurses while, on the other hand, there is a prohibition of management nurses to union membership. This,

of course, is the position for arbitration over wage issues and so forth, but the collectivity of nurses is affected. One group belongs to the union and the other to the bureaucracy.

In the hospital nursing practice, the time value is a source of conflict. The hospital operates within a specific time frame whereby certain functions, tasks, and procedures are ritualized--for example, bed making, baths, and surgical dressing techniques. The behavior can be likened to the description of ritual behavior by Geertz (1937:168). It is not just a pattern of meaning but a form of social interaction in the hospital nursing environment. Any changes alter not only the meaning but also the social interactive processes, thus resulting in serious frustration. Take, for example, the problem of physicians initiating procedures late in the afternoon or early evening. The nursing staffing plan is not organized to include infringements or additional disruptions in ritual staffing patterns.

To exemplify this problem more fully, the economic limitations of the nursing budget have created the problem of "reallocation" at St. Francis' Hospital. This factor, alone, is responsible for the majority of hostile reactions of the nurses and has contributed to the creation of grave consequential alterations in both ideological commitments and manifest "caring" behaviors of staff nurses. "Reallocation" to the nurses means reassignment to another unit, usually a medical ward with chronically ill, aged patients. The value for care to the aged is a low-priority from an educational standpoint as well as within this active-treatment, acute-care facility. The budget, although reported as adequate for providing staff to units, is not sufficient enough to

supply personnel to patients as defined within the present objectives of nursing service. The all- (nearly all) professional staff goal is not the need for all patients. Those aged patients who are hospitalized need people who can primarily give comfort, support, and presence. Administrative decision making becomes even more critical in the advent of changing needs, and especially when participant-observations reveal the rampant display of hostility of general staff nurses to the management group and to some of their patients.

There is an alteration in caring behavior as an outcome of the stresses imposed upon the nurses by these bureaucratic goals. The old value system which is professed in schools of nursing, in the philosophy and objectives of nursing service and, ideologically, by many nurses, is now being challenged by the younger generation of nurses who see themselves as professionals desiring advancement and personal benefits within the conditions defined by the hospital. This field research has clearly pointed to the fact that general staff nurses are moving away from their emphasis on responsibility to others and are becoming more concerned with self-interests of a social and economic nature in terms of decreased work responsibilities, shorter time spans for work allowing for home and recreational activities, overtime pay, better vacation scheduling, and so forth. The majority of nurses is no longer willing to engage in patterns of self-denial or extended personalized care in the interests of the patients, physicians, or the hospital. The care-orientation, to a large extent, is being undermined by the nurses themselves.

Education is a large factor in determining how well nurses are

able to be self-directed, which is a new value in nursing education. Although nurses tend to exhibit the trend toward self-emphasis, the concept of self-reliance relative to the "professional self" is being challenged by this younger generation of nurses.

Furthermore, in a nursing world which no longer idealizes "sacrifice" as part of its world view when, to a large extent, sacrifice is needed for caring, stress behavior can be predictable. Stress does naturally cause one to turn inward on the self. Could the forces behind "self-actualization" and concentration on "self-interests" contribute to the destruction of the essence of nursing? A question to reflect upon and ponder!

Bronfenbrenner (1977:40-47), a social scientist, states that we generally are no longer a caring society by virtue of how we abandon children--"an empty house is a poignant symbol of nobody caring." He continues by stating that the society has a terribly low opinion of caring. Children do not learn about caring or how to care. He also points out the needs that the elderly have for care and caring. If we accept Bronfenbrenner's ideas of the non-caring society as a basic assumption in present-day culture, then the consequences on nursing and nursing behavior are alarming.

The fact that patients have access to health care with little or no economic barriers has not increased the pattern of caring. There is a significant change in the commitment to caring evolving.

The fact that the increase in nurses' salaries to a competitive level with many other professions (excluding physicians) has not improved the caring capacity of nurses and nursing in the culture of

this hospital.

The "culture" of the hospital is, indeed, a valuable place from which to study the culture at large. Nursing has changed in light of many changes in the modern-day culture. Some nurses now value different meanings of care and caring. In the health care system of the hospital, the vital dimension of caring affects both the care provider--the nurse, and the care-recipient--the patient. A reciprocal relationship is necessary for the growth and development of caring behavior. Friedman (1977:8), a philosophical anthropologist, states:

Really to care means to be able to enter into the situation of the other, yet to bring with you some resources that the other does not have so that you may, not cause, but facilitate, the healing that may come to pass in the meeting between you.

Whether nurses can grow in their caring role depends upon the internalization of a shared value of caring developed through positive interactive behaviors. Bronfenbrenner (1977:40-47) believes that now and in the future there is a need to introduce a curriculum focusing on the notion of caring for the elementary grades and up. His research illuminates cultural non-caring phenomena because he believes children are not generally cared for. Therefore, because we are not a caring society, "caring skills will have to be taught in the schools." From the conclusions drawn in this study, Bronfenbrenner's ideas pose a critical problem for nurses and a challenge for nursing. How will nurses and the profession, as a whole, respond?

"Man the moon shooter--now I am here--now read me--give me a name" ends with a note of creation, of adventure, of excitement. Nurses, as members of a "caring" profession within hospitals or other health care institutions, must respond by education, by research and,

most of all, by human concern.

Recommendations

In this applied anthropological study, the goal is the development of planned change believed to assist in the solution of some complex problems elucidated by this research. The following is a list of recommendations which arise out of the ethnographic data of this study.

Recommendations Relative to the Care of the Aged

1. Articulation with hospital administrative staff regarding the concept of zero-based budgeting and redefinition of the philosophy and objectives of acute vs. chronic/aged hospital value systems
2. Staffing pattern improvements using both professional and non-professional personnel to reflect the changes in priority care for the aged
3. Increase recreational/occupational/rehabilitative care systems for the aged
4. Assist in the development of additional and/or continuing education programs in the concepts, principles and theories, practice conditions of aging, and other important topics
5. Interaction with Ministry of Health as to the redefinition of a portion of the hospital as a hospital for the aged and/or chronically ill in view of the fact that "hospital beds need to be closed if nursing home beds are opened"
6. Research study into the economic considerations regarding the allocations of monies in the construction budget of new nursing

homes vs. the utilization of a section of the existing hospital structure as a facility for aged/chronic care

Recommendations Relative to the
Bureaucratic Management

1. Group discussion with management service personnel, and representatives from the general nursing staff to examine the philosophy, purpose, and objectives of nursing and the hospital
2. An open recognition of the role of working women--married or single--with or without children--in the hospital
3. A Child Care Center to be established and staffed by caring personnel to alleviate and/or reduce stress of the working mother of young children
4. Research into a shortened work week of four days whereby new professional and recreational streams for growth and development may evolve, which also may allow for more unemployed nurses to return to the work force. Pay adjustment union negotiations based upon fewer work hours would be required
5. Increase the status of part-time nurses to full recognition and participation within the hospital and nursing communities, in consideration of work/home responsibilities of working women
6. Increase interaction with the union and its members regarding the question of a shortened work week, time off for family illnesses, changes in the reward system (both economic and human) for degrees of excellence in care and the caring role of nurses
7. Hair dressing and barber shop facilities to assist both nurses and patients (acutely or chronically ill) in the process of care.

8. Flex time research study in order to investigate whether new working hours and schedules could alleviate time stresses for nurses

Recommendations Relative to
Education and Research

1. Further research in order to test the hypothesis of altered care behavior developed in this study

2. Educational and nursing practice research into the philosophy and caring behavior of nurses from cross-cultural perspectives with the inclusion of various culture groups represented as patients in the hospital

3. Articulation with the community colleges in order to establish what goals and objectives of the educational program are relevant to the service goals and objectives

4. Individual and collective recommitment to the value of caring and what its intrinsic and extrinsic value changes have on the social context of health and illness

5. Research regarding educational preparation of the patient in order to investigate under what conditions patients learn and internalize values, attitudes, and subsequent behaviors about either pre-operative or post-operative conditions and high-risk medical problems--that is, the concept of "learned helplessness." Refer to patients with problems of congestive heart failure, coronary heart disease, post-coronary surgical by-pass problems with consequential medical and/or psychological sequelae

6. Research into organizational patterns of management in the

department of nursing with opportunities to test a number of organizational systems to reduce bureaucratic management problems

7. Examination of the cure versus care models of health provisioning with emphasis upon the Lalonde "health field concept," and models of nursing care

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APPENDIX A

GLOSSARY

1. Professional Nurse is a person who has completed a recognized program of study in a college, hospital, or university School of Nursing with a license to practice as a registered nurse for the purposes of providing knowledgeable nursing and health care services to patients/clients. Nurses may be engaged in roles as practitioners or care-providers (preventative and/or restorative), educators, researchers, and administrators who contribute to the welfare of nurses, the institution, and the profession; or to the health of the care-recipients (patients/clients).
2. Nurse Clinician is an individual who has completed a Bachelor of Science degree in nursing and is involved in teaching responsibilities with staff nurses, management staff, and patients/clients. He/she is considered in a non-unionized position within the nurse occupational groupings in the hospital.
3. Clinical Nurse Specialist is an individual with a Master of Science degree in nursing within a variety of clinical specialties such as intensive care, Medical-Surgical nursing; is both a formal and informal nurse educator in classroom and clinical areas; is a practitioner of nursing; is a researcher; and can have a joint appointment with the University School of Nursing and/or Medicine. He/she is in a non-unionized position within the nurse occupational grouping in the hospital.

4. Staff Nurses are nurses who are engaged in the delivery of health care services to patients in hospitals where their roles are specifically structured toward specialized tasks.
5. Nurse Practitioner is defined as a professional clinical nurse who has additional education in the clinical fields of assessment, diagnoses, independent decision making, management and evaluation of health problems.
6. Office Nurses are nurses who are engaged in delivering professional nursing and clerical services to clients in community physicians' offices.
7. Assistant Director/Director of Nursing is a professional nurse engaged in supervisory and top management services to nurses and clients within the organizational structure of the hospital.
8. Team Leader/Charge Nurse is a nurse functioning in a leadership position with responsibility for a group of nursing personnel (professional and non-professional) in direct nursing service as a care-provider to the patient; and functions in a coordinating role of health care delivery with physicians and nursing administrators.
9. Nursing in the broadest sense refers to a body of knowledge and specialized techniques and processes to help people with health-threatening problems or conditions. Nursing can be viewed as a helping service, preventative and restorative, which is concerned with the direct personalized care and treatment of people, and indirectly through advice, guidance, and supervision (Leininger 1970:29). Leininger has referred to nursing as a "subculture."

In this study the term "cultural subset" is used, as well.

10. Nursing Coordinator is an individual performing in a supervisory position with responsibility for nursing personnel and system organization.
11. Head Nurse is a nurse functioning in a leadership position with responsibility for a group of nursing personnel (professional and non-professionals) in direct service to the patient and in the coordination of health services with the physician.
12. Registered Nurse Assistant (R.N.A.) is licensed to practice as an assistant to the Registered Nurse with educational preparation from a recognized course and is a team member involved in direct patient care services.
13. Patient/Client/Care Recipient is defined, in general, as a person seeking and in need of the services of health care practitioners for the purposes of preventative, curing, and caring health care.
14. Hospital is defined as a complex, cultural organization/bureaucracy or institution where persons in need of specialized health care services for the purposes of diagnosis, surgery, medical and/or disease curing, and professional nursing care are admitted and accommodated during the course of their illness. Hospitals have institutionalized norms of behavior and interaction patterns among professional and non-professional personnel which are governed by a variety of ideologies of the occupational groups.
15. Unit/Ward is defined as a designated area or space within the hospital where patients are accommodated for specific illnesses or diseases and are in need of the specialized services of health

practitioners.

16. Ethnonursing is referred to as those culturally defined nursing knowledges and skills provided by persons in caring roles to assist people to attain and maintain their health state, or to recover from an illness or disability state. In general, ethnonursing includes two broad culturally defined domains: 1) preventative care, and 2) restorative care--both related to general health maintenance care by professional, semi-professional, or non-professional nursing care providers in different cultures (Leininger 1975).
17. Role refers to specific, "functionally" significant, intrasocietal differences in activities of humans, such activities being learned and interrelated in patterned ways (Atkins 1954:8; Sarbin 1954:225). Role also refers to individualistic response patterns built up in past interactions with specific other individuals (Atkins 1954:23).
18. Role Behavior refers to the system of action and attitude responses inherent in role performance or "role enactment" (Sarbin 1954:232).
19. Middleman (a term adapted from political anthropology and translated into a nurse role behavioral term) is defined as a professional clinical nurse who occupies a hierarchical, structural role, is the link between the physician and patient, the bridge between the culture of the hospital/institution and the patient group, and has assigned duties to mediate. In this study the term middleman will be used without reference to the gender (Ray 1976).
20. Entrepreneur (a term adapted from political anthropology and trans-

lated into a nurse role behavioral term) is defined as a professional clinical nurse who is a kind of middleman where ideas are implemented, where risks from traditional professional norms are taken, and where profit in terms of extra professional rewards is gained (Ray 1976).

21. Patron (a term adapted from political anthropology and translated into a nurse role behavioral term) is defined as a professional clinical nurse who is selecting values of his/her own choosing in response to clinical decision making, and is capable of delivering first-order resources in the process of care to patients (Ray 1976).

APPENDIX B

A PROPOSAL FOR RESEARCH:
AN APPLIED ANTHROPOLOGICAL STUDY
OF ROLE BEHAVIOR WITHIN THE PROFESSION OF NURSING
IN THE COMPLEX INSTITUTION OF THE HOSPITAL

Presented to the Research Committee Members
of St. Francis' Hospital
M. A. Thesis Committee Members
Department of Anthropology
McMaster University
Hamilton, Ontario

Submitted by
Marilyn A. Ray, R.N., M.Sc.
Candidate M.A. Anthropology
McMaster University

March 1977

Proposal for Research

Background Information

The development of the interrelationship between the fields of nursing and anthropology has been due to the efforts of Madeleine Leininger, R.N., Ph.D., the first nurse-anthropologist. The theme of her book, Nursing and Anthropology: Two Worlds to Blend (1970) is the interdigitation of the two disciplines so that each field will profit from the contribution of the other. Nursing is attempting to understand behavior of individuals and their health needs so that there will be improvements in nursing practice. Anthropology continues to gain insights into the behavior of individuals through the source of time and in a variety of geographical areas and localities. As an integrative discipline, nursing has adapted and blended knowledge from many fields of study. Anthropology is considered the integrating discipline of all the social sciences and is viewed as holistic. In its uniqueness, nursing applies knowledge from the various fields and synthesizes the knowledge to effect the delivery and/or improvement of nursing practice.

In applied research, anthropological investigations include a large theoretical component; however, to fulfill its goal, applied research produces practical data and theories in the form of information, ideas, insights, and knowledge which contribute to the solution of problems of concern to organizations and professional bodies. A formal definition by George Foster (Brink 1976:29) describes "applied anthropology" as a phrase commonly used by anthropologists to describe their professional activities in programs that have as primary goals

changes in human behavior believed to ameliorate contemporary social, economic, and technological problems, rather than the development of social and cultural theory.

Nursing practice, for the most part, is conducted in institutions; and nursing behaviour does not grow significantly unless there are valid reasons and avenues available for change and development. Before positive health care planning can take place, the implementors of health care must gain insights and develop awareness of the barriers and facilitators to quality health care delivery. Since nurses are the largest professional health care group, a knowledge of nursing behaviors in the care process of patients, the communication patterns and role relationships with other professional and non-professional groups, and the levels of commitment and beliefs about patients' care are imperative.

Purposes and Objectives of This Study

1. To gain insights into nursing behaviors in the process of care to patients by utilizing anthropological and social science research methods.
2. To become knowledgeable about the impact of structural realities of complex organizations on values and the consequences for nursing practice.
3. To develop awareness of the cultural norms, rituals, myths of nursing practice which influence, positively or negatively, the practice of nursing.
4. To understand the communication and decision-making patterns intra- and inter-professionally within the hospital.

5. To recognize some of the fundamental and important relationships between the fields of anthropology and nursing which have a bearing on the health-illness patterns of patient behaviors.

Methodology and Design

To a degree, this study has no tight research design. There are no well-constructed sets of hypotheses to be tested or sets of analytic procedures developed in advance. A data gathering instrument, Current Nursing Trends Questionnaire, will be utilized to gain insights into nursing approaches as they relate to decision making. The questionnaire was previously designed for a pilot study in applied anthropology and nursing (Ray 1976). The research problems will evolve in the course of the research progression. Anthropological theories will be applied as data are gathered. The questionnaire will relate information which can support ideas raised in the objectives of the study.

The major methods of investigation will be participant observation, key informant interviewing, structured interviews, and the questionnaire (Pelto 1970:89-105).

Time sampling will be made in all areas where nursing practice is conducted.

Time Commitment for the Staff

The study will be conducted from mid-March to June 1977. The time will increase from one day per week during mid-March and April to three days per week during the month of May.

The group which will have primary emphasis during the course of study will be the nursing coordinators; however, all the management

staff will be contributing to information gathering about nursing behaviors.

Intended Use of Research

The research will contribute to the understanding and awareness of nursing behavior intra- and inter-professionally, and its consequences on the patients within the complex institution of the hospital. The data derived from this study will be used for the purposes of recognition of barriers and facilitators to health care planning and implementation which affect nurses and other health professionals and the people whom they serve.

In terms of its contribution to anthropology, the data will serve as a base of knowledge in the understanding of interactional behavior which can be utilized in other complex institutions within contemporary culture.

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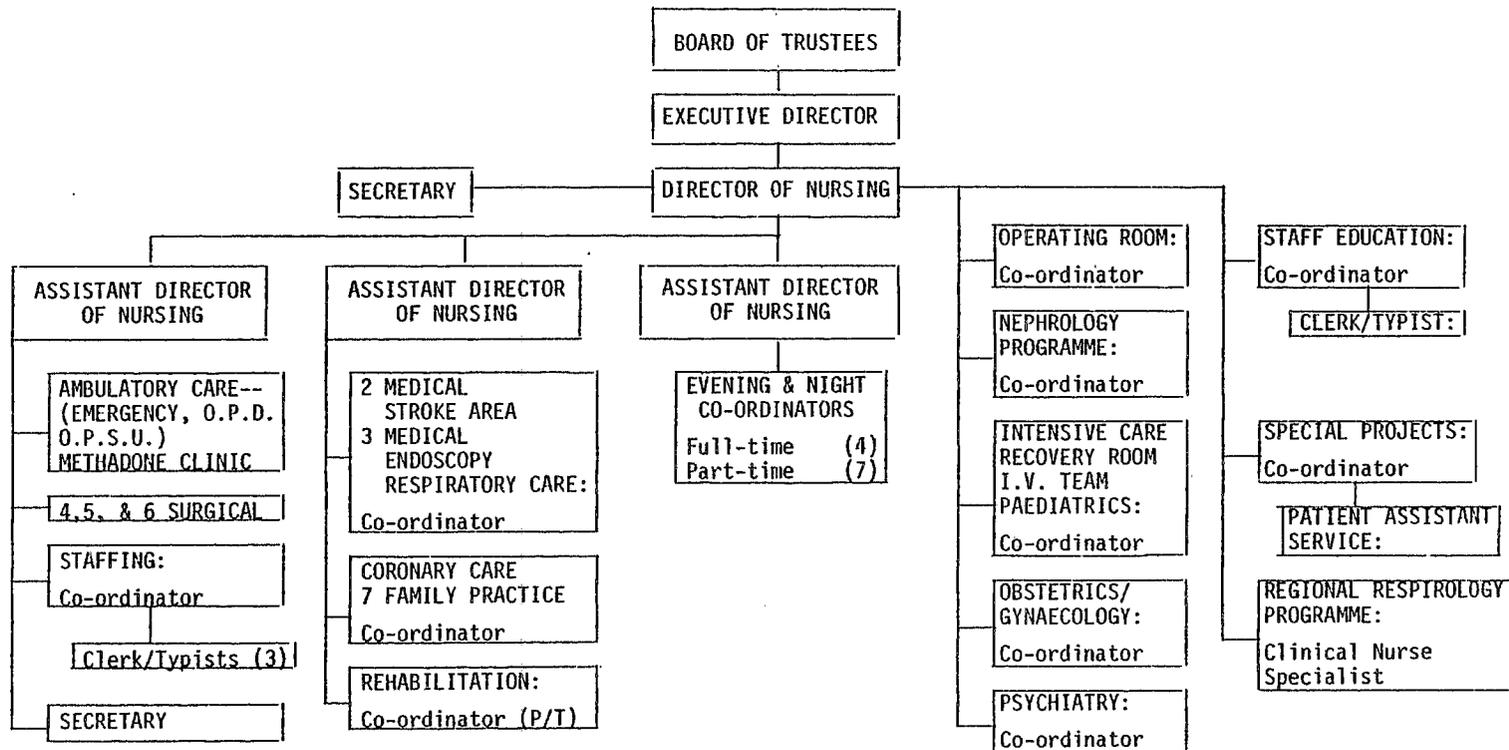
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*A more complete selected bibliography is available upon request.

Questionnaire

Current Nursing Trends Questionnaire Developed by Marilyn A.
Ray, 1976.

ORGANIZATIONAL CHART
DEPARTMENT OF NURSING - NURSING ADMINISTRATION



Revised July 1976
MLP/ab

APPENDIX C

CURRENT NURSING TRENDS

DECEMBER 1976

1. NAME _____
(optional)
2. YEAR OF DIPLOMA/DEGREE 1. _____ 2. _____ 3. _____
3. LIST HIGHEST NURSING EDUCATIONAL LEVEL _____
4. PRESENT POSITION - NURSE PRACTITIONER OFFICE NURSE STAFF NURSE
5. LENGTH OF TIME IN PRESENT POSITION YEARS _____ MONTHS _____
6. LENGTH OF TIME IN ACTIVE NURSING YEARS _____

The purpose of this questionnaire is to explore nursing approaches in a number of nursing settings, specifically as they relate to decision making. Please check each statement as to whether you:

agree strongly
agree
have no opinion

disagree
disagree strongly

Do not spend too much time on any one item.

The professional clinical nurse:

- | | | Agree strongly | Agree | No opinion | Disagree | Disagree strongly |
|--------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| M 1. | Is assigned specific duties to perform when an individual enters the health care facility. | <input type="checkbox"/> |
| MPE 2. | Has the responsibility and accountability for all professional actions. | <input type="checkbox"/> |
| P 3. | Is a team member with equal responsibility for care with the physician. | <input type="checkbox"/> |
| MPE 4. | Evaluates patient adaptation to changes in health status. | <input type="checkbox"/> |
| M 5. | Must implement the decisions made by the physician. | <input type="checkbox"/> |
| M 6. | Must recognize that the physician is the leader of the health team. | <input type="checkbox"/> |
| M 7. | Must report all minor health problems to the physician for action. | <input type="checkbox"/> |
| EP 8. | May challenge a physician's order. | <input type="checkbox"/> |
| E 9. | Should be an innovator of change in the agency (hospital, office, clinic, institution). | <input type="checkbox"/> |
| M 10. | Keeps the "peace" between physician and nurses. | <input type="checkbox"/> |
| MPE11. | Is a patient advocate. | <input type="checkbox"/> |
| M 12. | Should recognize that good doctors rarely make mistakes. | <input type="checkbox"/> |
| E 13. | Has the right to assess the patient's (client) health status to determine the needs for medical, nursing, or other therapeutic intervention. | <input type="checkbox"/> |
| M 14. | Is responsible for "how the agency (office, clinic, hospital) runs." | <input type="checkbox"/> |

	Agree strongly	Agree	No opinion	Disagree	Disagree strongly
M 15. Should identify medical problems.	<input type="checkbox"/>				
E 16. May exercise independent clinical judgement in the management of patient care.	<input type="checkbox"/>				
E 17. Should receive rewards (economic or praise) from physicians when initiating new ideas for health care delivery.	<input type="checkbox"/>				
EP18. Should teach individuals and families the specific knowledge and skills required to maintain health and prevent illness, e.g., nutrition, medication management, growth, aging, and development mechanisms, etc.	<input type="checkbox"/>				
M 19. Should communicate patient's needs to the physician.	<input type="checkbox"/>				
M 20. Must recognize that the doctor knows more than the nurse.	<input type="checkbox"/>				
E 21. Has a major responsibility in assessing and managing the utilization of pharmacological agents (medications) in the process of care.	<input type="checkbox"/>				
E 22. Is educated to counsel people of all ages in relation to health matters.	<input type="checkbox"/>				
MPE23. Should identify nursing problems.	<input type="checkbox"/>				
M 24. Interprets medical terminology to patients.	<input type="checkbox"/>				
M 25. Is subordinate to the physician.	<input type="checkbox"/>				
EP26. Should coordinate the health care of individuals with physicians and other health professionals.	<input type="checkbox"/>				
M 27. Has a responsibility in interpreting medication orders and dispensing them to the patient in a hospital environment.	<input type="checkbox"/>				
M 28. Accepts responsibility for patients' failure to comply with physicians' orders.	<input type="checkbox"/>				

	Agree strongly	Agree	No opinion	Disagree	Disagree strongly
M 29. Should transmit physicians' decisions to the patient.	<input type="checkbox"/>				
E 30. May refer patients to appropriate health professionals (or agencies) as needed.	<input type="checkbox"/>				
M 31. Has the responsibility but no accountability for the process of health care.	<input type="checkbox"/>				
EPM32. Has the professional capability to influence the agency and physicians in matters of health care.	<input type="checkbox"/>				
M 33. Must compromise her/his position to the decision-making position of the physician.	<input type="checkbox"/>				
RM34. Is legally protected by the agency (clinic, office, hospital) for all matters relative to nursing practice.	<input type="checkbox"/>				
EP35. Should resist dominance by the physician.	<input type="checkbox"/>				
M 36. Impresses agency administration by efficient use of resources (equipment, supplies).	<input type="checkbox"/>				
M 37. Is superior to the Registered Nurses' Assistant.	<input type="checkbox"/>				
M 38. Must acquiesce to the physicians' orders at all times.	<input type="checkbox"/>				
M 39. Must ensure patients comply with medical regimes.	<input type="checkbox"/>				
EPM40. Must exchange professional information with physicians.	<input type="checkbox"/>				
M 41. May be seriously reprimanded if physicians' orders are not implemented.	<input type="checkbox"/>				
M 42. Must report all major health changes to the physician for reevaluation.	<input type="checkbox"/>				

- | | Agree strongly | Agree | No opinion | Disagree | Disagree strongly |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| M 43. Is subordinate to the other health care professionals (pharmacists, physiotherapists). | <input type="checkbox"/> |
| EP44. Is a professional capable of problem-solving ability for interdependent decision making. | <input type="checkbox"/> |
| EP45. Can only be protected by Malpractice Insurance of the Registered Nurses' Association of Ontario for failing to comply with physicians' orders. | <input type="checkbox"/> |
| E 46. Is granted "time off with pay" for continuing education. | <input type="checkbox"/> |
| M 47. Is superior to the nutritionist. | <input type="checkbox"/> |
| EP48. Shares responsibility with the physician in the management of patient care. | <input type="checkbox"/> |
| EP49. May diagnose a health problem. | <input type="checkbox"/> |
| E 50. Has a "right" to the patient. | <input type="checkbox"/> |
| M 51. Impresses the physician by technical competence. | <input type="checkbox"/> |
| M 52. Is an assistant to the physician. | <input type="checkbox"/> |
| M 53. Has the responsibility but no authority for the implementation of a plan of care. | <input type="checkbox"/> |
| EP54. Should challenge unethical behavior of a physician. | <input type="checkbox"/> |
| EPM55. May intervene in critical care situations, and exercise clinical judgement, e.g., cardiac arrest. | <input type="checkbox"/> |
| M 56. Knows that medical care is more important than nursing care. | <input type="checkbox"/> |

APPENDIX D

April 21, 1977

Miss M. Ray, R.N.,
M.U.M.C.,
Department of Anthropology,
Hamilton, Ontario.

Dear Miss Ray:

We are pleased to inform you that your application for approval of a research project, entitled:

"The Study of Role Behavior within Nursing"

R.P. 77-212

has been approved by the Board of Trustees of St. Francis' Hospital in accordance with the written protocol submitted.

APPENDIX E

DEPARTMENT OF NURSINGPhilosophy

In accordance with the philosophy of St. Francis' Hospital, the Department of Nursing believes that:

1. The intrinsic worth and dignity of man is determined by his nature. Man is a composition of body and mind, a rational being with a free will, made to the image and likeness of God and destined for eternal happiness.
2. Teaching and care of the sick are an extension of Christ's work on earth, and as such they form an integral part of Christian nursing.
3. We also believe that:

"NURSING IS PRIMARILY ASSISTING THE INDIVIDUAL (SICK OR WELL) IN THE PERFORMANCE OF THOSE ACTIVITIES CONTRIBUTING TO HEALTH OR ITS RECOVERY (OR TO A PEACEFUL DEATH) THAT HE WOULD PERFORM UNAIDED IF HE HAD THE NECESSARY STRENGTH, WILL OR KNOWLEDGE. IT IS LIKEWISE THE UNIQUE CONTRIBUTION OF NURSING TO HELP THE INDIVIDUAL TO BE INDEPENDENT OF SUCH ASSISTANCE AS SOON AS POSSIBLE." (1)
4. We believe that staff education is an essential function of the Department of Nursing and that nursing personnel at all levels should have the opportunity to share their knowledge and experiences and to explore nursing problems together in the interest of patient care and personal growth.

OBJECTIVES of the DEPARTMENT OF NURSING which evolve from the foregoing philosophy are:

1. To organize and co-ordinate facilities and activities of nursing and related personnel in order to promote quality nursing care
2. To provide an environment conducive to learning, the promotion of job satisfaction and personal growth of individual members of the department
3. To provide an educational environment for students--nursing, medical, and para-medical
4. To promote effective communication within the hospital and the community

5. To conduct and contribute to research projects directed toward improved patient care

REFERENCE

- (1) Harmer, Bertha, Textbook of the Principles and Practice of Nursing, 5th Ed., revised by Virginia Henderson. New York: Macmillan, 1955, p. 4.

August 1965, Rev. June 1967, Rev. April 1968, July 1971, June 1974
/am

APPENDIX F

REPORT OF RESEARCH CONDUCTED
AT ST. FRANCIS' HOSPITAL

March--June 1977

by

Marilyn A. Ray, R.N., M.Sc.
Candidate--M.A. Anthropology
McMaster University

June 1977

REPORT OF RESEARCH CONDUCTED

...the shapes of change
ai ai they take their time
asking what the dawn asks
giving the answers evening gives
till tomorrow moves in
saying to man the moon shooter,
"Now I am here--now read me--
give me a name."

Carl Sandburg

Anthropology is the study of human beings. The largest sub-field, cultural anthropology, is concerned with cultures human beings have created. This present study deals with the ways in which nurses believe and behave within one complex institution where the delivery of health care services takes place. There are a variety of ways in which the anthropologist learns about the culture. The researcher listens to the people, observes the people and their interactions, talks to the people, and sometimes uses questionnaires to arrive at a selective type of knowledge from the data. Recording of the rituals and practices helps in the understanding of the life ways of the people. The common goal of all investigation is the discovery of the cultural similarities and the differences. Culture is the acquired knowledge that people use to interpret experience and to generate social behaviour (Goodenough in Spradley & McCurdy 1975:5).

Transcultural nursing is the study of cultural differences and similarities regarding the caring components of nursing practices, but with the emphases upon the systematic comparative study of values,

beliefs and patterns of caring behaviours (Leininger 1977:6).

Relative to the purposes and objectives of the research conducted at St. Francis' Hospital, anthropological and social science research methods were utilized. The questionnaire was given to the management staff for the purposes of investigating the belief systems of the political behaviour of the nurses. Political behavior relates to the terms of the roles developed in political anthropology--that is--middleman, entrepreneur, and patron. From this data, it was learned that the nurses in their ideational order tend to be very committed, innovative, caring, interdependent, and resourceful in their professional interactions with patients and other professionals. The impact of the structural realities of the complex organization on these values, however, reveals that there is a wide disparity between what is stated as belief and what is operationalized in nursing practice. The "caring" behaviour--the essence of nursing practice--is realized in forms inconsistent, also, with the philosophy of the hospital. The philosophy is definitely "other" oriented, whereby the nurse behavior of the present reality is oriented toward "self." Where it is normally believed that nursing is totally committed to patient care, the nurse, because of the demands of a highly materialistic, self-actualization process, concentrates her/his pursuits on economic and social gain as well as patient care responsibilities. In essence, there is evidence to suggest a two-fold professional and social need for growth and development. One is cognizant of the "leisure" vs. the "work" ethic in belief and action, which is consistent with the development of a post-industrial/technological age of mankind. The structural organiza-

tional policies have been developed only to reflect the basic "other-directed" care philosophy.

In terms of cultural norms, rituals, and myths which influence positively and negatively, the practice of nursing, the glaring reality of acute care vs. chronic or care of the aged demand attention. The basic philosophical disparity produces a set of assumptions and outcomes which causes a conflict between the expected and real nursing behaviors. The hospital, operating under the mythological assumptions of an acute care facility, has to be thoroughly examined relative to present humanistic, social, political, and economic factors. The norms of the hospital need redefinition. Thus, the outcomes expected will differ radically considering the change to a more realistic philosophical stance and set of assumptions relative to the objectives of a facility whose majority are chronically ill or aged.

Communication and decision-making patterns reveal the fact that there is a split between labour and management, or the nurse in direct patient contact, and the administration from the intra-professional standpoint. Needs, desires, and goals are inconsistent with the beliefs about nursing practice and administrative organizational policy. The basic assumption that the increased emphasis on holistic, comprehensive patient care, is inconsistent with the educational preparation from a two-year community college nursing program. For example, the nurse is required to develop the sets of behaviors to elicit the problem solving nursing process to assess the biological, psychological, sociological, cultural, and spiritual needs of the patient when, in fact, the community college program of education can

barely provide the time for technical training and some theoretical concepts. Professional goals and technical goals are in conflict.

Intra-/inter-professionally, the inter-hierarchical role structure is prevalent even though the new team concept is a highly valued ideational form. The idea that "health care" is practised is incongruent with the observable "curing" role of symptomatic care, e.g., the high number of readmissions to the Cardiac Care Unit. The physician group, with the "curing" role as the prime model of health care, focuses on symptoms rather than health education for prevention and promotion. The nurse is not professionally able to define the educational role as a prime function of caring. It can be traced to the educational system as well as institutional budgetary constraints.

The fundamental and important relationships between the fields of anthropology and nursing which have a bearing on the health-illness patterns of patient behaviour suggest the reflection of the larger culture in the culture of nursing within the hospital. The cultural shifts in youth to aged population, work to leisure ethic, manual to technological, and humanistic to material cultures are evidenced in observable behavior and social interaction. The cultural identity of nursing has changed. Cultural patterns based upon realistic investigation and description need redefinition within the profession of nursing. To conclude, this abstract has not dealt with all the particulars related to the research; however, it has highlighted some major problem areas.

A number of statements are as follows:

1. The policies and regulations of the hospital are in direct

conflict with the nursing role and the mother-wife or single-social role

2. The modern-day nurse in general has at least two conflicting roles--mother/wife and nurse/professional

3. The modern hospital facility has a basic philosophical disparity between acute care and chronic-aged care institutional beliefs and values

4. The modern hospital operates under the value system of symptomatic care which is in conflict with the principles of holistic health care

5. The present-day nurse is in conflict with the institutional goals and expectations of the nursing department and the goals of her/his educational preparation

6. The inter-hierarchical role structure is in direct conflict with the philosophically defined beliefs about team membership

7. The "egalitarianism" of union membership negates the opportunity to reward individual meritorious works of nurses

8. The wide disparity between belief and action indicates a high degree of stress-related activity, e.g., decreased staff vs. increased responsibility

9. Stress-related activity contributes to the increase in care for self vs. the decreased care for others

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APPENDIX G

REPORT OF THE MEETING OF ADMINISTRATORS RELATIVE
TO THIS RESEARCH STUDY

Last month Marilyn (Dee) Ray presented to this group a report on her research which included nine hypotheses regarding the role behavior of nurses at the hospital. The hypotheses relate to the possibility of specified conflict relationships between nurses and the hospital, in general, and the Department of Nursing, in particular.

There is a significant similarity between the research done by Dee and my research into the organizational climate of this hospital. All of you received a synopsis of the Climate Study in March of this year and were made aware of the major study which is available in the hospital library.

Today, I am going to zero in on one aspect of both research studies that seems to be of concern to you--that is, the issue of inter-hierarchical conflict or the "we-they" syndrome.

There will always be a "we-they" issue in every organization because organizations contain people and not machines which can be programmed to complete a task without having an emotional response to the task. The goal of managers, such as yourselves, is to ensure that the "we-they" issue does not result in conflict which is detrimental to the goals and objectives of this hospital. Your task is to balance the needs of individuals and the goals of this hospital within the nursing department and hospital hierarchical structure.

To illustrate the concept of balance, I have a short video tape presentation for you. After the tape, I will elaborate some more on the "we-they" issues, raise some questions that I think as individuals and as a department you should consider and, finally, I will deal with any questions or comments that you might have.

VIDEO

There was one part of this tape that relates directly to the "we-they" issue, and that is the statement that "caring" for employees and obtaining results from employees may be in conflict. All of you are familiar with the general thrust in organizational literature advocating the use of a humanistic approach to management. Organizational democracy has been in vogue for at least twenty years. Lately, there has been some question as to the validity of the basic assumption of this approach. A recent article in the journal Public Administration Review suggests "what must ultimately be faced is the divergence between individual's egotistic interests and organizational purposes. This appears to be an inherently intractable problem. Neither job enrichment nor participation can transmute this divergence into congruence. Management--whose members are also not immune to self-interested behaviour--are [sic] not likely to find a panacea for the problem of inducing individuals to serve collective purposes."

How do you as nurse managers begin to balance individual needs and hospital goals within a hierarchical structure so as to minimize a "we-they" problem?

1. Realize that no matter how hard you try, some people will

dislike you and work against you simply because you represent a higher authority.

Such dislike may not be personal but exists because you represent a controlling factor in their lives.

2. Recognize continually that certain methods to instill a "caring" element for employees can be in conflict with the effectiveness of the hospital (department meetings, as an example).

3. Realize that the various values that nurses bring to this hospital may be in conflict with your values and that you have a right to question the nurses' values only if there is a question as to the nurses' work performance.

In her research, Marilyn (Dee) Ray raised the issue of the role conflicts in which nurses presently find themselves (i.e., parent/mate-nurse-professions). Because of his/her needs and priorities, the nurse of today may be willing to contribute to this hospital only those hours that by legal agreement he/she needs to contribute.

This is going to sound like heresy to some of you, but I do not believe in loyalty to an organization. I believe in loyalty to a person or group of people, and I certainly believe in the value of tradition. But I am not nor will I ever be loyal to this hospital. And I think that my attitudes are held by many employees.

The issue is one of dissimilar attitudes. Many hospital staff have great loyalty to this hospital and wish to spend a great deal of time working for it. But it must be realized that other people see this hospital as a job, a 9-5, and, as managers, we do not have the moral or legal right to impose our value systems on those staff.

4. Realize that your role as a nurse and role as a manager has conflicting expectations. And, maybe more importantly, realize that many nurses do not see you as nurses but as managers. Somehow, you must come to grips with the stresses of being concurrently a professional caring individual and a manager, as well as the numerous other stressors of being parents, mates, friends.

Now I will pose to you a number of questions which are intended to raise issues that are important in attempting to deal with some hierarchical aspects of the rather complex "we-they" issue.

1. How should department of nursing meetings be set up so that the "we-they" issue is minimized without negatively affecting hospital goals?

I mentioned my views on my attending departmental meetings; I think that you should deal with the same problem.

1.1 Should coordinators attend unit meetings?

1.2 If asked not to attend staff meetings, should a manager respect that request?

1.3 Should head nurses and coordinators attend the same meeting? Are head nurses less likely to raise issues at these meetings because of the presence of coordinators?

1.4 To what extent and for what reasons should nurse coordinators, assistant directors of nursing, and the Director of Nursing be seen on the units?

2. How do nurse clinicians and clinical nurse specialists "fit" within the hierarchical structure?

2.1 What are their lines of reportability and responsibility?

2.2 Do staff nurses and nurse managers understand the clinicians and specialists' roles and responsibilities?

3. When should meeting minutes be kept? Who keeps the minutes? Who is on the distribution list for the minutes?

4. Should staff nurses be on nursing committees?

5. Who makes which decisions and how are those decisions articulated throughout the Nursing organizational structure?

There are many other questions which relate directly to the "we-they" issue. These questions at least must be raised if the issue is to be dealt with properly.

Being a manager can be a lonely job. Some management theorists and practitioners believe that the more senior the management position, the more lonely the job.

I think that the Director of Nursing deserves a great deal of credit for having the courage to push for organizational research within the Department of Nursing.

The results of such research can be threatening and, at times, quite embarrassing. But such research is absolutely necessary if the hospital wishes to expand its service, research, and education goals within an ever-changing society and ever-diminishing budget.

I will finish with a short prayer which I refer to as the manager's prayer.

God grant me the strength to change those things I can change.
The serenity to accept those things I cannot change, And the
wisdom to know the difference.

Thank you.

August 1977

APPENDIX H

REPORT OF THE RESEARCH PRESENTED TO THE
HEAD NURSES' MEETING

(Transcribed from the Tape July 12, 1977)

Role of the Researcher in Nursing

Marilyn (Dee) Ray pointed out the nursing problems:

Management Group vs. Staff Nurses

Questionnaire only given to the Management Group--there were questions about why only the one group. The main reason was because of the time in field study and the limited resources.

Inter- and intra-hierarchical role structure--political role behavior. The political roles: Entrepreneur, Patron, Middleman were explained. Higher scores on Entrepreneur and Patron than Middleman, thus resulting in the fact that the group was generally committed to more independent values regarding nursing and were open to change.

Validity of the Questionnaire

Previously tested with 3 different nurse groups in another study.
Positive role. How do we use it?
Canadian Health Care Delivery System tied to Politics.

Wording of the Questionnaire was developed in order to get at a reaction and attitude.

Research Statements and Hypothesis

Staff nurses regarding policies, rules, and regulations: majority of the nurses' complaints/problems had difficulty with their roles as nurses.

Pattern

Nurses' needs outside the hospital--economic considerations: wage earner, provided economic stability for the family.

Mothers

Dual commitment--priority over the nursing role for the motherhood role.

Conflict

Time off with families for holidays and vacations, or when child sick.

Other commitments are equal to or greater than the Nursing role and especially the economic considerations.

Nurses often have to lie because the policies are developed for non-mother nurses who have other responsibilities.

Woman's Role in Society

Problem of the child care, sharing responsibilities, commitment to family life, and the conflict with the nursing role.

Single/Social Role

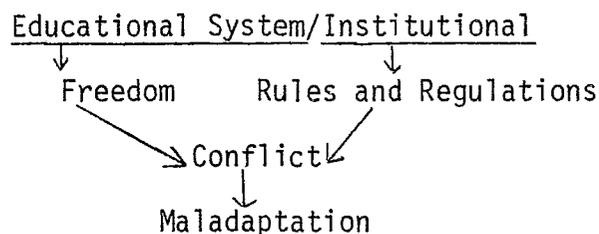
This group wants time off for social activities and travel. Very few mentioned that they wanted time for education.

Reflection of the larger culture regarding the Leisure Ethic.

Increased stress factors produce a different kind of nurse today.

The dichotomy between the philosophy of giving and self-actualization can be seen in the school system. There is neavy concentration on individualization. Filters into the nursing profession.

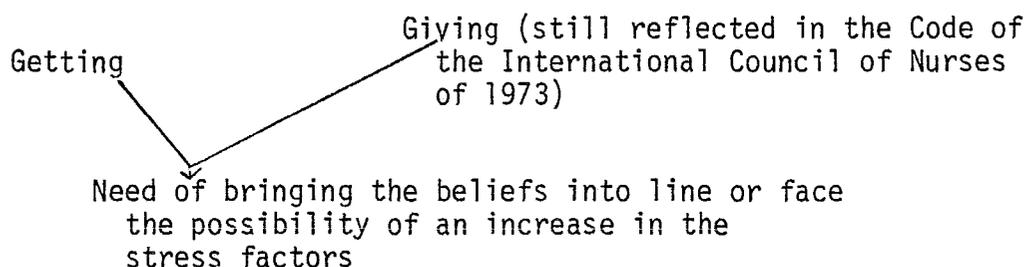
Produces:



At least 2 conflicting roles for working out growth and development.

Transitional culture--conflict of the working mother/wife and the professional nurse.

Overall philosophy of the hospital oriented toward "giving," but we are a "getting" society.



Wide value and operational disparity.

Management ideational order related to giving.

Variables of Stress

Complex Health Care System

More complex ways of caring: psycho-social and technological.
Increase in problem-solving process needed. Nursing Care Plans
increased responsibility.

Students do not learn the skills required for complex nursing. Cannot meet the expectations of the written philosophy, the rules, regulations, objectives of the hospital; therefore this causes an increased care for oneself and decreased care for others. Witnessed in the increased complaints and the needs and wants of the nurses.

2-Year Educational Program

Become "charge" nurses, but they cannot cope with the problems.

Cultural Identity of Nursing has changed, and it is not wrong. Reality is not wrong, but the hospital is basing today's needs on yesterday's philosophy.

Modern Hospital Facility

Conflict between acute and chronic care.

Shift in the population statistics from the youth to the aged.

The pyramid has turned up-side-down.

Working under false assumptions when one analyzes the composition of the patient population, e.g., Cardiac patients become chronic and long-term care when they are readmitted.

Concept of Illness different, e.g., the Renal Patients are chronic but admitted for active treatment.

Mental Illness is a chronic problem.

Aged

Utilitarian Philosophy: Old people put out by most in the culture.
"Out of sight, out of mind."

Emphasis on the youth in today's culture.

Different set of values and beliefs about the aged

Length of stay long. Nurses can't cope because the staffing is based on the active treatment status rather than on persons who take long to feed, bathe, ambulate, etc. Do we need an all-professional staff to give comfort?

Consider the feeding of the patients and their nutrition. Nurses said it is like an assembly line, and the food is pushed in because they haven't got time for them. They are too slow!

We need to examine what is going on.

Another problem is the intervention into the dying process. There is a philosophical disparity in the Care/Cure Process. Old people need CARING.

For example:

The Intensive Care Unit and the Patient with Congestive Heart Failure. In the Nursing Home they either forget to take their Medications, or they get mixed up. They are repeatedly admitted to the ICU. No one is coordinating their care with the VCN or the Public Health Nurses to see that they are getting their medications. They come back for curing. Who is doing the caring?

Problem of Symtomatic care and the Disease Process and Medical Model instead of the Total Health Care Model. The hospital is still physician-centered.

Problem of the Intra-/Inter-hierarchical Role Structure

Organizational structure and the concept of team. Split between labor and management. Union brings the profession into 2 camps. When something is introduced into the system, there are new problems set up.

All members are considered the same, therefore, can't reward some for excellence. Same problems as industry.

So many problems are tied to economics--we want money.

Still have the health care model defined by the physicians.

Professional--What does that mean? How can we as nurses meet our responsibilities?

A time for questions was introduced.

Summary

People were pleased with the project according to the response and reaction to the data presented.

The researcher was asked to return any time!