The Hospital Staff Nurse Position

as viewed by

Baccalaureate Graduates in Nursing

by

Laura L. Simms

W
4
S592h

THE HOSPITAL STAFF NURSE POSITION AS VIEWED BY BACCALAUREATE GRADUATES IN NURSING

by

Laura L. Simms

Submitted in partial fulfillment of the
requirements for the Degree of Doctor of Education in
Teachers College, Columbia University

1963

2 MAR 1970

All rights reserved by Copyright.

Copies may be purchased from the:
Office of the Dean
Cornell University-New York Hospital School of Nursing
1320 York Avenue, New York, N. Y. 10021
Price: $3.50 per copy

TABLE OF CONTENTS

CHAPTER		PAGE
I.	THE PROBLEM AND STUDY DESIGN	1
	The Problem	1
	Basic Assumptions	2
	Method and Procedures	3
	Method of Analysis	5
	Limitations of the Study	8
II.	NURSING FUNCTIONS IN PERSPECTIVE	10
	Preservice Education for Professional Nursing	10
	Practice following Graduation	11
	The Hospital as a Practice Field for Nurses	12
	Recent Attempts at Defining the Functions of Nursing	14
	Rationale of the Clinical Nursing Functions	16
III.	THE SETTING AND THE INTERVIEWEES	21
	The Setting	21
	The Institution and its Organization	21
	Ancillary Services and Supply Departments	22
	The Registered Nurse Staff	23
	The Auxiliary Nursing Staff	28
	Nursing Students	30
	The Interviewees	30
IV.	THE NURSES' OPINIONS ABOUT THE JOB WITH REFERENCE TO THEIR EDUCATIONAL PREPARATION	32
	General Staff Nursing as a Beginning Position	32
	General Staff Nursing as a Life-Time Career	35
	Perceived Differences Between Job Requirements and Educational Preparation	37
	Perceived Differences Between Baccalaureate and Diploma Graduates Working as Staff Nurses	41
	Summary and Conclusions	43
V.	PERCEIVED DETERRENTS TO THE PRACTICE OF CLINICAL NURSING FUNCTIONS; TIME	44
	Time and the Demand for Discrete Tasks	44
	Time and Priorities Among Patients	46
	Time and Sustained Contact with the Patient	47
	Time and Discrete Institutional Tasks	50
	Summary and Conclusions	53
VI.	PERCEIVED DETERRENTS TO THE PRACTICE OF CLINICAL NURSING FUNCTIONS; WORKING RELATIONSHIPS	55
	Informal Controls on the Nursing Unit	55
	The Subordinates	55
	The Peer Group	58
	The Individual Nurse	59
	The Patient	61
	Formal Controls on the Nursing Unit	61
	Instructor and Students	61
	Supervisors and Head Nurses	62
	Doctors	65
	Departmentation in the Hospital Organization	68
	Summary and Conclusions	72

CHAPTER		PAGE
VII.	CONCLUSIONS, RECOMMENDATIONS, AND IMPLICATIONS	74
	Conclusions Relating to the Respondents	74
	Conclusions Relating to the Practice Field	75
	Recommendations for Improvements in Utilization of Baccalaureate Nursing Graduates in the Hospital . . .	77
	Implications for the Nursing Profession	78
BIBLIOGRAPHY	. . . .	80
APPENDIX A.	INITIAL CORRESPONDENCE CONCERNING THE INTERVIEWS . .	84
APPENDIX B.	CHARACTERISTICS OF THE INTERVIEWEES	86
APPENDIX C.	CLASSIFICATION OF SUMMARIZED RESPONSES FROM ONE INTERVIEW	88
APPENDIX D.	SYSTEM OF CODING PERCEIVED DETERRENTS TO CLINICAL NURSING FUNCTIONS	92

LIST OF TABLES

TABLE		PAGE
I.	Registered Nurse Staffing Complement at the New York Hospital for Pay Period Ending July 29, 1962, By Clinical Nursing Positions	24
II.	Registered Nurse Staffing Complement at the New York Hospital for Pay Period Ending July 29, 1962, By Allottment to Clinical Nursing Departments	25
III.	Educational Preparation of Administrative and Supervisory Nurses at the New York Hospital, By Type of Position, August 1, 1962	27
IV.	Auxiliary Nursing Staff Complement for Clinical Nursing Departments at The New York Hospital for Pay Period Ending July 29, 1962, By Job Categories	29
V.	Eligibility of Ninety-Five Baccalaureate Graduates for Inclusion in the Study	31
VI.	Career Goals of the Fifty-Two Baccalaureate Graduates in Nursing	38

TABLES INCLUDED IN APPENDIX B

TABLE PAGE

I. Schools From Which The Fifty-Two Nurses Graduated 86

II. Year of Graduation for the Fifty-Two Nurses 87

III. Length of Service at NYH for the Fifty-Two Nurses 87

IV. Clinical Departments to Which the Fifty-Two Nurses were Assigned 87

V. Tours of Duty of the Fifty-Two Nurses 87

LIST OF FIGURES

FIGURE PAGE

1. Classification Sheet No. 1:
   Opinions about the Job with Respect to Educational Preparation 6

2. Classification Sheet No. 2:
   Opinions about Working Relationships 7

3. Classification Sheet No. 3:
   Perceived Deterrents to Clinical Nursing Functions 7

LIST OF EXHIBITS

EXHIBIT PAGE

1. Statements of Perceived Differences Between Education and Job, In Ability to Give Patient Care 37

2. Statements of Perceived Differences Between Education and Job, In Working Relationships 40

CHAPTER I

THE PROBLEM AND STUDY DESIGN

The present study was an attempt to discover certain factors in a large teaching hospital which may influence the professionally prepared nurse in carrying out her primary role as clinician. The study was undertaken with the belief that the quality of nursing care of patients undergoing treatment in the hospital can be enhanced through improvements in the utilization of the clinical skills of the nurse. The primary aim was to reveal what changes may be indicated in administrative and supervisory practices pertaining to the employment of baccalaureate graduates as staff nurses in the hospital.

THE PROBLEM

The general problem was to ascertain the kinds of institutional conditions and requirements that are perceived by baccalaureate graduates in nursing as militating against their practice of clinical nursing functions while employed as general staff nurses at The New York Hospital. Institutional conditions and requirements were defined broadly as administrative and supervisory practices, relationships, and stipulations, both formal and informal, within the employing hospital which were perceived by the nurses as cause for failure to accomplish any clinical nursing function. Since the nature and scope of clinical nursing practice are explored in Chapter II of the report, suffice it to list here the clinical nursing functions that were used for purposes of the study:

1. Evaluate patients' nursing needs and plan and implement comprehensive nursing care for them, taking into account emotional and cultural factors as well as physical needs, prevention and rehabilitation as well as immediate needs.

2. Guide and teach patients and their families to be aware of their role in the plan of therapy and be prepared for their part.

3. Collaborate with other professional workers of various related fields in meeting the total needs of patients.

4. Bring auxiliary workers of many types into their most effective place in patient care, delegating suitable duties to them and supervising and directing their work.

5. Use intramural and community resources to meet patients' nursing needs following their discharge from the hospital.[1]

The title of general staff nurse is used at The New York Hospital to mean the first level position in the registered nurse hierarchy. Essentially, it means the same as general duty nurse, used by the American Nurses' Association and certain other employing hospitals, or "bedside nurse" used in the common vernacular.

---

[1]Adapted from Virginia M. Dunbar, "A Statement of What We Expect of Graduates of Baccalaureate Programs," New York, Cornell University-New York Hospital School of Nursing, September 19, 1958. Typewritten.

BASIC ASSUMPTIONS

The study was based on the assumption that graduates of baccalaureate programs in nursing are prepared in beginning competence in the above clinical nursing functions; therefore, it was decided to limit the population to graduates of basic or generic programs that are fully accredited by the National League for Nursing. The League describes such a program as "one leading to a baccalaureate degree which is conducted by an educational unit in nursing (department, division, school, or college) that is an integral part of a college or university and is organized and controlled in the same way as similar units in the organization."[2] Graduates of these programs are described as being:

> . . . broadly prepared as practitioners of professional nursing to give nursing care to people in various settings, and to interpret and demonstrate such care to others. They have beginning competence in planning, directing, and evaluating the outcomes of nursing care given by associated nursing personnel working with them.
>
> Graduates are also prepared:
>
> 1. To function with increasing competence and to be adaptable to change.
>
> 2. To develop judgment in assessing new factors in nursing situations and to show initiative in instigating change based on that judgment as well as on the understanding of nursing principles.
>
> 3. To participate with numbers of other professions and citizens groups in community health programs and in solving health problems.[3]

A second assumption underlying the study was that the listed clinical nursing functions are needed for direct care of patients undergoing treatment in a general hospital. These functions would not seem out of line with the goal of other health professions to treat the person in his totality.[4] Moreover, they would seem in keeping with the objective of nursing care as stated by the Director of Nursing Service at The New York Hospital in her 1959 annual report to the Board of Governors:

> The objective of nursing care may be stated briefly as assisting the patient through his hospitalization in such a manner that his convalescence and ultimate rehabilitation are effected. This objective demands not only attention to the daily needs of the patient while in the hospital, but carefully planned teaching and provisions for necessary follow-up after his discharge as well.[5]

---

[2]National League for Nursing, Nursing Education Programs Today, Bulletin No. 11-891, New York, The League, 1961, pp. 12-13.

[3]Ibid., p. 14.

[4]William A. Steiger, Francis H. Hoffman, A. Victor Hansen, and H. Niebuhr, "A Definition of Comprehensive Medicine," Journal of Health and Human Behavior, 1:83-86, Summer, 1960.

[5]Muriel R. Carbery, "Report of the Director of Nursing Service," The Society of the New York Hospital, Annual Report for the Year 1959, New York, The Society, (1960), pp. 54-55.

In explaining programs and practices that aid in the accomplishment of the objective, the writer included the development of teaching and informational guides, the use of intramural and interagency referrals, individual nursing care plans, health team and nursing team conferences.[6] If graduates of baccalaureate programs have beginning competence to practice these clinical functions as claimed by the National League for Nursing, and if these functions are needed in patient care as claimed by the Director of Nursing Service, it would seem sound administrative practice that utilization of the graduates from the time of their initial employment at The New York Hospital be commensurate with their educational preparation.

A final assumption is that there are factors in the hospital field that can be demonstrated as militating against nurses performing these functions. This assumption is in keeping with the American Nurses' Association's Resolution on the Clinical Practice of Nursing adopted in 1962. Quoting from the resolution, we have specific reference to the hospital field:

> RESOLVED, That the American Hospital Association be invited with the American Nurses' Association to promote the recognition, development, and utilization of clinical practitioners in nursing in hospitals and thus improve the quality of nursing care for the public.[7]

METHOD AND PROCEDURES

The study was essentially exploratory in that it was an attempt to obtain nurses' opinions and perceptions regarding their work as general staff nurses at The New York Hospital. A method for obtaining subjective data was thus preferred, and the open-ended, intensive interview technique was selected as most suitable. An interview guide was designed for obtaining information about five general areas relating to the nurses' expectations and experiences in clinical practice. The areas of content included in each interview were as follows:

1. Opinions and attitudes about the general staff nurse position
   a. As a beginning position
   b. As a life-time career
2. Perceived differences between requirements of the job and expectations derived from the nurses' educational preparation.
3. Opinions about working relationships
   a. With subordinates
   b. With peers (including diploma graduates)
   c. With nursing superiors
   d. With doctors and paramedical personnel
   e. With others
4. Perceived deterrents to the performance of clinical nursing functions
   a. Planning and implementing nursing care
   b. Patient and family teaching
   c. Interdisciplinary collaboration
   d. Nursing team leadership
   e. Intramural and interagency patient referrals
5. Career goals of the nurse.

---

[6] _Ibid._, p. 55.

[7] "Resolution on the Clinical Practice of Nursing," _American Journal of Nursing_, 62:87, June, 1962.

The final guide for interviewing was developed through a pretest on comparable respondents at a large voluntary teaching hospital not unlike the New York Hospital in size and purposes. All interviews were tape-recorded and later transcribed into typewritten records.

Prior to the selection of interviewees, it was decided to limit the population to full-time staff nurses (1) who were graduates of generic baccalaureate programs accredited by the National League for Nursing, (2) who had been employed in the present position for at least two months, and (3) who had not had previous experience in positions of higher rank. It was also decided to exclude nurses who were working in the operating room since activities in this work area differ so greatly from those in other nursing units.

After the general plan for conducting the study was drawn up, the investigator sought authorization from the Director of Nursing Services to conduct the interviews. The latter wrote a memorandum to the seven clinical nursing department heads authorizing the investigator to proceed with arrangements for interviewing the nurses. A copy of this memorandum is shown in Appendix A.

The assistance given in all clinical nursing departments greatly facilitated the selection of interviewees and the scheduling of all interviews. By appointment, the investigator visited each departmental office and was granted access to the personnel records file in which pertinent biographical information is readily available on all employed nurses. The name of each nurse who had graduated from a generic baccalaureate program was recorded on a 3 x 5 index card along with the name of her school, the date of graduation, previous employment, and the date of employment at The New York Hospital. The 1962 list of baccalaureate and masters degree programs in nursing accredited by the National League for Nursing was used in checking each school for accreditation.[8] The cards for nurses graduating from non-accredited schools were removed, and the eligibility of the remaining nurses for interviewing was determined according to the above established criteria.

The interviews were scheduled by departments from July 16 through August 17, a period of five weeks. On Thursday preceding the week each nurse was to be interviewed, a letter explaining the interview and seeking the nurse's cooperation was attached to her pay envelope which is distributed from her departmental office. A copy of the letter is shown in Appendix A. Nurses who were working nights were scheduled to be interviewed at 8:00 A.M., following a tour of duty, and these nurses were granted compensatory time at a later date. All other nurses were scheduled to be interviewed during the course of their assigned tour of duty. Each nurse was informed of the date and hour of the interview by her supervisor.

The interviews were conducted in a private room in the executive suite of the main hospital and removed from the departmental offices. A tape recorder was set up on a table; ash trays and two comfortable chairs were provided. As each interviewee arrived for her appointment, she was invited to smoke, following which the purpose and nature of the study were explained in a conversational manner. Anonymity of responses which

---

[8]Department of Baccalaureate and Higher Degree Programs, "Baccalaureate and Masters Degree Programs in Nursing Accredited by the National League for Nursing--1962-63," <u>Nursing Outlook</u>, 10:410-11, June, 1962.

had been assured in the letter was reinforced. The purpose of the tape recorder was explained. A few of the nurses expressed some concern about having their voices recorded; however, since they did not have to speak directly into a microphone, their attention was soon diverted from the machine after the interview had begun. Following the introduction to the interview, the interviewee was given an opportunity to ask questions.

The investigator referred occasionally to a guide during the interview; however, all questions and items for discussion were presented in a conversational manner, and explanations and elaborations were offered as needed by each interviewee.

Following each interview, the nurse was asked for her reaction about it. A few expressed the hope that they had been of some help to the investigator, but a great majority stated that they had enjoyed the opportunity to talk about nursing to someone who seemed interested. A few even suggested the interview as a possible supervisory technique. Only one nurse said that she had felt uncomfortable, and she explained that she was not "much of a talker."

METHOD OF ANALYSIS

The content of each transcribed interview was analyzed by first classifying summary statements for responses pertaining to three major areas of interest: opinions about the job with respect to educational preparation, opinions about working relations, and perceived deterrents to clinical nursing functions. Three classification sheets were used in summarizing responses of each interview. The grouping of content areas is shown in Figures 1, 2, and 3. The classification of summarized responses from one tape-recorded interview is shown in Appendix C.

Preliminary inspection of each content area suggested certain categories for tabulating responses in that general area. These categories were listed for each of the three major classifications of data. The range of categories was then refined and narrowed with two aims in mind. The range should permit the inclusion of the greatest possible number of responses, and at the same time, it should be manageable for the purposes and scope of the study. Each category and sub-category was then coded for use in transcribing responses to tabulation sheets. The method of coding responses relating to deterrents to the practice of clinical nursing functions is shown in Appendix D.

Interview #______.

As a beginning position for a baccalaureate graduate	As a life-time career for a baccalaureate graduate
Expectations derived from education vs. present job requirements	Competence of baccalaureate graduates vs. diploma graduates working as staff nurses
Satisfactions	Dissatisfactions
Career Expectations	

FIGURE 1

CLASSIFICATION SHEET NO. 1

OPINIONS ABOUT THE JOB WITH RESPECT TO EDUCATIONAL PREPARATION

Interview #______.

Subordinates	Peers	Head Nurses
Supervisors	Doctors	Students & Others

FIGURE 2

CLASSIFICATION SHEET NO. 2

OPINIONS ABOUT WORKING RELATIONSHIPS

Interview #______.

Planning and implementing patient care	Patient-family teaching	Interdisciplinary Collaboration
Nursing team Leadership	Patient referrals	Specific Incidents

FIGURE 3

CLASSIFICATION SHEET NO. 3

PERCEIVED DETERRENTS TO CLINICAL NURSING FUNCTIONS

LIMITATIONS OF THE STUDY

The New York Hospital, with its practices pertaining to the employment and utilization of baccalaureate graduates in nursing, cannot be considered as entirely representative of all large voluntary teaching hospitals, and it would be even less representative of other types of hospitals. Even in a comparable hospital that was selected for pretest of the interview guide, there was some indication that the respondents tended to see their duties and responsibilities as being somewhat different from the respondents' in the study.

Staffing patterns vary considerably from hospital to hospital, particularly with reference to ratio of professional to non-professional personnel, ratio of nursing hours to patient days, levels and preparation of available nursing personnel, the manner in which nursing students receive their practical experience within the nursing service, and the amount and types of supervision. Other factors influencing the nurse's role and functions would be the nature and scope of available medical services, the extent to which paramedical and ancillary services are departmentalized, and the established system for assignment of patients to nursing units for care.

No attempt was made in this study to check the veracity of perceived job requirements and institutional conditions. Rather, the attempt was confined solely to trying to elicit from each respondent her honest opinions about the present job and its requirements in light of her educational preparation as she saw and understood each of these to be.

The fifty-two respondents in the study cannot be considered to be representative of all baccalaureate graduates in nursing. Nor can they be considered as representing the graduates of schools of nursing from which they came. Although thirty-two of the respondents were graduates of Cornell University-New York Hospital School of Nursing, the remaining twenty came from fifteen different schools widely scattered throughout the country. The selection of respondents for inclusion in the study was contingent solely upon their employment as staff nurses at The New York Hospital. Any conclusion concerning baccalaureate education in nursing today must be predicated on this fact.

Still another limitation is inherent in the methodology and analysis of data. The study was primarily exploratory in nature. Mere quantitative reporting of the responses could have been misleading and inappropriately used for making generalizations both about baccalaureate graduates in nursing and about practices pertaining to their utilization, even were the latter confined solely to The New York Hospital. On the other hand, descriptive reporting of all the data was neither possible nor tenable. A combinatio of the two methods was attempted with the intent that the reported findings might describe the range of responses. Thus, that a fourth or a half or more of the respondents identified a single factor could be of equal significance for purposes of this study. Too, that fewer respondents or even one responden identified another single factor that had not been negated by other respondent could be significant, since that factor might have been equally real for other respondents without their being able to find words for its expression in the open-ended interview.

Finally, there may be those who would criticize the study as lending itself to the introduction of bias on the part of the investigator as well as the respondents. At the time the interviews were conducted, the

investigator was on a leave of absence from her position as Department Head of Surgical Nursing at The New York Hospital. She was engaged in full-time work on her doctoral studies both during and nine months prior to the interviewing. Knowledge of the setting afforded the advantage of some degree of familiarity with many of the responses about the employing agency, its philosophy and practices. However, extreme caution was exercised that no response be accepted as enforcement of this familiarity without probing the respondents for clarification of their own honest opinions. Moreover, in order that no respondent feel threatened in expressing any opinion or any specific incident, the investigator assured anonymity of all responses both through a letter explaining the interview and immediately prior to each interview. Six of the respondents had worked under the direction of the investigator during the year previous to her leave of absence, and thirteen of the graduates of Cornell University-New York Hospital had been her students in a course in Professional Leadership during their senior year. Responses obtained from those interviewees seemed no less candid than those obtained from others who had had no direct contact with the investigator.

CHAPTER II

NURSING FUNCTIONS IN PERSPECTIVE

Nursing today embraces a wide range of functions and activities performed by personnel with varying levels of education and training.[1] A premise of this study is that the clinical functions of nursing are professional functions and as such are the prerogatives and responsibility of the professionally prepared nurse.

PRESERVICE EDUCATION FOR PROFESSIONAL NURSING

Baccalaureate programs in nursing education are slowly increasing in number and in excellence throughout the United States. The doors of the university were first opened to students in preservice nursing education in 1910, at the University of Minnesota.[2] In 1960, 170 colleges and universities conferred the baccalaureate degree on 4,134 graduating nurses.[3] The number represented less than 14 per cent of all nurses graduating from preservice programs; nevertheless, the percentage has shown a steady increase over the years since the inception of collegiate preparation for nursing.[4] Although baccalaureate education in nursing is not *ipso facto* professional education, there is considerable evidence that a *truly* professional level of preservice education is the goal and perhaps in many instances a reality. At the 1960 biennial convention of the American Nurses' Association, the Committee on Current and Long Term Goals introduced the following goal to the House of Delegates:

> To insure that, within the next 20-30 years the education basic to the professional practice of nursing, for those who enter the profession, shall be secured in a program that provides the intellectual, technical, and cultural components of both a professional and liberal education. Toward this end, the ANA shall promote the baccalaureate program so that in due course it becomes the basic educational foundation for professional nursing.[5]

Today professional education is generally regarded as providing the basis for long-term growth and ultimate high contribution rather than imparting immediate know-how and strictly technical skills.[6] Learning,

---

[1]Mildred L. Montag, *The Education of Nursing Technicians*, New York, G. P. Putnam's Sons, 1951, pp. 3-8.

[2]Committee for the Study of Nursing Education, *Nursing and Nursing Education in the United States*, New York, The Macmillan Company, 1923, p. 486.

[3]American Nurses' Association, *Facts about Nursing*, New York, The Association, 1961, p. 88.

[4]*Ibid.*, p. 89.

[5]Roberta R. Spohn, *The Future of Education for Professional Practice*, New York, American Nurses' Association, 1962, p. 14.

[6]Elliott Dunlap Smith, "Materials on General Education, Professional Education and Teaching," New York, Bureau of Publications, Teachers College, Columbia University, 1957, p. 21. Typewritten.

for the professional person, is not confined solely to the formal pre-service program; rather a spirit of learning must pervade all professional practice.[7] Doherty states that the prime objective pervading and unifying a professional education should be the development of the power of analysis and understanding, and the cultivation of a scholarly attitude and style; the educational program trains students to become, not to be practitioners.[8] Lambertsen challenges nurse educators to teach students "to think and to reason, and to equip them to grow throughout their lives in professional service, in personal stature and usefulness as citizens."[9] Professional education implies a changing social role for the practitioner; it must be "oriented not to the present nor to the past but to the future."[10]

PRACTICE FOLLOWING GRADUATION

Upon graduation, the professional practitioner is faced with having to meet the more immediate needs of society within the scope of available resources and within the structure of existing institutions through which his services reach the public. A second premise of this study is that a profession concerns itself not only with the education of practitioners but with social conditions and institutions which govern this practice as well. Florence Nightingale, when asked to suggest a scheme for training nurses for workhouse infirmaries, wrote as follows:

> Equal in importance to the provision of trained Nurses is the nature of the hospital authority under which these Nurses are to perform their duties. For, unless an understanding is come to on this point, the very existence of good nursing is an impossibility.
>
> In dealing with this question I may state at once that, to turn any number of trained Nurses into any workhouse infirmary to act under the superintendence or instructions of any workhouse Master, or workhouse Matron, or Medical Officer would be a sheer waste of money.
>
> This is not a matter of opinion but of fact and experience.[11]

Recent writers, representing other disciplines, have in fact concurred with Miss Nightingale's statement. Cottrell writes that teacher education "requires far more than a systematic preservice instructional program in college; it hinges upon a complimentary community situation in which the teacher may be encouraged as a learner, as a theorist of education in the making, and as a scientific student of the educational aspect of human affairs."[12] Lieberman's succinct statement of problems facing

---

[7]Robert E. Doherty, "The Professional Spirit," American Journal of Nursing, 37:371, April, 1937.

[8]Robert E. Doherty, The Development of Professional Education, Pittsburg, The Carnegie Press, 1950, p. 6-7.

[9]Eleanor C. Lambertsen, Education for Nursing Leadership, Philadelphia, J. B. Lippincott Company, 1958, p. 57.

[10]John S. Millis, "Nursing in Higher Education," Department of Baccalaureate and Higher Degree Programs, Excellence in Education, New York, National League for Nursing, Code No. 15-848, 1961, p. 61.

[11]Lucy Ridgely Seymer, comp., Selected Writings of Florence Nightingale, New York, The Macmillan Company, 1954, pp. 285-286.

[12]Donald P. Cottrell, ed., Teacher Education for a Free People, Oneonta, New York, The American Association of Colleges for Teacher Education, 1956, p. 393.

the educational practitioner might just as well have been written regarding the practicing nurse today:

> It is truly depressing to hear people discuss what the school or teachers "should be doing" in abysmal ignorance of the vocational condition which prevail in education. One might as well discuss what a farmer should produce in complete ignorance of the soil and moisture conditions which prevail on his farm, or criticize him for not cultivating something which these conditions have ruled out as impossible. Absurd as this may be, people continually criticize teachers for not accomplishing educational objective which simply cannot be achieved under the prevailing vocational conditions in education.[13]

Doherty warns that if a break in professional interest is permitted at the completion of formal education, it will be all the more difficult to resume it later and thus, all the more improbable that it will ever be resumed at all.[14] According to Lindsey, "the transition from formal preservice education to practice following graduation must not permit a break in the continuum of learning."[15]

Since nursing today is distributed to the public, by and large, through highly organized health agencies, we may assume that conditions governing the employment and utilization of young graduates by these agencies will greatly affect their continued professional development.

THE HOSPITAL AS A PRACTICE FIELD FOR NURSES

Currently, there is little evidence that there exists in actual practice a differentiation of levels of nursing.[16] Legally, graduates of baccalaureate degree, hospital diploma, and associate degree programs write the same state board examinations and receive the same licensure as Registered Nurse for beginning practice. They join the same professional organizations with an equal voice in all professional matters. They are employed by most agencies as general practitioners to perform the same functions for which they receive the same compensation.

Hospitals have become the largest employers of practicing nurses, and many newly graduated nurses, including those from preservice baccalaureate programs, receive their initial post-graduate experience as general staff nurses in these institutions.[17] This position is in reality an outgrowth of the position at one time held by hospital diploma students in their clinical practice. As late as 1927, the Committee on the Grading of Nursing Schools found that of 500 superintendents of nursing questioned 76 per cent indicated that they preferred students to graduate nurses in

---

[13]Myron Lieberman, *Education as a Profession*, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1956, p. 15.

[14]Robert E. Doherty, "The Professional Spirit," *American Journal of Nursing*, 37:371, April, 1937.

[15]Margaret Lindsey, *New Horizons for the Teaching Profession*, Washington, D. C., National Education Association of the United States, 1961, pp. 85-86.

[16]Martha E. Rogers, *Educational Revolution in Nursing*, New York, The Macmillan Company, 1961, p. 4.

[17]American Nurses' Association, *Facts about Nursing*, New York, The Association, 1961, p. 8.

providing bedside care for their patients.[18] However, following the great depression, many hospitals began employing larger numbers of graduate nurses, who could no longer find employment as private duty nurses.[19] According to Lambertsen, those nurses were fitted into the existing nursing service pattern that had been designed for students requiring supervision.[20]

Since that time, hospitals have undergone changes that are almost revolutionary in scope. Innovations in health and medical care have occurred so rapidly, particularly in the years following World War II, that unprecedented extensions of services have been required, frequently with little or no foresight and planning. Available knowledge has mushroomed in scope and in preciseness to the extent that hospitals, as well as other health agencies, have been hard-pressed for economic and human resources needed to put new knowledge to work for the public good.[21] Not only are there more hospital beds, but more significantly there is so much more to be done in the way of new and increasingly complex technical procedures at the bedside. It is claimed by some that this demand for technical procedures to be performed for hospital patients will continue to grow, and further, that there is nobody else to perform them but the nurse working as the doctor's assistant.[22]

On the other hand, the hospital has emerged from being a charitable institution for the sick poor to become a community-wide institution rendering services to all segments of the population.[23] In 1961, more than six and a quarter billions of dollars went for hospital care in the United States.[24] Hospitals assume the proportions of big business as they take on the characteristics of complex bureaucratic organizations, with departmentalization of services and the need for more and more official and administrative procedures.[25]

General staff nurses, employed by the hospital for whatever motive during the depression, are now sought in ever increasing numbers. Traditionally, the staff nurse position, whether filled by graduate or student nurse, has been geared to providing hygienic care to patients during illness, assisting the doctor with medical procedures, carrying out the latter's written orders for medications and therapeutic procedures, and performing certain managerial functions as an extension of administration. The

---

[18]Committee on the Grading of Nursing Schools, Nursing Schools Today and Tomorrow, New York, National League for Nursing Education, 1934, p. 91.

[19]Isabel M. Stewart and Anne L. Austin, A History of Nursing, New York, G. P. Putnam's Sons, 1962, p. 219.

[20]Eleanor E. Lambertsen, Education for Nursing Leadership, Philadelphia, J. B. Lippincott Company, 1958, p. 26.

[21]Henry N. Pratt, "The Need for Control of Hospital Utilization," Talk before Vermont Hospital Association, October 10, 1962. Typewritten.

[22]Robert M. Conningham, Hospitals, Doctors, and Dollars, New York, F. W. Dodge Corporation, 1961, p. 137.

[23]Temple Burling, Edith M. Lentz, and Robert N. Wilson, The Give and Take in Hospitals, New York, G. P. Putnam's Sons, 1956, p. 7.

[24]Health Insurance Council, "Analysis of the Health Care Dollar," Health Insurance Viewpoints, Vol. III, No. 1, March, 1963.

[25]Temple Burling, Edith M. Lentz, and Robert N. Wilson, The Give and Take in Hospitals, New York, G. P. Putnam's Sons, 1956, pp. 318-321.

increasing complexities of both the dependent or technical functions and the administrative or managerial functions have been largely responsible for the nurses' dilemma.[26]

RECENT ATTEMPTS AT DEFINING THE FUNCTIONS OF NURSING

In recent years, the medical and health professions have been made increasingly aware of newer dimensions in patient care. According to Esther Brown, the emphasis is shifting from "almost exlusive concentration upon the diagnosis and treatment of disease to the diagnosis and treatment of persons in their totality."[27] In step with this trend, Lambertsen states that professional nursing functions must "express the assumption of responsibility for a comprehensive program of nursing care."[28] She has defined nursing in keeping with this professional responsibility. She states:

> Nursing is a dynamic, therapeutic and educative process in meeting the health needs of society. Nurses, with other members of the paramedical group, forward the purpose of the physician in the over-all plan of medical care. The distinctive function of nursing refers to the physiological and/or psychosocial responses to health which may or do result in a state of dependence upon others for meeting needs which normally are within the potential of the individual or family. In a therapeutic educative relationship, nursing assists the individual and/or family to achieve their potential for self-direction for health.[29]

Lambertsen proposes as a base for attempting to define specific nursing functions, Tead's definition of a function. "A function is a nucleus of activities, responsibilities, duties or tasks so homogeneous in character that they fall logically into a unit for the purpose of execution."[30] Lambertsen goes on to say that a "major difficulty in defining functions of professional nursing has been the failure to differentiate between the occupation of nursing, which includes many workers with a variety of competencies, and the professional component of the occupation."[31]

Beginning in 1950, the American Nurses' Association went all out, initiating and sponsoring numerous studies, in attempts to define nursing functions. In 1958, a synthesis of the findings of the individual research projects and their implications for the nurse as a practitioner, her relationships to others in the work situation and the future of nursing were reported in *Twenty Thousand Nurses Tell Their Story*. The evidence of the combined reports placed a sad indictment indeed upon nursing, pointing out that the best educated nurses were engaged in "desk work," while leaving to practical nurses and aides the immediate care of the sick.[32]

---

[26] Lyle Saunders, "The Changing Role of Nurses," *American Journal of Nursing*, 54:1096-97, September, 1954.

[27] Esther Lucile Brown, *Newer Dimensions of Patient Care, Part 1*, New York, Russell Sage Foundation, 1961, p. 3.

[28] Eleanor C. Lambertsen, *Education for Nursing Leadership*, Philadelphia, J. B. Lippincott Company, 1958, pp. 81-82.

[29] *Ibid.*, p. 80

[30] Ordway Tead and Henry C. Metcalf, *Personnel Administration*, New York, McGraw-Hill, 1933, pp. 350-351.

[31] Lambertsen, *op. cit.*, p. 81.

[32] Everett C. Hughes, Helen Hughes, and Irwin Deutscher, *Twenty Thousand Nurses Tell Their Story*, Philadelphia, J. B. Lippincott Company, 1958, p. 272.

In 1952, the committees on functions, standards, and qualifications for practice were formed for each of the American Nurses' Association's sections. In the final report for the General Duty Nurses Section, there are three major functions listed for the general duty nurse. The first of these encompasses in part what the present investigator has referred to as the clinical functions of nursing. The over-all function and its major sub-divisions read as follows:

> The general duty nurse is aware of the total nursing needs of the patient and is responsible for seeing that they are fulfilled.
>
> A. Prepares, administers and supervises a patient care plan for each patient in the group for which she is responsible
>
> B. Applies scientific principles in performing nursing procedures and techniques through constant evaluation in the light of nursing and medical progress
>
> C. Performs therapeutic measures prescribed and delegated by medical authority
>
> D. Continuously evaluates symptoms, reactions and progress
>
> E. Assists in patient education and rehabilitation, including the promotion of mental and physical health
>
> F. Assists in the provision of optimum physical and emotional environment
>
> G. Teaches and directs nonprofessional nursing personnel for whom she or he is assigned responsibility.[33]

The second over-all function and its major sub-divisions are often referred to, by various writers, as the administrative functions, the managerial functions, the bureaucratic functions, or the nontherapeutic functions. The function reads: "The general duty nurse participates in the administration of nursing service in a general or special hospital."[34] The sub-divisions specify interpreting policies of the hospital, coordinating departmental activities, maintaining good interpersonal relationships, contributing to education of students during their clinical practice, and contributing to the improvement of the nursing service and nursing care. The third major function relates to the personal and citizenship responsibilities of the nurse. The present study is primarily concerned with the first over-all function quoted above, although this is not to deny the importance of the second and third.

The American Nurses' Association's statement on the functions of general duty nurses was an expression of what nurses employed in the position believed their functions were or should be. Lambertsen states as one of her premises in <u>Education for Nursing Leadership</u> that "the faculty and administration of a professional school have the responsibility of forwarding the goals of an occupational group with the emphasis of the educational program that of preparation for the potential of professional practice rather than that of current practice."[35]

---

[33]American Nurses Association, <u>Functions, Standards and Qualifications for Practice</u>, New York, The Association, 1959, p. 8.

[34]<u>Ibid.</u>, p. 8.

[35]Eleanor C. Lambertsen, <u>Education for Nursing Leadership</u>, Philadelphia, J. B. Lippincott Company, 1958, pp. 85-86.

In 1955, Virginia Dunbar, then Dean of Cornell University-New York Hospital School of Nursing, prepared, in collaboration with her faculty, a statement of what they expected to be the special competencies of graduates of baccalaureate programs in nursing. This statement was intended (1) to clarify the professional objectives of the school of nursing program, (2) to enlighten the public supporting the educational program, and (3) to serve as a guide for the employing agencies in assigning graduates of the program.[36] The original statement was revised and re-issued in 1958. The clinical nursing functions used in interviewing the nurses for this study are based on this statement.

RATIONALE OF THE CLINICAL NURSING FUNCTIONS

It is not enough to say that because of her broader preparation the graduate of the baccalaureate program should be able to do things _better_. Quality can be had and is needed at any level of operation.[37] The crux of the matter is that what needs to be done in "bedside nursing" today and in times to come is different from what was expected in the past.[38] The clinical nursing functions which follow represent a synthesis of much that has been written and said about nursing practice.

Evaluate patients' nursing needs and plan and implement comprehensive nursing care for them, taking into account emotional and cultural factors as well as physical needs, prevention and rehabilitation as well as immediate needs. The nursing needs of patients today are more complex requiring a "continuous adaptation of principles in the systematic analysis of problems."[39] Few nurses would disagree that "the specific needs or problems of individual patients must be the point of departure for the establishment of the nursing plan."[40] On the other hand, identifying what constitute nursing needs and placing priorities on often conflicting needs do not bring ready agreement.

The one function unique to nursing among all the health professions has been defined as ministering to the basic human needs of patients.[41] Even when agreement is reached on this point, there is still confusion and not enough is known about the relationship of the biophysical and psychosocial needs. Although still somewhat nebulous and in an as yet ill-defined manner, the behavioral sciences are beginning to make their impact felt. According to one sociologist, "the health professions are learning that the distinctive feature of mankind is not _Homo sapiens_ but _Homo socius_."[42]

---

[36] Virginia M. Dunbar, "A Statement of What We Expect of Graduates of Baccalaureate Programs," New York, Cornell University-New York Hospital School of Nursing, September 19, 1958, p. 3. Typewritten.

[37] Mildred Montag, from class notes of the author, course no. TN 4020, Advanced Seminar in Higher Education in Nursing, New York, Teachers College, Columbia University, January 23, 1963.

[38] Virginia M. Dunbar, "A Statement of What We Expect of Graduates of Baccalaureate Programs," New York, Cornell University-New York Hospital School of Nursing, September 19, 1958, p. 1.

[39] Eleanor C. Lambertsen, _Education for Nursing Leadership_, Philadelphia, J. B. Lippincott Company, 1958, p. 51.

[40] Committee on the Function of Nursing, _A Program for the Nursing Profession_, New York, The Macmillan Company, 1948, p. 38.

[41] Frances R. Kreuter, "What Is Good Nursing Care?" _Nursing Outlook_, 5:302, May, 1957.

[42] Robert M. Frumkin, _Hospital Nursing, a Sociological Point of View_, Buffalo, University of Buffalo Bookstore, (1956), p. 51.

The patient's medical problem(s) will have considerable influence upon the degree of his dependency on the nurse for any one or more of his basic needs. On the other hand, decisions about how the dependent needs can be met most effectively will be influenced not only by the medical problem, but by the egocentricities of the patient, the ethos and mores of his social groups, and his and/or the family's mental and emotional frame of reference concerning his health problem. As the body of knowledge in the behavioral sciences steadily increases, this knowledge must find its way into the assessment of nursing needs for individual patients and decisions about plans for action. Nelson states that the responsibility for designing the nursing regimen rests solely with the professional nurse.[43]

The second area of this clinical function, prevention and rehabilitation as well as immediate needs, is not new to medicine or nursing. Nevertheless the terms have acquired new dimensions as they relate to the curative process.[44] Prevention at one time referred almost entirely to the control of harmful forces in the physical environment. The therapeutic environment has been extended to include "harmonious and integrated relationships between the social system members," or in the hospital, between doctor, nurse, and patient.[45] Technology and specialization, while indispensable in modern diagnosis and treatment of disease have added immeasurably to emotional stress associated with hospitalization.[46] Tension arising from stress may be built up to intolerable heights, intensifying the patient's illness.[47] The nurse is charged with responsibility for preventing this through "activities which serve to give the patient immediate gratifications, and hence tension release, in his stressful situation of being ill and hospitalized."[48]

On the other hand, advances in medical technology have resulted in a prolongation of life, often with grave handicaps. The control of many death-dealing communicable diseases and the effective intervention and correction of once early-fatal congenital anomalies have brought in their wake a higher incidence of degenerative and chronic diseases.[49] The health professions are thus faced with ethical and moral obligations that their programs be geared not only to curing the patient of disease, but to rehabilitating him for a useful life as well. The goal of rehabilitation has been defined as "the restoration of the patient to the maximum degree of usefulness and happiness."[50] The implication for nursing care is that instead of doing things to and for the patient, the nurse must assist the patient in doing for himself.[51]

---

[43]Katherine R. Nelson, "How Will Individualized Care of the Patient's Nursing Needs Be Provided?" American Nurses Association, Improvement of Nursing Practice, New York, The Association, 1961, p. 25.

[44]Theda L. Waterman and Valarus F. Lang, Chronic Illness, St. Louis, The C. V. Mosby Company, 1955, p. 288.

[45]Miriam Johnson and H. W. Martin, "A Sociological Analysis of the Nurse's Role," American Journal of Nursing, 58:373, March, 1958.

[46]Esther Lucile Brown, Newer Dimensions of Patient Care, Part 1, New York, Russell Sage Foundation, 1961, pp. 11-15.

[47]Miriam Johnson and H. W. Martin, op. cit., p. 375.

[48]Miriam Johnson and H. W. Martin, "A Sociological Analysis of the Nurse's Role," American Journal of Nursing, 58:377, March, 1958.

[49]Theda L. Waterman and Valarus F. Lang, Chronic Illness, St. Louis, The C. V. Mosby Company, 1955, pp. 27-30.

[50]Ibid., p. 289.

[51]Ibid., p. 304-305.

Guide and teach patients and their families to be aware of their role in the plan of therapy and be prepared for their part. Lambertsen conceives of nursing in a "therapeutic educative relationship" as assisting the individual and/or family to achieve their potential for health.[52] Such a relationship requires that the nurse understand how people learn, what motivates them to learn, and the effects of sickness and stress upon the learning process.

The short stay of the patient in the hospital is often part of a longer period of convalescence in the home. Too, the patient suffering from a chronic disease is admitted to the hospital during acute exacerbations in his illness. Patient and family should leave the hospital equipped with information and knowledge to give them as much independence as possible in coping with the health problem.

Collaborate with other professional workers of various related fields in meeting the needs of patients. In the words of Burling:

> The scientific excellence of modern medicine can be brought to bear on patients' needs only if human agents are in flexible and creative relationship with one another and with the patient.[53]

An "interdependence of members of the health team" is necessary if specialization is not to result in fragmentation of services.[54] The patient is in no position to coordinate these services. The hospital nurse, because of the patient's dependency upon her for his basic needs, is in a strategic position to foster an inter-disciplinary approach to meeting the patient's total needs. Nursing care is of a comprehensive type only when it is an integral part of this approach.[55]

Bring auxiliary workers of many types into their most effective place in patient care, delegating suitable duties to them and supervising and directing their work. Auxiliary or non-professional workers may be assigned to participate in patient care by one of three methods. The functional method is a division of nursing with an emphasis on types-of-function and levels of preparation required for their execution.[56] This method has generally been discredited as providing a fragmented, "assembly line" type of service.[57] The case method, or the allocation of patients for total care by individual members of the nursing staff, has been discredited as not providing professional nursing for those types-of-cases

---

[52]Eleanor C. Lambertsen, Education for Nursing Leadership, Philadelphia, J. B. Lippincott Company, 1958, p. 80.

[53]Temple Burling, Edith M. Lentz, and Robert N. Wilson, The Give and Take in Hospitals, New York, G. P. Putnam's Sons, 1956, p. 3.

[54]Eleanor C. Lambertsen, Nursing Team Organization and Functioning, New York, Bureau of Publications, Teachers College, Columbia University, 1953, p. 10.

[55]Frances R. Kreuter, "What Is Good Nursing Care," Nursing Outlook, 5:303, May, 1957.

[56]Committee on the Functions of Nursing, A Program for the Nursing Profession, New York, The Macmillan Company, 1948, p. 39.

[57]Eleanor C. Lambertsen, Nursing Team Organization and Functioning, New York, Bureau of Publications, Teachers College, Columbia University, 1953, p. 18.

assigned to non-professional staff members.[58] Team nursing is a synthesis of the functional and case methods of assignment.[59] It is based upon the belief that the individual patient and his problems are the point of departure. Of paramount importance is the nursing care plan for which the professional nurse is ultimately responsible but in which all members of the team participate. This method is generally regarded as preferable from the standpoint of good patient care, but it has added to the general staff nurse's responsibilities that of motivating, assigning, and supervising non-professional personnel.

Use intramural and community resources to meet patients' nursing needs following their discharge from the hospital. Cost alone makes it imperative that both the length and frequency of hospitalization be no greater than is consistent with sound medical practice. There is increasing recognition that hospital beds should be reserved for those patients who truly need the complex diagnostic and therapeutic facilities which only a hospital can provide.[60] Put into practice, this means that the patient is frequently discharged from the hospital still in need of assistance and supervision during a longer period of convalescence and rehabilitation. The hospital has not discharged its obligation to the patient unless the resources of the community have been mobilized to focus on his continuing needs.[61] The social service department in a large hospital may be instrumental in initiating referrals for follow-up care of the patient by various community health and welfare agencies. Nevertheless, communication between nursing services is a nursing responsibility.[62] A knowledge of what the patient experienced in the hospital and where he stands in his progress toward self-dependence will make it possible for the receiving agency to continue the program of care begun in the hospital. In the same way, the hospital nursing service is in a better position to provide continuity of care when referrals from outside agencies are received and put to use.

Continuity of patient care is dependent not only upon interagency referrals. Departmentalization within the hospital itself, particularly in the large hospital, means that the patient will frequently receive care for multiple and long-term problems in more than one department and sometimes in a succession of totally different ones.[63] The use of established referral systems is now an accepted part of nursing's responsibility to the patient as he moves from department to department or from agency to agency.[64]

There may be those who would criticize those clinical functions of the hospital nurse as not including the managerial and technical functions. The managerial functions of planning, delegating, supervising, and

---

[58] Ibid.

[59] Ibid.

[60] Henry N. Pratt, M.D., "The Need for Control of Hospital Utilization," Talk before Vermont Hospital Association, October 10, 1963. Typewritten.

[61] Pearl Parvin Coulter, The Nurse in the Public Health Program, New York, G. P. Putnam's Sons, 1954, p. 121.

[62] Ruth Farrisey, "Referrals a Nursing Responsibility," Nursing Outlook, 5:19, January, 1956.

[63] Mamie Kwoh Wang, "The Intramural Nursing Referral," Nursing Outlook, 7:346, June, 1959.

[64] Ibid., p. 347.

coordinating are inherent in all of them. Management in this sense, however, is patient-oriented and thus may be regarded as "therapeutic" as distinct from institution-oriented or "non-therapeutic" management.[65]

The technical functions are inherent in the implementation of the nursing care plan since many of the activities in this plan are delegated by the physician to the nurse. Separate categories for institutional management and technical functions were not included because previous studies have shown that these two tend to usurp all the others in how the hospital nurse functions.[66, 67, 68, 69]

---

[65]Eleanor C. Lambertsen, "Toward a Clear Definition of the Nurse's Function," Hospitals, 35:51, July 16, 1961.

[66]Ronald G. Corwin, "The Professional Employee: A Study of Conflict in Nursing Roles," _American Journal of Sociology_, 66:604-615, May, 1961.

[67]R. W. Habenstein and E. A. Christ, _Professionalizer, Traditionalizer, and Utilizer_, Columbia, Mo., University of Missouri Press, 1955.

[68]Everett C. Hughes, Helen Hughes, and Irwin Deutscher, _Twenty Thousand Nurses Tell Their Story_, Philadelphia, J. B. Lippincott Company, 1958.

[69]Leonard Reisman and John H. Rohrer, _Change and Dilemma in the Nursing Profession_, New York, G. P. Putnam's Sons, 1957.

CHAPTER III

THE SETTING AND THE INTERVIEWEES

The Institution and Its Organization

The New York Hospital is a voluntary general hospital with an average daily inpatient census of approximately 900, and outpatients services accommodating an average in excess of 800 clinic visits a day.[1] Throughout its 191-year history, the hospital has adopted and furthered a fourfold concept of medicine: care of the sick, teaching, research, and preventive medicine.[2] It presently occupies a modern structure which is the hub of The New York Hospital-Cornell Medical Center.

The hospital is highly decentralized in its administrative organization, with departmentation of its services under three major divisions of line responsibilities. These divisions are generally classified as Professional Ancillary Services headed by an Associate Director, Ancillary Services and Supplies headed by a second Associate Director, and Nursing Services headed by the Director of Nursing Services. In addition, there are the staff departments of Personnel headed by the Personnel Director, and Accounting and Receiving headed by the Comptroller.

Superimposed on the administrative organization of the hospital is the organization of the medical staff. Each of the clinical departments is headed by a physician-in-chief, who is a member of the Medical Board, a practicing specialist in his own field, and a professor in the Cornell University Medical College. All of the physicians-in-chief are full-time geographic appointments made by the respective governing bodies of New York Hospital and Cornell University following recommendation by the Joint Administrative Board. In addition to the eight members of the Medical Board, there are seventeen other full-time geographic physicians.[3] The full-time geographic physicians all maintain their offices in the medical center, are salaried, and carry both attending and professorial ranks. There are approximately 675 other attending physicians with varying degrees of privileges, and a large majority of these also carry professorial rank on the faculty of the medical college.[4] The House Staff numbers approximately 220 residents, assistant residents, and internes.[5]

The organization of the nursing service is patterned more or less after that of the medical staff. There are seven departments; namely, Medical Nursing, Surgical Nursing, Obstetric and Gynecological Nursing, Pediatric

---

[1]The Society of the New York Hospital, _Annual Report for the Year 1961_, New York, The Society, (1962), pp. 83-84.

[2]_Ibid._, p. 2.

[3]Information obtained by telephone, from the Office of the Director, The New York Hospital-Cornell Medical Center, February 18, 1963.

[4]The New York Hospital Listing of Professional Staff, July 1, 1962-June 30, 1963. Typewritten. In the files of the Office of the Secretary to the Board of Governors.

[5]The New York Hospital Listing of Resident Staff Appointments, July 1, 1962-June 30, 1963. Typewritten. In the files of the Office of the Secretary to the Board of Governors.

Nursing, Outpatient Nursing, Operating Room Nursing, and Private Patients Nursing. Psychiatric Nursing is not an integral part of the nursing service organization of the main hospital since it falls under the administrative control of the psychiatrist-in-chief of the Payne Whitney Clinic, a separately endowed department. Nurses employed in the Payne Whitney Clinic were not included in the present study. In the main hospital, the director of nursing service, the seven clinical department heads, and certain members of the supervisory staff carry, in addition to their service responsibilities, appointments as faculty members of the Cornell University-New York Hospital School of Nursing.

The clinical nursing departments function with considerable autonomy, each with its own table of organization, budget, and administrative advisory committee made up of the clinical nursing department head, the physician-in-chief or his representative, and a representative from the hospital administrative staff. For all practical purposes, as far as clinical nursing personnel are concerned, the respective department head is the director of nursing services.

Ancillary Services and Supplies Departments

The nurse's role in any hospital organization is greatly influenced by services provided by other departments.[6] In the hospital under study, the supplies departments, including General Stores, Central Sterile Supplies, Linen, and Pharmacy, make deliveries to the nursing pavilions; however, except in a few experimental instances, supplies are not delivered automatically according to a standard, but are obtained by written requisitions which are relayed through pneumatic tubes by the nursing staff. Linen is shelved by workers from that department; all other supplies must be shelved by the nursing staff.

Building Services, including housekeeping and general maintenance of furnishings and certain specified equipment, are the responsibilities of maids, porters, and supervisory housekeepers, all under their own department head. Services from this department are automatic in accord with standard operating procedures; however, major repairs and installations must be requisitioned by the nursing staff from the Engineering Department. Preventive maintenance is fairly well provided through the biennial renovation of each nursing unit. At a scheduled time, the unit is closed to patients for a period of two weeks or longer; all patient rooms and work areas are painted; furnishings and equipment are checked and overhauled; and replacements are made as necessary. Once each week the Director of the Hospital, The Associate Director for Ancillary Services and Supplies, and the Associate Director of Nursing Service make rounds with the Chief Engineer, the Department Head of Building Services, and the respective Clinical Nursing Department Head to check on the maintenance and cleanliness in scheduled geographic areas.

Food services are the responsibility of the Nutrition Department and are largely decentralized. The food is prepared in one of two kitchens and sent in bulk to the pantry on each nursing unit. Patients' food trays are then set up by pantry aides under the supervision of nutritionists and dietetic internes who are responsible for the diet lists. The trays are served to patients from a truck by nursing staff and then returned to the truck for pick-up and clean-up by the pantry aides.

---

[6]Eleanor C. Lambertsen, "Toward a Clearer Definition of the Nurse's Function," Hospitals, 35:51, July 16, 1961.

The Social Service Department assigns individual social case workers to geographic patient areas throughout the hospital. A full-time chaplaincy service is available to patients, with representatives from the Catholic, Protestant, and Jewish faiths who visit each nursing unit periodically and on call. Library and miscellaneous canteen carts are regularly transported to patients in the nursing units by members of the Volunteer Department.

Ancillary diagnostic and therapeutic services are provided in some instances on the nursing units, and in other instances these services are provided in specialized areas housing highly complex and stationary equipment. Most electrocardiograms are done with portable machines carried to the patient's bedside and operated by technicians from the Heart Station. On the other hand, patients receiving x-ray, physical therapy, or occupational therapy are in most instances transported to and from specialized areas housing these facilities. Nevertheless, under certain circumstances, services from these departments are frequently provided on the nursing units by members from the respective departments. The Central Laboratories dispatch technicians to collect certain blood specimens at the patient's bedside; other specimens are collected by the doctors and still others by the nursing staff and sent to the laboratories for examination. There is a centralized messenger and transportation pool from which men are dispatched to transport patients to and from designated areas and to deliver specimens to the laboratories. The Operating Room has its own orderly pool for transporting patients from the nursing units to the Operating Room to the Recovery Room and back to the assigned unit.

The Registered Nurse Staff

The 1962 Table of Organization for the division of nursing services authorized 638 positions for registered nurses in all grades.* Through August of that year, when the interviews for this study were completed, the average monthly variation between authorized positions and actual complement was -22.9.[7] The variations for one weekly pay period in authorized registered nurse positions and actual complement within the clinical nursing departments and excluding the sixteen central nursing administrative positions are shown in Tables I and II. The weekly pay period ending July 29, 1962, was selected because it represented the midway point for the collection of data for this report.

The months of July and August generally represent low points in the registered nurse staffing complement, since many nurses choose to terminate their employment with summer vacations, and recruitment of new graduates beginning in July does not reach its peak until mid-September or early October. Table I shows that the greatest variation in authorized positions and actual complement occurred at the assistant head nurse and the staff nurse levels. Nurses filling these positions are more directly involved in bedside nursing care. Table II shows that the Medical Nursing Department was well over its authorized strength while the departments of Surgical Nursing, Obstetric and Gynecological Nursing, Pediatric Nursing and Private Patients Nursing were well below. The staffing discrepancies from department to department vary considerably from year to year and are not readily explained. Throughout July and August, all in-patient clinical departments had one or more nursing units closed at one time or another, either as a

---

*All staffing figures exclude full-time School of Nursing personnel but include those personnel with dual school-service appointments.

[7]The New York Hospital Personnel Status for August, 1962. Typewritten. In the files of the Personnel Department.

TABLE I

REGISTERED NURSE STAFFING COMPLEMENT AT THE NEW YORK HOSPITAL FOR PAY PERIOD ENDING JULY 29, 1962, BY CLINICAL NURSING POSITIONS[8]

Position Title	Authorized Positions	Actual Positions in Full-Time Equivalents	Variation
Department Head	7	6	- 1
Acting Department Head	0	1	+ 1
Administrative Assistant	9	8	- 1
Supervisor	64.5	62	- 2.5
Head Nurse	91	89	- 2
Assistant Head Nurse	81	58.5	-22.5
Staff Nurse	368.5	350	-18.5
Total	622	574.5	-47.5

[8]Information obtained from statistics filed in the Office of the Director of Nursing Service, The New York Hospital.

TABLE II

REGISTERED NURSE STAFFING COMPLEMENT AT THE NEW YORK HOSPITAL FOR PAY PERIOD ENDING JULY 29, 1962, BY ALLOTTMENT TO CLINICAL NURSING DEPARTMENTS[9]

Department	Bed Capacity	Authorized Positions	Actual Positions in Full-Time Equivalents	Variation
Medical	154	69*	80.5	+11.5
Surgical	291	117	108	- 9
Private Patients	233	108	95	-13
Obstetrics-Gynecology	206 + 102 bassinets	111.5	89.5	-22.5
Pediatrics	121	72	62	-10
Out-Patient		57.5	58	+ .5
O. R. and Recovery Room	25 (Rec. Rm.)	87	81.5	- 5.5
Total		622	574.5	-47.5

*The authorized positions had not been adjusted to reflect the opening of a new nursing unit.

[9]Information obtained from statistics filed in the Office of the Director of Nursing Service, The New York Hospital.

result of the "shortage" of registered nurses or in connection with the schedule for biennial renovation of nursing units.

Turnover for the year through August amounted to 28.9% for registered nurses and was greatest in the assistant head nurse and staff nurse positions.[10] Replacements in the staff nurse position are recruited and screened in the central nursing office and are then sent to the clinical department of their choice for official appointment. Appointments to the assistant head nurse and the head nurse positions are entirely promotional within each department. Appointments to the supervisory and administrative positions are made largely from outside the organization, although promotion from a supervisory to an administrative position is not uncommon.

In most instances, staff nurses work under the immediate supervision of a head nurse, who is responsible for the direct administrative and managerial functions associated with patient care in a nursing unit. On the evening and night tours of duty, supervision is less direct since evening and night supervisors cover more than one nursing unit and carry out certain departmental administrative functions as well. Many of the day supervisors hold appointments on the faculty of Cornell University-New York Hospital School of Nursing in addition to their nursing service appointments. These dual appointees are assigned to nursing units where students are having their clinical practice and instruction. Day supervisors who have full-time nursing service appointments generally are responsible for delegated administrative functions such as inservice education, methods improvements, and follow-up training of auxiliary staff, in addition to being responsible for one or more nursing units. All supervisors, including the dual appointees, share in week-end administrative coverage for their department.

Table III shows that the great majority of head nurses were graduates of hospital diploma programs and that they held no academic degree at the time of the study. Seven of the clinical supervisors who held no academic degree were assigned to the evening or night tour of duty. Of the total supervisory staff, twenty-eight held faculty appointments; twenty-six of these held a master's degree, and two held a baccalaureate degree.

The staff nurse generally is responsible for direct care of patients and for supervising auxiliary workers who assist in direct care. The assistant head nurse shares in the duties and responsibilities of staff nurses as well as assisting the head nurse in the managerial functions on the nursing unit.

Although staff nurses are assigned to the clinical department of their choice and are moved to another department only through an official request for transfer, they do not always receive their first choice of a specialty within that department. Certain of the departments have specialties that generally have little appeal for young nursing graduates who are looking for a variety of experiences. Some of these specialties include tuberculosis and metabolic diseases in Medical Nursing, ophthalmology and otolaryngology in Surgical Nursing, premature infants in Pediatric Nursing, and gynecology in Obstetric and Gynecological Nursing. For the most part, nurses are assigned to these specialties temporarily, awaiting assignment to nursing units offering "richer experiences." With few other exceptions, nurses are given "permanent" assignments to nursing units within each department. Some of the departments have a small corps of PRN nurses, who are sent from unit to unit wherever and whenever the need may be deemed most acute. By

---

[10]The New York Hospital Employee Turnover for August, 1962. Typewritten. In the files of the Personnel Department.

TABLE III

EDUCATIONAL PREPARATION OF ADMINISTRATIVE AND SUPERVISORY NURSES AT THE NEW YORK HOSPITAL, BY TYPE OF POSITION, AUGUST 1, 1962[11]

Position	Total in Position	RN, No Degree	RN, Bac. Degree	RN Masters Degree
Director of Nursing Service	1			1
Associate Dir., Nsg. Ser.	1			1
Administrative Assit., Nsg. Serv.	4	2		2
Assistant in Staff Education	2			2
Instructor of Auxiliary Staff	3	2	1	
Clinical Department Head	7			7
Clinical Adm. Ass't.	8	1	3	4
Clinical Supervisor	62	14	10	38
Head Nurse*	89	65	18	1
Total	177	84	32	56

* Figures were not available for five Head Nurses.

[11]Figures were compiled from Cornell University Announcements, Nursing 1962-1963. Ithaca, New York, Cornell University, August 1, 1962, pp. 31-38.

and large, these are per diem or part-time nurses and in a few instances, full-time nurses who specifically request this kind of assignment.

Staffing in-patient nursing units twenty-four hours a day, seven days a week requires flexibility either in the assignment of nurses to work locations or their assignment to work periods. Since most nurses at the New York Hospital are given permanent assignments to work locations, greater flexibility is required in their assignment to work periods. Here, nurses may accept a "permanent evening" or a "permanent night" work assignment. This is done voluntarily for a period of at least six months, in return for which these nurses receive the evening or night pay differential during holidays, vacation days, and compensable sick time. Nurses below the head nurse level may not elect a "permanent day" assignment in the in-patient units. Those who do not elect a permanent evening or night assignment are required to rotate to provide coverage on all three tours of duty. The pattern of rotation varies from unit to unit and from time to time, according to the total number of nurses available on a unit at a given time, and the number of these who have chosen a permanent evening or night assignment.

The work week extends from Monday through Sunday. All tours of duty are eight hours in length, five days a week. Days off for any one week are usually consecutive. Nurses may accumulate five consecutive days including scheduled holiday time and extending over two work weeks. Generally, there is an attempt to give each nurse every third weekend off duty. Rarely is the eight-hour tour of duty split; however, on some units, nurses may be required to take turns reporting on duty later in the day in order to provide "supper relief" for the evening nurse.

The Auxiliary Nursing Staff

Licensed practical nurses and auxiliary personnel in various job categories are employed to supplement the work of registered nurses. All practical nurses must have completed one year of training in a state-accredited program prior to licensure. Infant care technicians are employed to work in the newborn nurseries in the Department of Obstetrical and Gynecological Nursing. These workers have had one year of training prior to employment, but they are not licensed. Licensed practical nurses and infant care technicians are recruited and screened in the central nursing office before they are sent to a clinical nursing department for official appointment.

All other auxiliary workers for inpatient units are recruited and screened in the Personnel Department and are sent to the Nursing Staff Education Department for official appointment and training. Nursing aides, both male and female, receive four weeks of training which combines classroom lectures and demonstrations with supervised practice on selected nursing units. Floor clerks receive two weeks of intensive classroom training prior to assignment to a nursing unit. Clinic aides and desk clerks, employed by the Outpatient Nursing Department, are also recruited and screened in the Personnel Department; however, they receive on-the-job training in that department.

Table IV shows the variations in authorized positions and actual complement of auxiliary workers assigned to the clinical nursing departments for the pay period ending July 29, 1962. The excess in actual over authorized positions for nursing aides is a reflection of the established practice of employing "vacation relief." The table of organization authorizes an approximate ratio of one general staff nurse to one nursing aide for the total nursing service (368 general staff nurses to 371 nursing aides). The ratio in actual positions filled, however, varies at different periods throughout the year. The average monthly variation between authorized and

TABLE IV

AUXILIARY NURSING STAFF COMPLEMENT FOR CLINICAL NURSING DEPARTMENT AT THE NEW YORK HOSPITAL FOR PAY PERIOD ENDING JULY 29, 1962, BY JOB CATEGORIES[12]

Job Category	Authorized Positions	Actual Positions	Variation
Licensed Practical Nurse	95	90	- 5
Assit. Pavilion Manager	23	15	- 8
Floor Clerks	69	69	0
Nursing Aides	371	452.5	+81.5
Desk Clerks, Clinic	22	30	+ 8
O. R. Technicians	12	12	0
Total	592	668.5	+76.5

[12]Information obtained from statistics filed in the Office of the Director of Nursing Service, The New York Hospital.

actual positions for the year through August was +33.9 for total auxiliary staff as compared to -22.9 for registered nurses.[13] The fluctuation in staffing complement is greatest for general staff nurses and nursing aides.

The duties and restrictions placed on the various categories of auxiliary workers differ considerably from department to department. Some of this difference is attributable to the nature of the services provided. Nonetheless, it would seem that much of the difference could be attributed to the highly decentralized administrative and supervisory controls within the nursing service organization. For example, in the departments of Surgical Nursing, Obstetrical and Gynecological Nursing, and Private Patients Nursing, licensed practical nurses are allowed to give medications on a selective basis, while the giving of medications by practical nurses is strictly prohibited in Medical Nursing and Pediatric Nursing. In Surgical Nursing, floor clerks have been trained to post doctor's orders on the nursing Kardex and medication cards with the counter-signature of a registered nurse. This practice is not followed in any of the other departments. Nursing aides do not make routine observations of patients' pulse and respiration in Medical Nursing and Pediatric Nursing, while this is considered one of the duties of selected nursing aides in other departments.

Nursing Students

Students from the Cornell University-New York Hospital School of Nursing receive "laboratory" and "practical" experience in the hospital nursing service. This experience is under the immediate supervision of nurses holding faculty appointments. The laboratory experience is planned entirely around the student's learning, and it extends from sixteen to twenty hours a week, depending upon the student's placement in the program. The faculty have full control over the assignment of students to patients during the laboratory period. Practical experience rounds out the student's "work week" and varies in length from zero to twenty hours a week, depending upon the student's class and laboratory hours. This is considered "earning" time for the student's room and board. At the time of the study, this experience was not optional on the part of the student, but with all classes entering after September, 1962, students may decide whether they wish to pay all expenses or work to help subsidize the cost of their educational program. Practical experience in the present program is also under the direction of supervisors holding faculty appointments, but the assignments are more in keeping with the total work load of the nursing unit.

In addition to these students, there are affiliating students in the departments of Obstetrical and Gynecological Nursing and Pediatric Nursing. These students come from two different baccalaureate programs in nursing, but their experience while at The New York Hospital is controlled by Cornell University nursing faculty.

THE INTERVIEWEES

At the time the nurses to be interviewed were selected, there were 322 full-time staff nurses on the payrolls of the seven clinical nursing departments. Of these, ninety-five were graduates of generic baccalaureate programs in nursing. A total of fifty-five nurses met the criteria for inclusion in the study. Of these, three nurses were on vacations which were to be followed by leaves of absence that would extend beyond August 17, the date set for terminating the interviewing. The eligibility of the

[13] The New York Hospital Employee Turnover for August, 1962. Typewritten. In the Files of the Personnel Department.

ninety-five baccalaureate graduates for interviewing is shown in Table V. Many of the twenty-five nurses who had less than two months employment were June graduates of Cornell University-New York Hospital School of Nursing, who had taken temporary appointments on the staff until such time as they could write the state board examinations for licensure. A total of fifty-two nurses were interviewed. The characteristics of this group are shown in Appendix B.

TABLE V

ELIGIBILITY OF NINETY-FIVE BACCALAUREATE GRADUATES FOR INCLUSION IN THE STUDY

Eligibility Status	Number
Program not accredited by NLN	12
Period of employment less than two months	25
Previous experience in higher rank	2
Work assignment in operating room	1
Eligible but not available	3
Eligible and interviewed	52
Total	95

CHAPTER IV

THE NURSES' OPINIONS ABOUT THE JOB WITH REFERENCE TO THEIR EDUCATIONAL PREPARATION

In the first part of each interview, the nurse was asked to state her opinions about her present job in light of her educational preparation. She was asked to consider the job from the standpoints of:

1. A beginning position for a baccalaureate graduate
2. A life-time career for a baccalaureate graduate
3. Differences between present job requirements and educational preparation
4. Differences between baccalaureate graduates and diploma graduates working as staff nurses.

This chapter is devoted to the data collected on these opinions.

GENERAL STAFF NURSING AS A BEGINNING POSITION

With few exceptions, the respondents stated that general staff nursing, as they had experienced it, was a good beginning position. The reasons given fell under four major categories which are presented below in order of frequency.

1. Staff nursing provides the baccalaureate graduate with necessary experience before she moves into a leadership position. Approximately one half of the nurses saw the present position as providing them with the necessary foundation for moving upward. This moving upward was rarely identified with promotional opportunities in the employing agency; rather it related to the long-term practice of nursing in general.

> First and foremost, for anybody to be a good administrator, they've got to know what the problems are on a ward they're supervising. A new graduate does not have the understanding of what the problems are on a floor unless she has worked on every shift to see what each shift is like. You've got to get your sea legs before you move up to a supervisory position.[1]

Some of the nurses were more specific in stating that the baccalaureate graduate was obliged to move into more responsible positions after a period of staff nursing.

> I visualize baccalaureate graduates as the educators or as the administrators, as having the higher roles in nursing, but only after giving a period of one to one and a half years of bedside nursing. A baccalaureate graduate needs this continual experience at the bedside which they don't really get in their education.[2]

---

[1]Interview No. 30. Taped. (All tape recordings and transcriptions of the interviews are in the files of the investigator and are restricted.)

[2]Interview No. 36. Taped.

2. Staff nursing rounds out the baccalaureate graduate's educational preparation with needed practical experience. Many of the nurses felt that hospital staff nursing was an essential experience because of their limited practice as students.

> In my program, we paid our tuition, room, and board, and we had very few hours of work in the hospital. I feel staff nursing is very necessary for these girls. You have a lot of knowledge and you need an opportunity to learn to put it to use.[3]

3. Staff nursing provides the baccalaureate graduate with opportunity to carry responsibility on her own. The younger graduates particularly tended to see the greatest satisfaction in their present position as an opportunity to carry responsibility without immediate supervision.

> It's a big change from being a student. I like the change, the increased responsibility and the opportunity to do some thinking on my own. I was tired of having people tell me what to do.[4]

Many of these younger graduates elected to do an extended tour of evening or night duty in order that they might have this increased responsibility of being on their own.

> Well, I am on evenings, and it's a little like what I call 'playing head nurse,' which I'm pleased with right now, because I just graduated and I like the opportunity to get to know the floor and just get used to being a graduate nurse.[5]

> On nights there's more opportunity to apply what you learned than on days. You're more on your own, making decisions about when you should notify the doctor. On days, there's always someone to ask.[6]

This same desire to be solely responsible was evidenced by some of the nurses working in the outpatient department.

> When I first graduated, I was assigned to _____, which was an entire unit with only one nurse. Me. It was a mess when I went there; nothing was organized. I got this clinic set up the way I wanted, rearranged everything, which I loved. It was a situation where I was responsible and only me for what was going on.[7]

4. Staff nursing provides the baccalaureate graduate with opportunity to learn the over-all functioning of a nursing unit. Even while not cherishing the opportunity to work independently, other nurses felt that experience as a staff nurse was necessary to learn to manage larger assignments within the organizational framework of the nursing unit.

> You need the practical experience of carrying a bigger assignment, being responsible for a larger patient load,

---

[3]Interview No. 29. Taped.

[4]Interview No. 2. Taped.

[5]Interview No. 4. Taped.

[6]Interview No. 48. Taped.

[7]Interview No. 39. Taped.

> being responsible for supplies, seeing the over-all functioning of the whole ward instead of just one or two patients.[8]

Those nurses who did not feel their present position to be a good beginning position were not so critical of staff nursing in general but of the particular clinical specialty or service to which they were assigned. Throughout the interviews there was considerable evidence that the nurses saw their role, functions, and satisfactions as being influenced largely by "space" and "time," or by the unit to which they were assigned and the period of day during which they worked.

One nurse had transferred from an inpatient unit to the outpatient department because the hours were more suited to her married life.

> I miss the excitement upstairs. Sometimes in O.P.D. (outpatient department) I feel more like a social worker than a nurse.[9]

Nurses assigned to a new research unit in metabolic diseases felt useless and bored.

> In my present assignment, I don't feel I'm doing the work I was prepared to do. (Later in the interview) I don't feel challenged in my present assignment. Last night, I tried to stretch out the paper work. You know, it lasted until one thirty. Then until six there was nothing to do. I felt guilty knowing other nurses were so busy. Yet I think, 'What have I done? I've given a few pills and taken a few blood pressures. That's not enough to suit me.'[10]

While only one respondent was assigned to the Private Patients Department, others were assigned to private patient nursing units in the Pediatrics Department and in the Obstetrics and Gynecological Department. On these units. the respondents tended to see the patients themselves as exercising controls over what the nurse is able to do.

> In the position I am in now, I don't think the effect of my baccalaureate education really mattered. . . . On this floor, they are just looking for good physical care.[11]

> Now, private patients such as these are very wealthy and very influential; they may expect you to be a barmaid . . . . I had never received a check before I came here, but I do many things for these people, and I see others taking tips. But I'm not very pleased with myself.[12]

Nurses assigned to the premature nursery saw their work as a round of routines.

> I don't like the premature nursery. I would like to be moved out of it, and I am going to resign if I'm not. (What don't you like about it?) The routine of taking care of prematures, the repetition of feeding the babies, the boredom.[13]

---

[8]Interview No. 50. Taped.

[9]Interview No. 43. Taped.

[10]Interview No. 46. Taped.

[11]Interview No. 38. Taped.

[12]Interview No. 29. Taped.

[13]Interview No. 33. Taped.

While evenings, nights, and not infrequently weekends were cited as work periods offering greatest satisfactions, nurses in inpatient units at the same time gave as the source of greatest dissatisfaction the requirement of having to work during these periods.

> I don't like having to rotate shifts. (Later in the interview) I find evenings most satisfying, work-wise. It's not so busy then, more relaxed. You have more time to spend with the children, and I like being in charge.[14]

This nurse stated later in the interview that she would not like to take a permanent assignment on evenings because of her social life.

GENERAL STAFF NURSING AS A LIFE-TIME CAREER

Only two nurses stated positively, with no qualifications, that they considered their present positions to be life-time careers. One worked in an inpatient unit on permanent nights. She had been in her present assignment for five years.

> This is what I went into nursing for. I wouldn't mind teaching at the bedside but not in a classroom. (Later in the interview) I like the patient contact; I enjoy people. I love nights. There's much more responsibility since I'm the only one on. It's like playing God in your own little balliwick . . . . I have everything on nights, admissions, patients in different stages . . . . It's exciting and varied.[15]

Later in the interview this nurse stated that she had considered going to school to get a master's degree, but "I am afraid I couldn't get a job as a bedside nurse."

The second nurse worked in the out-patient department and had been in her present assignment slightly under four years.

> I like what I am doing. I wouldn't be interested in supervising or teaching . . . . I have a unique experience in that I am in charge of my own clinic half a day, then I float to other clinics. In this way I have the satisfaction of responsibility for my own clinic and a sense of satisfaction in working in a variety of other areas.[16]

To a remarkable extent, these two nurses working in different areas expressed the same satisfactions: (1) they found the work interesting; (2) they felt that they carried responsibility on their own; and (3) they saw their work as affording a variety of experiences.

Two other nurses were torn between the nursing ideal of remaining with the patient and the practicability of advancement. Neither, however, felt that she wished to remain in her present assignment.

> That's where the conflict comes. We were prepared to go on, or at least people expect us to go on and do more. Yet if everyone goes on and does more, who is going to be left doing the actual nursing? (Later in the interview) I have worked in surgery perhaps too long; I might find a new challenge by transferring to another service.[17]

---

[14]Interview No. 25. Taped.

[15]Interview No. 30. Taped.

[16]Interview No. 37. Taped.

[17]Interview No. 23. Taped.

> How long would they let a really good nurse with a B.S. degree just stay as a general staff nurse? You can't do it. If you don't go ahead, they'll say, 'You don't use your education. You're for leadership.' Personally, I couldn't stay just a staff nurse . . . . I'd get bored awful quick being in O.P.D. (outpatient) for a life-time.[18]

Three nurses felt that staff nursing could be a life-time career with certain qualifications. One working in an inpatient unit expressed the need for more recognition.

> It might be a life-time career if more recognition were given to staff nurses. (What kind of recognition?) On the same basis as for the assistant or head nurse.[19]

A second nurse, assigned to an outpatient unit expressed the need for greater "self-actualization" in her work.[20]

> It could be a life-time career if you could use the potential on hand. If they would keep in mind that nurses can do more than assist the doctor, and give her a chance to branch out in teaching and preventive measures.[21]

The third nurse also worked in an outpatient unit. Her suggestion for making staff nursing more stimulating was inferred in the expressed dissatisfactions of many of the respondents who felt that they had little opportunity to make any personal impact on the formal organization.

> I think it could be a life-time career. It could be made more stimulating. (Stimulating in what ways?) Well, I think that this, the fact that it is not stimulating, is because the supervisor doesn't follow through on our suggestions.[22]

The remaining nurses were more or less emphatic in stating that they did not consider staff nursing to be a desirable life-time career. With few exceptions, the reasons could be placed under one of two categories.

1. The baccalaureate graduate is prepared for more leadership and responsibility. More than half of the nurses felt that their education had laid the foundation for higher ranking positions following a brief tenure as staff nurses.

> We were told all through our education this was a beginning practice, a way to start. Being in a new place and learning the way that hospital thought something should be done. You need to start at the bottom. . . . Then you should go up and attain more responsibility.[23]

---

[18] Interview No. 43. Taped.

[19] Interview No. 25. Taped.

[20] Esther Lucile Brown, Newer Dimensions of Patient Care, Part 2, New York, Russell Sage Foundation, 1962, p. 115.

[21] Interview No. 45. Taped.

[22] Interview No. 35. Taped.

[23] Interview No. 33. Taped.

2. In time, staff nursing loses its challenge, becomes repetitious. The older graduates tended to relate less with their educational preparation and to express more personal dissatisfaction with the repetitiveness of their jobs.

> Staff nursing loses its challenge after a while. You find yourself running around doing small things -- making beds, taking blood pressures, emptying bed pans. . . . . Once you become competent in doing something, then you want a bigger challenge.[24]

As a final question, each interviewee was asked what she considered her career goals to be. Table VI summarizes responses to this question. The nurses who were not sure about their career goals were younger graduates, who felt that they would like to have experience in other fields of nursing prior to making a decision. Most of the nurses who indicated that teaching was a primary goal qualified their statements by saying that they considered this a means for remaining in close contact with the patient or that they would like to teach at the bedside or in a clinical field in the hospital. A few stated that they would first like to have experience as a head nurse. Those who placed marriage and family first were either married or engaged. Many of these stated that if they remained in nursing, the hours of work would be a deciding factor in any position they would accept. Only two of the married nurses indicated that they intended to pursue a career in nursing; both aspired to teach. One was working part-time on a master's degree in preparation for her career despite the fact that she was pregnant.

PERCEIVED DIFFERENCES BETWEEN JOB REQUIREMENTS AND EDUCATIONAL PREPARATION

In expressing differences between job requirements and educational preparation some nurses were more critical of deficiencies in their educational preparation while others were more critical of job requirements. The Cornell University-New York Hospital graduates, who were working in a familiar setting, tended to be more critical of their education, and graduates from other programs tended to be more critical of the job.

By far the greatest number of the nurses saw the difference in job and education as relating to patient care. Exhibit 1 lists the perceived differences in ability to give nursing care. The statements were selected to be all-inclusive, although some were mentioned more frequently than others.

EXHIBIT 1

STATEMENTS OF PERCEIVED DIFFERENCES BETWEEN EDUCATION AND JOB, IN ABILITY TO GIVE PATIENT CARE

1. You fall short in giving the patient the psychological care for which your education prepared you.
2. You don't have time to really delve into the patient's problems, the way you learned in school.

---

[24]Interview No. 1. Taped.

TABLE VI

CAREER GOALS OF THE 52 BACCALAUREATE
GRADUATES IN NURSING

	Stated Goal	No.
1.	Teaching, primary	24
2.	Marriage and family, primary	11
3.	Head Nursing, secondary to marriage	5
4.	Head Nursing, not sure beyond that	3
5.	Not sure, experience in other fields first	3
6.	Not sure, either teaching or administration	2
7.	Research, primary	2
8.	Stay in present position, no other plans	2
	Total	52

3. As a student, we were able to work more closely with patients, teaching them about their diseases and preventive measures.
4. In school, you could spend forty-five minutes just talking with a patient; as a graduate, you have to learn to use your time to better advantage.
5. Your education doesn't prepare you for the mass patient care you are faced with as a graduate.
6. You can't individualize patient care the way you could as a student, because then you might have only one patient.
7. In the Recovery Room, we don't have the opportunity to consider long range needs of patients as we were prepared to do.
8. In school, you work on a one-to-one basis which means you learn a very thorough type of care; as a staff nurse, you have to learn to compromise.
9. Theory is fine, but as a graduate, I have developed a more practical attitude about patient care.
10. You don't have the opportunity for the follow-up care you were taught.
11. Some of the things we learned we're not doing, like diet therapy and using community agencies.
12. Where I worked as a student, there might be one graduate for thirty patients. I was surprised that graduates here do bedside care.
13. You may not do everything as you were taught in school, but I think you can do the most important things.
14. We don't use the nursing care plans as we were taught.

The nurses tended to see their educational preparation for patient care as idealistic as compared to reality on the job.

> As a student, you don't see the realness of nursing. You have seven students taking care of seven patients. As a graduate, you realize it's not like that. I feel I have learned to use my time to better advantage to do what is more necessary.[25]

There was also some evidence that the nurses tended to see theory as apart from practice.

> In my program, we didn't have enough practice, an awful lot of theory. I needed a year after graduation to gain some confidence in myself as a nurse.[26]

> I think when I graduated, I certainly wasn't much of a nurse. Now at least I am a mediocre one. I think that theory is fine, but when we get into the reality of things we have to learn to organize our work.[27]

The second major difference that was perceived by the nurses to exist between job and education was in <u>working relationships</u>. Much of this difference pertained to team nursing, although there were other

---

[25]Interview No. 4. Taped.

[26]Interview No. 7. Taped.

[27]Interview No. 22. Taped.

nurses who saw the difference as lying within the nursing hierarchy and in doctor-nurse relationships. Exhibit 2 is not all-inclusive of statements of perceived differences in working relationships. The statements, however, were selected as representative of the majority of respondents, and some infrequently mentioned ones have been included on the basis of their value as judged by the investigator. Statements that seemed to have been based on personal differences not related directly to work were excluded.

EXHIBIT 2

STATEMENTS OF PERCEIVED DIFFERENCES BETWEEN

EDUCATION AND JOB, IN WORKING RELATIONSHIPS

1. My attitudes about the team system have changed; it just doesn't work the way we were taught.

2. We have the team plan on our floor, but as students, we had more of a conferencing type of thing.

3. In pediatrics, you are just assigned patients to give complete bedside care; you don't have the opportunity to do team leading which you had as a student.

4. Where I practiced as a student, we didn't have as good a system of team nursing as is true here.

5. Your education prepares you for more leadership than you are able to do as a staff nurse.

6. We were told we would be leaders, but there was so much stuff that I had never done that I couldn't right away start leading anyone.

7. We didn't have enough experience working with nursing aides as students.

8. Where I worked as a student, there were more practical nurses, and here there are more R.N.'s than anyone else.

9. The head nurse does not share my philosophy of nursing; she is a diploma graduate.

10. As a student you move around constantly, and you don't see the interpersonal relationships that help or hinder the work.

11. I think my education prepared me to move into more charge experience sooner.

12. The supervisors discourage you from having anything to do with students, and I think this is where we could do most of our teaching, which we were prepared to do.

13. Where I worked as a student, there weren't as many supervisors; I never saw so many supervisors as they have here.

14. As soon as we put on our whites, there was a more friendly atmosphere with the doctors.

15. The doctors will ask you questions as a graduate, which they would never do when you were a student.

16. As students, we never worked with attending's, and I have been shocked at the way they treat the resident.

PERCEIVED DIFFERENCES BETWEEN BACCALAUREATE

AND DIPLOMA GRADUATES WORKING

AS STAFF NURSES

The responses to the question of what, if any, differences were apparent between baccalaureate and diploma graduates working as staff nurses fell almost equally in three major categories.

1. There is no difference; it depends upon the individual or years of experience. Some of the nurses who saw no difference in the way that nurses with different levels of education function admitted that they had friends, relatives, or roommates who were diploma graduates. Others based their opinion more on their work experience.

> It depends on the individual. Someone may go to college and still not care much. We have a practical on our floor, and I thought she was an R.N. She is really good, and she knows everything.[28]

> On our unit, we have both baccalaureate and diploma graduates. I think it all depends on the individual. Each nurse will cut corners in her own way. I can't see cutting corners with patients. But this may be done by nurses, be they baccalaureate or diploma graduate.[29]

Other nurses admitted to a slight difference at first, but with experience the differences were less apparent.

> I think at the beginning you may have different expectations. But after you have been working in a given situation with other people for a given time, I think everybody changes. The diploma graduates, I think gain added awareness, and we gain speed and efficiency. And the differences tend to become less.[30]

A few of the nurses were more specific in their response that there should be no difference in the way the two were utilized.

> There should be no difference in their utilization until the baccalaureate graduate shows she has potential for leadership. The assistant head nurse on _____ is a diploma graduate, and she can work circles around a lot of baccalaureate graduates. I just oriented a new baccalaureate graduate on nights, and she was as ignorant as a Freshman student when it comes to nights.[31]

2. The only difference is in the personal satisfaction and edification of the nurse. A third of the nurses saw no difference in the way the nurses functioned but felt on the other hand that the broader education of the baccalaureate graduate made nursing more interesting and satisfying.

> I don't see really very much difference as far as their care of the patient, or their interest or ability. More

---

[28]Interview No. 7. Taped.

[29]Interview No. 30. Taped.

[30]Interview No. 23. Taped.

[31]Interview No. 2. Taped.

> education makes nursing more interesting for you, but I can't see it changes your role one bit.[32]

Some of the responses in this category implied, in addition to personal edification, an advantage of the baccalaureate graduate in the move upward.

> The baccalaureate graduate is more questioning about the work, a lot more intellectually oriented. She has more theory background. Baccalaureate education prepares you to go on if you like--a bit of a head start. And you don't have to go evenings to make up a lot of courses.[33]

3. The difference is apparent in the nurse's work with patients and/or others. The remaining nurses, slightly more than one third, stated that there was a difference in the ways that baccalaureate and diploma graduates performed as staff nurses. The difference pertained primarily to the psychosocial aspects of patient care.

> The big difference is that they (diploma graduates) don't treat the child as a member of a family. They don't take into consideration the family as a whole unit. And they are lacking in consideration of the social background, the religion, and the culture of the family.[34]

Others saw a difference in working relationships.

> I think the baccalaureate graduate is able to assume more of a leadership role. In college you meet more people and you understand relationships better.[35]

> The diploma graduates I have known I think make poor team leaders. They seem more dependent on the head nurse to tell them what to do.[36]

A few of the nurses saw the diploma graduate as having an advantage over the baccalaureate graduate during the early period of employment.

> At first it was very difficult to work with nurses who come from diploma programs. They work very well in stress situations. They were far ahead of me in organization and technical skills. They could take six, seven or eight patients and they were far ahead of me . . . . I feel I have more knowledge about the personality of the patient, his problems and his illness.[37]

Only two of the nurses mentioned friction between the two levels of graduates.

> There is a lot of resentment from the diploma girls. Not so much here as where I worked last. There the three-year diploma girls just absolutely detested us. They were more service oriented; they didn't stop to think about nursing care.[38]

---

[32]Interview No. 16. Taped.

[33]Interview No. 22. Taped.

[34]Interview No. 20. Taped.

[35]Interview No. 4. Taped.

[36]Interview No. 41. Taped.

[37]Interview No. 21. Taped.

[38]Interview No. 43. Taped.

The second nurse had also worked in another hospital prior to her present employment.

> Some of the diploma graduates are resentful, because it's the vogue nowadays to be a baccalaureate graduate.[39]

SUMMARY AND CONCLUSIONS

The majority of the nurses expressed the opinions that staff nursing was a good beginning position, but that it would not be a lifetime career for a baccalaureate graduate. The primary reasons for both opinions were related. (1) The baccalaureate graduate should have experience as a hospital staff nurse before moving into positions of greater responsibility. She needs the practical experience of having larger assignments, carrying responsibility on her own, and managing the nursing unit during the absence of the head nurse. (2) Baccalaureate education is a foundation for higher ranking positions in nursing. The great majority of nurses without family responsibilities aspired to teach nursing in the clinical setting. Many of the older nurses expressed dissatisfaction with staff nursing because in time it loses its challenge and becomes repetitious. There was considerable evidence that the nurses saw their role, functions, and satisfactions as being influenced largely by their assignments to work locations and work periods.

The perceived differences in educational preparation and job requirements pertained to patient care and working relationships. Many of the graduates saw their educational preparation for patient care as idealistic and theoretical and the job requirements as realistic and practical. They felt they had been prepared for more leadership in working relationships than the present job required.

The nurses were almost equally divided on three viewpoints of perceived differences in baccalaureate and diploma graduates working as staff nurses: (1) there is no difference; (2) the only difference is in personal satisfaction in nursing; (3) the difference is apparent in the way the nurses relate to patients and others. Some of the nurses felt that baccalaureate education gave them an advantage over diploma graduates in being able to move upward without loss of time.

The evidence seems to point to certain gaps which exist between preservice education and practice in the hospital. These gaps relate to ability to give patient care within the organizational framework of the hospital and ability to exert leadership in working relationships. In the next two chapters we shall take a closer look at perceived deterrents to the realization of expectations in clinical nursing practice.

---

[39]Interview No. 21. Taped.

CHAPTER V

PERCEIVED DETERRENTS TO THE PRACTICE OF CLINICAL NURSING FUNCTIONS: TIME

Originally, the investigator's intent was to have each interviewee itemize what she considered to be three of the most important clinical functions of the nurse working with patients in the hospital. Following this, the nurse was to state what she considered to be deterrents to the practice of functions which she had identified. During pretest of the interview guide, however, it was found that the respondents were very vague in their statement of functions. Too, there was practically no agreement from one respondent to the next. It was therefore decided by the investigator to define the functions first and then have each nurse identify what she perceived as deterrents or roadblocks to her practice of each function. The five functions and their rationale were presented in detail in Chapter II of the report. An abbreviated statement of each function is presented here for the convenience of the reader.

1. Planning and implementing nursing care for individual patients
2. Teaching patients and their families
3. Collaborating with other professional workers on comprehensive patient care
4. Supervising auxiliary workers within the nursing team
5. Referring patients to provide continuous and follow-up care.

The organization of this chapter and of the one to follow does not center around these functions; rather it centers around the categories of deterrents that grew out of analysis of the data. Reference will be made to specific nursing functions in the discussion of deterrents. The categories of deterrents were classified under two major headings; namely (1) time and (2) working relationships. This chapter is devoted to the first of these, while Chapter VI is devoted to the second.

In pretesting the interview guide, the investigator very soon became aware that time would perhaps be seen as the most important factor influencing the staff nurses' work. It was therefore decided that whenever a respondent mentioned time, she would be interrogated for further clarification of demands made on her time. All responses concerning time were categorized, and with very few exceptions they fell under four major headings. The categories are presented in order of frequency of responses in each.

TIME AND THE DEMAND FOR DISCRETE NURSING TASKS

The evidence was almost overwhelming that time was seen by the nurses as a schedule of discrete tasks. These tasks were mentioned as deterrents primarily to planning and implementing nursing care for individual patients and to teaching patient and family.

Most of the nurses working in inpatient units mentioned various segmented nursing activities as comprising tasks. The activities varied considerably according to work location and clinical specialty. In post-partum obstetrical units they centered around getting mothers ready to receive their babies for feeding.

> Much of our work revolves around when babies come out to be fed. You have to get whatever you can done before, and what you can't do you finish after.[1]

In the Labor and Delivery Suite, the nurse may be interrupted by a delivery.

> Ninety per cent of our patients are normal. But the feeling going on inside the mother and the relationships with the family are things a nurse could work with if she had the time. You may want to stay with a patient in labor when you are called to assist in a delivery.[2]

In pediatric units the nurse may be thwarted in comforting a child because of the feedings.

> I would like to spend more time with a child who is homesick or having a crying spell. But it's a matter (on evenings) of getting them to bed and doing the feedings. . . . The aide knows that feedings are her responsibility, but very often she may have more than she can do. And I will do as many as I can.[3]

Nurses who worked with adult patients in surgical units were particularly inclined to mention tasks prescribed by the doctor.

> Sometimes you are not able to do a good job because of lack of time. . . . You find yourself doing things like. . . . taking blood pressures, doing treatments, ambulating patients. . . . doing dressings and irrigations. Things that are contributing; everyone is contributing. But I feel sometimes I am not making my maximum contribution.[4]

Many nurses in adult medical or surgical units saw the patients' physical needs as usurping the time needed to minister to their psychological needs. It might almost appear that there should be a time scheduled to care for these latter needs.

> I feel I've lost interest in communicating with patients. . . . The way I learned in school. I just don't have the time. . . . During the day, it's just the physical care of patients. There's not too much time to give the patient psychological care, or sometimes even to do complete physical care.[5]

There was evidence that some of the nurses associated psychosocial care of the patient with an idealistic education. Many nurses stated that they felt patients in this hospital received excellent care. On the other hand, many of these same nurses stated that they did not have time to relate with the patient, really get to know the patient, or delve into the patient's

---

[1]Interview No. 30. Taped. (All tape recordings and transcriptions of the interviews are in the files of the investigator and are restricted.)

[2]Interview No. 28. Taped.

[3]Interview No. 47. Taped.

[4]Interview No. 1. Taped.

[5]Interview No. 3. Taped.

problems the way they had learned in school. The patient's emotional needs were almost always separated from his physical needs.

> Sometimes she (the new baccalaureate graduate) may lean too strongly on psychosocial aspects of nursing. And she will go into great detail about this patient's emotional needs when actually there is a lot about the physical needs she is missing.[6]

Even when at the patient's bedside, many nurses seemed to feel that they were too busy to establish a relationship with the patient.

> Just doing A.M. care is a routine. A lot of times because you are rushing, you don't have time to talk with patients. As a student you have one or two patients, and as a graduate you are very busy with everyone on your team. . . you are more concerned with getting your work done.[7]

Others seemed to feel that the nursing activity that took them to the patient's bedside was not conducive to a "good relationship."

> A patient may have a painful foot ulcer and you have to treat it. And you may be hurting him. This is no time to really establish any kind of relationship.[8]

> There are days when we don't go to the bedside except to give medications and treatments. The aides are doing most of the actual bedside care. . . . The aides can't always take care of psychological problems that may come up.[9]

TIME AND PRIORITIES AMONG PATIENTS

Even when time was not seen necessarily as a schedule of segmented nursing activities, there was evidence that conflicts in the demands for time existed in the nurses' assessment of priorities among different patients. This was particularly true for nurses working with children. The work schedule often required that a nurse be at the bedside of one patient while feeling that she was neglecting others.

> We have to get the less sick children taken care of so we can get them off to the playroom. And our sickest patients are left to last. This bothers me because I feel the sickest patients are neglected.[10]

Sometimes the conflict arose because patients in different stages of treatment were located on the same floor.

> The post-operative children may take so much of my time that I feel I neglect the pre-ops.[11]

A nurse in surgery attributed the conflict in the demands on time to older patients.

---

[6] Interview No. 2. Taped.

[7] Interview No. 41. Taped.

[8] Interview No. 26. Taped.

[9] Interview No. 15. Taped.

[10] Interview No. 25. Taped.

[11] Interview No. 21. Taped.

> Today they are operating on the older people who require say double or triple the amount of care of someone ten to fifteen years younger. . . . Where they do a lot of surgery on a very old patient, that patient may require one nurse really the whole morning. Meanwhile, you have five other patients you're supposed to be taking care of.[12]

The demands of immediate post-operative patients or acutely ill patients were seen as deterrents to rehabilitating other patients.

> You're just skimming the surface, but I'd like to sink my teeth in it if I had the time. . . . Just like rehabilitation, you may have a post-op or a patient who needs the nurse with him all the time, and you don't have time to be with a patient who needs rehabilitation, so his hospital stay is lengthened instead of shortened.[13]

The need to divide the nurse's time among patients was frequently mentioned as a deterrent to teaching the patient. Again teaching was often identified with an idealistic education.

> Well, I think that some of the ideal situations just don't--you just don't have time to do them. Some of the teaching programs I'm sure could be more complete and elaborate, but yet you don't have time to spend all morning with one patient to teach him something as you would like to ideally. . . . I think time is the greatest conflict. . . . For instance, sometimes the patient just wants to sit there and talk, and I keep talking and kind of backing myself out of the curtain, because, you know, something has to be done for the next patient.[14]

TIME AND SUSTAINED CONTACT WITH THE PATIENT

There were, proportionately, almost as many responses that related to conflicts made on the patient's time as there were responses of conflict made on the nurse's time. Lack of sustained contact with the patient was seen as a major deterrent in planning and implementing nursing care and in teaching patient and family.

In the inpatient units in all clinical departments, nurses saw demands made on the patient's time, particularly during the day tour of duty, as frustrating and confusing. In many instances this conflict arose because of nursing students who were receiving laboratory experience on the unit.

> From the time the student comes on in the morning until she leaves at eleven, the patient is completely hers and the instructor's. Even though she may be assigned to your team, there is very little that goes on with the student until she reports off. (Later in the interview) The student is assigned to a patient for maybe a period of three or four days until the patient is up and doing all right; then the patient is turned over to the staff nurse.[15]

---

[12]Interview No. 1. Taped.

[13]Interview No. 4. Taped.

[14]Interview No. 6. Taped.

[15]Interview No. 5. Taped.

A few of the nurses felt that their assignments to patients depended entirely upon the student's need for learning experiences and that the staff nurse was filling in or taking what was left over.

> Well, what usually happens is the students are assigned to their patients first, and then the graduates do the patients that are left over. So that our assignments often change from day to day depending on the students. . . . Occasionally, I get a patient that I would like to take care of for several days.[16]

> If there are any students on, whoever is in charge of students will figure out who they want. And then all the patients who are left over, we just sort of sit down and decide what rooms we are going to take.[17]

Many nurses were frustrated in sustaining contact with the patient because of the latter's brief stay in, or periodic absences from, the nurse's work station. One nurse working in an outpatient clinic saw herself confined to an examining cubicle with only brief encounters with patients. The following is a synthesis of some of her statements.

> We don't get to spend time with a patient who may have a problem. . . . It's more like we are assisting the medical students. . . . In _____ clinic, the doctor examines the patient and then he takes her into his office. We don't know what he instructs her. . . . Oftentimes, the patients are referred to the social worker. . . . Patients with problems are sent to the conference room, and there they have a nurse supervisor and a dietician. . . . Students attend these conferences but the staff nurse doesn't. . . . It's out of my jurisdiction. . . . Sometimes I feel that patients are processed through (my cubicle) like cattle. . . . I am trying hard to make what is routine, not just routine, like conversing with the patient, even for a few minutes.[18]

Although none gave quite so vivid an account, respondents working in inpatient units saw their patients as "moving about," particularly on days, leaving the nurse in attendance of the work station. Some nurses indicated a preference for evenings or nights in order to avoid the confusion on days and to have closer or more prolonged contact with patients.

> On days patients are going off to all sorts of tests or functions. On evenings you can start something and finish it. Or if you have to leave you can come back and continue where you left off, because patients aren't apt to be running off to x-ray or medical conferences or physical therapy. . . . I think evenings and nights are the better chance for continuity than days.[19]

Nurses working on units where the patient's hospital stay was relatively short saw this as a deterrent to using nursing care plans.

> Our patient turnover is very great on _____. These patients are usually in for a short stay so that a care plan might have

---

[16]Interview No. 25. Taped.

[17]Interview No. 52. Taped.

[18]Interview No. 50. Taped.

[19]Interview No. 4. Taped.

very little on it. Whereas on ____ where the patients are there for a long time, you have greater nursing care problems.[20]

A few nurses in in-patient units attributed the lack of sustained contact with the patient to their own scheduled work periods.

It's hard to plan (for patients) with days off. When I'm just coming back after two or three days off, there may be a number of patients on my team that I don't know.[21]

Nurses in the Recovery Room saw little opportunity to engage in comprehensive care and long-range planning.

Well, in the Recovery Room, comprehensive care, I don't think is easy to do just because your time with the patient is so short. And probably your evaluation of the patient isn't as accurate as that you could make after a long time with the patient. . . . As far as actually planning any kind of long-range thing, I don't think that we have--we have very little to do with that.[22]

This nurse admitted later in the interview, that although she liked the Recovery Room, she did miss the opportunity to get to know the patient and to do follow-up care. Another nurse in the same work station said that her greatest satisfaction was "starting fresh every day with new patients."[23]

A nurse working in the Labor and Delivery Suite stated that long range planning was not the role of the staff in that area. She expressed equal satisfaction in being with a patient or circulating in the delivery room.

When we are in the delivery room, we're either with the patient, if it's our case so to speak, the person we've been with in labor. Or we circulate, open things, you know. . . . I enjoy both really. . . . If it's not your patient, if you've never seen the patient before, then I don't have any desire to be with that patient too much. But then I get more satisfaction in seeing that the other things run right in the room.[24]

Nurses in the outpatient department saw individualized care as requiring more time to talk with patients, and many expressed that the lack of this opportunity was one of their greatest frustrations. Some expressed satisfaction in seeing the patient on repeated visits.

Sometimes the number of patients to be seen is too great. . . . Sometimes there are a number of patients with individual problems, and I can't talk with them in as great length as I would like. . . . I have to take care of more pressing needs and hope that the next time the patient comes in I can spend more time with him.[25]

It is worth noting here that this nurse saw patients only in connection with their scheduled visits to see the doctor. Moreover, seeing

---

[20]Interview No. 20. Taped.

[21]Interview No. 19. Taped.

[22]Interview No. 42. Taped.

[23]Interview No. 10. Taped.

[24]Interview No. 31. Taped.

[25]Interview No. 37. Taped.

the patient on his next visit would hinge entirely upon the nurse's being assigned to the specific work location at the time of the patient's next appointment. The chances that this particular nurse would be available for repeated visits of patients were good since she was assigned to one specific work location. Apparently, such is not always the case.

> I don't quite understand their methods of arranging the staff. Like, for instance, I was moved from _____ to the _____ clinic without any consultation or anything. The supervisor talked to me on Thursday and sort of said, "Well, you know, I'm going to move you on Monday". . . . They move people out of the _____ clinic, then bring new people into that clinic. And it always seems like the ones that are moved don't want to be moved, and the ones that want to move somehow are stranded. I don't understand the system at all.[26]

Nurses in inpatient units saw as the greatest single deterrent to teaching and preparing the family for their role in the patient's care, the lack of contact with family members. Many of the respondents, however, expressed considerable ambivalence about the family.

> Many times we don't see enough of the patient's family. . . . And there are some patients' families we wish would let us alone. . . . Many times you can't get into a serious discussion over the bedside of a patient. And you oftentimes don't have time to take the patient's family out in a group or an individual member of the family and sit down and say, "Well, I'd like to tell you what we're doing with the patient," and talk to them. Many times, it falls upon the doctors, I think. And I think they (the family) wish we could be drawn into it more, and I sometimes wish we could too. But because of our responsibilities and the time. . . .[27]

TIME AND DISCRETE INSTITUTIONAL TASKS

Institutional tasks are used here to mean those activities that relate neither directly nor indirectly to the immediate or long-range care of patients. Rather, these tasks are geared more to the upkeep of equipment and supplies or to the paper work and routines associated with institutional management.

These tasks were mentioned by the nurses with considerably less frequency than were those tasks related to the care of patients. There was ample evidence that the nurses in the present study saw most of their time as being spent in patient care even though they tended to see nursing activities as segmented. For some of the nurses who had had experience in other hospitals, this direct care of patients came as a surprise.

> When I first came here, I was assigned four patients, and I had to give them bed baths. Well, I never had given a bed bath since I was a student, you know. (eighteen months in previous position) That wasn't your job; that was the aide's job. . . . At first I thought it was really--I felt as though--well, not that I was too good for it, but it was sort of a waste of time as there were things that were more important. . . . Now I realize that everything is taken care of and things will get done, and you have time to give a bed bath.[28]

---

[26]Interview No. 50. Taped.

[27]Interview No. 19. Taped.

[28]Interview No. 7. Taped.

Nurses mentioning insitutional tasks associated many of them with the work periods, nights and week-ends, in the inpatient units. During these periods, floor clerks are not available. Paper work was a major complaint on nights. On the other hand, nurses who worked permanent nights saw paper work as creating no problem.

> Some people seem to think there is an awful lot of paper work on nights. But it doesn't take me that long to do it. And when something comes up you can always put it (the paper work) aside until later.[29]

Young graduates having their first experience on nights tended to see paper work as a meaningful experience.

> Actually nights are mostly paper work and treatments. (Does the paper work interfere with patient care?) No, I don't think so. I think it helps, because you know the total care of the patient. And also, what position you are in in relation to the other parts of the hospital. Even to fill out slips, I think that helps. Filling out slips you know what they are doing in these other places and you know what x-rays are being done.[30]

Nurses who mentioned paper work as a deterrent or a cause for dissatisfaction on nights tended not to like nights. One nurse who said she didn't like nights was asked why.

> Oh, filling out--well, making the stool list. I think the night nurse is the most bowel conscious person in the world. Also changing Kardex slips. We spend a great deal of time just flicking little flag slips around.[31]

Occasionally, younger graduates criticized older graduates or felt guilty themselves when the institutional tasks were neglected.

> I feel that sometimes some of the hospital routines have been a little lax compared to some of the things we've been taught. When I first came here, the narcotics weren't being counted at the change of shift. Now this is something I know all of us have been taught to do (that the nurse going off duty counts the narcotics with the nurse coming on duty.) But at first, some of the nurses seemed to just shrug their shoulders if you asked for a narcotic count, and you would just have to count them by yourself. Now, I'm happy to report this has been taken care of (by the new head nurse).[32]

> On some floors the routines are just not done; they are ignored. On _____, for instance, getting a permit for an LP (lumbar puncture). Now everyone knows this is the rule, but sometimes it's just not done, because very often the patient is unconscious and a relative may not be available. I don't know if this is known (by administration).[33]

---

[29]Interview No. 5. Taped.

[30]Interview No. 51. Taped.

[31]Interview No. 48. Taped.

[32]Interview No. 11. Taped.

[33]Interview No. 2. Taped.

Occasionally, a nurse indicated that there were things she had to do because there were not enough nursing aides.

> Sometimes the team just consists of you and one nursing aide, so you may wind up making an empty bed. . . . I can remember the biggest sin in school: "Don't be caught making an empty bed." Yet you can't give everything to the aide, and your patient is up and ambulating or in x-ray, and there you are making an empty bed. And the patient in the next bed might really need you to be giving them the comprehensive care you would like to be giving.[34]

> Sometimes the aides don't get to all the cleaning, and sometimes you have to help them.[35]

Very often the nurses tended to associate institutional tasks with the supervisor. Working relationships with supervisors and head nurses will be discussed in more detail in Chapter VI.

> Our concepts of things are just a little bit different. She (the supervisor) is of the opinion that one should always pay attention to very tiny things. Like, for instance, the way a shelf is set up and with what happens to be on it. Now, to me, if I have somebody to talk to or if I'm involved in teaching somebody something, this (the shelf), to me, is completely unimportant, and this disturbs her. . . . And I don't feel that I am wrong. And if she is happy like she is, I don't want to change her. But we do not work closely together nor happily.[36]

> I don't get along too well with the night supervisor. She's too exacting and detailed. She's always saying, "Why isn't such-and-such on the bedstand, and why isn't so-and-so here?" When here I am running around trying to check on the patients. I'm just now learning the patience to say yes with her and not try to argue. Maybe she is right, and I guess if I were supervisor, I'd be looking for the same things.[37]

Nurses less frequently associated institutional tasks with head nurses, and when they did, they were more kindly toward the head nurse.

> Well, when I came on this floor there were medicines a year outdated in the refrigerator. I couldn't believe it. I nearly died. And there were supplies all over the place. And they brought in this new head nurse (from another floor). And within five weeks everything was labeled and in its place. She just got things done. It was terrific; she was a tremendous organizer. She also hurt people and stepped on people in doing it. Some people just seemed to criticize her, but I think they were blind to much that she did.[38]

It was not uncommon for younger graduates to welcome the opportunity to get things organized and rearranged.

---

[34]Interview No. 1. Taped.

[35]Interview No. 3. Taped.

[36]Interview No. 39. Taped.

[37]Interview No. 21. Taped.

[38]Interview No. 43. Taped.

> On this floor where I was, more than half the patients were long-term tuberculosis. And there's not much to do. I was just itching to get off this floor, and they wouldn't let me move. Until finally, I screamed so much they let me float. Now this has given me a chance to learn how to organize, how to go on a floor and re-arrange a whole utility room, this type of thing. And this has helped me in the long run.[39]

SUMMARY AND CONCLUSIONS

Almost without exception, the respondents saw the utilization of time as a matter over which they had limited control. How they occupied time was dependent upon the work schedule that had become established for given work locations at given work periods. The activities of the night nurse differed from those of the day nurse as well as those of the evening nurse. There was little evidence that these activities at different work periods were seen in relation to nursing care plans for individual patients.

The majority of the nurses identified time with the <u>demand for discrete nursing activities</u>. The nurses in inpatient units saw themselves as spending a large portion of their time in direct contact with patients. On the other hand, this contact was usually related to tasks on the work schedule. The nurses stated that they were often so busy with A.M. cares, dressings, treatments, medications, feedings, ambulating patients, that they did not have time to talk or communicate with patients, comfort a patient, or give "psychological" care.

Many of the responses seemed to indicate that the nurses felt they had little control over assessing <u>priorities among patients</u>. In some cases, this was attributed to the work schedule which required that certain patients be prepared to leave the nursing unit or to have a treatment at a specified time. In other cases, the more immediate needs of some patients conflicted with the long-range needs of others. Here, the nurses tended to label teaching and long-range needs as ideal, as something they would like to do if they had more time.

Lack of <u>sustained contact with the patient</u> was seen as a deterrent to planning and implementing nursing care, both immediate and long-range, and to teaching patient and family. Almost as many responses related to demands made on the patient's time as to those made on the nurse's time. Nurses working on units where nursing students were having practice saw the latter as caring for "the more interesting patients" with staff nurses taking what was left over or filling in during the students' absence. Nurses working in inpatient units frequently complained that contact with the patient was interrupted by treatments or procedures which took the patient away from the nurse's work station. Nurses working in outpatient clinics, the Recovery Room, and the Labor and Delivery Suite described their contact with patients as a "brief encounter." In any case, it was evident that the nurse's contact with the patient rested upon the latter's being available in the nurse's work station at the time the nurse was scheduled to work.

The <u>demand for discrete institutional tasks</u> relating to care of equipment or to paper work not associated with nursing the patient seemed a relatively minor problem for the nurses when compared to discrete nursing tasks. Nurses who rotated on the three work shifts tended to dislike nights most, and they associated this dislike with the paper work. Nurses who worked permanent nights rarely identified paper work as a deterrent. The

---

[39]Interview No. 43. Taped.

respondents tended to see their supervision as being geared more to institutional tasks which not infrequently conflicted with what the staff nurses thought they should be doing. These tasks were related to keeping the nursing unit in order.

In the next chapter, we shall take a closer look at conflicts and deterrents which were perceived to stem from supervision and other working relationships.

CHAPTER VI

PERCEIVED DETERRENTS TO THE PRACTICE OF CLINICAL NURSING FUNCTIONS; WORKING RELATIONSHIPS

The remaining categories of deterrents have been classified under working relationships. Unlike in the previous chapter, these deterrents are not presented in their order of frequency of mention. Rather they are presented in the logical arrangement progressing from the nursing unit to the organization at large. Some of the wording in quotations has been changed somewhat in order to maintain the anonymity of individuals; however, an attempt was made to use the exact wording about the relationship itself. Where it was judged by the investigator that a response was strictly personal without direct relevance to the work situation, that response was discarded. There were relatively few of such responses.

As might be expected, these deterrents relate primarily to the clinical functions of nursing team leadership, interdisciplinary collaboration, and patient referrals, although some do relate to the more immediate care of the patient.

INFORMAL CONTROLS ON THE NURSING UNIT

The term informal controls is used to mean those behavioral checks or sanctions in the interpersonal or intergroup working relationships that are not immediately ascribed to the formal power structure.[1] There is no attempt to relate informal controls to the formal organization, although this is not to deny that such a relationship may exist.

The data, as analyzed, revealed informal controls to emanate primarily from the nursing aide group, the peer group, and from within the nurse herself. To some extent, others were identified within the nurse-patient relationship.

The Subordinates

All of the respondents agreed that their education had prepared them for leadership of the nursing team. There are many nursing units in the hospital, particularly on adult medical and surgical units, where the team method of patient care assignment is an established pattern. In most instances, nursing aides receive their work assignments from a general staff nurse who is designated on the work assignment sheet as Team Leader A or Team Leader B.

One of the greatest difficulties encountered by the younger graduates was the resistance of older nursing aides to her leadership. These aides comprised the "old guard" in many instances.

> Some of the aides really have down what they're going to do and what you do. . . . They have a set pattern. It is hard, because the aides are not accepting of the new

---

[1]Robert P. Bullock, "Position, Function, and Job Satisfactions of Nurses in the Social System of a Modern Hospital," Nursing Research, 2:4, June, 1953.

> graduate right away. I found that true myself. . . . They'll feel you out and see how much work you are going to give them and things like that.[2]

The problem was more acute on evenings or nights, when the head nurse was not available.

> At this point in my career I don't feel able to guide nursing aides to give nursing care that is needed. They're older; they've been on the floor longer; and they resent me telling them what to do. . . . I have incurred animosity from these girls on the floor. And I work with them every night. It's awful hard to work with someone who glares at you every time you look at them. And then I'm afraid to ask them to do anything, and it just seems to get worse.[3]

A young graduate found no support in a commonly understood hospital rule which forbids sleeping on duty.

> Being new, I guess, I sometimes feel very hesitant about waking them (nursing aides) up.[4]

Even a more experienced graduate continued to exercise caution in giving her aides their assignments.

> I feel I'm the nurse, and I tell the aides what they have to do. But it's not just commanding the situation, because if you take to bossing or commanding them, they won't help you any.[5]

Occasionally, the nurses stated that they would do the work themselves rather than risk the overt resistence of the nursing aides.

> There are terrible night aides on _____, dreadful people, the worst aides I ever worked with. . . . I don't know why this is, but they are poor, and they won't even answer your questions. And they're not good to the patients, so you wind up doing all the work yourself.[6]

> They complain if they think their assignment is too large or if they think you're not doing more work than they are, because you're making more money, this type of thing. Sometimes they're insolent, and this I never expected. As a result I try not to give them patients that need much care.[7]

A few nurses cited examples of conflicts between nurses and nursing aides which required intervention by the head nurse and/or supervisor.

---

[2]Interview No. 6. Taped. (All tape recordings and transcriptions of the interviews are in the files of the investigator and are restricted.)

[3]Interview No. 48. Taped.

[4]Interview No. 47. Taped.

[5]Interview No. 4. Taped.

[6]Interview No. 2. Taped.

[7]Interview No. 34. Taped.

> Then it all came to sort of a head, and it was discussed with them (with the nursing aides, by the head nurse and supervisor). And they felt that the nurses did not, for instance, help them pass out trays. And, you know, it's a pretty good legitimate gripe, because we don't. And also that we do not take the bedpans away, which is a pretty good gripe. So a new system was put in (by the supervisor and head nurse) where the evening nurse would give the 6 o'clock medications, and the supper relief nurse would help the aides pass trays.[8]

In the hospital under study, the great majority of nursing aides are negro while the majority of nurses are white. Two nurses cited racial difference as posing problems in working relationships. Both worked in the same department. One came from the midwest.

> (How do your working relationships with nursing aides compare with what you had expected?) Well, here again this is a big adjustment for us in that I had never worked with Negroes before. . . . And I think especially for a negro (nursing aide), the fact that I was a fairly young graduate, and my physical appearance--Some of them are not as ready to accept--especially a new girl coming into the hospital--to accept them as a leader.[9]

The other nurse was a graduate of Cornell University-New York Hospital School of Nursing.

> A majority of the aides on our floor are Negro people. So, there's a lot of feeling of white versus black type of thing. And that's what has caused the bad feeling in the end.[10]

While the evidence of informal controls operating between nurse and nursing aide was sufficient to warrant their being considered a deterrent to the nurses' leadership, there was also evidence that many of the nurses saw working relationships between the two groups as being more harmonious. Most of the nurses, however, seemed to feel some compassion or concern for the "underprivileged" auxiliary worker.

> Just because you are a smart young kid does not mean that you are better than these people. I think if you show interest in them as people, well, there really isn't too much of a problem.[11]

> I mean, I think that their interest in the patient is latent. . . . but it's just their lethargic facade. I mean, because little things that they have done have conveyed to me that the interest is there. . . . If you show the auxiliary personnel that you are interested not only in the patient, but also in them, I think they pick up some of this.[12]

---

[8]Interview No. 16. Taped.

[9]Interview No. 29. Taped.

[10]Interview No. 31. Taped.

[11]Interview No. 26. Taped.

[12]Interview No. 36. Taped.

It may be significant that very little mention was made of practical nurses. The numbers of nursing aides and staff nurses working in the hospital are about equal, while there are relatively few practical nurses. Practical nurses do not work in some nursing units, and rarely would more than one be assigned to any one unit. When the practical nurse was mentioned, it was usually an expression of amazement that she could do just about everything that the staff nurse could.

> At first I was a little surprised at this. In seeing the way some of them (practical nurses) work, considering the education that they have, I think that-- I mean, we have one especially that does a very good job, and we trust her judgment in just about everything.[13]

The Peer Group

Reference was made to peer relationships in Chapter IV, in the discussion of perceived differences between baccalaureate graduates and diploma graduates working as staff nurses. Rarely were these differences cited as deterrents in working relationships. The most frequently cited deterrent as far as peer relationships were concerned might be categorized as "passive resistance" or indifference of other staff nurses to certain efforts which the respondents saw themselves as making.

> As students we were taught to write nursing care plans on the Kardex. But I have found a lot of nursing care plans I may make out for patients, nobody ever looks at them.[14]

Even when the nurse felt that she had the backing of the head nurses, she was inclined to see her efforts as being of little avail.

> As far as planning patient care, there's a little place on the Kardex for that. And when I came here, I was surprised how many of them were blank. And those that were filled in were histories, and that's not a nursing care plan. And when _____ (first name) was made the head nurse, we discussed this. . . . And with her, any time you wanted to put a nursing diagnosis down (write it on the Kardex) you could. And I think this was good. But no matter what we did, you could not stress the importance for everybody to read these.[15]

Occasional responses pointed to more active sanctions from peers.

> Even sometimes when I empty bedpans, other nurses will tell me to call the aide. I tell them it's not always left up to the aide to do; we were taught to empty bedpans too.[16]

Few of the respondents felt that they were in a position to correct recalcitrant peers.

> Once in a while I work with a lazy nurse. . . . and I don't know anything that makes me madder. . . . When there is a patient who needs a nurse and she just sits

---

[13]Interview No. 14. Taped.

[14]Interview No. 5. Taped.

[15]Interview No. 43. Taped.

[16]Interview No. 4. Taped.

> there, that makes me mad. And I don't feel that I am in a position to say anything to her. And I also don't feel, quite honestly, that I am in a position to run and tattle. So I do nothing, because I would consider it tattling. And I think that the powers that be should be aware and knowing of the situation that exists.[17]

Younger graduates tended to see older graduates as being lax in that the latter seemed not to follow "the procedure."

> Most of them (staff nurse co-workers), they don't think. That's what bothers me. It's just little things. Well, for example, giving a formula to a baby. This requires, you know, that you look at the name on the formula and check it with the baby's name, which they don't do. And the feeding of three o'clock babies at two o'clock. Little things like this.[18]

Older graduates tended to see younger graduates as being poorly prepared for managing the work load or being in charge of the nursing unit.

> We were given a lot more responsibility as students than is true today. In some ways we were even used, but I think this is good for students. It gives them a sense of responsibility, makes them toe the mark. I was able to take charge of a ward after I graduated. . . . Some of our new graduates are school paced, and I don't like it a bit.[19]

Occasionally younger graduates expressed fear of incurring ridicule from co-workers.

> Well, I just never really get to spend the time with the patient that I would like to spend. Even when we aren't busy--it seems like you could go in and sit with a patient, but everyone laughs. And it's, "Oh, she's not nursing; she's talking to the patients."[20]

<u>The Individual Nurse</u>

Many responses categorized as informal controls were non-specific as to groups or individuals. Some of these seemed to imply that the respondent herself, as well as her peers, was at fault.

> As far as just going in and talking with a patient, just to establish rapport, I feel that I don't do this as much as I should or I might. (Do you know why you don't?) Well, there's one thing I do know; its' not unique with me. . . . We've never actually sat down and discussed why we don't, why none of us do this. . . . Maybe you're really being afraid of exposing yourself to something. But then, I don't think it's this, because you do expose yourself when you go

---

[17]Interview No. 10. Taped.

[18]Interview No. 33. TTaped.

[19]Interview No. 30. Taped.

[20]Interview No. 43. Taped.

> in and do something for the patient. But it's just this business of going into the patient's room and initiating something, just for the sake of initiating it, I think.[21]

Other responses seemed to stem from informal insitutional expectations which had become internalized by the nurse.[22]

> And nobody tells you what you should be doing, but it's just the feeling you get that you shouldn't be by the chart rack unless you are charting. . . . It is the same feeling that all the beds should be made by eleven. There is no rule, but if your team happens to be slow or busy and you don't have all your beds done, nobody says anything to you, but you don't feel right.[23]

Informal controls in the organization did not seem to support a sustained interest in learning on the part of the staff nurses.

> I think we should try to maintain ourselves at the level which we left our programs and continue to seek new experiences, and continue to go to libraries, and continue to be stimulated to learn more about diseases and the medical plans as well as the nursing care plans. And even have some interest in the ANA, things like that, go to ANA meetings. . . . But there just isn't much interest in that. It seems to be, 'Let's get today over with, and tomorrow will take care of itself.' (Can you account for staff nurses not continuing to do these things?) I don't know, but I think it would do a lot for us if we could be stimulated or even compelled to learn. Maybe if we had something to challenge us in that way.[24]

There was very little evidence that the respondents accepted personal responsibility for more than cursory or on-the-spot learning.

> Once in a while you get a patient who comes from a country where you haven't had much experience with patients from that country. I think then that it's really going on your own to find out more than you know. (Do you usually seek more information when you care for such a patient?) I don't think I do it as much as I should. (Can you tell me why not?) Well, I think it's more on your own time, to put it that way. It means trying to go and read after hours. But sometimes you can get something just in general conversation with people. I know I talk to the doctors about certain things, and they're very helpful and willing to give out information.[25]

---

[21]Interview No. 16. Taped.

[22]Kenneth D. Benne and Warren Bennis, "The Role of the Professional Nurse," <u>American Journal</u> of Nursing, 59:198, February, 1959.

[23]Interview No. 5. Taped.

[24]Interview No. 11. Taped.

[25]Interview No. 6. Taped.

particularly was impressed by the fact that just because she was head nurse, she did not sit at the desk all day--and she would get out and see patients and care for patients.[39]

By the same token, negative statements about the head nurses were most frequently directed at her seeming lack of interest in the patients or her failure to participate in direct care.

She (the head nurse) doesn't always know what is going on or what is being done for the patients. I think she should be seen doing some of the patient care.[40]

Although the great majority of head nurses were diploma graduates, only four nurses mentioned that this posed a problem. The problem was stated as a difference in philosophy or attitudes about patient care.

She (the head nurse) is more interested in getting the work done, and this may keep you from doing some of the things you would like for patients.[41]

The supervisor was most frequently criticized for her seeming concern about things that different nurses described as petty, trivial, picayune, or unimportant.

Some of our supervisors have never worked on the floor and they don't really know the problems on a floor. If someone is running around like a chicken without a head with 14 admissions in one day, that's not the time to stop them and ask why didn't you dot an 'i' here or cross a 't' there. Or to stop you and have a conference when you don't even have enough staff to admit patients or take care of patients. . . . If the floor needs help the supervisor should have the wherewithal to pitch in and help.[42]

Generally, the nurses identified more closely with evening and night supervisors than with day supervisors, and they were much kinder in criticizing them. Occasional references were made by permanent evening or night nurses to the fact that people working on these shifts (including the supervisors) were a close-knit group. The relationship with the supervisor was often cited as a friendly one.

If it's a light evening, and she (the evening supervisor) has a minute, and she looks tired, I say, 'Come have a cup of coffee with me.' And we discuss little differences of opinion--like procedures. . . . It's good to talk to her and hear what she thinks, because I'm not right all the time.[43]

Nonetheless, evening or night supervisors were rarely mentioned in connection with patient care. They were commended for sending help when the unit was busy or for locating needed equipment or drugs.

She (the evening supervisor) is a person who is on call in case I need something I can't get hold of. . . . She has

---

[39]Interview No. 26. Taped.

[40]Interview No. 2. Taped.

[41]Interview No. 28. Taped.

[42]Interview No. 30. Taped.

[43]Interview No. 29. Taped.

> more time to track it down. She knows where to go where I would have to look through all these things. . . . And sometimes I call her when we run out of medications or when the doctor orders something new that we don't have on the floor.[44]

Occasionally, the evening or night supervisor was commended for helping out on the nursing unit when the staff nurse was very busy. This help usually came in the form of assistance with the paper work or other administrative details.

> Many times the supervisor will come down when there's a death on the floor. And she will take care of a lot of the forms for you. And this relieves you so you may spend time with the patient's family who oftentimes needs you very much at this time.[45]

Occasionally, supervisor or head nurse was seen as taking from the staff nurse some of the activites that the latter considered her prerogative. The head nurse, particularly, was criticized for coming between staff nurses and doctors.

> She (the head nurse) is very possessive about the house staff; she won't even let the staff nurses near them.[46]

Night nurses occasionally complained that they had to call the supervisor before they could call the doctor.

> Well, it seems to me just a waste of 10 minutes to call the supervisor first--by the time we get her and explain the situation. Then she says, 'call the doctor'. . . . Sometimes it just seems so silly. In fact one time a patient was going into shock, so I paged the supervisor after I called the doctor. I had his call on another extension while I was talking to her.[47]

A few nurses cited instances where the supervisor or head nurse came between the nurse and her patient.

> She (the head nurse) takes over all the patient teaching, and she gives us the more menial things to do.[48]

> She (the supervisor) is very young. . . . And she wants a lot of experience for herself. I got so mad one day--she took my cardiac arrest away from me, and I was so mad, I could have stamped on tacks.[49]

Not infrequently the nurses cited instances of conflict between day supervisors and evening and night supervisors, between supervisors and higher nursing authority, between supervisors and head nurses, and between supervisors and doctors. Such conflict might be regarded as a deterrent to collaboration as well as to team work.

> It's something you can't help but notice when there's tension. . . . There's a tremendous amount of tension

---

[44]Interview No. 4. Taped.

[45]Interview No. 19. Taped.

[46]Interview No. 17. Taped.

[47]Interview No. 43. Taped.

[48]Interview No. 3. Taped.

[49]Interview No. 43. Taped.

> between the supervisors and Miss _____. It's obvious. People get to the point where they don't even try to hide it. And, as I said, a few of the supervisors (evenings) are your friends, not just working associates, but they're really your friends. And that's when you find out that it isn't just your imagination, and that these things are really true what everyone's saying.[50]

Doctors

Many nurses stated that they had a more direct working relationship with doctors during the evening work period than was possible on days or nights. This direct relationship between resident doctor and nurse seemed more conducive to a feeling of shared responsibility and was therefore more satisfying to the nurse.

> Sometimes (on evenings), I forget he (doctors, in general) is the doctor, when we are working together with a patient. [51]

> When you work evenings, you have a wonderful relationship with the doctors, because then you go directly to the doctor with things and you work right along with him.[52]

> On days, working with the doctor is more indirect. The lower nurses can tell the head nurse about a particular problem a patient may have, and she will take this up with the doctor.[53]

Nurses in inpatient units tended to see as one of the major deterrents to patient-family teaching the failure of the doctor to give adequate notice of the patient's discharge from the hospital.

> The doctors should be required to write discharge orders in advance. Quite often you find the patient is going home the morning of discharge. (Check-out hour is 11:00 A.M.)[54]

Occasionally the doctor was criticized for failure to communicate to the nurses what he had communicated to the patient.

> The only time when I have run into a snag is sometimes they (doctors) will tell a patient something and neglect to tell use. You may see a patient walking down the corridor, and you go tearing after him thinking he is on bed rest. And you feel a little funny when he says, 'My doctor said I could be up.'[55]

Other nurses criticized the doctor for making demands on their time which interrupted their work or conflicted with what they felt they should be doing.

---

[50]Interview No. 27.. Taped.

[51]Interview No. 4. Taped.

[52]Interview No. 24. Taped.

[53]Interview No. 13. Taped.

[54]Interview No. 2. Taped.

[55]Interview No. 19. Taped.

> On days it's sometimes frustrating having doctors telling you they're going to do such-and-such, and you have to stop your work and set up for this procedure.[56]

> The doctor may expect you to tie yourself up for three hours holding a child during a treatment, and you may have a post-op return from the recovery room, and you think you should go see about this patient. And the doctor says, 'Oh, he (the patient) will be all right. You stay here.' And meantime, there's another doctor sitting at the desk, just reading charts.[57]

At times, some of the nurses saw themselves as caught between hospital policy and the doctor's expectations.

> It's against hospital policy that we irrigate IV's (intravenous infusions). But if you call a resident at two o'clock in the morning and tell him you think his IV isn't running, and you haven't irrigated it, you are in for trouble.[58]

The private attending doctors were seen as putting nurses in an awkward position because the former failed to support hospital policies.

> The obstetricians break the rules about visiting hours, the numbers of visitors that are allowed. And everyday we have a big fight with the visitors.[59]

Nurses saw themselves as unable to exercise control over what the doctors did, and frequently mentioned the need for controls from above.

> The private men should be sent a circular to make known to their patients to expect thus-and-so. A private patient may come in expecting a private room, and you don't have one. Now, I think this is the doctor's fault. The patient says, 'My doctor promised me a private room. So where is it?' And we have to take this abuse.[60]

The majority of the nurses expressed some ambivalence in their feelings about nurse-doctor relationships. In almost every instance where some doctors were criticized, others were commended.

> I have found most of the doctors here are very good, and they will go out of their way to answer your questions. (Later in the interview) Right now, we have a situation where the doctors do not measure up to what we feel they should do as doctors. . . . We have to keep a sharp eye on what goes on and try to compensate for it.[61]

Only one nurse described a working relationship with a doctor that might be considered truly collaborative.

---

[56]Interview No. 8. Taped.

[57]Interview No. 21. Taped.

[58]Interview No. 43. Taped.

[59]Interview No. 52. Taped.

[60]Interview No. 30. Taped.

[61]Interview No. 39. Taped.

> That's the nicest thing about working on _____, Dr. _____ is so interested in our suggestions for these patients. Right now he is working with us on a teaching manual for _____ patients.[62]

For a large majority of the respondents, the hospital nurse was seen as dependent upon the doctor not only for much that she does but for his good graces as well. The doctors were good at answering the nurse's questions.[63] The doctors respected the nurse if she really proved herself.[64] The doctors who were Cornell graduates were a little more respectful of the role of the nurse (herself, a Cornell graduate).[65] If the nurse assumed too much responsibility she might find that the doctors were not willing to work along with her.[66] Some of the doctors gave the nurse credit for knowing something, in which case it was a pleasure for her to work with them.[67] The older doctors were a "little easier to work with than a young resident or a young interne."[68] The doctors respected the nurse more as a graduate than they had when she was a student; they frequently asked her questions as a graduate.[69] One nurse described the "typical" nurse-doctor relationship in this manner:

> In talking to the doctor, I never say, 'I think such-and-such,' but rather, 'Do you think--?' And I think they appreciate this very much.[70]

On many of the medical and surgical nursing units there are regularly scheduled health team conferences. The resident doctor usually presides at these conferences. There was little agreement among the respondents who had attended these conferences about their purpose or value as far as patient care was concerned. Some of the nurses thought the conferences were primarily for the benefit of the social case worker.

> We have social service rounds once a week. . . . The doctor discusses the medical history, and then the patients' social and financial problems are discussed.[71]

All of the respondents who stated that they had attended these conferences were asked to relate what usually transpired. The following response is not atypical:

> The doctor gives the prognosis, the treatments, and what has been done. And all of this is for the benefit of the social worker, but as far as my impression is concerned, this should be a more cooperative routine. But

---

[62]Interview No. 1. Taped.

[63]Interview No. 2. Taped.

[64]Interviews No. 23 and 38. Taped.

[65]Interviews No. 5 and 41. Taped.

[66]Interview No. 6. Taped.

[67]Interview No. 16. Taped.

[68]Interview No. 36. Taped.

[69]Interview No. 51. Taped.

[70]Interview No. 17. Taped.

[71]Interview No. 15. Taped.

> it just ends up that the doctor is telling you all of this that you can read right off the chart. And unless you have a question that related to the physical condition of the patient there is very little else said. The nursing needs are hardly ever mentioned.[72]

DEPARTMENTATION IN THE HOSPITAL ORGANIZATION

Each nurse was asked specifically about her working relationships with social case workers, dieticians, physical therapists, and occupational therapists. She was then asked whether she could identify other departments with whom she worked in providing comprehensive care for her patients.

The majority of the nurses stated that they had little or no direct contact with representatives from these departments which provide specialized patient services. Many of the nurses seemed to feel that the head nurse was responsible for communicating with other departments.

> I feel I don't have much to do with these people. When I see a problem, I bring it up with the head nurse. . . . You have to go through channels to the physical therapist. Sometimes you may bring up a problem with the dietician when she comes around. And there are rounds with the social worker, but the head nurse takes care of this.[73]

Some of these nurses stated that the head nurse failed to communicate back to the staff nurses.

> The social worker has weekly meetings with the resident, and the head nurse usually goes to these meetings. . . . I think something should be done so this information is shared. Maybe staff nurses should take turns in going.[74]

Nurses who worked with patients receiving physical therapy were particularly critical of lack of communication with that department.

> A patient may be walking up in physical therapy, and on the floor you don't know this. So here you are having to carry the patient or practically drag her to get her out of bed.[75]

One nurse stated that the only way to find out what was being done in physical therapy was to ask the patient.[76] Another was afraid to answer the parents' questions about their child's crutch walking because she did not know what the child had been taught in physical therapy.[77] This nurse then said that she felt the parents thought she was "stupid not to know." Still another nurse stated that she found patient-family teaching difficult because the mothers usually accompanied the children (private patients) to physical therapy, and the nurses on the floor didn't know what had been taught in that department.[78] This same problem was verbalized by a nurse working with

---

[72]Interview No. 5. Taped.

[73]Interview No. 14. Taped.

[74]Interview No. 26. Taped.

[75]Interview No. 41. Taped.

[76]Interview No. 6. Taped.

[77]Interview No. 21. Taped.

[78]Interview No. 45. Taped.

fracture patients, who stated that she was at a loss to know how the patient was progressing or what she could expect him to do for himself.[79] None of the nurses had had an opportunity to go to the physical therapy department except during orientation or as students at Cornell University-New York Hospital School of Nursing.

Contact with the occupational therapist was acknowledged by the respondents only rarely and usually described as casual.

> The occupational therapist comes around with this little cart, and she will ask you if it's all right to go into a patient's room.[80]

One nurse, working in a unit where the occupational therapist was a frequent visitor with long-term hospitalized patients, cited a case of open conflict over professional prerogatives.

> A mother of one of the patients taught two other patients to knit. And when the O.T. worker found this out, she said to us, 'Okay, you are doing occupational therapy. So you can have it.' And for a long time she wouldn't come on the floor, and she wouldn't give us any materials.[81]

Nurses who mentioned the dietician seemed to regard food problems or patient's complaints about food as lying outside the domain of nursing. Once the food problem had been reported to the dietician, the nurse's responsibility had ended.

> When we have a patient with a food problem, we just write on a slip to the dietician, 'Please see patient--Kosher,' or 'please see patient--vegetarian.'[82]

> A patient may have likes and dislikes about food, and this is relayed to the dietician. And she'll come in and talk to the patient.[83]

Occasionally the nurses expressed annoyance with the dietician because the latter failed to do anything about the patient's complaints.

> The dietician comes around to see the patients, but the patients still get the same thing they dislike, which is too bad. Because they get cold coffee or cold oatmeal, and some may not like oatmeal, and this is too bad.[84]

> Sometimes you are annoyed dealing with a problem that belongs to a dietician, because she is not always available.[85]

One nurse seemed to express some misgivings about the manner in which the patient's complaints about food were handled.

---

[79]Interview No. 9. Taped.

[80]Interview No. 52. Taped.

[81]Interview No. 43. Taped.

[82]Interview No. 30. Taped.

[83]Interview No. 26. Taped.

[84]Interview No. 2. Taped.

[85]Interview No. 19. Taped.

> I think we have a tendency when the patient complains about food to just say, 'We'll have the dietician in to see you.'[86]

Indirecly, nurses who had attended health team conferences seemed to place the dietician below the nurse in the hospital "pecking order," while they placed the social worker between the doctor and the nurse.[87] This description of a health team conference makes specific mention of all of these disciplines:

> We have health team conferences on Tuesdays. Now that's to help the social worker. . . . I feel sometimes the social worker is quite one-sided and only sees her point, and in conference she often dominates us. (Can you tell me something about the way the health team conference is conducted?) The doctor usually gives the patient's physical problem and what they've done and what they plan to do. The social worker plans for the future. She'll be interested in what can be done and if the patient will have to come back to the clinic and if he'll be going home or what. And the dietician is there, but she doesn't say much at our health team conferences; she just sits there. And the nurses more or less ask the doctor questions about different patients' physical problems.[88]

Another nurse stated that the doctor spoke directly to the social worker in these conferences, and that the nurses were there to offer any suggestions about what the patient had verbalized to them.[89]

One nurse cited a problem which she had encountered with the social worker in referring a patient to a nursing home.

> I told a social worker last week that I would like to send some information with a patient to a chronic care home--nursing-wise. . . . She didn't say there was anything wrong with me--she just said that she couldn't quite understand this, because nobody ever wanted to do this before. And it took me forty-five solid minutes of trying to explain myself, to get to the point where she would even acknowledge that there was something a nurse could contribute that the doctor and social worker had not already contributed.[90]

Two other nurses stated that patient referrals were the responsibility of the social worker and that the nurse had little to do with these.[91] A nurse working in the premature nursery stated that nurses working in that unit had little opportunity to teach parents since "most of the contact with the parents is with the social worker."[92] Another nurse saw the social worker as intruding at inopportune times.

---

[86]Interview No. 16. Taped.

[87]Marjorie Taubenhaus, "Hospital Hierarchy," The Atlantic, 203:88-89, June 1959, reprinted in Esther Lucile Brown, Newer Dimensions of Patient Care, Part 2, New York, Russell Sage Foundation, 1962, Appendix 3, pp. 165-167.

[88]Interview No. 6. Taped.

[89]Interview No. 13. Taped.

[90]Interview No. 32. Taped.

[91]Interviews No. 13 and 22. Taped.

[92]Interview No. 33. Taped.

> The social worker sometimes comes in to see a patient at the wrong time--when he is upset about something. This is no time to ask the patient a lot of questions, and this bothers me.[93]

Nurses rarely made mention of departments other than those mentioned by the investigator. When they did, it was usually another nursing department. Nurses working in the Recovery Room mentioned problems encountered with floor nurses. The Recovery Room falls under the administrative control of the Operating Room. These nurses were critical of floor nurses for not supplying needed information about the patient.

> I recently attended Nursing Rounds (a student-faculty conference), and I walked in a little late, and they were discussing a mentally retarded child who was a patient who had had surgery. . . . All of a sudden I thought to myself, 'That is the boy I took care of on Monday.' He was the subject of the entire rounds, and I found out then and only then that he was mentally deficient. And I found out the amount of pre-op preparation that had gone on, and the arrangements that had gone on prior to his surgery. . . . I wish that a nursing care plan could accompany the chart to help us.[94]

The respondent went on to say that she hated to suggest anything like an intramural referral, because that would add to the floor nurses' paper work. Another nurse working in the Recovery Room stated that there was quite a bit of antagonism between the recovery room nurses and the floor nurses, and that this was apparent when the recovery room nurse returned a patient to the floor.[95] She attributed this to a lack of understanding among floor nurses about the function of the Recovery Room.

One nurse working in a medical clinic gave a vivid account of the possible effects of departmentation and formal organizational controls on patient care. The problem occurred between two clinics rather than between departments. This nurse cited the incident as an example of the "red tape."

> We had a patient who receives an injection from the visiting nurse on Tuesdays and Fridays. . . except every other Friday when the patient comes into clinic. . . . So on this day the patient called VNA to tell them he was coming to clinic (on a non-scheduled day). . . . But the patient went to ENT (ear, nose, and throat), not to General Medicine, because he had developed an ear infection. And when he asked for his injection, ENT would not touch it or give him the injection, because it was not ordered there. So he comes down to General Medicine to get his injection, and he had to wait two hours while we got the chart. (Why was it necessary to have the chart?) We had no order there except on the visiting nurse referral, and we can't give a medication from that*. . . . Now, this isn't a bed-making problem.

---

[93]Interview No. 49. Taped.

[94]Interview No. 10. Taped.

[95]Interview No. 42. Taped.

*The visiting nurse referral was a copy of one which had been sent by the General Medical Clinic to the Visiting Nurse Association.

> You've got this patient with a cardiac condition, sitting there for two stupid hours, just because you don't have the order (on the chart), even when you know he gets it.[96]

SUMMARY AND CONCLUSIONS

There was little evidence that the respondents saw themselves as exerting leadership in rearranging or modifying established working relationships within the organization. This lack of leadership related to the informal group controls as well as to the formal organization.

The informal group controls which were identified in responses about working relationships stemmed largely from subordinates, peers, the internalized expectations of the individual nurse regarding her role and functions in the hospital social system and occasionally from patients themselves. The nursing aide group might almost be considered the "old guard" in the organization. They are a relatively stable group when compared to the staff nurse group. The young graduates were put in the position of having to acquaint themselves with the established work patterns of nursing aides assigned to different work locations and work periods. Resistence from the aides was sometimes seen as passive; at other times as more active or overt. Nurses who described a more harmonious working relationship between themselves and the nursing aides tended to express pity for the latter group as not receiving the recognition they deserved.

The peer group was most often criticized for their indifference to certain ideals or efforts of the respondents. Frequently these "ideals" were defined as exactness in following the nursing procedure in the manner prescribed by the respondents' preparations or training. Older graduates tended to criticize younger graduates for the latter's inability to manage the work load. The respondents seemed to be more inclined to adapt their behavior and the way they functioned as nurses to informally established patterns rather than incur the risk of ridicule. Not infrequently the respondents seemed to have internalized these established patterns. There was very little evidence that the respondents accepted personal responsibility for continued learning other than seeking on-the-spot answers to their questions. A few of the respondents seemed critical of the formal organization for its failure to sustain their interest in learning.

Formal controls on the nursing unit were identified with instructors and students, supervisors, head nurses, and doctors. Respondents working in nursing units where students were assigned for clinical practice saw themselves as having little to do with the students' learning practice.

The head nurse was more frequently described as a "work model" for the nurses than was the supervisor. Less than 75% of these head nurses had academic preparation other than that received in hospital diploma programs. With few exceptions, the supervisors had academic preparation in a college or university, and more than one-half had advanced or graduate preparation. Supervisors were criticized for their concern with what the respondents considered trivia particularly when the latter saw themselves as taking care of patients. Supervisors were commended for sending help, locating equipment, and assisting with administrative details on the nursing units. There was some evidence of conflicts and tension between different levels in the nursing hierarchy as well as between supervisors and doctors.

Only one nurse described her working relationship with a doctor as a collaborative one. Doctors were criticized for failure to keep the nurse

---

[96]Interview No. 43. Taped.

informed, for failure to abide by hospital rules and regulations, and for interrupting the nurse's work schedule. They were commended for their willingness to answer questions and for respecting the nurse.

The respondents tended to see their relationships with representatives from departments providing specialized services as indirect. Information was usually channeled through the head nurse to the social service worker, the dietician, the physical therapist, and the occupational therapist. The nurses were most critical of a lack of communication with the physical therapy department. When communication with this department was indicated or would have been helpful for the nurse in caring for her patient, there was no evidence that any of the respondents took the initiative to seek such information either directly or "through channels."

Nurses working on units having regular health team conferences may or may not have attended these conferences. For those who had attended, the purpose of the conference was usually identified as helping the social case worker. The nurses seemed quite willing to rid themselves of patients' food problems or complaints and to refer such to the dietician. Communications to the dietician were made in writing or through the head nurse.

The evidence reported in this chapter supports two major conclusions. Patient care in a large general hospital is affected by both the formal organization and the informal controls at work between groups and individuals all of whom may verbalize primary interest in the patient and his welfare. Baccalaureate nursing graduates working as staff nurses in this hospital were unable to cope with either the formal or informal forces bearing upon the care of patients as a whole and continuous flow of events.

CHAPTER VII

CONCLUSIONS, RECOMMENDATIONS, AND IMPLICATIONS

The study was an attempt to identify certain factors in the hospital practice field which may militate against the utilization of the clinical skills of the professionally prepared nurse. It was thought that finding out what baccalaureate nursing graduates perceived to be deterrents to their practice of clinical nursing functions could provide information useful to the nursing service at the New York Hospital in improving patient care through more effective utilization of these nurses.

In this chapter, the findings reported in Chapters IV through VI, are utilized in making certain conclusions relating to the respondents themselves and other conclusions relating to factors in the practice field which may have hindered the nurses' execution of clinical nursing functions.

Following the conclusions, suggestions are proposed for improving administrative and supervisory practices pertaining to the employment of baccalaureate graduates at the New York Hospital. Finally, implications are drawn from the study findings concerning both education and practice in nursing.

CONCLUSIONS RELATING TO THE RESPONDENTS

A study of perceptions lends itself to the formulation of certain inferences or conclusions about the values, judgment and cognition of the perceivers as well as the nature of the object or situation which they perceive. No attempt was made in the present study to determine the degree of correspondence between what the interviewees said they perceived and what they actually encountered. Thus, conclusions about the respondents may be of equal significance for future study as are conclusions about the practice field.

The conclusions about the respondents are not presented as criticism of the nurses or of their limitations; rather it is hoped that these conclusions may suggest certain clues for changes in baccalaureate education in nursing and opportunities for practice and continued learning following graduation.

1. Inability of the nurse to exert personal leadership. The baccalaureate graduate in nursing may be limited in her ability to exercise leadership as an individual in developing and guiding the nursing care of patients within the social system of the hospital. There is evidence that how the individual nurse utilizes her time conforms to established work patterns and schedules which vary according to work locations and work periods. Interest and challenge, or their absence, are associated with external motivating factors, with the types of patients and work activities on the nursing unit, and with the persons with whom the individual nurse works.

2. Failure to accept personal responsibility for continued learning. There is evidence that the baccalaureate graduate in nursing has a limited interest in the independent search for increasing knowledge and understanding as a practitioner. She resolves her problems largely through seeking on-the-spot answers to her questions, usually from the doctor or the head nurse. She evinces little motivation to participate in professional matters beyond the immediate confines of her day-by-day practice. She criticizes the

formal organization for its failure to challenge or even compel her to seek learning opportunities. She regards going to the library as being "on her own time."

3. Limitation in ability to manage an "uncontrolled" nursing situation. There is evidence that the baccalaureate graduate in nursing associates the clinical nursing functions with an idealistic type of nursing, possible only when one nurse is working with one patient, but unrealistic when caring for a group of patients in the hospital. She perceives herself as needing experience as a staff nurse in order to learn to care for more than one patient at a time, to engage in the interpersonal relationships in the nursing unit, and to take charge of the nursing unit. She tends to assimilate the established system for doing these things.

4. Limitations in ability to relate theory to practice. There is evidence that the baccalaureate graduate tends to associate theory with an idealistic education. She experiences difficulty in relating theory to her day-by-day practice, and there is no evidence that she considers practice as theory in the making. She sees psychosocial care and physical care as two separate entities. Because she is so busy meeting the physical needs of patients, she does not have time to meet patients' psychosocial needs even when working directly with a patient. At the patient's bedside, her mind is preoccupied with other patients or other tasks. When she criticizes her peers, it is usually in relation to infractions made on hospital rules or for lack of exactness in following nursing procedures "the way we were taught."

5. Unwillingness to assume a different role from that of the diploma graduate. Although the baccalaureate graduate admits that she has a better theoretical base on which to work, she is loathe to suggest that a difference should be made between her initial job requirements and those of the diploma graduates. She tends to defend the abilities of the diploma graduate, to suggest that any difference made between the two would be undemocratic; to desire that both be given an equal chance to prove themselves. She tends to perceive her education as providing the basis for her move into higher ranking positions without loss of time, but only after she has experienced what it is like to be a staff nurse. Teaching tends to be her favored career goal, and she perceives teaching as a means for remaining in close contact with patients.

CONCLUSIONS RELATED TO THE PRACTICE FIELD

To what extent do the above-mentioned characteristics and limitations of the respondents stem from the nature and character of their preservice education, and to what extent do they stem from conditions governing their practice following graduation? This exploratory study cannot offer an answer to the above questions. The intent was to look at perceived deterrents in the practice field, and the conclusions which follow were derived from what the respondents said about the staff nurse position and what they saw as deterrents to the practice of defined clinical nursing functions.

1. Limitations in the work climate. The evidence is strong that the nurses work in at atmosphere geared to completing the work load and to meeting a time schedule. The demands on time are for doing, not verbalizing. Any planning of patient care is more or less casual; information about the patient is passed on by word of mouth with each taking for granted that all will be in accord with what to do about the information.

Nursing care is perceived as a series of discrete activities that emanate from preconceived schedules which relate to work locations and work periods. The work schedule is perceived as a barrier to caring for patients' psychosocial needs, to teaching patient and family, or to providing continuity in patient care through effective utilization of intramural interagency referrals. Because nursing activities are perceived as isolated segments they become highly repetitive in time, lose their challenge, and cause the nurse to feel that she is stagnating.

2. Lack of formalized expectations concerning the performance of the clinical nursing functions. The evidence is strong that the baccalaureate nursing graduate does not perceive her job requirements to be focused on the clinical nursing functions. Thus, recognition in the form of approval from coworkers or rewards from the employing agency could hardly be perceived as forthcoming for attempts to carry out these functions. Also, there is ample evidence that the baccalaureate nursing graduate perceives expectations regarding her performance to be about the same as those regarding the performance of diploma graduates, and in some instances, even of practical nurses. Moreover, continued experience in staff nursing is perceived to add little more to the nurse's competence than greater speed and efficiency, ability to do "more of the same," ability to do what is more important through knowing what "corners to cut."

3. Barriers exercised by the informal groups in the organization. Standards of performance for the nurses appear to be influenced more by informal group controls than by formalized expectations. The young staff nurse seems to prefer to conform to the level of performance of her peers, regardless of differences in educational background, rather than risk overt or covert resistance or even ridicule should she attempt to deviate from the norm.

The nursing aide, while subordinate to the nurse in the hierarchy, holds tenure which in itself seems to carry prerogatives that permit the aide to decide what she will accept in the way of assignments, supervision, and direction from the younger staff nurse. These controls which have grown up among nursing aides may present a barrier which the young graduate cannot overcome alone. At best, they are not conducive to the team leadership role which the nurse may have expected to assume.

4. Remoteness of the supervisor as a work model. The evidence is strong that the staff nurse tends to admire and to suggest a desire to emulate her head nurse more than her supervisor. Admiration for the superior is usually in proportion to the extent to which she is perceived as engaging in direct patient care. The supervisor, with far more academic preparation than the head nurse, is perceived to be more concerned with the students if she is also an instructor; and when not on the unit as an instructor, the supervisor is perceived to be more removed from patient care. Therefore, she is criticized for being concerned with things that seem unimportant to the busy staff nurse. The head nurse, more than the supervisor, is described as the resource person for matters pertaining to patient care even though her immediate concern is getting the work done as expeditiously as possible. The young practitioner may thus perceive her work model as a doer rather than as intelluctualizer, planner, teacher, or collaborator in patient care.

5. Barriers between the learner and the practitioner in the nursing unit. There is evidence that students are perceived as being zealously protected by their instructors. The instructor stakes out her claim for patients to be assigned to students, and as long as students are on the unit, these patients are "out of bounds" to staff nurses. With such an arrangement, the staff nurse could hardly put herself in the role of work model for the neophyte.

6. Barriers to collaboration among members of the health team. The perceived role, functions, rights, and prerogatives of various members in the health team appear to conform with traditional stereotypes. There is evidence that nurses in the hospital, both collectively and individually, reinforce and strengthen these sterotypes in their attitudes and behavior toward different categories of professional workers. This appears to be true even when the interests of the patient are at stake. Nurses in the health team conference seem willing to accept a minor role both to the physician and to the social worker. They tend to put the dietician beneath the nurse in status. The health team conference as described seems little more than a ritual of obeisances to its stereotyped members.

RECOMMENDATIONS FOR MORE EFFECTIVE UTILIZATION

OF BACCALAUREATE NURSING GRADUATES

1. Provision of opportunity to practice the clinical nursing functions on selected nursing units. The author proposes that each clinical nursing department at the New York Hospital assess each of its nursing units to determine the extent to which the five defined clinical nursing functions are indicated in the care of patients undergoing treatment in that unit. Applicability as well as means for implementating the functions would vary in outpatient units, in premature infant units, in recovery room, in long-term and short-term units, etc.

2. Provision of distinct work specifications for baccalaureate graduates in nursing. The author proposes that specifications for first level positions for baccalaureate graduates in nursing be differentiated from those for diploma graduates. It is suggested that specifications for baccalaureate graduates in nursing be focused on the clinical nursing functions as set forth in Chapter II or on an adaptation thereof.

The author proposes that formal recognition in the form of increasing salary and grade be established for these practitioners as they demonstrate increasing competence in executing the clinical nursing functions.

3. Provision for experimental units in staffing patterns. The author proposes that following the assessment of individual nursing units for applicability of the functions, selected units be designated for experimentation of staffing patterns. The purpose of such experimentation is suggested as finding the most appropriate and most economical pattern which will allow that the clinical nursing functions be performed by baccalaureate nursing graduates without enfringement on the technical and administrative functions which are essential to modern medical and hospital care.

Furthermore, it is suggested that carefully planned inservice education for all members of the nursing team be an incorporated part of the experimentation. Such inservice education should be directed at giving all categories of nursing personnel an understanding and appreciation for the significance and importance of the contribution of each to the total nursing effort.

4. Review of the roles of the head nurse and the supervisor. The author proposes that the roles of supervisor and head nurse be studied with a view toward combining the advantages of accessibility and clinical expertness in one position. The author realizes that certain functions now carried by head nurse and others carried by supervisor might require reallocation, but she suggests that nursing authority should come from one person in the form of immediate and continuing consultation and collaboration with young practitioners in the daily care of patients.

5. Removal of barriers between learner and practitioner. The author proposes that the school of nursing and the nursing service consider ways for strengthening the bonds between learner and practitioner. It is suggested that young students should have the opportunity to work more closely with competent nurse practitioners. This is not to suggest that the head nurse practitioner should be given a faculty appointment. Rather, it is to affirm that teaching the neophyte is inherent in the role of any professional practitioner whenever the two find themselves together in the practice field.

6. Removal of barriers to collaboration among members of the health team. There is no ready solution to this problem since attitudes are difficult to change. Nonetheless, there are resources in the hospital under study that might be brought to bear on lessening the barriers. The author proposes that a series of inservice education programs be planned to focus on helping nurses to understand how their own attitudes and behavior tend to reinforce and strengthen existing stereotypes of individuals in the hospital. It is suggested that these programs need not be delayed until such time as the experimental units might be set up, but that they should begin in the immediate future and involve young baccalaureate graduates who are having their initial experience as staff nurses.

IMPLICATIONS FOR THE NURSING PROFESSION

The study findings suggest certain implications for both nursing education and nursing service. First and foremost, the nursing profession must re-evaluate the purposes and content of the baccalaureate program in nursing. Does this program prepare a practitioner who can function at a different level from the graduate of the diploma program? What about the ability of its graduates to exert personal leadership and their acceptance of personal responsibility for continued learning and professional development? Is it possible to incorporate these as objectives in the baccalaureate program, or is this program still geared to teaching nurses the <u>way</u> to nurse "the individual patient?" Even for psychosocial needs, one might infer that the graduates feel there is <u>a way</u> to meet these needs of patients. The way seems to be "delving into patient's problems," one patient at a time. What about the psychosocial forces in the immediate environment that affect the well-being of individual patients collectively? Are these simply hospital factors, unworthy of the attention of baccalaureate nursing students?

The individual patients to whom Miss Nightingale and her nurses ministered are long since forgotten, but what she and these nurses did to the hospital in the interest of individual patients collectively is recorded in history. Perhaps no single area in health care today offers a greater challenge for personal achievement and superior performance in nursing than that of rearranging the psychosocial climate of the hospital so that patients may see their care as a harmonious whole rather than as isolated bits of technological procedures performed by a multitude of task-oriented functionaries. A premise of this study is that the clinical nursing functions as defined are tools for bringing about such harmony.

Is it being entirely realistic to have the professional content of nursing education focus almost exclusively upon the care of the "individual patient" or upon the "nurse-patient dyad" or even upon the "nurse-doctor-patient tryad?" Such an approach seems to be geared more to preparation of the special duty nurses or private practitioners. But what about the multitude of patients whose health problems do not require that the nurse be in constant attendance? Are they to be subjected to whatever forces prevail in the institutions which distribute nursing and medical care? One may argue that these forces or factors lie outside the domain of nursing, that

they should be the concern of institutional management. Yet the trend toward the distribution of health services through employed professionals working in combined efforts, including even medical practice, seems to be increasing. Complex organizations are a by-product of specialization. With prepayment plans for comprehensive care on the increase, the American public may be expected to seek more and more of this care in a "packaged" form. At a time when nursing seems to be trying to free itself from the package, other health professions are being drawn in. The employed professional must have some understanding of how to manipulate the organization for the most effective distribution of his services; else he loses control over what the nature of these services shall be.

Let us now look at the hospital nursing service. License to practice professional nursing is not finalized when the new graduate receives a licensing certificate from the state education department. Since the chances are great that she will seek employment with an organization, she must depend upon that organization granting her the authority to practice her profession. To what extent does authority in nursing emanate from the patient's bedside, and to what extent does it emanate from a nursing procedure manual which has become a book of rules for her supervisor or head nurse? We may take as an example a young surgeon performing his first appendectomy. One could hardly imagine his chief handing him a written procedure on "how we do appendectomies in this hospital." We must ask ourselves in nursing service whether our supervision is slanted more on the book of rules than on the patient. Does our supervision allow a young practitioner to verbalize a problem and find the solution for herself, perhaps from a number of alternatives? Or does our supervision supply a ready-made answer to the problem from the book of rules? Further, is our supervision geared to helping young practitioners develop awareness of a widening range of problems as well as a widening range of solutions?

Learning, in practice as well as in the classroom, implies not simply doing with the hands, but ability to intellectualize what one is doing. Man intellectualizes with words. If a spirit of learning is to pervade nursing practice, the practitioner must have the opportunity to verbalize nursing care as well as to do nursing procedures. Is our supervision geared to collaboration and consultation with the young practitioner, to meaningful reports, nursing care plans, conferences, and evaluations of the outcome of nursing which our patients receive? Or is it geared solely to the work schedule, the things that are to be done, when and how they are to be done, the things that have not been done?

Nursing supervision must provide an atmosphere conducive to continued learning in practice, to using the problem-solving approach to patient care, to intellectualizing nursing care in process. Nursing education must equip its graduates with a sustained interest in learning, in finding the solution to problems through intellectual processes rather than ready-made answers. Finally, it is suggested that nursing education and nursing service must find the means for reuniting learning and practice. The move of nursing education to the university must not be a move into an "ivory tower" at a time when the university itself is beginning to move its laboratories into the community. The great possibilities of the future can be realized only by dealing with the present with respect and understanding of the past. Events flow continuously through time even though we are not always able to comprehend their continuity. Investigation of questions that have grown out of the findings of the present study are needed in order to give direction for the future.

BIBLIOGRAPHY

1. BOOKS

Alexander, Edythe, et al. Nursing Service Administration. St. Louis, The C. Y. Mosby Company, 1962. 270 p.

American Nurses' Association. Facts about Nursing. New York, The Association, 1961. 265 p.

________. Functions, Standards, and Qualifications for Practice. New York, The Association, 1959. 39 p.

Brown, Esther Lucile. Newer Dimensions of Patient Care. Part 1: The Use of the Physical Environment of the General Hospital for Therapeutic Purpose. New York, Russell Sage Foundation, 1961. 159 p.

________. Newer Dimensions of Patient Care. Part 2: Improving Staff Motivation and Competence in the General Hospital. New York, Russell Sage Foundation, 1962. 194 p.

________. Nursing for the Future. New York, Russell Sage Foundation, 1948. 198 p.

Burling, Temple, Edith M. Lentz, and Robert N. Wilson. The Give and Take in Hospitals. New York, G. P. Putnam's Sons, 1956. 355 p.

Committee for the Study of Nursing Education. Nursing and Nursing Education in the United States. New York, The Macmillan Company, 1923. 585 p.

Committee on the Function of Nursing. A Program for the Nursing Profession. New York, The Macmillan Company, 1948. 108 p.

Committee on the Grading of Nursing Schools. Nursing Schools Today and Tomorrow. New York, National League for Nursing Education, 1934. 268 p.

Cottrell, Donald P., ed. Teacher Education for a Free People. Oneonta, New York, The American Association for Teacher Education, 1956. 456 p.

Coulter, Pearl Parvin. The Nurse in the Public Health Program. New York, G. P. Putnam's Sons, 1954. 309 p.

Cunningham, Robert M. Hospitals, Doctors, and Dollars. New York, F. W. Dodge Corporation, 1961. 275 p.

Department of Baccalaureate and Higher Degree Programs. Excellence in Education. The Role of Accreditation in Collegiate Nursing Education. Code No. 15-848. New York, National League for Nursing, 1961. 56 p.

Doherty, Robert E. The Development of Professional Education. Pittsburg, The Carnegie Press, 1950. 31 p.

Frumkin, Robert M. Hospital Nursing, a Sociological Point of View. Buffalo, New York, University of Buffalo Bookstore, 1956. 75 p.

Habenstein, Robert W. and Edwin A. Christ. Professionalizer, Traditionalizer, and Utilizer. Columbia, Mo., University of Missouri Press, 1955. 164 p.

Hagen Elizabeth and Luverne Wolff. Nursing Leadership Behavior in General Hospitals. New York, Institute of Research and Service in Nursing Education, 1961. 198 p.

Hughes, Everett C., Helen MacGill Hughes, and Irwin Deutscher. Twenty Thousand Nurses Tell Their Story. Philadelphia, J. B. Lippincott Company, 1958. 280 p.

Inter-professions Conference on Education for Professional Responsibility. Education for Professional Responsibility. Pittsburg, The Carnegie Press, 1948. 207 p.

Lambertsen, Eleanor C. Education for Nursing Leadership. Philadelphia, J. B. Lippincott Company, 1958. 197 p.

_______. Nursing Team Organization and Functioning. New York, Bureau of Publications, Teachers College, Columbia University, 1953. 89 p.

Lesser, Marion S. and Vera R. Keane. Nurse-Patient Relationships in a Hospital Maternity Service. St. Louis, C. V. Mosby Company, 1956. 301 p.

Lieberman, Myron. Education as a Profession. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1956. 540 p.

Lindsey, Margaret. New Horizons for the Teaching Profession. Washington, D. C., National Education Association of the United States, 1961. 243 p.

McGlothin, William J. Patterns of Professional Education. New York, G. P. Putnam's Sons, 1960. 288 p.

Montag, Mildred L. The Education of Nursing Technicians. New York, G. P. Putnam's Sons, 1951. 146 p.

National League for Nursing. Nursing Education Programs Today. Code 11-891. New York, The League, 1961. 15 p.

Nelson, Katherine R. "How Will Individualized Care of the Patient's Nursing Needs Be Provided?" American Nurses' Association. Improvement of Nursing Practice. New York, The Association, 1961. pp. 19-26.

New, Peter K., Gladys Nite, and Josephine M. Callahan. Nursing Service and Patient Care, a Staffing Experiment. Kansas City, Mo., Community Studies, Inc., 1959. 124 p.

Reissman, Leonard and John H. Rohrer. Change and Dilemma in the Nursing Profession: Studies of Nursing Service in a Large General Hospital. New York, G. P. Putnam's Sons, 1957. 450 p.

Rogers, Martha E. Educational Revolution in Nursing. New York, The Macmillan Company, 1961. 65 p.

Seymer, Lucy Ridgely, comp. Selected Writings of Florence Nightingale. New York, The Macmillan Company, 1954. 397 p.

Spohn, Roberta R. The Future of Education for Professional Practice. New York, American Nurses' Association, 1962. 68 p.

Stewart, Isabel M. and Anne L. Austin. A History of Nursing. New York, G. P. Putnam's Sons, 1962. 516 p. 5th ed. rev.

Tead, Ordway and Henry C. Metcalf. Personnel Administration; Its Principles and Practices. New York, McGraw-Hill, 1933. 519 p.

Waterman, Theda L. and Vararus F. Lang. Chronic Illness. St. Louis, The C. V. Mosby Company, 1955. 343 p.

2. PERIODICALS

Benne, Kenneth D. and Warren Bennis. "The Role of the Professional Nurse." The American Journal of Nursing, 59:196-98, February, 1959.

Bullock, Robert P. "Position, Function, and Job Satisfaction of Nurses in the Social System of a Modern Hospital." Nursing Research, 2:4-14, June, 1953.

Cornell University Announcements, Nursing 1962-1963. Ithaca, New York, Cornell University, August 1, 1962. 46 p.

Corwin, Ronald G. "The Professional Employee: A Study of Conflict in Nursing Roles." American Journal of Sociology, 66:604-15, May, 1961.

Cottrell, Donald P. "A Philosophy of Education for the Professions." The American Journal of Nursing, 40:914-922, August, 1940.

Department of Baccalaureate and Higher Degree Programs, "Baccalaureate and Masters Degree Programs in Nursing Accredited by the National League for Nursing--1962-63." Nursing Outlook, 10:410-11, June, 1962.

Diamond, Lorraine K. and David J. Fox. "Turnover among Hospital Staff Nurses." Nursing Outlook, 6:388-91. July, 1958.

Doherty, Robert E. "The Professional Spirit." The American Journal of Nursing, 37:369-372, April, 1937.

Farrisey, Ruth. "Referrals a Nursing Responsibility." Nursing Outlook, 5:19-21, January, 1956.

Goss, Mary E. W. "Influence and Authority Among Physicians in an Out-patient Department." American Sociological Review, 26:39-50, February, 1961.

Health Insurance Council. "Analysis of the Health Care Dollar." Health Insurance Viewpoints, Vol. III, No. 1, March, 1963.

Hubbard, Ruth W. and Mathilda Scheuer. "Organization of Referral Programs." Nursing Outlook, 5:18-19, January, 1956.

Johnson, Dorothy E. "A Philosophy of Nursing." Nursing Outlook, 7:198-200, April, 1959.

________. "The Significance of Nursing Care." The American Journal of Nursing, 61:63-66, November, 1961.

Johnson, Miriam and H. W. Martin. "A Sociological Analysis of the Nurse's Role." American Journal of Nursing, 58:373-377, March, 1958.

Kreuter, Frances R. "What Is Good Nursing Care," Nursing Outlook, 5:302-04, May, 1957.

Lambertsen, Eleanor. "Toward a Clearer Definition of the Nurse's Function." Hospitals, 35:51, July 16, 1961.

McQuillan, Mary. "How Do Graduates of Collegiate Programs Rate?" Nursing Outlook, 9:100-102, February, 1961.

Merton, Robert K. "The Search for Professional Status." The American Journal of Nursing. 50:662-64, May, 1960.

Meyer, Genevieve Rogge. "Conflict and Harmony in Nursing Values." Nursing Outlook, 7:398-99, July, 1959.

Pearsall, Marion. "Supervision - A Nursing Dilemma." Nursing Outlook, 9:91-92, February, 1961.

Resolution on the Clinical Practice of Nursing." American Journal of Nursing, 62:87, June, 1962.

Saunders, Lyle. "The Changing Role of the Nurse." American Journal of Nursing, 54:1094-98, September, 1954.

Steiger, William A., et al. "A Definition of Comprehensive Medicine." Journal of Health and Human Behavior, 1:83-86, Summer, 1960.

Taubenhaus, Marjorie. "Hospital Hierarchy." The Atlantic, 203:88-89. June, 1959.

The Society of the New York Hospital. Annual Report for the Year 1959. New York, The Society, 1960. 89 p.

The Society of the New York Hospital. Annual Report for the Year 1961. New York, The Society, 1962. 93 p.

Wang, Mamie Kwoh. "The Intramural Nursing Referral." Nursing Outlook, 7:346-47. June, 1959.

3. UNPUBLISHED MATERIALS

Dunbar, Virginia M. "A Statement of What We Expect of Graduates of Baccalaureate Programs." New York, Cornell University-New York Hospital School of Nursing, September 19, 1958, 6 p. Typewritten.

Nursing Staff Statistics filed in the Office of the Director of Nursing Service, The New York Hospital.

Pratt, Henry N. "The Need for Control of Hospital Utilization." Talk before Vermont Hospital Association, October 10, 1962. Typewritten.

Smith, Elliott Dunlap. "Materials on General Education, Professional Education and Teaching." New York, Bureau of Publications, Teachers College, Columbia University, 1957. 56 p. Typewritten.

The New York Hospital Listing of Professional Staff, July 1, 1962 - June 30, 1963. Typewritten. In the files of the Office of the Secretary to the Board of Governors.

The New York Hospital Listing of Resident Staff Appointments, July 1, 1962 - June 30, 1963. Typewritten. In the files of the Office of the Secretary to the Board of Governors.

The New York Hospital Personnel Status for August, 1962. Typewritten. In the files of the Personnel Department.

The New York Hospital Turnover for August, 1962. Typewritten. In the files of the Personnel Department.

APPENDIX A

INITIAL CORRESPONDENCE CONCERNING THE INTERVIEWS

I. Memorandum from the Director of Nursing Service to the Clinical Nursing Department Heads.

To: Clinical Nursing Department Heads
Medical Nursing
Surgical Nursing
Pediatric Nursing
Obstetric and Gynecological Nursing
Operating Room Nursing
Outpatient Nursing
Private Patients Nursing

Subject: Interviews of baccalaureate program graduates

Date : July 6, 1962

During the months of July and August, Miss Laura Simms will be interviewing graduates of basic baccalaureate programs in nursing who are employed as staff nurses in this Medical Center. In connection with her doctoral study at Teachers College, she is interested in learning the opinions and attitudes of these graduates regarding staff nursing in the light of their educational preparation.

I have granted Miss Simms permission to contact each of you to make arrangements for the interviews. Each interview will require approximately one hour and should be considered on-duty time for the nurses selected.

The findings of this study and the interviews will be shared with all of you and should provide us with helpful evidence concerning the satisfactions in general staff nursing.

Thank you for your cooperation.

Dean, School of Nursing
Director, Nursing Service

II. Letter from the Investigator to the Interviewees.

445 East 68th Street
New York 21, New York
July 13, 1962

Miss Jane Doe, R. N.
525 East 68th Street
New York 21, New York

Dear Miss Doe,

In connection with my doctoral studies at Teachers College, Columbia University, I am conducting a study of the opinions and attitudes of baccalaureate graduates regarding staff nursing in light of their educational preparation. The study is limited to baccalaureate graduates who are employed as staff nurses at The New York Hospital-Cornell Medical Center. In this study, I am particularly interested in identifying what factors (policies, relationships, conditions of employment, etc.) these graduates see as roadblocks or deterrents to professional nursing practice at the staff nurse level. I am also interested in what factors they see as promoting professional nursing practice.

In the near future, I shall be contacting you to make arrangements for an interview. This interview will require approximately one hour and will be considered by your department head as on-duty time. All responses to questions asked during the interview will be strictly confidential, and complete anonymity is assured in the report of the study. The results of the study will have value only to the extent that you share your honest thinking about the staff nurse position, your educational preparation for nursing, and your concepts of good nursing practice.

The findings of this study will be shared with you and should provide us with helpful evidence concerning hospital staff nursing as a work experience for baccalaureate graduates. I look forward to my interview with you and hope that you will find it an interesting and stimulating experience.

Sincerely yours,

Laura L. Simms, R. N.

APPENDIX B

CHARACTERISTICS OF THE INTERVIEWEES

TABLE I

SCHOOLS FROM WHICH THE 52 NURSES GRADUATED

	School	Number
1.	Adelphi College, New York	1
2.	Boston University, Massachusetts	1
3.	Columbia University, New York	1
4.	Cornell University-New York Hospital	32
5.	Duke University, North Carolina	1
6.	Georgetown University, Washington, D. C.	1
7.	Hunter College, New York	1
8.	Russell Sage College, New York	3
9.	Rutgers, The State University, New Jersey	1
10.	St. Olaf College, Minnesota	1
11.	Skidmore College, New York	3
12.	Syracuse University, New York	1
13.	Tuskegee Institute, Alabama	1
14.	University of California in L. A.	1
15.	University of Michigan	1
16.	University of North Carolina	2
		52
	Total CU-NYH Graduates	32
	Total from 15 other schools	20
		52

TABLE II

YEAR OF GRADUATION FOR THE 52 NURSES

Year	Number
1957	1
1958	4
1959	8
1960	9
1961	22
1962	8
	52

TABLE III

LENGTH OF SERVICE AT NYH FOR THE 52 NURSES

Length	Number
6 mos. -	9
6 mos. +	7
1 yr. +	27
2 yrs. +	5
3 yrs. +	2
4 yrs. +	1
5 yrs. +	1
	52

TABLE IV

CLINICAL DEPARTMENT TO WHICH THE 52 NURSES WERE ASSIGNED

Department	Number
Medical	16
Obstetrics-Gynecology	6
O.R.-Recovery Room	4
Out-patient	7
Pediatric	7
Private Patients	1
Surgical	11
	52

TABLE V

TOURS OF DUTY OF THE 52 NURSES

Tour	Number
Rotating	40
Permanent Evenings	3
Permanent Nights	4
	52

APPENDIX C

CLASSIFICATION OF SUMMARIZED RESPONSES FROM ONE INTERVIEW

Opinions About The Job With Respect To Educational Preparation

Interview # 15 .

As a Beginning Position

GOOD EXPERIENCE, OPPORTUNITY TO TRY MANY THINGS I HADN'T DONE AS A STUDENT. BECOME SKILLFUL IN PROCEDURES, SEE WHAT JOB OF HEAD NURSE IS LIKE DOING CHARGE DUTIES ON EVENINGS AND NIGHTS, GAIN CONFIDENCE IN MY ABILITIES. NEEDED BEFORE PROMOTION. (P. 11)

As a Life-Time Career

AFTER A WHILE ONE BECOMES — NOT BORED, BUT SO AUTOMATIC. YOU FEEL LIKE YOU ARE DOING THE SAME THING EVERY DAY.

Career Expectation TEACHING

Expectations vs. Present Job Requirements

HAD EXPECTED MORE OF A CHANCE TO TEACH THE PATIENT AND TO TEACH OTHER PERSONNEL. THIS WAS EMPHASIZED A GREAT DEAL IN OUR TRAINING. AT FIRST HAD EXPECTED I WOULD BE A LEADER, BUT SO MUCH I HADN'T DONE AND DIDN'T KNOW COULDN'T LEAD ANYONE. (P. 5)

Perceived Differences in Bac. and Dipl. Grads

UNDER IMPRESSION IN SCHOOL THAT THERE SHOULD BE SOME KIND OF SUPERIORITY (OF BAC. GRAD.), BUT IT WASN'T CLEAR IN WHAT WAY. WE WERE TO BE LEADERS, MORE OR LESS, BUT SEE NO DIFFERENCE BETWEEN BAC. AND DIPL. GRADS.

Satisfactions

TAKING CHARGE ON EVENINGS AND NIGHTS, SEEING WHAT JOB OF HEAD NURSE IS LIKE.

I LIKE THE FACT THAT YOU HAVE A CHANCE TO DO EVERYTHING. (ON EVENINGS) CHARGE DUTIES ARE HELPFUL IN THIS WAY.

Dissatisfactions

THE ROTATION BUSINESS.

JUST GIVING MEDICATIONS AND TREATMENTS, NO OPPORTUNITY TO SIT AND CHAT WITH PATIENTS, GIVE THEM A BATH AND STAY WITH THEM A LONG TIME.

Opinions About Working Relationships

Interview # 15

Subordinates	Peers	Head Nurses
They have such a good program (training) before they come to the ward that there is very little we can teach them. They seek our help whenever anything is going on they can't solve for themselves, but there is very little of that.	Have found most nurses I work with here are excellent. Does seem to be a lack of initiative. Maybe if we could have some sort of get-togethers, air our problems, and get each others opinions (p. 26) (Suggestion made as a means for stimulating initiative.)	A resource person, whenever things come up that you can't handle yourself. Example: You have a question as to whether you should withhold a drug. She She takes care of it, you know, finding out from the doctor.
Supervisors	**Doctors**	**Students and Others**
I'm kind of afraid of supervisors. Was as a student. Feel that they come in to find mistakes. On evenings, supervisor very helpful. If a med. is not available, call her. If patient has a change, call her first (before the doctor) if doctor is not on floor.	They, some, not all, but some hold themselves apart. There isn't that feeling (between doctors and nurses) that there should be. Sometimes you find those who rely on your thinking ability.	Several times we have called the dietician, and either she doesn't come, or it takes her a week to get there. She may come to see a patient and you know nothing about it.

Perceived Deterrents to Clinical Nursing Functions

Interview # 15.

Planning and Implementing Nursing Care	Patient- Family Teaching	Interdisciplinary Collaboration
DAYS WHEN WE DON'T GO TO BEDSIDE EXCEPT TO GIVE MEDS., RX'S, TAKE BLOOD PRESSURES. DON'T HAVE TIME TO SIT AND CHAT WITH PATIENT. AIDES DO MOST OF BEDSIDE CARE AND THEY CAN'T TAKE CARE OF A PSYCHOLOGICAL PROBLEM THAT MAY COME UP. YOU MAY SEE PT. HAS A PROBLEM AND BE UNABLE TO GET OTHER PEOPLE TO CO-OPERATE (THE DIETICIAN).	DIFFICULT UNLESS FAMILY IS INTERESTED ON THEIR OWN -- MAY NOT CARE. SOMETIMES WHEN FAMILY ARE THERE, FIND YOURSELF INVOLVED IN OTHER THINGS -- AT THE DESK ORDERING A MED. LOSE THE OPPORTUNITY. GUESS THINGS COULD BE PUT ASIDE, BUT YOU HAVE YOUR WORK ASSIGNED TO YOU AND YOU HAVE TO DO IT. (P. 17)	SO MANY CHANNELS -- ONE HAS TO GO TO THE SUPERVISOR, TO THE DOCTOR. MEANWHILE NOTHING IS DONE. HAVE SOCIAL SERVICE ROUNDS ONCE A WEEK -- DISCUSS PTS.' MED. HIST., SOCIAL AND FINANCIAL PROBLEMS. LACK OF COMMUNICATION WITH DIETICIAN (P. 14)
Nursing Team Leadership	**Patient Referrals**	**A Specific Nursing Problem**
HAD EXPECTED MORE OF A CONFERENCE TYPE OF THING. GIVING ASSIGNMENTS TO AIDES WOULD BE BETTER IF WE HAD A CONFERENCE. PROBLEM IS GETTING THE BREAKFAST TRAYS OUT. SOMETIMES YOU ARE ASSIGNED TO BE TEAM LEADER; SOMETIMES TO GIVE MEDS. AND RX'S; SOMETIMES TO TAKE CARE OF SICKER PATIENTS. DEPENDS ON HOW WELL WE ARE SET UP (STAFFING).	THIS IS DONE HERE MORE THAN IN HOSPITAL WHERE I TRAINED. NO PROBLEMS CITED.	1- PATIENT REQUIRING THAT DAUGHTER BE TAUGHT TO GIVE HER INJECTIONS. PATIENT LIVED WITH DAUGHTER, BUT LATTER NOT EVEN INTERESTED ENOUGH TO PHONE IN. FINALLY WE HAD TO RESORT TO VISITING NURSE SERVICE (P. 16) 2. PATIENT WITH EXTREME PAIN ON BEING MOVED. WE MADE A TURNING SHEET. HAVE HAD NO PLANNING SESSION, MORE OR LESS INFORMAL PLANNING. (P. 23)

APPENDIX D

SYSTEM OF CODING PERCEIVED DETERRENTS TO CLINICAL NURSING FUNCTIONS

Clinical Nursing Functions

Pt c - Planning and Implementing Nursing care
Te - Teaching Patients and Families
In C - Interdisciplinary Collaboration
T L - Nursing Team Leadership
Pt. R - Patient Referrals

Perceived Deterrents

1. Time

    A - Demand for discrete tasks - unspecified
    A.1 - Demand for discrete tasks - nursing
    A.2 - Demand for discrete tasks - institutional
    A.3 - Assisting the doctor
    B - - Priorities among patients
    C - Sustained contact with patient or family

2. Informal Controls

    D - Informal group controls - Subordinates
    E - Informal group controls - Peers
    E - Internalized role expectations
    F - Patient-family controls

3. Formal Institutional Controls

    G - Head nurse
    H - Supervisor
    I - Institutional policy or regulation
    I - Unit to which assigned

4. Fragmentation or departmentalization

    J - Communications within nursing hierarchy
    J - Communications with other nursing departments or units
    K - Communications with other disciplines or departments
    L - Overlapping of responsibilities within nursing
    L - Overlapping responsibilities with other disciplines

Miscellaneous - Subscripts

Dr - Doctor
Se - Self
PT - Physical therapy
SW - Social worker
Nt - Nutritionist
NA - Nurse aide
LPN - Licensed practical nurse
St - Student in nursing