THE ROLE OF THE NURSE: VIEWS OF THE PATIENT, NURSE AND DOCTOR IN SOME GENERAL HOSPITALS IN ENGLAND

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Doctor of Philosophy

by
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ABSTRACT

The main purpose of the study was to investigate patient-nurse-doctor role views in an attempt to 1) devise a method for rating patient satisfaction with nursing care as a tool for measuring the quality of nursing, and 2) identify differences in attitudes about the role of the nurse which might help to explain conflicts within the hospital organisation.

Five hospitals of different size and training schemes were visited, and a total of 400 people completed the survey (326 by interview, and 74 by self-completion of the questionnaire). The convenience sample included 201 male and female patients, 105 student and graduate nurses, and 94 doctors, on medical and surgical wards.

Questions were asked about what was expected of the nurse and the ward sister, about illness and the sick role, communications and interpersonal relations, the education and training of nurses, the shortage of nurses, the nursing structure, and the activities included in the nursing role.

Analysis of data consisted in its summarisation by per cent, chi-square, Spearman's rank correlation, and reliability analysis.

Two-thirds of the patients were highly satisfied with nursing care. No relationship was found between the ranking of nursing activities by nurses and patients, and satisfaction with care. The technical aspects of the nurse's work were emphasised by patients, nurses and doctors when ranking nursing activities. A large number of nurses expressed negative feelings about visitors, hospital administration, and doctors. It was important to the doctor to have nurses accompany them on ward rounds.

It was concluded that patients should have the opportunity of expressing their opinions about nursing care. More effective methods could be used to combat the nursing shortage. Well planned ward rounds might improve the nurse-
patient-doctor relationship. A way should be found to enable the ward sister to advance in position while remaining in clinical nursing.
I should like to express my sincere thanks to all the patients, nursing staff, administrative staff and doctors at the hospitals involved in this study.

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GLOSSARY

1. Ancillary help: Auxiliary help such as clerks, housekeepers, couriers, kitchen workers, volunteers.

2. Basic care: Those activities concerned with the sustenance of the patient; food, drink, bedmaking, bathing, giving and taking of bedpans.

3. Bedside care: Those tasks which directly involve the nurse with the patient; as opposed to those tasks which are administrative, or supervisory, and are only indirectly involved with patient care.

4. BTA: British Tuberculosis Association.

5. Clerical/reception duties: Those activities concerned with the completion of forms, case notes, certificates; general filing; ordering and receiving drugs, treatments, stores, linens; answering telephone calls; receiving visitors; writing ward notices. Also called 'administrative duties'.

6. Chi-square test: A statistical test used to analyse the significance of differences among groups that are being compared in terms of qualitative variables.

7. Convenience sample: Subjects are selected because they happen to be available for participation in the study at a certain time.

8. CSE: Certificate in Secondary Education.

9. Emotional support: Maintenance of effective verbal and non-verbal communication to create a therapeutic environment; includes social interaction, and talking with patients to promote productive interpersonal relationships.

10. GCE: General Certificate of Education.

11. GNCET: General Nursing Council Entry Test.
12. Kardex: A book type file containing individual cards for each patient currently on the ward, giving pertinent background and medical data.

13. Likert-type scale: An ordinal type scale in which the variable is evaluated by a series of statements that, when responded to by study subjects, can provide a criterion measure of the variable.

14. Nightingale wards: Open wards named after Florence Nightingale. Beds, usually about 30 in number, are arranged in two rows along, and at right angles to, the longer walls of the room. The ancillary rooms are usually at one or both ends of the ward.

15. Nursing care: A service to people, sick or well, to help them cope with their total health needs (preventive, physical, emotional, environmental, social and restorative).

16. ONC: Orthopaedic Nursing Certificate.

17. Ordinal rating scale: A qualitative scale in which the different categories included are related in terms of a graded order.

18. Patient assignment nursing: The system of organising a ward nursing team so that a given number of nurses cater to all the needs of the patient. Also called 'group assignment method'.

19. Pilot study: A study carried out before a research design is completely formulated. Questions are usually tried out on a group similar to the sample for the main study.

20. Projective technique: Involves the presentation of a stimulus situation designed because it will mean to the subject not what the experimenter has arbitrarily decided it should mean, but whatever it means to the personality who gives it his private, idiosyncratic meaning. Examples are the word association test and the Rorschach test.
21. Q-sort: A technique for deriving an ordinal scale for measuring certain kinds of variables. The rater is asked to sort a collection of items into a number of piles to determine the rater's own attitudes toward the object being rated. The number of items that can be placed in each pile follows the pattern of the normal curve.

22. Race-track ward: A ward where all or a substantial part of the ancillary accommodation is placed centrally with patients' rooms on the perimeter.

23. Reliability analysis: A method of scoring a random sample of responses by independent judges who familiarise themselves with a description of the categories. The resulting level of mutual agreement constitutes the reliability index.

24. SCM: State Certified Midwife.

25. SEN: State enrolled nurse; she is a 'practical' nurse who trains for two years as a pupil nurse.

26. SRN: State registered nurse; a qualified graduate nurse who trains for three years as a student nurse.

27. Spearman rank order correlation: A measure of association which requires that the variables be measured in an ordinal scale so that the subjects may be ranked in two ordered series.

28. Task assignment nursing: Nurses are responsible for performing set tasks for all the patients. Also called 'work assignment method'.

29. Technical care: Highly specialised skills, such as dressing wounds, taking vital signs, giving medicines, attending to intravenous infusions, and various other treatments.

30. TPR and BP: Temperature, pulse, respirations and blood pressure. Also called 'vital signs'.

31. Tutor: A teacher or 'clinical instructor'.

32. Ward sister: A nurse who is in charge of a ward. Also called 'head nurse'. 
PART I:

NURSE-PATIENT EXPECTATIONS AND ROLE PERCEPTION
INTRODUCTION TO THE STUDY

Research in Nursing

Virtually all nursing research has as its ultimate aim the improvement of patient care. Until recent years, hospital-based studies have been carried on by physicians, and social and physical scientists. It is the author's opinion that if nurses are to justify their professional role among the health professions, they must evolve a nursing science that will clarify the theories and concepts related to nursing.

There are three broad areas of research into nursing problems: nursing education, nursing administration, and nursing practice. The earliest type of research was done in nursing education, dealing with problems of recruitment, curriculum development, and evaluation of student performance. Nursing administration studies have been concerned with maintaining the operation of nursing. Nursing practice research has related to the direct and indirect care of patients (1).

In the study of nursing care, one of the main problems is establishing criteria or standards of quality. It is difficult to measure because nurses are involved both in practical manual techniques, and human relations skills (2). Some of the ways include the use of expert professional judgement as to what constitutes good nursing care, testing the effectiveness of a given practice, or assessing the receiver's satisfaction with the care. From the humanitarian viewpoint, it is important that the patient's feelings about his care be the concern of those who provide the care. It is also possible that the physical progress of a patient may be affected by his mental well-being (3). One must consider the fact that if a number of patients are dissatisfied with some aspect of nursing care, there may be some inadequacy in the nursing practice.
The main purpose of this study was to investigate patient-nurse-doctor role views in an attempt to 1) devise a method for rating patient satisfaction with nursing care, as a tool for measuring the quality of nursing, and 2) identify differences in attitudes about the role of the nurse which might help to explain stresses and conflicts within the hospital organisation. The implications of studies of role and counterrole in nursing are both theoretical and practical. The nurses's self-respect is dependent on the esteem of the public, whose views will promote or impede progress in the field. When role discrepancies are identified, nursing leaders can help decide what direction nursing needs to take, what changes can be made for improved relationships, and what adaptation is needed for teaching programmes.

Critical Factors Affecting the Field of Nursing

The increased involvement of the British Government in the health field since 1948 has resulted in the use of hospitals for expanding segments of the population. Besides direct patient care, the hospital is also used for its diagnostic facilities and its elaborate treatment equipment (4). The hospital has become a complex organisation of professional specialists, paramedical workers, and administrators.

With the advent of antibiotic therapy, there has been a decrease in the number of patients being treated for acute infections, and an increase in the number of older patients with chronic illnesses requiring rehabilitative and social support (5). Programmes such as early ambulation, progressive patient care, and early discharge have increased the turnover of patients admitted to and transferred from the ward (6). The patients are not only different in terms of their illness and age. They have higher standards of living, and are more educationally aware of their medical needs. Patients increasingly express a desire for personalised care. They also want to achieve a more independent status within the hospital system.
The field of nursing has been influenced by a religious, militaristic, and paternalistic background. The nurse has been instilled with a missionary attitude of dedication and humanitarianism. Her apprenticeship training has been affected by disciplinary and authoritarian approaches. Nurses acquired their procedures from the doctor who was also their teacher. Nursing has been a predominantly female occupation, and its progress and status parallels the progress of women in general. Its position as a profession has been affected by its attachment to the hospital for apprenticeship without also being attached to the University.

The functions of the nurse have been influenced by many factors; one is the downward movement of procedures from the physician to the nurse. Taking vital signs, dressing wounds, removing stitches, giving dangerous drugs, testing urine, catheterisation, attending intravenous infusions are some examples. In turn, the SRN has passed to the enrolled nurse and to ancillary help many of the tasks she once performed; the distribution of meals and drinks, stripping and making of beds, bathing and feeding patients, cleaning, dusting, etc. This process has created supervisory and legal problems for the nursing staff, and the need for additional training in management as well as proficiency training for specialised techniques. Sometimes this has meant that qualified nurses are employed with administrative, teaching and supervisory tasks, leaving students and domestic staff at the operational level with patients.

The underlying problem of shortage of staff necessitates the delivery of quality nursing with fewer trained personnel.

There is an expanding perspective of what constitutes good nursing care; this now includes preventive care, rehabilitation, and social services.

As an occupation strives to become a profession, its practitioners assume responsibility to develop a body
of theoretical knowledge. The nursing theories focus on areas of practice where the profession assumes prescriptive authority. The major responsibility for the biological pathology of patients rests with the physician, whose care includes diagnosis, and correction of the diagnosed pathology. The nurse assists in the procedures, but she is given specific medical guidelines. The major focus of nursing theory, in the U.S.A. at least, has been on behavioural science theories. The role of the nurse is one of a social practitioner who is now in a position to manipulate behavioural science variables to help the patient satisfy those needs with which he is unable to cope himself. The nurse has independent prescriptive authority over the psycho-social aspects of patient needs, and she is stressing this function with the professionalisation of nursing (11).

Although the Salmon (12) report sets forth the function of each grade of nurse, the actual tasks that nurses perform vary with the assignment of personnel to any given ward (13). If a hospital has a housekeeping service, a courier service, a dietary department, and ward clerks, then cleaning, food service, clerical duties and the running of errands will not be nursing duties. If a hospital trains medical students and resident staff, the qualified nurses may do fewer technical procedures. If there is a shortage of trained nursing staff, ancillary help may perform many of the bedside tasks.

Finally, it is important to mention the effect that the returning emphasis of patient-centred care has had on nursing service. Patient assignment is being introduced, particularly in Canada and in the U.S., so that a nurse can give total care to her patients instead of being responsible for performing set tasks for all the patients (14).

**An Overview of Studies Concerned with Nursing Roles**

There has been an interesting variety of research into the role of the nurse, exploring her self-concepts as
well as the perception of significant others in her relationships. Some of these studies identify conflicts resulting from the difference between actual and expected behaviour. Others point out the product of role deprivation, anxiety, ambiguity in role relationships, interpersonal difficulties, and lack of communication.

The psychological aspects of nursing have been studied in an attempt to help choose students, assign trained personnel, and explain the relationship between the personality traits of nurses, and interpersonal problems within the hospital structure. MacGuire (15) feels that personality tests have demonstrated a negligible power of prediction in the selection of nurses. Navran and Stauffacher (16) translate their results into nurses who are 'work-orientated', and those who are 'people orientated'. Simmons (17) is convinced that a large portion of interpersonal problems in the hospital have their dynamics in the institutional system as much as, or more than, the personalities involved.

Meyer (18) classified nurses into four groups:

1. Those who preferred an undivided relationship with the patient.
2. Those who were patient-oriented, but who recognised the importance of teaching and supervising.
3. The colleague oriented nurse who still had some recognition of the importance of patient care.
4. The completely technical-administratively oriented nurse.

She felt that nursing was in transition between patient-centred care and technique orientation.

The Reissman and Rohrer (19) typology of nurses included:

1. The 'dedicated nurse' who chose nursing for positive reasons, and hoped to continue in nursing.
2. The 'converted nurse' who entered nursing for negative reasons, but who wanted to continue in nursing.
3. The 'disenchanted nurse' who entered nursing for positive reasons, but no longer wished to remain.

4. The 'migrant nurse' who entered nursing for negative reasons, and did not wish to stay.

Many writers tend to see role conflict in nursing as the identification of dichotomous role sets. Saunders (20) described the nurse as torn between her 'patient-centred' role and her 'managerial' role. He concluded that the present function of the nurse is not to nurse, but to see that the patient is nursed. He recommended that the nurse admit this role, and move ahead with it.

Schulman (21) felt that the nurse plays many roles, but the two principal ones were the 'mother surrogate', who deals with the every day aspects of living which, for the time being, the patient is unable to do, and the 'healer', whose activities centre upon having the patient regain his optimal health state. The behaviour in the 'mother-surrogate' role is similar to the 'mother-child' role; there is intimacy, tenderness and compassion which is protective of the child's interest. The 'healer' role has its 'save the patient' concepts, which leave no room for idle conversation. The conflict results when the nurse is caught between the poles of these two roles. The hospital system sanctions the 'healer' role, and the general public has an image of her as a 'mother surrogate'.

Corwin et al (22) suggest that the conflict is between the nurse's humanitarian image and her bureaucratie professionalisation. They tested whether role conception, role consensus and favourableness of the image of nursing was related to the variable levels of success and satisfaction in nursing.

Bonne and Bennis (23) felt the conflict was created between the nurse's realistic image and her idealistic image. Bedside care ideally was felt to be her legitimate function, whereas in reality she had to organise, teach, deal with administration and technical nursing.
Nurses often express their dislike of administration, yet the status ladder takes them to just such a set of tasks.

Arguing that previous writers have erroneously seen the conflict as a dichotomous role set identification, Schmitt (24) says there have always been differences in the way nursing has been carried out. The present emphasis on team nursing and 'total care of the patient' will blend the humanitarian spirit with professional skills.

Because the nurse often feels she is not performing the skills for which she was trained, she develops a condition known as 'role deprivation'. Kramer (25) studied the relationship between role conception, role deprivation, and the length of exposure to bureaucratic employment. She found that those nurses who had high professional/low bureaucratic concepts when they graduated from training had higher deprivation scores than those nurses with high bureaucratic/low professional concepts. Those with high deprivation scores tended to change jobs or leave nursing.

In hospital, there is a high level of tension and anxiety among nurses. Henzies (26) suggests that student withdrawal from training, high sickness rates, and changing of jobs are the result. Nurses take up roles against anxiety, using defensive techniques in an attempt to alleviate the primary anxiety producing situations. The net result, however, is that secondary anxiety is aroused, and thus anxiety is in no way contained. The author suggests that the success and viability of a social institution are intimately connected with techniques used to contain anxiety. Some of the defensive techniques used by nurses are:

1. The use of lists of tasks restricting prolonged contact with any one patient.
2. Denial of the significance of the individual by using bed number or disease entity instead of the patient's name.
3. Use of the nurse's uniform with its expression of uniformity.
4. Detachment and denial of feelings by the use of a brisk manner, and use of reprimand and discipline for errors.

5. An attempt to eliminate decision making by ritual task performance.

6. Reduction of the weight of responsibility in making a decision by the use of checks and counterchecks by personnel senior to them.

7. Purposeful obscurity in the formal distribution of responsibility by a failure to define who is responsible for what and to whom.

8. Idealisation and underestimation of personal developmental possibilities.

9. Avoidance of change which threatens the existing social defences against deep and intense anxieties.

Revans (27) feels that anxiety in the hospital is enhanced by uncertainty, which is magnified by communication failure. There is a vicious cycle of anxiety leading to uncertainty leading to communication blockage which goes back to anxiety. The adjustment to hospital life comes through learning, which would be facilitated by an environment which was less official, less authoritarian and less code ridden.

The character of the nurse's role is determined not only by her self-expectations, but also by the expectations of her colleagues. Duff and Hollingshead (28) found that the physician assigned to the nurse the role of assistant to carry out his orders. Nurses were seen as keeping records, and acting as liaison for physicians. The writers felt that the bonds between nurse and doctor are stronger than the bonds between patient and nurse.

In Ford and Stephenson's (29) study of the physician's attitude toward nursing problems, the nurse was thought to be spending too much time in administration and clerical tasks, and not enough time with bedside tasks. However, the doctor thought that some of the tasks the nurse performed could be done by auxiliary personnel.
Coser (30) points out that the doctor sees subordinate roles for the nurse rather than self-sufficient qualities; she obeys orders, and follows routines.

Doctors and nurses have a 'professional' role and status, but the patient has a 'lay' role and status. The patient is less an 'actor' than a 'passive observer'. As far as personnel are concerned, they are more of a vital reference group (31). Wilson (32) says that one of the big problems in the care of the patient is the conflict between the dependent needs of patients who are seriously ill, and the opposing needs of patients who are convalescent, and moving back towards personal responsibility and independence. Dependency in a sick patient may be a source of comfort, but it hurts his self-esteem. Coser (33) suggests that the role of the patient has contradictory imperatives of passivity and effort. The elderly patient who has already lost many of his roles outside the hospital, can relax in passivity, follow instructions, and more easily accept the patient role.

Patients often feel obliged to be co-operative, considerate, and undemanding. They are reluctant to discuss any rights they might have while in hospital. Mauksch and Tagliacozzo (34), using projective picture tests, found that patients attach tremendous importance to the personality attributes of physicians and nurses, and to personalised care. The most tangible activities are the prompt response of the nurse and a 'good explanation' from the physician. Kindness reduces the patient's fear of being rejected, and willing and spontaneous responses make 'being demanding' less necessary. Since patients are not competent to judge the skill and technical knowledge of professional personnel, interest in the patient is indirect proof of competence.

If the need for supportive and personalised care remains unfulfilled, anxiety in the patient may find expression in hostility to the nurse. Thus the role of the nurse has increasingly become identified as her potential for modifying patient behaviour as she deals with his
anxieties. Robinson (35) feels the nurse should be aware of the part that anxiety plays in causing the patient to regress and become dependent.

Finally, it is important to predict the potential role of the nurse in the future. Mussallem (36) suggests that her role has already expanded from care of the sick person in the hospital to concern for his restoration, and maintenance of good health. Doctor-nurse partnerships in the form of medical health teams in the community are being advanced. The nurse in 1980 may be moving freely between home and hospital, being responsible for family groups in a role similar to that of the family practitioner. This changing role will require much adaptation for the nursing profession.
References:


7. Simmons, L.W. & Henderson, V. op cit.


17. Simmons, L.W. & Henderson, V. op cit.


33. Coser, R. op cit.


NURSING AND ROLE THEORY

Definition of Role

Anthropologists, psychologists, sociologists and philosophers have all contributed to the study of roles. Despite conflicting definitions, Banton (1) feels there is some consensus in describing role as "a set of norms and expectations applied to the incumbent of a particular position" (p.29).

Approaches to Role Theory

There are two main traditions of approach: the psychodynamic view of the individual and of relationships, and the structural approach where role is a "pattern of expected behaviour reinforced by a structure of rewards and penalties which induces individuals to conform to the pattern" (p.22).

Role and the Person

Ruddock (3) suggests that although roles can be seen as demands and constraints imposed by society on the individual, they also meet fundamental personal needs. For example, the hospital system is socially necessary, but it also provides a role-system which meets important staff needs. No matter how much the actions of the nurse are reduced by the sociologist to the rights and obligations of her role, there is always the irreducible personal element of moral action. Downie (4) points out that one can accept or reject the rights and duties, and also give individual expression to the role.

The Role Set

The position of 'nurse' identifies a particular body of expected behaviour, or the role of nurse. Role is
a relational term; the nurse plays her role as nurse in
c relation to the counter position of the patient (5). What
is expected of the nurse are her role obligations or
duties. The expectations between the nurse and a number
of different counter positions (or relevant others such as
the doctor, visitors, ancillary personnel, etc.) make up
the role set (6).

**Actual, Expected and Ideal Behaviour**

The nurse's role enactment (her *actual* behaviour)
may be different from her role demands or prescriptions
(*her expected* behaviour), and this may not be identical to
ideal behaviour (*what she should do*). Rank discrepancies
between these dimensions may prove to be critical indices
of personal stress on the part of the personnel involved.

**Complex Role Demands**

The nurse is frequently presented with the
problem of meeting complex role demands; these may arise
because the role prescriptions are unclear, too numerous,
or mutually contradictory (8). For example, the ward sister
is responsible for the care of patients, the supervision of
students, the assistance of physicians, the assignment of
staff, the clerical and domestic tasks, the report to ad-
ministration, etc. If the demands are excessive, 'role
strain' may result, and the sister is forced to eliminate
or delegate some of her roles, or remove herself from an
untenable situation.

**Role Conflict**

Role conflict, any situation in which the incum-
bent of a position perceives that she is confronted with
incompatible expectations (9), may be experienced by the
nurse at two levels: within her own body of roles, and
between her own roles and those of others. There needs to
be relative consensus (agreement about the allocation of
roles and rewards within the system) to contain and resolve conflicts. However, many writers suggest that some dis-
sensus is healthy for a vocation, pushing the role bearer into developing and improving his services.

**Role Skills**

Role skills (those characteristics possessed by the individual which result in effective and convincing role enactment (10)) include the nurse's aptitude, experience, and training. Despite suggestions that a good nurse is 'born to the role', her skills can be improved with instruction and practice. Skill in role taking facilitates social interaction. A significant aspect of the role of nurse may be the cognitive abilities of empathy, identification or social sensitivity, and the ability to communicate effectively.

Sprott (11) points out that when social psychology is applied to the practical problems of life, a principle involved is the importance, for a sense of security and happiness, of harmonious relations. The social treatment a person experiences must be viewed from his or her point of view. The spectator may feel someone is 'well treated', but the way the individual sees it is what is important.

In the present study, it was hypothesized that patient satisfaction with nursing care would be greater when his expectations of the nurse were similar to the nurse's self-expectations. The role of the nurse and the counter position of the patient were examined through the analysis of two questionnaires. The sample, tools for collecting data, methods of analysis, findings, and conclusions are summarised in the succeeding chapters.
References:


2. Banton, M. op cit. 22.


7. Simmons, L.W. & Henderson, V. (1964) "Nursing Research - A Survey and Assessment" Appleton-Century-Crofts, N.Y., Ch. 9.


THE PLAN OF THE RESEARCH

The Research Setting

Although a nurse may work in any number of settings, (school, factory, home, physician's surgery) this research was conducted in a general hospital. The setting was established by the project (The Study of Nursing Care by the Ministry of Health and the Royal College of Nursing) with which the author worked. The size, location, type of training scheme, and willingness to participate were the factors affecting the choice of the three hospitals used.

The Method of Research

The natural setting of the hospital, and the information desired, contributed to the use of the non-experimental method for conducting the research (1-7). Although this method cannot establish causal relationships, it was hoped to establish associative relationships, which can be useful in making predictions. The choice was affected by limitations in time, finance, and co-operation of target organisations.

The Sample

Since the focus of the research was the role of the nurse and the counterposition of the patient, the sample consisted of male and female patients, and nurses in positions varying from student to ward sister. A random sampling was not possible in this study, and a convenience sampling was obtained. The patients and nurses who were on the ward at the time the researcher was interviewing were used for the study. Medical and surgical patients of both sexes who had been in the hospital at least four days, and who were able to talk with the interviewer 20-30 minutes, were selected. Male and female ward
sisters, staff nurses, enrolled nurses and students were included in the nursing survey.

The Collection of Data

In order to obtain large numbers, and to assure anonymity, the original conception of the method for the collection of data was the self-recording by nurses and patients. During the pilot study, it was found that patients were willing to co-operate only when assistance was provided by the researcher. There was also a high non-response rate among nurses of foreign birth. The technique was therefore changed to the use of interviews with all patients, and with those nurses who preferred the interview to self-recording. One hundred and fifty-six patients and 40 of the 83 nurses were interviewed for the main study. A comparison was made of the responses of nurses who completed the survey themselves with those who were interviewed. It was concluded that no constraints were felt by those who were interviewed, for they made as many additional comments and critical remarks about the hospital administration, visitors, doctors, ward sisters, quality of foreign students, lack of equipment, problems of student teaching and staff shortage as did those who completed the survey by themselves.

The Development of the Research Instruments

In the pre-test, a small number of patients were interviewed using a semi-structured technique. They were asked to discuss:

1. Patient expectations of the nurse, placing them in order of importance.
2. How they developed their ideas about what nurses do.
3. The different kinds of personnel working on the ward.
5. The most important part of a nurse's work.
It was found that patients have a very generalized idea about what nurses actually do. They assume competency in tasks as a prerequisite to the obtaining of registration. Many of their expectations dealt with interpersonal relations. Since patients were unable to identify specific nursing tasks, it was decided to present to them ten of the more time consuming activities identified by the Ministry of Health efficiency studies (8). These included basic bedside care, technical tasks, administrative duties, assisting the physician, and activities for the psychosocial support of the patient. Both patients and nurses were asked to rank these activities in order of importance to them.

There are two major limitations that have to be considered when using the questionnaire method. One is that it is to a large extent public and impersonal in character; the private attitudes of the respondent probably are discovered through indirection, after a long period of acquaintanceship, or when the subject wholeheartedly and candidly co-operates. The second problem is that we cannot be certain that the questions we ask are understood, and that the answers the people give are what they mean to say (9). Keeping these limitations in mind, various methods for eliciting information were tested. To evaluate the nursing care the patient received, an ordinal rating scale was presented. A Likert-type scale was attempted from statements about patient conceptions of nurses. A Q-sort of nursing activities by patients was attempted. In addition, multiple choice questions, and sentence completion were tested.

It was found that patients could not express a degree of agreement/disagreement into four categories of response. They were therefore simply asked to agree or disagree with statements made in the main study. The Q-sort was confusing to many patients, especially the elderly and the uneducated; it was replaced by the straight ranking method. Multiple choice questions often elicited multiple responses, and their use was limited to three questions in the main study, with one using open choice.
Sentence completion has been used as a projective device to get at a deeper layer of feeling than does direct questions. This method was found to be very effective when talking to patients. It gave their response some direction without limiting the scope of their thoughts. However, as Meyer (10) suggests, "it carries with it the responsibility of devising a reliable system for interpreting the attitude responses" (p.37). Coding categories were established after the completion of the pilot study, and a reliability analysis was done for the main study.

A small section at the end of the questionnaire was left for additional comments. The opportunity for the patient to express his feelings on any subject having to do with hospitalisation was rewarding to both the patient and the researcher. The patient liked the unstructured freedom of discussing his illness, the hospital environment, other patients, etc. From these comments, it was possible to classify criticism into problems of communication, staff shortage, nursing practice, lack of individual attention, nursing personality, and environment.

A hospital study concerned with relationships may be affected by a great number of variables. For the patient, biographical data was obtained as to sex, age, marital status, country of birth, number of previous hospitalisations, job, education, length of hospitalisation, and reason for hospitalisation. For the nurse, sex, age, marital status, country of birth, education, father's occupation, previous employment, and present position were ascertained.

Analysis of Data

Much of the analysis of data in this survey consists in its summarisation by percentage in table form. Validation of some of the patients' factual responses was made against the patient record. The chi-square test was used to determine the significance of the differences between the highly satisfied patients, and those who were less satisfied, as to background factors. Chi square was also
used to test the statistical significance of differences found between patient and nurse responses in the three hospitals, and between different grades of staff (11-14).

The formula for the chi square test is:

\[ x^2 = \sum \frac{(A-E)^2}{E} \]

where \( A \) = actual result
\( E \) = expected result

In the section where nurses and patients were asked to rate, in order of importance to them, some of the activities of nurses, Spearman's rank order was calculated (15). This was used to test the hypothesis that a patient's satisfaction with nursing care would be greater when his expectations of the nurse were similar to those of the nurse herself. Spearman rank correlation coefficient (\( r_s \)) is a measure of association which requires that the variables be measured in an ordinal scale so that the subjects may be ranked in two ordered series. The formula for the Spearman rank order is:

\[ r_s = 1 - \frac{6 \sum d^2}{n(n^2-1)} \]

where \( n \) = number of subjects being ranked.

For the categories designed to code incomplete sentence items, reliability analysis was used (16). This involved the use of three independent judges who familiarised themselves with a description of the categories, and separately scored a random sample of at least 10% of the total number of responses. The resulting level of mutual agreement constituted the reliability index. The category was either discarded when the reliability index was below 85%, or the information was presented as the researcher's interpretation, and as such, was not statistically significant.

Six statements about nurses were presented to patients to get a positive/negative score on their image of nurses. Two statements were expressed positively, so that agreement gave a score of plus 1; four statements were expressed negatively, so that disagreement gave a
score of plus 1. The lower the score, the less positive was the patient's image of the nurse. This was related to satisfaction with care.

Data was summarised for the total sample of patients and nurses, and for each hospital for comparative purposes. In addition, nurse responses were analysed by position: pupil-enrolled, student, staff, and ward sister.

The responses of pupil nurses and enrolled nurses were combined because the numbers were too small to give separately (4 pupil nurses and 3 enrolled nurses). Their responses were first analysed, and it was found that their views were similar. It was felt that it was important to include the views of this group, and their combined responses were used for statistical presentation.

The patients' criticisms were classified, and related to satisfaction with care. From the findings of the survey, suggestions were made for consideration.

The research instruments have been reproduced in the appendices.
References:


CHAPTER 4

THE PILOT STUDY

The Setting

The pilot study was carried out in an acute general hospital which had 370 beds, and was a nurse training school for the register. The new section of the hospital had race-track type wards, and the old part of the hospital Nightingale wards. The study was explained to the matron of the hospital, and she presented it to her ward sisters.

The Sample

Five wards were visited: male medical, female medical, male surgical, female surgical and mixed (male and female) surgical. On each ward the Kardex was used to determine which patients had been in hospital at least four days, and were suitable for interview. The ward sister then checked this list, and helped to eliminate from interview those who were too ill or confused to be included in the survey. A list of the nursing personnel, who happened to be working on the ward on the day it was visited, was secured, and questionnaires were distributed to those staff members who had been assigned to the ward for at least four days.

Eight to ten patients were usually available for interview on any given ward. For example, ward A had a census of 25. Five patients had been in hospital less than four days; 10 patients were seriously ill or confused, and the remaining 10 patients were approached for interview. For the five wards visited, 51 patients were available, and 45 were interviewed, giving a response rate of 88%. The nursing staff were asked to complete the questionnaires by themselves and, as has already been indicated, this yielded a lower response rate. With persistence, all of the questionnaires from the ward sisters were obtained. Of the 36 questionnaires distributed, 22 were completed, giving a 61% response rate.
The distribution of the variables for the patient and nurse samples was as follows:

**Patient Survey (No. 45)**

1. **Age:** (Range 18-80)
   - 16-39: 10
   - 40-59: 14
   - 60+: 21

2. **Sex:**
   - Men: 21
   - Women: 24

3. **Marital Status:**
   - Single: 6
   - Married: 30
   - Widowed: 7
   - Separated: 2

4. **Country of Birth:**
   - England: 42
   - Ireland: 1
   - Scotland: 1
   - South Africa: 1

5. **Education:**
   - None: 1
   - To 14 yrs. of age: 23
   - To 18 yrs. of age: 16
   - Post Secondary: 5

6. **Social Class:**
   - I or II: 13
   - III: 21
   - IV or V: 11

7. **Type of Patient:**
   - Medical: 19
   - Surgical: 26

8. **Number of Previous Hospitalisations:**
   - None: 11
   - One: 10
   - Two: 7
   - Three or more: 17

9. **Length of Present Hospitalisation:**
   - 4-7 days: 10
   - 1-2 weeks: 12
   - 2-4 weeks: 17
   - over 4 weeks: 6

*Registrar General Classification.*
The Patient Survey

For the patients, there was a wide age range, and a similar distribution of sex included in the sample. Most were born in England, were educated to at least 14 years of age, and had been hospitalised on previous occasions. All social classes were included, and there were a few more surgical patients than medical patients. Half the patients had been hospitalised for more than two weeks at the time of interview.

The nurse sample was predominantly female, single and young. Over half of them were students, and their education prior to entering nurse training was typically of the secondary school type. Of the registered nurses, five had taken first line management courses, and four of them had taken at least one part of the SCM.

A summary of the pilot findings appears in Tables
Findings of Patient Survey

Patients were asked to rate the nursing care of the ward. Although four categories were presented (in the form of a multiple choice response), the patients used only two: highly satisfactory, and satisfactory with a few reservations. Table A depicts the relation between satisfaction with care, and the variables of age, sex, number of previous hospitalisations, social class, length of stay in hospital and type of patient. Men were more satisfied with care than women, and satisfaction increased in percentage with age. There were a larger proportion of highly satisfied medical patients than surgical patients. High satisfaction was lowest among patients hospitalised for one month or more. Similarly, high satisfaction decreased as the number of previous hospitalisations increased. Social class bore a direct relationship to satisfaction, with social classes IV and V having the largest percentage of high satisfaction.

In Part I of the patient questionnaire, patients were asked to discuss the difference between pupil and student nurses, how they identify the different types of ward personnel, and what they thought their main duties were.

It was found that the unstructured, generalised question is very hard for the patient to answer. Very little seems to be known about the pupil nurse. About one-third of the patients know that the colour of belts on the uniform indicates rank. The main group of workers on the ward that were mentioned by the patients (besides nursing staff) were 'the cleaners'. Usually the ward sister is thought of in terms of her supervisory capacity.

Part I was eliminated from the main study. It was found to be too time consuming for the information gained, and a source of confusion to the patient.

Part II contained eight sentence completions designed to find out what the patient expects of a nurse,
how the 'role' of patient is seen, what upsets patients, what action the patient feels he should take when he is worried, and if the role of 'today's' nurse is thought to be different from nurses 'years ago'.

Table B presents the percentage response of patients to three sentences concerned with patient expectations of the nurse. It is interesting that even though the patient is asked for the main thing (in the singular) he expects of a nurse, his response often gives multiple expectations. Responses were categorised into 'Technical Care' which included basic care, treatments, and the general meeting of physical needs, and 'Emotional Support', which included kindness, sympathy, civility, encouragement, availability, and patience. For some expressions used by the patient, it was not clear what was implied, and the interviewer probed for clarification. For example, 'attention' could mean 'an act of civility or courtesy' or 'observant care'. When the patient was asked to describe what he meant when he said "The main thing a patient expects of a nurse is attention", he usually referred to specific physical aspects of care, so 'attention' was taken to signify 'technical care'. If, on the other hand, the patient answered 'sympathetic attention', both the technical and emotional components were included.

In the main study "A good nurse is one who" was eliminated from the sentence completion section, since many patients complained that it appeared to be redundant.

Both the technical aspects of a nurse's work, and her emotional support seen important to the patient, with some additional stress given to the significance of her personal attributes.

When patients were asked to compare today's nurses with those of years ago, 13 of them felt there was no basic difference, two felt that years ago nurses were more dedicated and professional, and the remaining 30 felt that today's nurse was more kind, relaxed, and better informed.

Because a significant number of patients felt
their lack of past experience or youth in previous hospitalisations made comparisons difficult, these two questions were deleted from the main study.

Table C gives the patient self-role conceptions. Those who felt the good patient was one who is obedient, patient, or polite, were included in the 'passive' category. There is no activity on the part of the patient; sometimes the response is concerned with what the patient does not do. For example "The good patient is one who does not make demands". The 'co-operative' patient was helpful, appreciative, pleasant, adaptable; some measure of activity was implied. The 'independent' patient helps himself, asks for what he wants, makes decisions, and is quite active. If the response included two categories, the more active one was coded. "A good patient is one who is obedient, and helps in every way", was coded as 'co-operative'.

Half the patients feel they should assume a passive role in hospital. Very few feel the patient should be independent.

When patients are asked what upsets patients in hospital, some deny that anything has upset them. Some feel there has been some physical discomfort; pain, vomiting, a wet bed, or a general neglect of physical care. The largest group of discomforts have an emotional basis; lack of communication, anxiety about the nature of their illness, or unkind behaviour on the part of personnel. See Table D.

When a patient is worried, most feel he should talk about it to someone. Only three of the patients felt they would keep it to themselves. The reference group (Table E) was most commonly the sister (or another nurse). Doctors were also mentioned frequently, and a few referred to the almoner, social worker, chaplain, another patient, or just 'someone'.

Part III contained six statements made about nurses, and patients were asked to agree or disagree with the statements. This included patient opinion about the general quality of care, the amount of time being spent in
bedside nursing, the personality of nurses, and their dedication to nursing. Patients with a score of five or six were considered to have a high positive image of nurses.

There was a strong relationship between high satisfaction with care, and a positive image of nurses in general. Of the 43 patients who completed this section, 23 were highly satisfied with nursing care. Of these patients, 20 scored a high positive image of nurses (score five or six) and only three scored four or below. Of the 20 patients who indicated satisfaction with reservations, eight had a high positive image, and 12 scored four or below. Figure 1 shows this relationship in percentage form.

In addition, each statement was analysed separately for the number of patients who agreed or disagreed with the statement. The greatest problem suggested by this section was that nurses spend too much time away from the bedside. Nineteen patients thought this to be true, and many felt it was a matter of shortage of staff. Sixteen patients agreed that nurses do not take enough time to talk to patients, and answer their questions, but many of these patients indicated that it was not that the nurse didn't take the time so much as she didn't have the time. From this section, the only change made for the main study was to reduce the four point scale to a simple agree/disagree decision.
In Part IV, the patients were asked to rank, in order of importance to them, the activities on which nursing staff spend their time. Only those patients who ranked all ten items were included in the average (34). Their average rank order:

1. (2.6) General basic care (baths, beds, bedpans).
2. (3.1) Giving medicines and doing treatments.
3. (3.7) Taking temperature, pulse, respiration and blood pressure.
4. (4.3) Talking with patients to provide reassurance and support.
5. (5.3) Preparing and distributing meals and drinks.
6. (6.4) Answering patient and family questions.
7. (6.5) Assisting doctors with technical procedures.
8. (6.6) Attending on medical staff.
9. (7.4) Reporting and receiving report on change of shift.
10. (9.0) Clerical/reception duties.

For each of the five types of nursing activities (technical care, basic care, emotional support, assistant to the physician, and administrative duties) there were two descriptions of each. By averaging the two scores, the relative importance of each of these five types of activities was ascertained. For example, technical care ranked 3.1 and 3.7, giving an average of 3.4. Basic care, which included baths, beds, bedpans and the preparing and distributing of meals and drinks, ranked 2.6 and 5.3 for a combined average of 3.8. Emotional support included talking with patients (4.3) and answering questions (6.4) giving an average of 5.4. In a similar manner, the averages were obtained for assisting the doctor, and accomplishing administrative tasks.

Patients placed the five types of activities in the following order:

1. (3.4) Technical care.
2. (3.8) Basic care.
3. (5.4) Emotional support.
4. (6.6) Doctor's assistant.
5. (8.2) Administrative duties.
The ranking of nursing activities remained intact, and became Part I of the main study.

Part V contained five multiple choice questions. The first enquired into the patient's reference group when he was concerned about his illness. Several patients included both the doctor and the nurse. One patient summed up the problems of reference with: "One ought to talk to the doctor, but because of educational differences, attitudes of superiority, or general looking down on patients, you don't. If one talks to sister, she either doesn't have the information, or is limited in what she is allowed to say." The doctor was mentioned by 23 patients, the nurse by 16, other patients by five, and the family by three.

The second question was designed to find out what the nurse-patient relationship was felt to be. More than half the patients responded that nurses are able to get to know their patients very well, but many added that it depends on the length of a patient's hospitalisation.

The patient was next asked to whom he would turn for information relating to his illness. The doctor was considered the main source of reference in this case. He was mentioned by 33 patients, the nurse by 14 patients, and the almoner and physiotherapist by one patient each.

The fourth question asked about the primary role of the ward sister. She was seen almost equally as a manager (13 patients), a person with knowledge and skill (13 patients), and one who is kind and understanding (14 patients).

Assuming adequate staffing, the fifth question asked patients how the trained nurse should spend her additional time. Forty-four per cent of the patients felt she should devote it to the teaching of students, and twenty-four per cent to talking with patients. Next in importance was improving ward facilities.

The section ended with a four part rating of nursing care to establish the degree of patient satisfaction.
High satisfaction was indicated by 56% of the patients, and satisfaction with reservation by 44%. For the main study, the rating of nursing care was reduced to three choices: highly satisfactory, satisfactory, and poor.

When presented with a choice of answers, the patients often felt that all answers were important, and because of this, the number of multiple choice questions in the main study were reduced to three. "A good ward sister is one who" was moved to the sentence completion section. "When a patient is worried about his illness, he usually talks about it to..." was deleted, as was "When a patient needs some information relating to his illness, he can turn to...".

On the biographical data sheet, five changes were made. Diagnosis was changed to "Reason for hospitalisation". Religious affiliation was deleted as essentially irrelevant. Details about schooling was replaced by "age when schooling was completed". Job description was limited to a more general description, and "number of days on this ward" was added.

In the additional comments section, it was interesting to find that the number of patients who were critical of the ward bore a direct relationship to the percentage of high satisfaction on the ward.

1. High satisfaction 78% No patients made critical remarks.
2. 70% 1 patient
3. 63% 4 patients
4. 40% 6 patients
5. 25% 8 patients

Ten patients commented about understaffing, and they often linked this to problems of lack of individual attention.

There were relatively few comments on general environment. These had to do with sanitation, food, noise, visiting hours and the moving of patients from ward to ward.
Communication problems included doctors who gave vague answers, nurses who were limited in what they can tell, and patients who feel nervous about talking to the medical or nursing staff.

Comments about nursing practices included the difficulty of obtaining bedpans, the infrequency of baths, the lack of attention to the dietary needs of a patient, general organisational problems, the amount of responsibility given to students, and the need to free nurses for more nursing care by having domestics do more of the cleaning and serving of meals.

There were four adverse comments made about the personality of nurses. "The ward sister is a bit of a bully." "One of the nurses shouted at a member of my family." "Old people are handled like a sack of potatoes." "They should try to be kinder to the very old."

Two patients mentioned the problem of boredom while in hospital. There were many positive comments about the general nursing care, and the kindness of the staff.

The Nurse Survey

In Part I, the nurses were asked to complete eight sentences like the ones asked of the patients. In addition there were 12 other sentence completions concerned with staff relationships, nurse relationships with doctors and visitors, general hospital expectations, ward organisation, job satisfaction, student nurse training, problems in nursing, why nurses choose the profession, and individual future vocational plans.

Findings of the Nurse Survey

As Table F indicates, nurses often mention both the technical aspects and the emotional supportive self-role concepts. But whereas the average responses of patients stress emotional aspects, the nurse responses place more emphasis on the technical aspects. Ward sisters were found
to mention technical care more often than students or staff nurses.

There were two sentence completions about the patient: "I like patients who...", and "A good patient is one who...". Table G shows the nurse preferring the cooperative patient.

Most of the nurses feel that patients get upset most frequently because of emotional rather than physical problems. See Table H.

All nurses suggest that when a patient is worried, he should talk about it. The nurse is mentioned in 13 responses, the doctor in five, and a general "someone" by eight. See Table I.

Almost all nurses compare the nurse of today more favourably than with nurses years ago. She is seen to be more on a par with doctors, with a better education, given more responsibility, less frightened of her superiors, and projecting a more sympathetic and professional image.

A well run ward is considered by 50% of the nurses to be one which is well organised; 45% feel that a pleasant atmosphere is the significant factor. Included under 'atmosphere' was that the ward was a happy ward, sister was pleasant, relationships were good, and patients felt secure. See Table J.

The nurses thought that hospital expectations of them included loyalty, competence, hard work, and personal attributes of honesty, politeness and cheerfulness. Five of the nurses felt the hospital held impossible expectations of them. See Table K.

Almost half the remarks made about visitors are negative. Nurses see them as getting in their way, staying too long, treating the staff as 'hotel-maids', or expecting too much attention. One-fourth of the nurses feel they are beneficial to the patient, and another one-fourth feel they have personal requirements of the nurse (a source of information, for example). See Table L.
Doctors are seen as expecting nurses to be cooperative, technically competent, observant and able to carry out orders. Six nurses feel that the doctors expect too much of them. See Table M.

Thirty-six per cent of the nurses feel that a staff nurse is like a sister, or acts as her liaison. Twenty-seven per cent mention her acceptance of responsibility and general nursing duties. Others see her as teaching or helping students. See Table N.

Student nurses are thought to be taught most frequently by the nursing staff. Also mentioned are doctors, tutors, other students, their experience through patient contact, their mistakes, and their studies. See Table O.

The pupil nurse did not train in this particular hospital. Having her was seen as a potentially positive contribution to the nursing team by 41% of the nurses. She was thought to be superior in general nursing care, and a great deal of practical help. No-one had anything negative to say about pupil nurses. Many gave a neutral description of what she does, or should do. See Table P.

Nurses choose their profession to help people, because there is a personal satisfaction found in nursing, or because they like people in general, and nursing gives them an opportunity to be with them. Occasionally a nurse enters nursing because she was tired of another job, or some family member encouraged her in that direction. See Table Q.

Patients are the main reason for nurses entering nursing, and the nurse-patient relationship is the main source of satisfaction for them. As Table R shows, patients remain the central theme. Satisfaction is felt when patients recover, are happy, are comfortable and receive care and sympathy. In addition, over half the nurses mention the self-gratification of learning something new, working efficiently, resolving problems, and completing their tasks. Staff relationships are mentioned by 41% of the nurses: a
team spirit, a friendly atmosphere, and satisfying the doctor or the ward sister.

The greatest problem in nursing was seen as the shortage of staff which nurses think is caused by low pay, long hours, and non-nursing duties. Some of the other issues mentioned were hospital bed shortage, caring for the elderly, lack of equipment, lack of social life, attitudes of favouritism, and the need for additional domestic help. See Table S.

Five years from now, 68% of the nurses plan to be in nursing (as a staff nurse, charge nurse or sister). A small number thought they would be out of nursing because of retirement or marriage. Some of the responses were too vague to be coded. See Table T.

The sentence completion section was changed to Part II in the main study. "Years ago nurses ..." and "Today, nurses ..." were eliminated as in the patient survey. "A good patient is one who ..." was deleted since "I like patients who..." gave similar responses. "When I have spent a satisfying day on the ward, the things that have made it that way include ..." was shortened to "A day on the ward is satisfying to me when ...".

In Part II, the nurses gave the following average rank order to the nursing activities:

1. (2.9) General basic care (baths, beds, bedpans).
2. (3.1) Giving medicines and doing treatments.
3. (3.5) Talking with patients to provide reassurance and support.
4. (4.2) Taking temperature, pulse, respiration and blood pressure.
5. (4.5) Reporting and receiving report on change of shift.
6. (6.3) Attending on medical staff.
7. (6.7) Answering patient and family questions.
8. (7.0) Preparing and distributing meals and drinks.
9. (7.2) Assisting doctors with technical procedures.
10. (9.6) Clerical/reception duties.
For each of the five types of nursing activities, an average ranking was obtained (as described in the patient survey). The nurses placed the five activities in the following order:

1. (3.7) Technical care.
2. (5.0) Basic care.
3. (5.1) Emotional support.
4. (6.8) Doctor's assistant.
5. (7.1) Administrative duties.

Both the patients and nurses rank the five types of nursing activities in the same order. Report is seen by nurses as being more important than it is to patients. Patients consider the preparing and distributing of meals of greater importance than do nurses. Many feel this is a non-nursing duty.

In the main study, the ranking of nursing activities remained intact, and became Part I.

Part III contained six multiple choice answers about reference groups for patient worries, how well nurses get to know patients, to whom a patient turns when seeking information, the characteristics of a good ward sister, how nurses should spend additional time, and how the nursing care could be improved on the particular ward.

When a patient is worried about his illness, the nurse feels he usually talks about it to the nurse. This response gives an interesting difference from that made by the patient, who mentioned the doctor as his major reference group. Sixty-four per cent of the nurses feel that the patient usually talks to the nurse when he is worried, 23% to other patients, and a few mention the doctor, the family or no one.

Fifty-four per cent of the nurses feel that nurse's tasks are such that she can get to know the patients very well. Forty-one per cent suggest she can only get to know a little about the patient, and only one nurse feels it is impossible to get to know a patient.
The nurses feel that the doctor is the main source of information concerning the patient's illness, although 41% of the nurses also mention the nurse.

Sixty-eight per cent of the nurses consider a good ward sister one who manages the ward with efficiency, but also mentioned by half the nurses is that she be kind and understanding to patients. The importance of her skill and knowledge was mentioned by only one nurse, but one-third of the patients mentioned this aspect of a ward sister role.

Almost all of the nurses felt that if qualified nurses had more time, they could devote it to the teaching of students and other staff.

When asked how nursing care on the ward could be improved, 55% of the nurses felt there should be more nurses. Other suggestions included improved communications among the staff, better equipment, and more use of ancillary staff.

The multiple choice section was reduced to three questions, as was done in the patient questionnaire.

Two additions were made on the personal information sheet. The nurse was asked her father's occupation, and the length of time she had worked on the ward where the interview took place.

The additional comments section was used to discuss student problems of education, inadequate salaries, the amount of time devoted to administrative duties, and environmental problems affecting nursing care.

The pilot study was used to test the adequacy of the data collecting instruments. There was opportunity to eliminate those questions which were confusing, irritating or ineffective. The interviewer developed a consistent technique of interviewing for use in the main study. The data was summarised, and decisions made as to how the material would be organised into statistical tables.
CHAPTER 5

THE MAIN STUDY

The Setting

The main study was carried out in three hospitals of varying size, one in a large city, and two in outlying districts. The small hospital had 128 beds, and was training for the general register. It was an old hospital with Nightingale wards, and student nurses were in short supply. The medium sized hospital had 500 beds, and was training pupil nurses and students for the general register. The hospital was quite old with Nightingale wards, and was situated on attractive grounds in the country. The large hospital was a 700 bed post-graduate teaching hospital in a large city. Training was for the general register, and also a school for training midwives, pupil nurses, and a four year integrated scheme for training mental and general nurses. Most of the wards were Nightingale, and some had been rebuilt into cubicles.

The Sample

Eighteen medical and surgical wards were visited. Of 180 patients approached, 156 completed the questionnaire, giving a response rate of 87%. For the nursing staff, 83 of the 108 approached completed a questionnaire, giving a response rate of 77%. This improved response rate (as compared with 61% for the pilot study) was accomplished by interviewing 40 nurses.

The distribution of the variables for the patient sample was as follows:

<table>
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<th>Medium Hospital (No. 52)</th>
<th>Large Hospital (No. 54)</th>
<th>Total (No. 156)</th>
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</thead>
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<tr>
<td>40 - 59</td>
<td>23</td>
<td>19</td>
<td>25</td>
<td>67</td>
</tr>
<tr>
<td>60+</td>
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<td>22</td>
<td>15</td>
<td>53</td>
</tr>
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<td>Small Hospital (No. 50)</td>
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<td>Large Hospital (No. 54)</td>
<td>Total (No. 156)</td>
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<td>----------------------</td>
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<td>--------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>20</td>
<td>28</td>
<td>29</td>
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<tr>
<td>Women</td>
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<td>24</td>
<td>25</td>
<td>79</td>
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<tr>
<td>3. Marital Status:</td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>8</td>
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<td>21</td>
</tr>
<tr>
<td>Married</td>
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<td>39</td>
<td>118</td>
</tr>
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<td>5</td>
<td>4</td>
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<td>Separated</td>
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<td>1</td>
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<td></td>
</tr>
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<td>48</td>
<td>37</td>
<td>129</td>
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<td>1</td>
<td>5</td>
<td>9</td>
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<tr>
<td>Wales</td>
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<td>3</td>
<td>5</td>
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<td>1</td>
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<td>3</td>
<td>5</td>
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<td>2</td>
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<td>Poland</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nigeria</td>
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<td>0</td>
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<td>1</td>
</tr>
<tr>
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<td>1</td>
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<td>1</td>
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<td>5. Education:</td>
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</tr>
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<td>0 - 12 yrs. of age</td>
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<td>4</td>
</tr>
<tr>
<td>to 14 yrs. of age</td>
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<td>19</td>
<td>28</td>
<td>73</td>
</tr>
<tr>
<td>to 16 yrs. of age</td>
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<td>16</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>to 18 yrs. of age</td>
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<td>4</td>
<td>23</td>
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<td>I or II</td>
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<td>34</td>
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<td>67</td>
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<tr>
<td>IV or V</td>
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<td>20</td>
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</tr>
<tr>
<td>7. Type of Patient:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>19</td>
<td>18</td>
<td>49</td>
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<td>Surgical</td>
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8. Number of Previous Hospitalisations:

<table>
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</tr>
</thead>
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<td>8</td>
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<td>19</td>
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</tr>
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<td>Two</td>
<td>9</td>
<td>12</td>
<td>7</td>
<td>28</td>
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<tr>
<td>Three or more</td>
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<td>13</td>
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9. Length of Present Hospitalisation:

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<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - 7 days</td>
<td>23</td>
<td>21</td>
<td>17</td>
<td>61</td>
</tr>
<tr>
<td>1 - 2 weeks</td>
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<td>16</td>
<td>17</td>
<td>50</td>
</tr>
<tr>
<td>2 - 4 weeks</td>
<td>8</td>
<td>8</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>over 4 weeks</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>17</td>
</tr>
</tbody>
</table>

For the patients, there was a wide age range, and a similar distribution of sex included in the sample. Most were married, born in England, were educated to at least 14 years of age, and had been hospitalised on previous occasions. All social classes were included; the small hospital had a larger group of patients from social classes IV and V, and fewer in social classes I and II. Two-thirds of the patients were admitted to the surgical team. There was a larger number of patients with hospitalisations lasting more than two weeks in the city teaching hospital.

The distribution of the variables for the nurse sample was as follows:

<table>
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<th>Large Hospital</th>
<th>Total</th>
</tr>
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<td>under 20</td>
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<td>9</td>
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<td>20 - 29</td>
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<td>12</td>
<td>27</td>
<td>53</td>
</tr>
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<td>30 - 39</td>
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<td>3</td>
<td>7</td>
</tr>
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<td>40 - 49</td>
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<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>50 - 59</td>
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<td>6</td>
</tr>
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<td>1</td>
</tr>
<tr>
<td>Women</td>
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<td>36</td>
<td>82</td>
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<td>15</td>
<td>32</td>
<td>59</td>
</tr>
<tr>
<td>Married</td>
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<td>7</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Widowed</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
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<td><strong>4. Country of Birth:</strong></td>
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<td>2</td>
<td>9</td>
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<td>Wales</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
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<td>2</td>
<td>9</td>
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<td>Ceylon</td>
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<tr>
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<td>1</td>
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<td>Singapore</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Liberia</td>
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<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nigeria</td>
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<td>Germany</td>
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<td>0</td>
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<td><strong>5. Education:</strong></td>
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<td></td>
<td></td>
<td></td>
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<td>Secondary</td>
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<td>35</td>
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<tr>
<td>Grammar</td>
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<td>7</td>
<td>21</td>
<td>34</td>
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<tr>
<td>Comprehensive</td>
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<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Convent &amp; Others</td>
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<td>6</td>
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<tr>
<td><strong>6. Route of Entry into Nursing:</strong></td>
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<td></td>
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<td>GCE</td>
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<td>42</td>
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<td>5</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>School Leaving Cert. or Gen. Entrance Ex.</td>
<td>11</td>
<td></td>
<td></td>
<td>28</td>
</tr>
</tbody>
</table>
Almost half the sample were qualified nurses. In contrast to the other two hospitals, the large hospital had an 89% age group of under 30 years of age. Almost all were women, and 70% were single. Over half of the total number of nurses were born in England, but the distribution is not similar; almost three-fourths in the large hospital, slightly over one-half in the medium hospital, and less than one-quarter in the small hospital. These differences are also seen in the type of education and scholastic achievement, with the large hospital having the greatest percentage of nurses from grammar schools, and achieving O and A levels. Thirty percent of the qualified nurses had completed the hospital course for midwifery. A small number had taken post-registration courses. Prior to their entry into nursing, one-fourth of the sample had been employed as a nanny, teacher, beautician, secretary, clerk or with
None of the nurses' fathers were in the medical profession. A small number of their fathers were teachers, politicians, engineers, and diplomats. Five were farmers, and the rest were in such diverse occupations as carpenters, clerks, miners, storekeepers, mechanics, tailors, police, and businessmen.

**Satisfaction with Care**

There have been numerous studies assessing patient and personnel satisfaction with patient care. Often hospitals send out a form letter at the time of a patient's discharge, or there is a visit by an interviewer in the patient's home. AbdeIlo.h and Levine (1) developed a refined ordinal scale for the measurement of the adequacy of patient care, focusing on nursing events. Raphael's (2) survey of patients' views of life in hospital included overall contentment (53% liked their stay very much, 41% in most ways, 4% fairly well, and 2% not at all) in addition to questions about food, sanitation, activities, staffing and ward and equipment. In Cartwright's (3) sample, 20% of the patients were critical of hospital. Willcock (4) compared patient answers about nursing methods in terms of the total number of complaints made. Haywood et al (5) tested 100 patients about their attitudes toward medical and nursing staff. One question asked was "Did nurse give you enough personal attention?". Thirty-two per cent said 'yes' with enthusiasm, 32% 'yes', 25% 'yes with qualifications' and 11% said 'no'. In McGhee's (6) study, 21% were fully satisfied with nursing care, 48% were satisfied with reservations, 28% were dissatisfied with reservations, 1% were dissatisfied, and 2% gave no response.

In the present study, two-thirds of all the patients interviewed were highly satisfied with their nursing care. One-third of the patients considered the care satisfactory with some need for improvement, or found the care poor. Only three patients ranked the care as poor, and, because of their small numbers, are included.
with the second group, who found their care satisfactory with reservations. Table 1 shows the relations between high satisfaction with care and the variables of age, sex, number of previous hospitalisations, social class, length of stay in hospital, and type of patient.

### TABLE 1
Per cent of highly satisfied patients by age, sex, number of previous hospitalisations, social class, length of stay in hospital, and type of patient.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Small Hospital</th>
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<th>Large Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td><strong>AGE:</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>16 - 39</td>
<td>5 (45)</td>
<td>7 (64)</td>
<td>10 (71)</td>
<td>22 (61)</td>
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<tr>
<td>40 - 59</td>
<td>16 (70)</td>
<td>10 (53)</td>
<td>19 (76)</td>
<td>45 (67)</td>
</tr>
<tr>
<td>60+</td>
<td>12 (75)</td>
<td>14 (64)</td>
<td>11 (73)</td>
<td>37 (70)</td>
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<td><strong>SEX:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13 (65)</td>
<td>16 (57)</td>
<td>23 (79)</td>
<td>52 (68)</td>
</tr>
<tr>
<td>Female</td>
<td>20 (67)</td>
<td>15 (63)</td>
<td>17 (68)</td>
<td>52 (66)</td>
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</tr>
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<td>None</td>
<td>2 (67)</td>
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</tr>
<tr>
<td>Two</td>
<td>5 (56)</td>
<td>5 (42)</td>
<td>5 (71)</td>
<td>15 (54)</td>
</tr>
<tr>
<td>Three or more</td>
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<td>8 (62)</td>
<td>24 (77)</td>
<td>53 (72)</td>
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<td>18 (53)</td>
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<td>13 (65)</td>
<td>14 (56)</td>
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<td>IV or V</td>
<td>16 (70)</td>
<td>11 (92)</td>
<td>16 (80)</td>
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<td><strong>LENGTH OF STAY IN HOSPITAL:</strong></td>
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<td></td>
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</tr>
<tr>
<td>4 - 7 days</td>
<td>14 (61)</td>
<td>12 (57)</td>
<td>16 (94)</td>
<td>42 (69)</td>
</tr>
<tr>
<td>1 - 2 weeks</td>
<td>12 (71)</td>
<td>10 (63)</td>
<td>9 (53)</td>
<td>31 (62)</td>
</tr>
<tr>
<td>2 - 4 weeks</td>
<td>5 (63)</td>
<td>7 (38)</td>
<td>9 (75)</td>
<td>21 (75)</td>
</tr>
<tr>
<td>over 4 weeks</td>
<td>2 (100)</td>
<td>2 (29)</td>
<td>6 (75)</td>
<td>10 (59)</td>
</tr>
<tr>
<td><strong>TYPE OF PATIENT:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>8 (67)</td>
<td>13 (68)</td>
<td>14 (78)</td>
<td>35 (71)</td>
</tr>
<tr>
<td>Surgical</td>
<td>25 (66)</td>
<td>18 (55)</td>
<td>26 (72)</td>
<td>69 (64)</td>
</tr>
<tr>
<td><strong>HIGH SATISFACTION</strong></td>
<td>33 (66)</td>
<td>31 (60)</td>
<td>40 (74)</td>
<td>104 (67)</td>
</tr>
<tr>
<td><strong>SATISFIED</strong></td>
<td>16 (32)</td>
<td>21 (40)</td>
<td>12 (22)</td>
<td>49 (31)</td>
</tr>
<tr>
<td><strong>LOW SATISFACTION</strong></td>
<td>1 (2)</td>
<td>0 (0)</td>
<td>2 (4)</td>
<td>3 (2)</td>
</tr>
</tbody>
</table>

In the small hospital, satisfaction increased with age, but in the other two hospitals, no such relationship existed. The total average shows a slight tendency for
satisfaction to increase with age, but this was not statistically significant (Chi square = .83).

For the total patient sample, there is little difference between men and women in satisfaction with care; in the large hospital, there was a higher percentage for men, and in the medium sized hospital, there was a higher percentage of satisfied women. (Chi square = 3.8, and was not significant.)

Patients who are hospitalised for the first time indicate a high rate of satisfaction; this drops for succeeding hospitalisations, and increases again amongst those who have had multiple hospitalisations. (Chi square = 7.41 with 3 df, which was not significant at the 5% level.)

Satisfaction bears a direct relationship to social class, with those in unskilled occupations having the highest rate of satisfaction with care. (Chi square = 6.60, significant with 2 df at the 5% level.)

The length of time patients were in hospital at the time of the interview did not relate to satisfaction with care. (Chi square = 1.34, and was not significant.)

Medical patients showed a higher percentage of satisfaction than did surgical patients, but this was not statistically significant. (Chi square = .64.)

Since high satisfaction on the 17 wards visited ranged between 30% and 90%, it was thought likely that there were other factors besides the above variables affecting patients' attitudes about nursing care.
References:


CHAPTER 6

THE RANKING OF NURSING ACTIVITIES

Patients and nurses were asked to rank, in order of importance to them, the activities on which nursing staff spend their time. All 83 nurses completed this part. Only those patients who ranked all 10 items were included in this section (124 patients). Table 2 gives the average ranking of nursing activities by patients and nurses, and the separate ranking for each hospital.

Comparison of Three Hospitals

When comparing the three hospitals, there was striking agreement in the patients’ average ranking of activities. In the large hospital the patients reversed (by 1) meals and answering questions; all the other activities were placed in the exact same order. The patients emphasise the technical aspects of the nurse’s work, and place administrative tasks last.

The nurses rank the giving of medicines and treatments, basic care, and talking with patients in the first three positions, with small variations for each hospital. Report is relatively important, but clerical/reception duties are consistently placed last.

Comparison of Nurses and Patients

When comparing the average ranking by nurses with those of the patients, there are two main differences. The nurses put reporting and receiving reports on change of shift in fifth place, and attending on consultants ninth. The patients obviously consider the medical visits essential to their welfare, but have little understanding of the significance of report. Both nurses and patients
ranked the preparing and distributing of meals and drinks in eighth place. It is rather surprising to find the patients relegating such a basic need as food to a low position, but many of them indicated that they felt this was a non-nursing task. (See Fig. 2).

### TABLE 2

Average ranking of nursing activities: comparison of three hospitals, and total.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Small (No. 40)</th>
<th>Medium (No. 41)</th>
<th>Large (No. 43)</th>
<th>Total (No. 124)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(2) 3.7</td>
<td>(2) 3.2</td>
<td>(2) 3.3</td>
<td>(2) 3.4</td>
</tr>
<tr>
<td>Medicines and Treatments</td>
<td>(1) 3.4</td>
<td>(1) 2.7</td>
<td>(1) 3.0</td>
<td>(1) 3.0</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(4) 4.6</td>
<td>(4) 5.1</td>
<td>(4) 5.1</td>
<td>(4) 5.0</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(3) 3.3</td>
<td>(3) 3.3</td>
<td>(3) 3.5</td>
<td>(3) 3.5</td>
</tr>
<tr>
<td>Report</td>
<td>(9) 7.0</td>
<td>(9) 7.3</td>
<td>(9) 6.9</td>
<td>(9) 7.1</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(7) 6.8</td>
<td>(7) 6.4</td>
<td>(8) 6.7</td>
<td>(7) 6.6</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(6) 5.9</td>
<td>(6) 6.0</td>
<td>(6) 5.7</td>
<td>(6) 5.9</td>
</tr>
<tr>
<td>Meals</td>
<td>(8) 6.8</td>
<td>(8) 6.7</td>
<td>(7) 6.6</td>
<td>(8) 6.7</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(5) 5.9</td>
<td>(5) 5.8</td>
<td>(5) 5.5</td>
<td>(5) 5.7</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 7.4</td>
<td>(10) 8.5</td>
<td>(10) 8.6</td>
<td>(10) 8.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>B. Nurses (No. 22)</th>
<th>B. Nurses (No. 24)</th>
<th>B. Nurses (No. 37)</th>
<th>B. Nurses (No. 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(3) 4.0</td>
<td>(1) 2.6</td>
<td>(1) 2.2</td>
<td>(1) 2.8</td>
</tr>
<tr>
<td>Medicines and Treatments</td>
<td>(2) 3.9</td>
<td>(2) 3.6</td>
<td>(3) 3.4</td>
<td>(3) 3.6</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(1) 3.0</td>
<td>(3) 3.8</td>
<td>(2) 2.5</td>
<td>(2) 3.0</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(5) 4.8</td>
<td>(5) 4.6</td>
<td>(4) 4.6</td>
<td>(4) 4.7</td>
</tr>
<tr>
<td>Report</td>
<td>(4) 4.4</td>
<td>(4) 4.4</td>
<td>(6) 5.6</td>
<td>(5) 4.9</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(6) 5.7</td>
<td>(9) 6.9</td>
<td>(5) 5.2</td>
<td>(6) 5.8</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(8) 6.9</td>
<td>(7) 6.6</td>
<td>(7) 6.9</td>
<td>(7) 6.6</td>
</tr>
<tr>
<td>Meals</td>
<td>(9) 7.5</td>
<td>(6) 6.4</td>
<td>(8) 6.9</td>
<td>(8) 6.9</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(7) 6.1</td>
<td>(8) 6.7</td>
<td>(9) 8.1</td>
<td>(9) 8.1</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 8.6</td>
<td>(10) 9.3</td>
<td>(10) 9.4</td>
<td>(10) 9.2</td>
</tr>
</tbody>
</table>

The Spearman rank-order correlation between the average ranking of nursing activities by patients and nurses was .73. This shows similarity in the ranking by both groups, with a disparity in the two activities having to do with the nurse's function as an administrator, and as a doctor's assistant. The correlation of .73 was significant at the 5% level, but not at 1% for 10 activities.
FIGURE 2

Rank order of ten nursing activities by patients and nurses.
### TABLE 3
Average ranking of types of nursing activities: comparison of three hospitals, and total.

#### A. Patients

<table>
<thead>
<tr>
<th>Activity</th>
<th>Small (No.40)</th>
<th>Medium (No.41)</th>
<th>Large (No.43)</th>
<th>Total (No.124)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Care</td>
<td>(1) 3.6</td>
<td>(1) 3.0</td>
<td>(1) 3.3</td>
<td>(1) 3.3</td>
</tr>
<tr>
<td>Basic Care</td>
<td>(2) 5.1</td>
<td>(2) 5.0</td>
<td>(2) 5.0</td>
<td>(2) 5.0</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>(3) 5.7</td>
<td>(3) 5.8</td>
<td>(4) 5.9</td>
<td>(2) 5.8*</td>
</tr>
<tr>
<td>Doctor's Assistant</td>
<td>(4) 5.9</td>
<td>(4) 5.9</td>
<td>(3) 5.6</td>
<td>(4) 5.8*</td>
</tr>
<tr>
<td>Administrative Duties</td>
<td>(5) 7.2</td>
<td>(5) 7.9</td>
<td>(5) 7.8</td>
<td>(5) 7.6</td>
</tr>
</tbody>
</table>

#### B. Nurses

<table>
<thead>
<tr>
<th>Activity</th>
<th>Small (No.40)</th>
<th>Medium (No.41)</th>
<th>Large (No.43)</th>
<th>Total (No.124)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Care</td>
<td>(2) 4.4</td>
<td>(1) 4.2</td>
<td>(2) 4.0</td>
<td>(1) 4.2</td>
</tr>
<tr>
<td>Basic Care</td>
<td>(3) 5.8</td>
<td>(2) 4.5</td>
<td>(3) 4.6</td>
<td>(3) 4.9</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>(1) 4.4</td>
<td>(3) 5.4</td>
<td>(1) 3.9</td>
<td>(2) 4.4</td>
</tr>
<tr>
<td>Doctor's Assistant</td>
<td>(4) 6.5</td>
<td>(4) 6.7</td>
<td>(5) 7.5</td>
<td>(4) 6.9</td>
</tr>
<tr>
<td>Administrative Duties</td>
<td>(5) 6.5</td>
<td>(5) 6.9</td>
<td>(4) 7.5</td>
<td>(5) 7.0</td>
</tr>
</tbody>
</table>

*Note: When two types of nursing activities ranked the same, the average was taken to the nearest .01 to determine position.

### Comparison of Types of Activities

Both patients and nurses are most concerned with the technical aspects of the nurse's tasks. This type of activity is one on which ward staff have been found to spend the most time (according to the Ministry of Health study of 1966 (1)) and therefore should present little conflict between nurses and patients. However, the distributing of meals and drinks to patients is the next most time-consuming activity mentioned in the Ministry of Health study, and the present findings indicate that nurses and patients feel this is a non-nursing task. Clerical/reception duties were found to take over 19 hours per week of a nurse's time, yet this study shows that both patients and nurses feel that administrative duties are the least important of a nurse's work. Increasing the use of ward clerks and domestic help might aid this situation.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Student 1st year (No. 5)</th>
<th>Student 2nd year (No. 8)</th>
<th>Student 3rd year (No. 23)</th>
<th>Staff (No. 20)</th>
<th>Ward Sister (No. 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>1.3</td>
<td>1.7</td>
<td>2.5</td>
<td>2.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Medicines &amp; Treatments</td>
<td>3.5</td>
<td>3.0</td>
<td>4.3</td>
<td>2.9</td>
<td>3.7</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>4.3</td>
<td>3.0</td>
<td>2.4</td>
<td>3.7</td>
<td>2.5</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>3.0</td>
<td>4.1</td>
<td>3.7</td>
<td>5.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Report</td>
<td>5.0</td>
<td>4.9</td>
<td>5.4</td>
<td>4.5</td>
<td>4.4</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>7.5</td>
<td>7.0</td>
<td>5.6</td>
<td>5.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>7.3</td>
<td>6.6</td>
<td>6.7</td>
<td>6.9</td>
<td>7.0</td>
</tr>
<tr>
<td>Meals</td>
<td>5.7</td>
<td>6.3</td>
<td>7.4</td>
<td>7.0</td>
<td>7.7</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>7.8</td>
<td>8.9</td>
<td>7.9</td>
<td>7.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>9.0</td>
<td>9.6</td>
<td>9.1</td>
<td>9.2</td>
<td>9.2</td>
</tr>
</tbody>
</table>
Comparison of Different Grades of Staff

It is interesting to compare the ranking of nursing activities to see if there is a shifting of attitudes as nurses progress from student to the position of ward sister. Sarbin (2) suggests that role enactment produces changes in significant aspects of belief and conduct. For example, when the ward sister occupies her position, she adopts certain components of the role expectations. To validate her position she engages in appropriate behaviour. For the ward sister, this would mean assuming a supervisory role, taking on administrative tasks, making rounds with consultants, acting as liaison between patient and physician, and so forth. We might expect her to rate these activities more highly than do other grades of nursing staff. If she doesn't, there will be a discrepancy between the expectations of her role by others, and her own role image.

Attending on consultants is placed fifth in importance by ward sisters, and ranked ninth by all other groups. Report is rated fourth by staff and ward sisters, and fifth by students. Giving general basic care and distributing meals show a progressive decline in importance from student to ward sister, as does the taking of vital signs. There is no obvious shifting of attitudes about medicines and treatments, talking with patients to provide reassurance and support, answering patient and family questions, assisting doctors with technical procedures, or clerical/reception duties. Assisting doctors with technical procedures takes up relatively little of the ward sister's time, but she may spend as much as 50% of her time on clerical/reception type duties. The fact that she consigns it to 10th place along with the rest of the nursing staff probably indicates a conflict between what is expected of her, and what she considers important in her role.

Hypothesis Tested

It was thought that there would be a relationship between the ranking of nursing activities by nurses and
To test this hypothesis, Spearman's rank order of correlation of the 10 nursing activities was calculated between the ward sister and her patients, and between all the nursing staff on a ward and the patients. No relationship was found, as Table 5 indicates. The wards are listed in descending order of per cent of high satisfaction with nursing care. One private ward was excluded from the list because only three patients were interviewed. Two wards had two ward sisters, and both their scores are included for the ward.

On 11 of the wards, correlation was greater between the total nursing staff and the patients than between the ward sister and the patients.

**TABLE 5**

Relationship between per cent of highly satisfied patients on a ward, and the ranking of nursing activities: Correlation between patients and nurses.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Per Cent of High Satisfaction</th>
<th>Correlation Score</th>
<th>Correlation Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ward Sister &amp; Patients</td>
<td>Nursing Staff &amp; Patients</td>
</tr>
<tr>
<td>4B</td>
<td>90</td>
<td>.60*</td>
<td>.55</td>
</tr>
<tr>
<td>4E</td>
<td>88</td>
<td>-.10</td>
<td>.26</td>
</tr>
<tr>
<td>3B</td>
<td>88</td>
<td>-.50</td>
<td>.65*</td>
</tr>
<tr>
<td>3E</td>
<td>86</td>
<td>.31</td>
<td>.67*</td>
</tr>
<tr>
<td>2F</td>
<td>78</td>
<td>.20</td>
<td>.26</td>
</tr>
<tr>
<td>2C</td>
<td>75</td>
<td>.15</td>
<td>.64*</td>
</tr>
<tr>
<td>3D</td>
<td>75</td>
<td>.82*</td>
<td>.84*</td>
</tr>
<tr>
<td>3A</td>
<td>73</td>
<td>.73*</td>
<td>.84*</td>
</tr>
<tr>
<td>3C</td>
<td>73</td>
<td>.14*</td>
<td>.62*</td>
</tr>
<tr>
<td>2A</td>
<td>70</td>
<td>.73*</td>
<td>.58</td>
</tr>
<tr>
<td>2D</td>
<td>60</td>
<td>.45; .26</td>
<td>.68*</td>
</tr>
<tr>
<td>4C</td>
<td>57</td>
<td>.04</td>
<td>.51</td>
</tr>
<tr>
<td>3F</td>
<td>56</td>
<td>.58</td>
<td>.56</td>
</tr>
<tr>
<td>4A</td>
<td>55</td>
<td>.36</td>
<td>.13</td>
</tr>
<tr>
<td>4D</td>
<td>55</td>
<td>.10</td>
<td>.57</td>
</tr>
<tr>
<td>2B</td>
<td>50</td>
<td>.77*</td>
<td>.74*</td>
</tr>
<tr>
<td>2E</td>
<td>30</td>
<td>.54; .76*</td>
<td>.60*</td>
</tr>
</tbody>
</table>

* Those wards with a correlation of .60 or more have been starred.

Of the four wards with over 80% high satisfaction with care, two of these had a negative correlation between the ward sister and her patients. There were major differences of ranking in almost all activities, but most
marked were basic care, report, medications and treatments, and answering patient and family questions. In contrast, the two wards with the lowest per cent of high satisfaction had .60 and .7% correlation.

Comparison of Wards with High and Low Satisfaction

The two ward sisters from the wards with high satisfaction percentages rated basic care last, and technical care next to last. Both placed emotional support first, and administrative duties second. The patients are technically oriented, placing it first, and basic care second, with emotional support third or fourth, and administrative duties last. The sisters felt it was important to spend time talking with patients, and answering their questions. They also have validated their positions as ward sisters by rating their administrative duties highly.

The two ward sisters from the wards with low satisfaction percentages rated technical care first, and basic care second, just as the patients did. Emotional support was placed third by one sister, and last by the other. Administrative duties were fourth or fifth. There was thus high correlation between the patient and ward sister ranking of nursing activities. See Table 6.

The Direct and Indirect Method of Eliciting Responses

There is an interesting discrepancy between the expectations of the nurse when the nursing activities are ranked, and the expectations elicited in the sentence completion section. Copp, (3) in an American investigation of the nurse-patient psycho-dramatic role perception and expectation, found a marked difference between the perceptions elicited from the direct method, and the indirect method. She concludes that nurses consciously suggest certain things in the direct method, but in the indirect method, they bring out things they are less willing to admit, or are actually less aware of.
**TABLE 6**

Comparison of ranking between ward sister and patients on two wards with over 80% high satisfaction, and two wards with under 60% high satisfaction.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Medicines &amp; Treatments</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>TFR and BP</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
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<td>Report</td>
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<td>3</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Answering Questions</td>
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<td>3</td>
<td>10</td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>6</td>
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<tr>
<td>Meals</td>
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<td>10</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Per Cent of High Satisfaction</td>
<td>88</td>
<td>33</td>
<td>50</td>
<td>30</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Correlation Score</td>
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<td>-.50</td>
<td>.77</td>
<td>.76</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In this study, when patients are given a forced choice of ten activities to rank, they seem to feel that, from the logical point of view, they should give precedence to the technical aspects of their care, since treatments and other technical care are the main reason they have to be in hospital. Yet in the indirect section, when they are asked to complete "The main thing a patient expects of a nurse is ...", two-thirds of the patients mention some form of emotional support. It seems to be their indirect proof of nursing care competence.

Comparison of Student Ranking in U.S.
with Responses in Present Study

In a study by Seward (4) which compared nursing students and auxiliary worker’s ranking of the activities which best described nurses, the students rated the helping with the physical and emotional needs of patients first. The giving of medications and taking of vital signs were rated very low. The American students offer an interesting contrast to the British students, who rank the technical care highly along with physical care, and reassurance of patients.

Summary

In all three hospitals, patients ranked nursing activities in the same way. Of the nurse’s five main divisions of work, the patients rate technical care highest, basic care second, and administrative functions last.

The nurses rate technical care, emotional support and basic care very closely, in that order.

There was no association between high satisfaction on a ward, and the ranking of nursing activities by patients and nurses.
References:


THE IMAGE OF THE NURSE

People often are identified in terms of their vocations (1). When one knows that a person is a nurse, one tends to estimate her education, income, prestige, level of living, and possibly her cultural interests. We form our image of an occupation early in life, and tend to maintain this idea. The image of an occupation is of great significance to its membership, and the views of the public will promote or impede progress in an occupation.

When Florence Nightingale wished to become a nurse, the main objection of her wealthy family was the notorious immorality of hospital nurses, who were described as drunkards and prostitutes (2) (p.58). Miss Nightingale pressed for the improvement of the status and character of women entering the profession. The Nightingale nurses came to be known as efficient, professional and educated women who were suffering from a feeling of their superiority! (2) (p.483).

It is curious that the present image of Miss Nightingale is so different from the realities of her existence. Her name is synonymous with the dedicated nurse devoting her lifetime to the welfare of her patient, spending day and night at the bedside. Most of Miss Nightingale's life was, in fact, spent as a semi-invalid in her home writing monumental reports on sanitation, finance, hospital construction, and the education of nurses. Many of today's nurses see no need for a well educated nurse, and feel the apprentice nurse is all the profession requires (3). Thus, they deny the importance of the image of the nurse as someone who is well educated.

In this study's pilot questionnaire, patients and nurses were asked to compare the nurses of today with nurses years ago. The nurse's image was similar to that of the pre-Nightingale era. She was described as a drunkard, overworked and underpaid, poorly educated, and with little
social life, many domestic chores, and having to contend with poor facilities. In addition, she was austere, formal, strict, bossy, starchy, and a blood-letter! Today's nurse was the antithesis of this.

Studies About the Image of the Nurse

Wilson (4) said that nursing is interesting to people, and will continue to attract if suitable conditions of employment are provided. With some variation, he found that there was high prestige in the community for the role of the nurse.

In Davis' study (5), which compared role expectations of nursing and social work, it was found that the public tends to connect the nurse's role almost exclusively with the hospital. Nursing was seen as a traditional role for women. It called for one to be an industrious, methodical, dependable individual while being co-operative, considerate, conventional and adaptable. The tendency toward submissive and subordinate roles was regarded as limiting occupational freedom.

Hughes et al (6) found that women have a more favourable image of the nurse than do men. Women saw the nurse as interested in the problems of others, and less self-oriented, and the men described the differences of nurses from other women on the basis of training, education and knowledge. (Men occasionally expressed hostility, resentment, and competitive feelings about nurses.) The image for both sexes became more favourable as they descended the socioeconomic ladder. When people were asked: "How do nurses differ from most other women?" the upper classes described them as 'unladylike', hardened, cynical, indifferent to human suffering, nervous, not refined, etc. There was a servant-like relationship suggested. The lower classes consistently saw the nurse as a more sympathetic, hygienic, protective, superordinate figure. There was a slight improvement of the image of nurses with older patients. Hughes et al also found that doctors rated nurses lower than did men in general, but older doctors rated them
more favourably than did the younger ones.

Friendson (7) found that the lower the social scale, the stronger was the use of nurses (in the public health field) as a substitute doctor.

Burling (8) pointed out that the newer generation of nurses see their role as more of a shared task with doctors, with a steadily decreasing social distance. Yet Wessin (9) described the nurse's status as ambiguous because, although she has a professional status, her upward mobility is blocked by the doctor.

Many of the studies into the image of the professional nurse gave descriptions in terms of the philosophy of nursing. The nurse is pictured as loyal, forthright, modest, steadfast, dutiful, trusting, methodical, tolerant, able to compromise, open-minded, flexible and so forth (10).

In MacGuire's (11) study of the British student nurse's conception of nursing, the personal qualities of sympathy, kindness, patience, understanding and gentleness were significant, along with interest in patients, and being skilled in nursing procedures. The importance of skills increased as the student progressed in training.

Coser (12) found that patients see the nurse's essential task as one of lending personal reassurance and emotional support to their lives. They describe the good nurse as one who has a 'kind' or 'personal' manner. They seldom see the nurse in the decision-making field, in the information-giving field, or as having a job that involves much professional skill.

Haukash (13) also found that the patients' evaluation of a good nurse focused on the nurse's mode of dealing with patients. They stressed her personality, wanting her to be friendly, warm, kind and benign. They expect her to give willing and spontaneous service by promptly responding to their call. Supportive care (that is, expectations that are only indirectly relevant to their medical care) is mentioned by 90% of the respondents, whereas expectations
involving therapeutic dimensions are mentioned 64% of the time.

Simmons (14) identified six related concepts in occupational image theory:

1. The social position of the incumbent

2. The reference groups associated with the above position

3. The role image or concepts consisting of attributes accorded to, and expectations held toward, the occupant of the position by pertinent reference groups

4. Discrepancies existing between actual behaviour or services of the occupant of the role position, and the expectations of the reference groups or incumbent

5. The stresses experienced by practitioners as a consequence of the discrepancies between performance expectations and behaviour

6. The coping patterns acquired by practitioners in coming to terms with, or making adaptations to, the above stresses

Satisfaction with Care and the Image of the Nurse

In the present study, patients were asked to agree or disagree with six statements made about nurses. They explored the image of her personality, dedication to nursing, bedside orientation, concern for the patient as a person, role in supporting the patient's communication needs, and the general quality of her nursing care. As in the pilot study, patients with a score of five or six were considered to have a high positive image of nurses. There was a strong relationship between a high positive score, and high satisfaction with nursing care. (Chi-square = 50.5 with 1 df, was significant at .01 level.)

Of the highly satisfied patients, 94% had a high positive image of the nurse. For patients who were less
satisfied with nursing care, 43% had a high positive image of the nurse.

TABLE 7
Relationship between the positive/negative image of the nurse, and satisfaction with care.

<table>
<thead>
<tr>
<th>Score</th>
<th>Small (No.33)</th>
<th>Medium (No.29)</th>
<th>Large (No.39)</th>
<th>Total (No.101)</th>
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<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
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<th>Medium (No.22)</th>
<th>Large (No.15)</th>
<th>Total (No.54)</th>
</tr>
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<td>4</td>
<td>2</td>
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<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: No. = 155; 1 patient did not complete this section

In the small hospital, 91% of the highly satisfied patients had a high positive image, and 18% had a high positive image among those patients who were less satisfied.

In the medium sized hospital, 97% of the highly satisfied patients had a high positive image, and 65% of those who were less satisfied had a high positive image.

In the large hospital, 94% of the highly satisfied patients had a high positive image, and 67% of those who were less satisfied had a high positive image.

There was no statistical relationship between a
high positive image, and the variables of age, sex, and social class. Therefore it seems probable that the patient's image of the nurse is affected by his hospital experience.

**TABLE 8**
The relationship between the image of the nurse and variables of age, sex, and social class

<table>
<thead>
<tr>
<th>Age</th>
<th>High Positive Image</th>
<th>Low Positive Image</th>
<th>Total Patient Sample Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
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<td>26</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>40 - 59</td>
<td>52</td>
<td>44</td>
<td>15</td>
</tr>
<tr>
<td>60+</td>
<td>40</td>
<td>34</td>
<td>12</td>
</tr>
</tbody>
</table>

Chi-square = .23 with 2df, and not significant

**Sex**

<table>
<thead>
<tr>
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<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
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<td>50</td>
<td>18</td>
<td>49</td>
<td>77</td>
<td>49</td>
</tr>
<tr>
<td>Female</td>
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<td>50</td>
<td>19</td>
<td>51</td>
<td>79</td>
<td>51</td>
</tr>
</tbody>
</table>

Chi-square = 0 with 1df, and not significant

**Social Class**

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I or II</td>
<td>21</td>
<td>18</td>
<td>13</td>
<td>35</td>
<td>34</td>
<td>22</td>
</tr>
<tr>
<td>III</td>
<td>54</td>
<td>46</td>
<td>13</td>
<td>35</td>
<td>67</td>
<td>43</td>
</tr>
<tr>
<td>IV or V</td>
<td>43</td>
<td>36</td>
<td>11</td>
<td>30</td>
<td>55</td>
<td>35</td>
</tr>
</tbody>
</table>

Chi-square = 5.24 with 2df, and not significant

**Analysis of Statements**

Besides a total score for the image of the nurse, each statement was analysed separately for agreement/disagreement. The first two statements were phrased so that agreement meant a positive attitude. The next four statements were phrased so that disagreement meant a positive attitude toward the nurse. A summary of the total number of patients expressing a positive or negative attitude for each of the six statements is shown in Table 9.
TABLE 9
The number of patients expressing positive or negative attitudes for the 'Image of the Nurse' Statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Positive Attitude</th>
<th>Negative Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%.</td>
</tr>
<tr>
<td>1.</td>
<td>132</td>
<td>85</td>
</tr>
<tr>
<td>2.</td>
<td>148</td>
<td>95</td>
</tr>
<tr>
<td>3.</td>
<td>90</td>
<td>58</td>
</tr>
<tr>
<td>4.</td>
<td>143</td>
<td>92</td>
</tr>
<tr>
<td>5.</td>
<td>126</td>
<td>81</td>
</tr>
<tr>
<td>6.</td>
<td>147</td>
<td>95</td>
</tr>
</tbody>
</table>

(No. 155)

Statement 1: "In general, the quality of nursing service has improved over the past ten years."

Some patients felt it was difficult for them to compare, especially if this was their first hospitalisation. When patients indicated that the quality of nursing service had been excellent both in the past and in the present, this was scored as a positive attitude. Those who agreed that the quality of nursing service has improved over the past ten years did not usually make any additional comments. Of the 23 patients who felt that nursing service had deteriorated, some made qualifying remarks:

"The educational standards were higher in 1947."

"In the older days, there was probably better hygiene."

"They are definitely more lax now, which is not good."

"It was better nine years ago; there were more nurses."

"They were more professional 10 years ago than now."

"There may be better facilities, but the personnel hasn't improved."

"Now there is a better class of girl, but communication on a serious level is poorer now."
"Up in North England there are no nurses, and so many of them are foreign."

**Statement 2:** "Nurses are careful to respect the dignity of the patient."

Almost all patients agreed with this statement. There were a few additional remarks:

"Some of them do, but many of them don't."

"Old folks are laughed at."

"There are times when they have to be cruel to be kind."

"There is a thin line; occasionally they talk down to patients, and treat them like children."

"Most are gentle, but some are rough."

**Statement 3:** "Nurses don't take enough time to talk to patients, and answer their questions."

This statement produced the largest number of negative feelings. Many qualified the statement by indicating that it wasn't that she didn't take enough time to talk; she didn't HAVE the time to talk. Some felt that nurses will explain if the patient initiates the conversation. One thought that the shy patient was in particular difficulty. Other remarks:

"We don't need them; the housemen answer for you."

"You can't expect too much."

"Nurses don't seem to know the patient's needs here."

"Nurses are the servants for the doctors, and they don't know enough about the patient to answer their questions."

"The skill part is what is important."

"Everyone disappears at visiting time."

"You would like to put some questions to them, but you don't because they are too busy."
Statement 4: "Nurses tend to be cold and disinterested in patients."

Ninety-two per cent of the patients said this was not true. Qualifying remarks included:

"They have to be so up to a point."

"Not in this hospital, but in others."

"Their job entails other things besides chitter chat."

"The younger nurses are more friendly."

"There is no need to be interested in patients; they have no knowledge of the patient's complaint."

"There is a tendency that way now."

Statement 5: "Nurses spend too much time away from the patient, and not enough time doing bedside nursing."

Many of the patients felt that this was due to shortage of staff. One thought it depended on the patient's condition. Some thought if she were freed from non-nursing tasks, she could spend more time with bedside nursing.

Other remarks:

"One doesn't WANT them by the bed."

"You often have to call the nurse for other patients."

"Right after surgery, you get a lot of attention."

"If there were more nurses, they could deal more individually with patients."

Statement 6: "Nurses today seem more concerned with their own problems than with the care of patients."

Most patients see nurses as dedicated; there were a few who felt there was an occasional nurse who was not. Other qualifying remarks:
"The nurse may have a row with her boyfriend. Then she snaps at her patients."

"It depends on if they are married (and have more problems), and especially if they have children."

"They are more concerned with routine than with the care of patients."

**Comparison of Three Hospitals**

Table 10 compares the per cent of negative attitudes for the six statements in each of the hospitals.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1.</td>
<td>10</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>2.</td>
<td>3</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>24</td>
<td>48</td>
<td>23</td>
</tr>
<tr>
<td>4.</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>5.</td>
<td>14</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

(No. 155)

Criticism of the quality of nursing service was lowest in the large teaching hospital. Concern for the patient as a person (statement 2) was seldom criticised in any of the hospitals. There was a decreasing number of patients with a negative attitude about the nurse's role in supporting communication needs as the hospitals increased in size. This may have been associated with shortage of staff, or possibly be related to different methods of communication used in the hospitals. There was a slightly larger per cent of patients in the large hospital who felt that nurses tend to be cold and disinterested in patients. Criticism about the lack of bedside orientation of nurses
was greatest in the small hospital; their shortage of student nurses may have had an affect on this attitude. In all three hospitals, attitudes about the nurse's dedication to her profession were essentially the same.

**Summary**

Although other researchers have found a relationship between the respondent's age, sex, and social class and their image of the nurse, these factors were not significant in this study. There was a strong relationship between a high positive image of the nurse, and high satisfaction with nursing care. Forty-two per cent of the patients felt that not enough time was spent talking with patients, and answering their questions. Nineteen per cent of the patients indicate that the nurse spends too much time away from the patient. Seventy-six per cent of the total patient sample had a high positive image of the nurse.
References:

1. Taves, M., Corwin, R. & Haas, J.E. (1963) "Role Conception and Vocational Success and Satisfaction" Research Monograph 112, Ohio State Univ.


GENERAL EXPECTATIONS OF THE ROLE OF NURSE

In nursing, one can attempt to describe the distinctive skills used by the nurse, both the complex technical tasks, and the basic care skills. However, as Reissman (1) points out, the nurse's activities depend on several levels of knowledge: the physiological, the psychological, the social, interpersonal phenomena, and a cultural level. Work done on a physiological level can be, and has been, measured in terms of patient morbidity, mortality, and days of hospitalisation. This does not measure the other four levels of activity. Can we scientifically measure the nursing care involved in allaying the patient's anxieties? Can we measure the sense of security a patient may feel because of the nurse's presence? Can we score the ability of a ward sister to interact well with physicians, other nurses, students, auxiliary personnel, and patients? Lastly, can we take into account that the culture pattern demanded in orthopaedic wards has different features from that demanded in a surgical recovery ward?

We are dependent for our findings on what people say in these matters. Unfortunately there is often a dramatic difference between what people say and what people do. For example, nurses are known to verbalise about the importance of spending time at the bedside, but when given the opportunity to do so, utilise the time for administrative tasks, or other activities oriented away from patients.

Another problem for attitude studies undertaken in a hospital setting is that the patient may be hesitant to criticise because he is fearful of reprisal. In addition, he may be reluctant to speak negatively about nurses when the wards are so frequently understaffed, and the nurse is expected to do so many 'unpleasant' tasks.

Those engaged in the study of the social behaviour of man recognise that they can seldom generate an hypothesis
that has generality to the level of the social behaviour of all men. Nevertheless, one can see the significance of a set of variables for the prediction of man's activities.

Comparison of Nurse and Patient Expectations

What the patient expects of a nurse, and how the nurse sees her own role were categorised from the following two sentence completions:

1. "The main thing a patient expects of a nurse is ..."
2. "A nurse should always ...

Table 11 compares the responses to these two sentence completions by patients and nurses.

TABLE 11
Patient and Nurse expectations of the role of nurse

A. The main thing a patient expects of a nurse is ...

<table>
<thead>
<tr>
<th></th>
<th>Technical Care</th>
<th>Emotional Support</th>
<th>Both T.C. and E.S.</th>
<th>No answer or Not Coded</th>
<th>Total</th>
</tr>
</thead>
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<td>36</td>
<td>71</td>
<td>45</td>
<td>156</td>
</tr>
<tr>
<td>Nurses</td>
<td>14</td>
<td>17</td>
<td>41</td>
<td>49</td>
<td>83</td>
</tr>
</tbody>
</table>

B. A nurse should always ...

<table>
<thead>
<tr>
<th></th>
<th>Technical Care</th>
<th>Emotional Support</th>
<th>Both T.C. and E.S.</th>
<th>No answer or Not Coded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>28</td>
<td>18</td>
<td>104</td>
<td>67</td>
<td>156</td>
</tr>
<tr>
<td>Nurses</td>
<td>29</td>
<td>35</td>
<td>40</td>
<td>48</td>
<td>83</td>
</tr>
</tbody>
</table>

Technical care included physical care, treatments, medications, efficiency, technical knowledge, assisting the physician, and use of such terms as 'care and attention', and 'to be nursed'. Emotional support included personal
qualities of kindness, sympathy, encouragement, patience, being available, and answering questions.

The number of times specific words were used in the responses was counted. **Kindness** was used most often by both nurses and patients. Next most commonly used by both groups was **understanding**. Other words that were used several times by both groups were **availability**, **gentleness**, **tenderness**, **patience**, **sympathy**, and **consolation**. The patients frequently mentioned **civility**, **courtesy**, or **politeness**, but the nurses mentioned this only once. The nurses more commonly emphasised **confidence** and **reassurance**, which was infrequently used by patients. The majority of the references to technical care were non-specific, except when the respondent was asked to qualify his terminology. Then the patients would mention the **bedpan**, or assistance with positioning.

As Table 11 indicates, some respondents could not restrict themselves to a single answer, and stress the importance of both the technical and emotional aspects of the nursing role. In the remaining responses, it can be seen that in both sentence completions, emotional support was stressed over technical care by patients and nurses.

**Comparison of Three Hospitals**

The response by each hospital is shown in Table 12.

The responses for each hospital are similar to the total responses with one exception. A greater number of nurses in the large hospital, when completing "A nurse should always ..." answered in the 'technical care' category.

**Comparison of Grades of Staff**

Table 13 compares the responses of pupil-enrolled, student, staff and ward sister, taking the two sentence completions together. The pupil-enrolled nurses are the only group having a larger number who respond in the technical
TABLE 12
Comparison of hospitals: Patient and nurse expectations of the role of nurse, by number.

A. The main thing a patient expects of a nurse is ....

<table>
<thead>
<tr>
<th></th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Technical Care</td>
<td>Emotional Support</td>
<td>Both</td>
</tr>
<tr>
<td>Patient</td>
<td>16</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>Nurse</td>
<td>2</td>
<td>12</td>
<td>8</td>
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</table>

B. A nurse should always ...

<table>
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<tr>
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<th>Medium</th>
<th>Large</th>
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</thead>
<tbody>
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<td>Emotional Support</td>
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<tr>
<td>Patient</td>
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<tr>
<td>Nurse</td>
<td>6</td>
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<td>3</td>
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</table>
As their numbers increase in the general hospital situation, it will be important for their tutors to stress the emotional aspects of nursing care as well as the technical.

**TABLE 13**

Nurse expectations of the role of nurse: comparison of pupil-enrolled nurse, student, staff nurse and ward sister, by number.

<table>
<thead>
<tr>
<th></th>
<th>Pupil-Enrolled</th>
<th>Student</th>
<th>Staff</th>
<th>Ward Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
<td>5</td>
<td>42</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>Technical Care</td>
<td>7</td>
<td>11</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Both T.C. &amp; E.S.</td>
<td>2</td>
<td>18</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Not Coded</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>72</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

Note: Total No. 166 instead of 83; each nurse has been scored twice for her answers to both completion sentences.

There were two miscellaneous responses that could not be coded in the categories used for this section. 'A nurse should always go off duty exactly on time' and 'The main thing a patient expects of a nurse is too much; they show a bit of selfishness'. Although they cannot be coded, they tell a lot about the student and staff nurse who responded with such statements.

The reliability analysis of the categories for these two sentence completions, with three independent judges, yielded the following agreement levels:

A. From Patient Questionnaire

1. The main thing a patient expects of a nurse is ... 88%
2. A nurse should always ... 92%
B. From Nurse Questionnaire

1. The main thing a patient expects of a nurse is ...
   90%

2. A nurse should always ...
   87%

Summary

Both patient and nurse expectations of the nurse agree that she should be kind, understanding, patient, sympathetic, cheerful, and available to the patient. They feel she should give good nursing care, be knowledgeable, efficient, and quick to act in an emergency. In addition, the nurse feels she is expected to show confidence, and be observant. The patient stresses that she must also be courteous, civil, and polite. The patient also hopes the nurse will respond promptly to his request for a bedpan.

Emotional support was stressed more than technical care by both patients and nurses. The pupil-enrolled nurses lay more emphasis on the technical aspects of nursing care than did other grades of staff.
References:

The Ward Sister

The role of the ward sister has already been mentioned in the chapter on role theory as being one with complex demands. Duff and Hollingshead (1) described the 'head nurse' (American ward sister) as being everything to everybody except the patient. She directed the care of the patient, but was not able to spend time with patients individually. Barnes (2) felt that the ward sister was the one who was most highly trained in direct nursing care, and yet did the least of it. She felt that the ward sister's inability to delegate responsibility caused severe problems. Revans (3) said the patients judged the ward sister by the ward atmosphere (that is, the relationship between staff within the ward, and between patient and staff). He felt the perceptions of the sister were related to those above her (the matron, doctor, and so forth), and there was a downward transmission of attitudes to the wards. He found that the ward sister spent 39% of her time with administration, 20% with basic nursing, 30% with technical nursing, and 11% with domestic and miscellaneous activities. Revans also said that sisters who became absorbed in written work spent little time with their students; there was a significant negative correlation between the time they spent on basic nursing, and time spent on administration.

Cartwright (4) found that 63% of the patients interviewed were enthusiastic about the ward sister, 4% were critical, and the rest were "intermediate". "Efficient" was the most common word used to describe the ward sister.

Despite Menzies (5) feeling that students of nursing are the only nurses at the operational level with patients, this researcher found many of the ward sisters occupied with basic nursing. There was great variation from ward to ward, and the two factors that seemed to be
responsible for the ward sister's actual behaviour were
the amount of junior staff assigned to a given ward, and
the ward sister's personal interests.

**Patient Expectations of the Ward Sister**

How the patient saw the role of the ward sister
was explored by their completion of the sentence:

"A good ward sister is one who ..."

Coding of patient responses was: manager,
personal qualifications, and technical competence. Relia­
ability analysis was only 70% agreement among the judges,
which is below the index of 85%. The lack of agreement
seemed to be caused by the overlapping implications of
the patient responses. For example, 'A good ward sister
is one who, anything you ask for, she does for you', sug­
gests that the nurse has a willing disposition, but might
also be coded as technically competent. When a good ward
sister is one who 'maintains discipline', one might code
this as an aspect of her managerial responsibility, or
place it in the category of a nurse's personality.

Because the patient responses help to identify
their perception of the role of the ward sister, the in­
formation is presented here as the researcher's interpret­
ation of their answers, and as such, is not considered to
have statistical significance.

Some patients felt that a ward sister must be a
good manager, technically competent and personable; fre­
quently they mentioned at least two of the qualifications.
The category of manager included the ward sister's ability
to supervise, keep things in control, show leadership, be
in charge, or discipline her nurses. Technical competence
involved knowing the patient's drugs, answering patient
questions, making beds, knowing all aspects of nursing, or
being professional. Personal qualifications were that the
ward sister be kind, pleasant, cheerful, strict, truthful,
happy, understanding, fair, friendly, humane, firm, prac­
tical, dedicated, available, concerned about her patients,
Again, we find that patients consider the personal qualifications of the ward sister to be very important. Two-thirds of the patients include this aspect in their response. It is interesting that in the small hospital, the concept of firmness, strictness or being a disciplinarian is mentioned by 20% of the patients. Several patients used this sentence completion to make personal comments about specific ward sisters.

"A good ward sister is one who is experienced and cheerful (but we don't see her much)."

"A good ward sister is one who looks after her patients (like the one we have), and is kindness itself."

"A good ward sister is one who comes around and talks with patients (which this sister doesn't do)."

Sometimes the patient sees the role of the ward sister mainly in relation to the rest of her staff:

"A good ward sister is one who mainly shows fair dealing to the nurses, and doesn't reprimand them in front of the patients."

Often the patient worries that his communications to professional people will be considered inconsequential.

"A good ward sister is one who is efficient, keeps a clean and tidy ward, has time for her patients, even though what you say seems to be trivial."

She is seldom mentioned as one who gives bedside care, except in unusual circumstances.

"A good ward sister is one who goes around daily and makes sure the staff nurse gives the nurses all the help. She directs supervision to do their duties properly; also, in some cases if the ward is understaffed, she should lend a hand."
One patient, who had been in and out of the hospital several times over a 12 month period, felt that a ward atmosphere completely depended on the sister.

"This ward is good; the sister sets the tone of the ward. This sister is consistently pleasant, quietly sympathetic without being effusive. She has a sincere interest in her patient's general well being. She treats patients as human beings, and accepts their different backgrounds. She is never too busy to listen. There is no tension among the staff; they are not afraid of sister. The patients who are getting well are free to laugh and joke. The communications between nurse and patient are good. On the other ward, the sister presented me with a large meal, and I had been vomiting. When I refused to eat, she said: 'You're the kind that just doesn't want to get well'. On that ward there was a frigid atmosphere; none of the girls talked with patients."

Nurse Attitudes About the Ward Sister

Attitudes about the ward sister from the nurse's viewpoint were frequently elicited in the sentence completion:

"A well run ward is one . . ."

In the small hospital, 36% of the nurses mentioned the ward sister; in the medium sized hospital, 29%, and in the large hospital, 11%. They thought a well run ward depended on a sister who was interested in her ward, was well organised, conscientious, considerate, consistent, and happy. In the small hospital, the student nurses also mentioned the ward sister in the additional comments section.

"If there were younger, married sisters who would treat nurses as human beings with feelings, nurses could be much happier and more co-operative. Also if sister would treat nurses according to their merit rather than their personal feelings, there would be less unhappiness."
"After sister gives report and assigns work, she shouldn't harass the junior nurses; she should let them do their chores without running errands."

As the hospitals increase in size, there is an increasing number of comments concerning the ward sister's role as a supervisor, and a corresponding decrease in comments about her technical role.

Reliability analysis for this sentence completion, with three independent judges, yielded an agreement level of 97%.

Nurse Perceptions of the Staff Nurse

The perceptions of the staff nurse role vary with the nurse's rank. For example, the student nurse often sees her as a teacher of students; the ward sister thinks of her as a substitute sister, or acting as her liaison.

Comparison of Hospitals

In the small hospital, most of the ward sisters and staff said she was sister's deputy, in charge in her absence, and with supervisory tasks. One student felt the staff nurse had to do too many non-nursing tasks, and another saw her as more approachable than the higher staff.

In the medium sized hospital, most of the ward sisters referred to the personal qualities of their staff; loyalty, willingness, and a sense of responsibility. Two of the sisters made negative remarks:

"Staff nurses are usually unsure of themselves."

"Staff nurses usually are general dogs' bodies."

Half the staff likened their job to that of a ward sister. As was the case in the small hospital, students often mentioned that staff nurses helped and taught them.
In the large hospital, half of the ward sisters see her as sister's deputy, and the other half mention her personal qualities.

"Staff nurses usually react well to responsibility."

"Staff nurses usually are a joy to watch as they develop self-confidence."

Some of the enrolled-pupil nurses were ambivalent.

"Some are good and some are bad; they usually take sister's place when she is not here."

"They have administrative tasks; they should see instead that the care of patients is carried out in full."

Table 14 compares the responses in each hospital.

**TABLE 14**

<table>
<thead>
<tr>
<th>Nurse expectations of the role of staff nurse: comparison of hospitals, by per cent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurses usually ...</td>
</tr>
<tr>
<td>Small</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Like a ward sister</td>
</tr>
<tr>
<td>General nursing duties</td>
</tr>
<tr>
<td>Teacher or student helper</td>
</tr>
<tr>
<td>Pos. personal qualities</td>
</tr>
<tr>
<td>Neg. personal qualities</td>
</tr>
<tr>
<td>No answer or not codable</td>
</tr>
</tbody>
</table>

*Note: Multiple responses give total of more than 100%*

The per cent of nurses describing the staff nurse in terms of her teaching role decreases as the size of the hospital increases. None were described as having negative personal qualities in the small hospital; 13% were described negatively in the medium sized hospital, and 24% were so described in the large hospital.

**Comparison of Different Grades of Staff**

Many of the students mention that the staff nurse
is similar to a ward sister. In addition, they expect her to help and teach students. Her teaching role was not mentioned by pupil-enrolled nurses, or by ward sisters. Table 15 compares the expectations of the staff nurse by the different grades of staff.

Reliability analysis for this sentence completion, with three independent judges, yielded an agreement level of 88%.

**TABLE 15**

Nurse expectations of the role of staff nurse: comparison of ward sister, staff, student and pupil-enrolled nurse, by numbers.

<table>
<thead>
<tr>
<th></th>
<th>Ward Sister (No. 20)</th>
<th>Staff (No. 20)</th>
<th>Student (No. 36)</th>
<th>Pupil-Enrolled (No. 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Like a ward sister</td>
<td>9</td>
<td>9</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>General nursing duties</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Teacher or student helper</td>
<td>0</td>
<td>4</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Pos. personal qualities</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Neg. personal qualities</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>No answer or not codable</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Multiple responses give total of more than 83.

**Role Conflict for the Student Nurse**

Much has already been written about the recruitment, training, and withdrawal of the student nurse. The report of the Platt Committee on the Reform of Nursing Education (6) and Dr. MacGuire's (7) surveys of students during the induction period, the follow up of their whole training, and post qualification period, give us a valuable summary of the student nurse situation in Great Britain. MacGuire used the following items as evidence of the student's identification with the nursing profession:

1. A career plan which includes specialisation
2. A career plan which includes a post in the United Kingdom
3. A career plan which includes completion of basic training before marriage
4. An expressed interest in the practical aspects of nursing
5. A definition of hierarchical differences in terms of nursing skills
6. The inclusion of nursing skills in the definition of a "good" nurse
7. Self-image as a nurse
8. A picture of nursing involving personal service
9. The selection of "the care of the patient" as the main aim of nursing service.

She found that students who expressed interest in the academic aspects of the training in preference to the practical aspects were more likely to withdraw from student training. Thirty-eight per cent of the student nurses she interviewed included some technical aspect in their definition of a 'good' nurse. The self-perception of the student nurse was as students rather than nurses. Over the years, there were few attitude changes about nursing; MacGuire concluded that basically their identification with nursing took place before entry into a school of nursing.

The student nurse has a significant role conflict between her position as a 'learner' and her hospital employment as a nurse. In the present survey, most nurses felt that more time should be devoted to the teaching of students. This is clearly shown in the multiple choice question:

"If qualified nurses had more time, they could devote it to:-"

a. explaining things to patients
b. the teaching of students and other staff
c. improving the facilities of the ward
d. assisting the doctor
In the small hospital, 91\% of the nurses selected answer b; in the medium size hospital, 92\% and in the large hospital 78\%. The patients, who were given a similar multiple choice question, also gave a higher per cent of response to b. than to any other of the possible answers. In the small hospital 40\% of the patients answered b; in the medium size hospital, 37\% and in the large hospital 33\%.

When nurses are asked to complete the sentence:

"Student nurses learn from ..."

over half of all nurses feel that students learn from ward experience. Thirty-seven per cent mention nurses (using terms such as senior nursing staff, ward sister or staff), 17\% tutors, 8\% doctors, and a few mention books, other students, or vague 'others'.

In the additional comments section, the problem of learning was often mentioned.

"Nurses should spend more time in school in their first year of training, so they can cope better when they get on the wards, and not be lost. Nurses should have teaching sessions on the ward. Students are used as a pair of hands."

"There should be 30-60 minutes of each day devoted to teaching. After 8-9 hours on the ward, it is impossible to study for exams."

"Student nurses shouldn't have to clear up dishes and do other domestic work. Sister should be given a special time to take her students for teaching."

"Students need more teaching from staff about procedures such as dressings."

Views About the Pupil Nurse

As the doctors have passed on certain tasks to the nurse, so have the qualified nurses passed on some of their
jobs to the enrolled nurses, and auxiliaries. In the U.S.A., much of the bedside nursing is done by practical nurses, who train for one year.

The Dan Mason Nursing Research Committee's (8) findings about the enrolled nurse indicated that she was satisfied with the practical aspects of nursing, but was dissatisfied with the lack of status, poor relationships among the staff, the lack of prospects for promotion, and (in smaller numbers) the salary and hours of work. The Committee felt that a clearer definition of the duties and responsibilities of the enrolled nurse was needed. They also suggested that there should be improvements in the training programme, improved conditions for married women, better publicity for the two year training programme, introduction of a senior grade for those enrolled nurses who carry additional responsibilities, and a settlement of the problem that the enrolled nurse's training was not being recognised overseas.

Nurses were asked to complete the sentence:

"The pupil nurse ..."

Many nurses simply defined her position in a neutral manner. "The pupil nurse normally does more practical work than theory." "The pupil nurse is taught less than the student nurse, and has less responsibility, but the same tasks." "The pupil nurse is part of the ward team." Reaction to the pupil nurse varied from positive acceptance to ambivalence to negative feelings about their introduction to British nursing. "The pupil nurse will be a good practical nurse, and this is good for nursing." One ward sister said: "Some are good and interested; others who are disinterested are no help." Another ward sister felt "They are alright for some wards, but not on Gynae." A staff nurse thought they were overrated in general, not of sufficient intelligence, and therefore not good for nursing.

One of the pupil nurses expressed her dismay over the 'inferior' position of the enrolled nurse. She felt
the attitude prevailed among the student nurses and qualified staff, and was the cause of pupil nurse withdrawal from training. No pupil nurses were trained in the small hospital, but one former enrolled nurse who was training for the register also mentioned this problem. "The pupil nurse is not given enough status quality as nurses." One of the enrolled nurses in the large hospital felt that the biggest problem was the lack of clarification of what the enrolled nurse is permitted to do. She resented being asked continually: "Are you allowed to ...?"

The pupil nurse is seen positively by 73% of the nurses in the small hospital, 65% in the medium sized hospital, and 43% in the large hospital. Few gave negative responses: 9% in the small hospital, 4% in the medium size hospital, and 5% in the large hospital. The rest gave a neutral description of her work. It should be noted that the hospital where there was no pupil nurse training scheme had the highest positive attitudes; in the large hospital where there were pupil nurses being trained, the response was more neutral or guarded.

Reliability analysis for "Student nurses learn from ..." was 80%, which is below the index of 85%. This was caused by differing interpretations of the use of the word "seniors"; the researcher put it under a vague category of "others" and some of the judges scored it separately under doctors, tutors and nurses. No table is presented because of this, and the percentages mentioned are the researcher's interpretation of the answer. This is also the case for "The pupil nurse ..." where the reliability analysis was 76%. The judges scored some statements as positive and neutral, or negative and neutral, when the researcher gave a single overall score.

Summary

The patients' perception of the role of the ward sister stresses personal qualities of kindness, humanity, and concern for her patients. One-third of the patients mention her technical competence, and one-third mention
her managerial role. Nurses feel the ward sister should be well organised, conscientious, considerate, consistent, happy and interested in her ward.

Nurses most commonly see the staff nurse as being like a ward sister, or acting as her liaison. The student nurse also stresses the importance of her role as teacher and helper to students.

The student nurse has conflicting roles of student and hospital employee. Many nurses feel more time should be devoted to her learning needs.

The pupil nurse is seen positively by nurses in the role of a practical bedside nurse. Her duties and responsibilities need to be more clearly defined and publicised.
References:

6. A Reform of Nursing Education (1964) (Sir Harry Platt, Chairman) Royal College of Nursing & National Council of Nurses of the United Kingdom.
CHAPTER 10

THE SICK ROLE, THE PATIENT ROLE, AND EXPECTATIONS OF THE ROLE OF PATIENT

With Parson's (1) publication of "The Social System" in 1951, there came a systematic statement of the sociology of illness. Four aspects of the institutionalised expectation system of the sick role were outlined as follows:

1. The sick person is exempted from discharging some of his normal social obligations.

2. The sick person is exempted from a large measure of responsibility for his own condition.

3. The role is socially defined as undesirable.

4. There is a corresponding obligation on the sick person to seek technical and competent help, and to cooperate in the process of getting well.

Based on Parson's formulation of the sick role, Gordon (2) made an empirical investigation of his assumptions, and found that the general public perceived two sick roles; one in which illness or disability had stabilised, and the other in which it progressed and resulted in death or recovery. He called these the 'sick role' and the 'impaired role', and felt that the unimodal approach of Parsons was limiting.

Butler (3) pointed out, however, that when Parson defined illness in terms of incapacity for relevant task performance, it is presumed that as clinical symptoms become more severe, the person is more likely to consider himself ill, and enter the sick role. The data from the study of which he was a part confirmed that a large amount of illness is handled outside the framework of the sick role.
Separation of the Sick Role from the Patient Role

The sick role is a generalised role offered to ill people which justifies their non-performance of certain roles as seen by the relevant significant others. The patient role is the role allocated to the person who seeks medical help. A person with the 'flu' may assume the sick role by resting in bed and not attending work for two days, but if he does not seek medical help, he does not assume the patient role.

Social Movements Affecting the Role of the Patient

Folta and Deck (4) describe three social movements affecting the role of the patient. The Protestant Ethic, which lasted until the late 1940's, had fixed roles for men and women, and saw the hospital organisation as similar to that of the family. The male physician gave orders to the female nurse, and the subordinate patient was like their child. Then came the Freudian Ethic with its less strictly defined roles, where the sick appeared less deviant, and all illness was believed to have a psychic component. The role of the patient changed, for he was now expected to express his feelings, talk about himself, and assist in his treatment. More recently an Experiential Living Movement is viewing illness as a defect in societal functioning. After assuming the patient role, an individual is expected to fully participate in all aspects of treatment and care, and be responsible for some aspects of his movement toward health.

When a patient assumes the patient role, he exchanges freedom, autonomy and self-direction, for controls. At the same time he gains protection, care and freedom from responsibility. Relevant others accept this role change because it is not deliberately entered, but is considered to be beyond the control of the individual.

Anticipatory Socialisation of the Patient into his Role

To take on the particular role of the ill person
requires a learning process involving changes in beliefs, values and self-conception. If a patient is independent and aggressive, he may have trouble taking on the role of patient. When he becomes a patient, he goes through a process known as anticipatory socialisation. He develops some notion of the values and self-conception that he must hold for himself, that others expect of him, and that he can expect of others. As the patient is socialised into his role, he breaks with the old ways of living.

Coser (5) divided patients into two groups on the basis of their general attitude toward the hospital. The first she called 'primary' patients, and they viewed the hospital as a source of gratification of such needs as attention, rest, friendship, psychological support, and good food. They adapted better to the role of patient, but were reluctant to resume normal roles in society. The second group were 'instrumental' patients who saw the hospital as a place to alleviate disease. They adapted less well to the role of patient, but were better at resuming their normal roles in society.

Titmuss (6) says "To feel ill is to feel unadventurous, to want to retreat from life, to have one's fear removed, and one's needs met without effort. Physical illness can play queer tricks with our thoughts and our behaviour. This does not mean, as some all too easily suppose, that we are neurotics. In being gregarious and ungrateful, demanding and apathetic in turn, we are in fact behaving as ill people". (p. 124.)

Passive, Co-operative and Independent Patients

In the U.S., Reissman and Rohrer (7) attempted to find out what type of patient is considered to be 'ideal' by the hospital personnel. They found that as one moves up the job hierarchy from aide to head nurse, the more active patient became more desirable. Meyer (8) adapted their passive-active continuum to her data to see if there were differences among her four types of nurses. The co-operative
patient was found to be the most popular among all nurses, but the 'ministering angel' type nurse tended to like the more active-independent patient, and the 'technical-administrator' type nurse tended to like the passive-co-operative patient.

In the present study, nurses were asked to complete the sentence:

"I like patients who ..."

and the patients completed the sentence:

"A good patient is one who ..."

There were three categories used to code the data:

1. The passive patient was submissive, obedient, patient, helpless, or polite. The category included descriptions of what he should NOT do: 'he doesn't make demands' OR 'he doesn't fuss'. No activity was expressed.

2. The co-operative patient was helpful, cheerful, appreciative, understanding and pleasant. Instead of simply obeying, he was willing to adapt. Some activity was expressed.

3. The independent patient helped himself, and had the willpower to get better. He was active in helping toward his own recovery.

A few responses could not be coded because the completion was irrelevant to this system of coding.

The reliability analysis of the three categories for these two sentence completions, with three independent judges, yielded the following agreement levels:

1. From the nurse questionnaire;
   'I like patients who ...' 97%

2. From the patient questionnaire;
   'A good patient is one who ...' 96%
Patient Expectations of the Role of Patient

Over 50% of the patients describe the good patient as one who is passive. Only in the small hospital was the co-operative patient stressed over the passive patient, See Table 16. The main difference could be found among the male patients there, only 25% of whom were passive, as compared to 64% and 69% in the other two hospitals. Also the medical patients in the small hospital were less passive than the surgical patients, and this was reversed in the other two hospitals. It was surprising to find such a large percent of young patients in the medium and large hospitals who described the good patient as one who is obedient and passive. Social classes tended to follow the expected pattern, with the largest percent of passive responses coming from social classes IV, V. Satisfaction with care did not relate to passivity-independent attitudes except for the three patients who considered the nursing care to be poor. They did not classify the good patient as passive, See Table 17.

TABLE 16

Patient expectations of the role of patient; comparison of hospitals and average.

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Passive</td>
<td>20</td>
<td>40</td>
<td>30</td>
<td>57</td>
</tr>
<tr>
<td>Co-operative</td>
<td>25</td>
<td>50</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>Independent</td>
<td>5</td>
<td>10</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Not Coded</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The average of all patient responses show fewer differences than each hospital analysis. Fifty-three percent of men and 53% of women consider the good patient to be one who is passive. Passivity is high among the young patients, and only a few express independent attitudes (15%) as compared with the middle age, and older patient (8% and 5%). Surgical patients tended to have a slightly higher percent (11%) of independent responses than medical patients (4%).
TABLE 17
Patient expectations of the role of patient: comparison of passive-independent attitudes by sex, age, type, social class and satisfaction with care, by per cent

<table>
<thead>
<tr>
<th>SEX</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25</td>
<td>70</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
<td>33</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 - 39</td>
<td>36</td>
<td>36</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>40 - 59</td>
<td>39</td>
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<td>0</td>
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<td>60+</td>
<td>50</td>
<td>44</td>
<td>6</td>
<td>0</td>
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<tr>
<td>Medical</td>
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<td>Surgical</td>
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<td>0</td>
</tr>
<tr>
<td>SOCIAL CLASS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I or II</td>
<td>29</td>
<td>71</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>III</td>
<td>30</td>
<td>50</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>IV or V</td>
<td>57</td>
<td>39</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>SATISFACTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Sat.</td>
<td>46</td>
<td>48</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Satisfied</td>
<td>37</td>
<td>44</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Low Sat.</td>
<td>0</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key:  P. = Passive  I. = Independent  C. = Co-operative  N.C. = Not Coded
It is difficult to understand why the small hospital responses were more toward the co-operative-independent continuum than were the other two hospitals. One of the main problems found in this hospital was the acute shortage of student nurses. One might hypothesise that patients felt a strong need to be co-operative in this situation.

**Nurse Expectations of the Role of Patient**

Fully 20% of the nurses found it impossible to answer what kind of patient they liked. Several said: "I like all patients", or did not complete the sentence at all. Those whose answers were irrelevant to the system of coding answered "surgical patients" or "patients who are in and out of hospital quickly", etc. The majority of nurses like a patient who is co-operative, as Table 18 indicates.

| Nurse expectaions of the role of patient: comparison of hospitals and average |
|--------------------|-----------------|-----------------|-----------------|-----------------|
|                    | Small Hosp. | Medium Hosp. | Large Hosp. | Average |
|                    | No. | %    | No. | %    | No. | %    | No. | %    |
| Passive            | 4   | 18   | 3   | 13   | 7   | 19   | 14  | 17   |
| Co-operative       | 10  | 45   | 19  | 79   | 19  | 51   | 48  | 58   |
| Independent        | 0   | 0    | 1   | 4    | 3   | 8    | 4   | 4    |
| Not Coded          | 8   | 36   | 1   | 4    | 8   | 22   | 17  | 21   |

When comparing the different grades of nurses, the ward sister liked the independent patient more often (10%) than any other group. Student nurses had the largest percentage response for passive patients (25%), as is shown in Table 19.

In the small hospital, none of the staff nurses coded for the passive patient, none of the nurses mentioned the independent patient, and a large number said they liked all patients. In the medium sized hospital, all the passive
responses were from the student nurse group, and the only independent response was from one ward sister. In the large hospital, passive patients were mentioned by all grades of staff, and two students and one ward sister liked the independent patient. See Table 20.

### TABLE 19
Nurse expectations of the role of patient; comparison of pupil-enrolled nurse, student, staff nurse and ward sister

<table>
<thead>
<tr>
<th></th>
<th>Pupil-Enrolled</th>
<th>Student</th>
<th>Staff Nurse</th>
<th>Ward Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive</td>
<td>No. 1 14</td>
<td>No. 9 25</td>
<td>No. 1 5</td>
<td>No. 3 15</td>
</tr>
<tr>
<td>Co-operative</td>
<td>No. 4 57</td>
<td>No. 21 58</td>
<td>No. 12 60</td>
<td>No. 11 55</td>
</tr>
<tr>
<td>Independent</td>
<td>No. 0 0</td>
<td>No. 2 6</td>
<td>No. 0 0</td>
<td>No. 2 10</td>
</tr>
<tr>
<td>Not Coded</td>
<td>No. 2 29</td>
<td>No. 4 11</td>
<td>No. 7 35</td>
<td>No. 4 20</td>
</tr>
</tbody>
</table>

### TABLE 20
Nurse expectations of the role of patient; comparison of the grades of staff in each hospital, by number

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A.  B.  C.  D.</td>
<td>A.  B.  C.  D.</td>
<td>A.  B.  C.  D.</td>
</tr>
<tr>
<td>Passive</td>
<td>0 3 0 1</td>
<td>0 3 0 0</td>
<td>1 3 1 2</td>
</tr>
<tr>
<td>Co-operative</td>
<td>0 6 2 2</td>
<td>2 5 5 7</td>
<td>2 10 5 2</td>
</tr>
<tr>
<td>Independent</td>
<td>0 0 0 0</td>
<td>0 0 0 1</td>
<td>0 2 0 1</td>
</tr>
<tr>
<td>Not Coded</td>
<td>0 2 3 3</td>
<td>0 0 1 0</td>
<td>2 2 3 1</td>
</tr>
</tbody>
</table>

**Key:**
A. - Pupil-Enrolled  
B. - Student  
C. - Staff Nurse  
D. - Ward Sister

**Summary**

The patient still tends to define his own role in terms of the Protestant Ethic. The subordinate patient takes his orders from the physician who passes these orders...
on to the nurse. Socialisation into the patient role includes settling down and doing what you are told. The few patients who considered nursing care to be poor were from the non-passive group. For the rest of the patients, passivity-independence did not relate to satisfaction with care.

The majority of nurses define the patient role within the Freudian Ethic. They want the patient to be cooperative, cheerful, and appreciative. This is similar to the findings in the U.S.A. The few nurses who prefer an independent patient come most frequently from the ward sister grade. Student nurses had the largest percentage response for passive patients.
References:


Total Institutions and their Affect on the Role of Nurse

Institutions which look after the majority of the needs of its members, and which have a clear boundary between member and non-member, are referred to as 'total institutions' by de Berker (1). The hospital, the armed forces, prisons and boarding schools are examples of total institutions, and are often similar to one another in the way they function. These institutions have means whereby new members are introduced to the roles within it, and are led to accept them. Ritualism is often used as a means of reinforcing and inculcating roles. When the patient gives up his own clothing, eats unfamiliar food served in an unfamiliar way, and is placed in a position of 'asking permission' for things, he is being 'stripped' of his former roles, and introduced into the patient role.

Benne and Dennis (2) feel that the character of the nurse's role is also affected by the institution in which she works. It is determined by self-expectations, by the nurse's reference groups outside her work situation, by her colleagues, subordinates and peers within the work situation, and by the official expectations. If there are conflicts at any of these levels, her work may be affected.

Sofer (3) points out that in general, hospitals are run in a relatively rigid way, and even when formal rules are introduced, informal traditions, values, and relationships persist, and may remain out of gear with formal arrangements.

Revans (4) believes that the organisation of certain hospitals leads to attitudes and beliefs which adversely affect the hospital morale.

Nurse Positive/Negative Hospital Expectations

In the present study, the nurses were asked to
complete the sentence:

"The hospital expects the nurse to ..."

and their responses were coded into positive and negative statements. It was felt that if the 'hospital' was seen positively, it would be less likely that conflicts were being felt at the nurse's working level.

Positive statements included: having loyalty to the hospital, doing her work properly, knowing her job, studying, taking good care of patients, maintaining certain nursing standards, and being punctual, clean, intelligent, professional, reliable and kind hearted.

Negative remarks included: having to work when ill, being slaves, doing work no one else will do, working overtime without reward, expecting too much of students, and generally having impossible expectations for nurses.

Table 21 gives the nurse's positive/negative hospital expectations, and compares the responses for each hospital.

<table>
<thead>
<tr>
<th>TABLE 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse positive/negative hospital expectations; comparison of hospitals and average, by per cent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Small Hosp. (No. 22)</th>
<th>Medium Hosp. (No. 24)</th>
<th>Large Hosp. (No. 37)</th>
<th>Average (No. 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive 50</td>
<td>44</td>
<td>59</td>
<td>51</td>
</tr>
<tr>
<td>Negative 50</td>
<td>52</td>
<td>32</td>
<td>45</td>
</tr>
<tr>
<td>No Answer 0</td>
<td>4</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

Half the nurses in the small and medium hospitals gave negative responses; in the large hospital there was a lower per cent of negative remarks. In the small hospital, resentment seemed to centre on the amount of work expected of them. "The hospital expects the nurse to work, work, work, even with a bad cold and a high temperature!" Shortage of staff there probably was related to this attitude. In the medium sized hospital, there were comments about
having too much to do, and having many non-nursing jobs. In the large hospital, where complaints were fewer, the student often felt too much was expected of her.

The responses of pupil-enrolled nurses, students, staff and ward sisters were analysed for positive/negative attitudes. Students were the most positive, and staff nurses the most negative overall, with variations for each hospital. See Table 22.

In the small hospital, the staff nurse attitudes were quite negative; in the medium sized hospital, both the ward sister and the pupil-enrolled nurses were antagonistic, and in the large hospital, it was again the staff nurse.

The Nurse-Doctor Relationship

Collaboration between nurse and physician is of utmost importance for the achievement of superior nursing care. To search for ways of increased understanding between the professions, conferences have been held for the two groups in the U.S. (5). In a study of roles and relationships, it was felt that the doctor saw the nurse as working 'under' him, and the nurse saw herself as working 'with' the physician.

Both Mok (6) and Jacobs (7) stress that, with the 'scientification' of nursing, there will be a shift of all role boundaries within the hospital system. There will be a breakthrough of the caste system of the hospital organisation. The 'wall' built by the medical profession in order to avert the independence of nurses will have to be broken down because it is detrimental to good relationships.

Benne and Bennis (8) speak of a nurse-doctor conflict caused by the accelerating professionalisation of nursing, with its increased interest in the social and behavioural sciences. The nurses feel they are training to exercise judgement, whereas the doctors expect nurses to be obedient extensions of their own professional judgement.
TABLE 22

Nurse Positive/negative hospital expectations; comparison of pupil-enrolled nurse, student, staff and ward sister in each hospital and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>0 64 17 57</td>
<td>0 75 57 12</td>
<td>80 70 22 67</td>
<td>43 70 35 43</td>
</tr>
<tr>
<td>Negative</td>
<td>0 36 83 29</td>
<td>100 13 43 88</td>
<td>20 18 67 0</td>
<td>57 22 61 43</td>
</tr>
<tr>
<td>No Answer</td>
<td>0 0 0 14</td>
<td>0 12 0 0</td>
<td>0 12 11 33</td>
<td>0 0 4 14</td>
</tr>
</tbody>
</table>
Nurse Positive/Negative Doctor Expectations

There were so few nurses who were critical of doctors in Meyer's study (9) that she used no category for negative responses. In the present study, 30% of the nurses expressed negative feelings in completing the sentence:

"Doctors expect nurses to ..."

Positive attitudes about the doctor's expectation of the nurse were expressed by a large number of the nurses in the small and medium sized hospitals. Some students worried that the doctor wanted them to know too much. Higher grades complained that the doctor expected the nurse to 'wait on them' and 'be at their beck and call'. A few nurses felt that the doctors hold impossible expectations of them. Positive remarks included:

"Doctors expect nurses to co-operate with them at all times."

"... be observant and clear in their report."

"... carry out procedures properly."

"... be efficient and understanding toward their patients."

See Table 23 for positive/negative doctor expectations by the nurse.

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>82</td>
<td>79</td>
<td>46</td>
<td>69</td>
</tr>
<tr>
<td>Negative</td>
<td>18</td>
<td>21</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>No Answer</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

When comparing the responses of the different grades of staff, over 70% of the pupil-enrolled nurses and
student nurses expressed positive attitudes about the
physician, and 50% of the staff nurses and ward sisters
were positive, as is shown in Table 24.

| TABLE 24 |
| Nurse positive/negative doctor expectations; | comparison of grades of staff, by per cent |
| | Pupil-Enrolled | Students | Staff | Ward Sisters |
| | (No. 7) | (No. 36) | (No. 20) | (No. 20) |
| Positive | 71 | 72 | 50 | 50 |
| Negative | 29 | 25 | 50 | 50 |
| No Answer | 0 | 3 | 0 | 0 |

In addition to the positive/negative attitudes
expressed in the response, these answers were coded accord­
ing to the type of doctor expectations as seen by the nurse.
Some felt the doctor expected the nurse to follow his orders
(obey orders, carry out instructions), assist him (co­
operate, attend to them, help the doctor, wait on them),
have nursing competence (carry out procedures, treatments,
observe patients, report on patients, be intelligent, ef­
ficient, have technical knowledge). Several of the com­
pletions gave multiple expectations, so the responses in
Table 25 add to more than 100%.

| TABLE 25 |
| Nurse conceptions of doctor expectations of nurse; | comparison of hospitals and average, by per cent |
| | Small Hosp. | Medium Hosp. | Large Hosp. | Average |
| Follow orders | 32 | 25 | 11 | 23 |
| Assist doctor | 55 | 38 | 54 | 49 |
| Nursing Comp. | 32 | 46 | 43 | 40 |
| No answer | 0 | 0 | 3 | 1 |
| Impossible Expectations | 0 | 0 | 16 | 5 |

It is interesting that there are fewer mentioning
'following orders' as the size of the hospital increases.
The alternate responses indicate that the nurse feels the doctor wants her to be competent, and an assistant, rather than simply carrying out instructions.

**Nurse Views of the Visitor**

The visitor is, of course, very important to the patient as a contact with his normal home relationships. In recent years most hospitals have increased visiting hours, recognising its importance for the patient's emotional well-being. Yet many nurses view visitors as being disruptive to the patient and/or nurse. In Meyer's (10) study, the most frequent response was to see the visitor in terms of his own personal qualities or situation. Of her total group, 25% of the nurses found the visitor to be disruptive; surgical nurses mentioned negative behaviour more frequently than other specialties.

In the present study, 36% of the nurses made negative comments about visitors. "Visitors never keep to visiting times", "stay too long", "expect too much from nurses", "come to the office with queries when I want a 7-7.30 break, and I don't get it!". Even some of the nurses who give positive responses are ambivalent about the visitor. "Visitors are usually very grateful; sometimes critical." "It varies; sometimes they can be very helpful; sometimes they drive you mad!" "Visitors are usually courteous to the staff; others have found them nasty. They ask a lot of questions about patients." Some nurses are completely positive, finding the visitor a comfort to the patient, and a great help. A fairly large group of nurses see the visitor in terms of his own personal qualities or situation. "Visitors are usually worried and apprehensive about their relatives," "need information about their relatives", or "like to discuss the patient's prognosis". See Table 26.

In the medium sized hospital, 54% of the nurses responded antagonistically to the visitor. As in other completion sentences, some nurses gave multiple responses.
TABLE 26
Nurse conceptions of the visitor; comparison of hospitals and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>41</td>
<td>42</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>Negative</td>
<td>23</td>
<td>54</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Personal Qual.</td>
<td>45</td>
<td>17</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>No answer</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

The visitor was seen by a few of the students and pupil nurses as a threat. "Visitors usually ask a lot of awkward questions". They "can be a bit difficult; you should try to be calm, and not panic in front of them". "Visitors stare one out of countenance; I feel uncomfortable in the presence of relatives". However, when the responses of the different grades of staff were analysed separately, the students were found to be the most positive, and the others negative by comparison. The student seems to have a good comprehension of the needs of the visitor, and the importance of the visitor to the patient. To the rest of the staff, the visitor is an added task and burden. See Table 27.

TABLE 27
Nurse conceptions of the visitor; comparison of grades of staff, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Pupil-Enrolled</th>
<th>Students</th>
<th>Staff</th>
<th>Ward Sisters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>29</td>
<td>39</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>Negative</td>
<td>57</td>
<td>19</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Personal Qual.</td>
<td>14</td>
<td>36</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>No answer</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

The reliability analysis of the categories for these three sentence completions, with three independent
judges, yielded the following agreement levels:

1. The hospital expects the nurse to ... 97%
2. Doctors expect nurses to ... 100%
3. Visitors usually ... 97%

Summary

A large number of nurses react negatively to the 'relevant others' in the nurse-patient situation. Students are more positive in their attitudes than the other grades of staff. Negative feelings about the doctor's expectation of the nurse increased as the size of the hospital increased. In the large hospital, the nurse was less likely to describe herself as 'following doctor's orders' suggesting rather that the physician wanted her to be competent, and willing to assist him. Visitors are seen as a comfort to the patient, and as people needing information, but a large number of the non-student staff find the visitor a burden to their daily routine.
References:


CHAPTER 12

MOTIVATION AND ORIENTATION IN NURSING PRACTICE

Reasons for Becoming a Nurse

With the present problem of recruiting sufficient nurses to meet the increasing demand for professional nurses all over the world, it seems desirable to understand:

1. why those already in the profession chose nursing as a career
2. what satisfactions are gained in their role as a nurse in a general hospital
3. what the nurse sees as the major problems confronting the profession
4. whether those nurses who are currently active plan to continue in the field.

MacGuire (1) found that the main reason for entering nursing was the opportunity to help other people in a tangible way. A small number mentioned a preference for working with people, the sureness of a job, the payment while training, and the glamour and uniform.

In Meyer's (2) study, 40% of the responses to "I wanted to be a nurse because ..." indicated a desire to help people. It is interesting that the responses in the U.S. are similar to that of this study (37%). The subjects were asked to complete the sentence:

"I chose nursing as a career because ..."

The responses were coded into five different categories. "Helping people" was considered to be a different concept than "liking people". A third category was "the general desire to be useful" with no mention of people. "I felt it was a job that was of use to the community". Another group was primarily concerned with the personal satisfaction derived from nursing. "It is a fully absorbing career"; "I enjoy the life"; "it is a challenge". Grouped together
under "other" are: family influence, being tired of other jobs, status, the opportunity to travel, and "the only course open to girls when I started."

One group of nurses avoided answers, and could not be coded. "I chose nursing because I wanted to" or "I always wanted to nurse". A few nurses gave multiple answers. See Table 28.

<table>
<thead>
<tr>
<th>TABLE 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for choosing nursing as a career; comparison of hospitals, and average, by per cent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason</th>
<th>Small Hosp. (No. 22)</th>
<th>Medium Hosp. (No. 24)</th>
<th>Large Hosp. (No. 37)</th>
<th>Average (No. 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help People</td>
<td>32</td>
<td>29</td>
<td>49</td>
<td>37</td>
</tr>
<tr>
<td>Be Useful</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Like People</td>
<td>14</td>
<td>17</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Personal Sat.</td>
<td>27</td>
<td>33</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>13</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>Not Coded</td>
<td>18</td>
<td>21</td>
<td>14</td>
<td>18</td>
</tr>
</tbody>
</table>

Almost as many nurses (30%) felt they chose nursing because of a personal satisfaction with the work as for the desire to help people. In the medium sized hospital, personal satisfaction rated higher than the desire to help people. Among the pupil-enrolled nurses, a large per cent chose nursing to help people, and a few mentioned other factors such as having been ill in hospital, and wanting to do nursing as a result, or having worked with old people in a home, and deciding to train after this experience. Students respond in a similar manner to the total hospital average, as do staff, but a large number of ward sister responses cannot be coded, and the next largest per cent mention personal satisfaction with nursing work. See Table 29.

Satisfactions in Nursing Practice

If over half the nurses feel they chose nursing
as a career because they like working with, or helping people, then one needs to know if this orientation toward people continues in nursing practice, and produces satisfaction with their work.

**TABLE 29**
Reasons for choosing nursing as a career; comparison of grades of staff, by per cent

<table>
<thead>
<tr>
<th>Reason</th>
<th>Pupil-Enrolled</th>
<th>Student</th>
<th>Staff</th>
<th>Ward Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help People</td>
<td>57</td>
<td>33</td>
<td>45</td>
<td>20</td>
</tr>
<tr>
<td>Be Useful</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Like People</td>
<td>14</td>
<td>17</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Personal Sat.</td>
<td>14</td>
<td>25</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>19</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Not Coded</td>
<td>0</td>
<td>11</td>
<td>20</td>
<td>30</td>
</tr>
</tbody>
</table>

Navran and Stauffacher (3), in a study of personality traits of nurses, found that some nurses are 'work-oriented', and some are 'people-oriented'. Lentz and Michaels (4) found differences between medical nurses (who like a quieter work station, a slow turnover of patients, and a greater contact with patients), and surgical nurses (who like a fast turnover of patients, a busy work station, the impersonality of surgery, and the many techniques of nursing). Reissman (5) asked nurses what part of their work gave the most satisfaction, and coded the responses into patient care, administration and teaching, equipment care, just doing a job, and all of it. For the "dedicated" nurses, patient care was their main satisfaction on the job, but the relative importance of patient care decreased among his "converted", "disenchanted" and "migrant" nurses.

Two meaningful sets of categories were devised to code the response of nurses to "A day on the ward is satisfying to me when ..."
The first set of categories were built around relationships: patient, doctor, staff etc. The ward sister who says: "A
A day on the ward is satisfying to me when I can see some patients improving, some going home, and there is relief of someone's discomforts in some way or other" is identifying with the patient. When a student states she is satisfied "when the staff are working co-operatively", her concern is with staff relationships. The self-oriented nurse is satisfied when "I've been useful" or is gratified that "the day has been uneventful, and nobody has died". Some do not mention relationships, but find the general ward atmosphere good. "A day on the ward is satisfying when there is just enough to do so that the ward is run efficiently". Some responses include many relationships: "A day on the ward is satisfying to me when the nurses are happy, the patients are happy, and you and the doctors have done a proper job", says one staff nurse. See Table 30.

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>59</td>
<td>42</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Staff</td>
<td>32</td>
<td>25</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Doctor</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Self</td>
<td>45</td>
<td>33</td>
<td>73</td>
<td>54</td>
</tr>
<tr>
<td>General Atmosphere</td>
<td>41</td>
<td>42</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>No answer</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Reliability analysis was only 72% agreement among the judges for the coding of what kind of work gives satisfaction, and only 62% for the coding of relationships and satisfaction. The information presented is therefore the researcher's interpretation of answers, and as such, is not meant to have statistical significance. The lack of agreement seemed to be caused by statements such as "A day on the ward is satisfying to me when everything is done, and
no work is left for someone else", or "there are no
complaints". Where the researcher considered such res-
ponses as part of a 'general ward atmosphere', some judges
coded it as part of 'self-gratifications', 'staff relation-
ships' or even under 'doctor relationship'. Also there
were many multiple responses to this sentence completion,
and it was difficult to decide whether to take the response
for its overall significance, or for its multiple implic-
ations.

About half the nurses mention the patient, and
half are self-oriented. There are some interesting dif-
ferences in the hospitals. No one in the large hospital
mentioned staff relationships, and self-orientation was
very high there. One would like to ascertain if the large
teaching hospital appeals to or selects a different type
nurse, or if, because of their better staffing, they are
able to seek self-satisfaction from their work.

The second set of categories looked at the actual
work situation. The biggest single factor seemed to be
satisfaction with the completion of tasks. Almost half
the nurses were concerned with getting their work done.
The next most significant thing was making patients com-
fortable and happy. In the large hospital, many of the
nurses expressed satisfaction with having felt useful and
needed. Time for teaching or learning was mentioned in-
frequently. Administration and supervision was never men-
tioned specifically, although a few ward sisters were
pleased when the ward was running smoothly, and this may
imply satisfaction with their supervisory abilities. See
Table 31.

Satisfaction in the work situation can also be
elicted from the nurses' response to

"A well run ward is one . . ."

Some like to work on a ward with a happy atmosphere, one
that is calm, pleasant, where everyone is kind, consider-
ate, cheerful, happy or consistent. Others feel that the
organisation of the ward is the most significant factor; they want an established routine, efficiency, team work, a methodical system, and a competent ward sister. About 75% of the nurses want a well organised ward, and 40% of the nurses mention a happy atmosphere. Some nurses mention both categories: "A well run ward is one which is efficiently run with a happy atmosphere." See Table 32.

TABLE 31
Nurse satisfactions in nursing practice; comparison of hospitals, by number

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 22)</th>
<th>Medium Hospital (No. 24)</th>
<th>Large Hospital (No. 37)</th>
<th>Total (No. 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of tasks</td>
<td>12</td>
<td>12</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>Patient comforts</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Feeling useful</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Time to talk with patient</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Keeping busy</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Ill patients recover</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Regular routine day</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Time to teach</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>See interesting cases</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Keep ward tidy</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

TABLE 32
Nurses views of the characteristics of a well run ward; comparison of hospitals and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation</td>
<td>82</td>
<td>67</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>Atmosphere</td>
<td>32</td>
<td>46</td>
<td>49</td>
<td>42</td>
</tr>
<tr>
<td>No Answer</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
In the small hospital, many students felt it was hard to adjust to a ward where the routine was not made clear. Thirty-six per cent of the nurses there mention the importance of the ward sister. In the medium sized hospital, 25% of the nurses mention the ward sister, but she is mentioned by only 11% of the nurses in the large hospital.

Problems in Nursing

What the nurse sees as the major problems confronting her profession were ascertained by her completing:

"The greatest problem in nursing today is ..."

By far the greatest number mention shortage of staff. Ford and Stephenson (6) felt that the nursing shortage cannot be solved by manpower alone, because there are not enough schools to train sufficient numbers. Therefore they felt we must look into the delegation of some nursing duties, and also find more efficient ways to perform her current functions. Burling et al (7) felt there was a problem of nursing leadership without training, and a general dislike by nurses of supervision and paper work. Yet, as Barnes (8) pointed out, the status ladder for nurses takes her to administration and teaching, and the apprenticeship form of training is no preparation for these new functions. Wilson (9) mentioned the problems of a restricted social life for nurses as a result of her hours of duty.

All of these factors were mentioned by the nurses in this study. In the small and medium sized hospitals, over 70% of the nurses gave shortage of staff as the greatest problem in nursing. Poor pay, long hours, the 'split shift', and 'off duties' were also discussed, as were lack of communication, lack of time to teach students, loss of foreign nurses when they return overseas, and lack of equipment.

In the better staffed large teaching hospital, shortage of staff was mentioned by fewer nurses, but this was replaced by a host of other problems: 'keeping up to
date with procedures', paper work, Salmon changes, education problems, red tape, division of nursing tasks, specialisation, lack of student status for students, 'petty sisters with petty rules', and keeping in contact with patients. Lack of communication was mentioned by several nurses. See Table 33.

**TABLE 33**
Nurse views of problems in nursing; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Shortage</td>
<td>73</td>
<td>71</td>
<td>27</td>
<td>57</td>
</tr>
<tr>
<td>Low Wages</td>
<td>27</td>
<td>13</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Poor Hours</td>
<td>18</td>
<td>5</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>25</td>
<td>59</td>
<td>40</td>
</tr>
<tr>
<td>No Answer</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>5</td>
</tr>
</tbody>
</table>

Although the number of nurses in practice has increased substantially, demands for nursing service have increased even faster. In the U.S., the report of the Surgeon Generals' Consultant Group on Nursing projected a need to increase graduates from schools of nursing by 75% to meet the need for 850,000 professional nurses by 1970 from the 550,000 in practice in 1962. Three-fifths of these nurses were needed on hospital staffs (10).

In the hospitals of England and Wales in 1969, there were 262,644 nurses, of whom 87,129 worked part time (11). Within 2½ years after qualification, one-third of female nurses are married (and two-thirds of these are not working), and only 44% of the female nurses are still working in hospital. Most of the men in post intend to continue in hospital nursing; (29,368 males working whole time). Only a small percentage of staff nurses intend to become ward sisters (12).

In Reissman's study (13), the nursing staff were asked "If you could have your way, what would you most like
to be doing about five years from now?" Forty-eight per
cent of the personnel (which included aides as well as
nurses) thought they would still be working in the hos-
pital, 38% hoped to be retired or not working, and the
other 24% wished to have a job outside of the hospital.

**Keeping the Nurse in General Hospitals**

In this study, nurses were asked to complete the
sentence:

"Five years from now, I hope to be ..."

Their answers were categorised into those who planned to
remain in nursing (whether part time, in the same job,
advancing to another job, or working as a nurse outside of
the general hospital) and those who thought they would be
out of nursing (because of retirement, marriage, or change
of career).

As Table 34 indicates, responses were similar in
all three hospitals. Over 70% of the nurses plan to con-
tinue in nursing.

<table>
<thead>
<tr>
<th>TABLE 34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected number of nurses staying in nursing; comparison of hospitals, and average, by per cent</td>
</tr>
<tr>
<td>Small Hosp.</td>
</tr>
<tr>
<td>In Nursing</td>
</tr>
<tr>
<td>Out of Nursing</td>
</tr>
<tr>
<td>No Answer</td>
</tr>
</tbody>
</table>

These statistics seem encouraging, but a further
breakdown of their comments reveals a grim picture for the
staffing of nurses in the general hospitals in England. Of
the 59 nurses who plan to remain in nursing, 14 hope to be
married and work as part-time nurses. Eight mention nurs-
ing abroad. Seventeen plan nursing careers outside of the
hospital (5 midwifery, four health visitors, one in a
Cheshire Home, one in an "old people's home", one in psy-
chiatric nursing, and three as clinical instructors, and
two simply state they plan to continue nursing, but not in a hospital. This leaves approximately 25% of the nurses interviewed who plan to continue with hospital nursing on a full time basis.

Of the 19 nurses who hope to be out of nursing, six mention retirement, eight marriage without work, three non-nursing careers (one a social worker, one a medical programmer, and one a 'different job because of the poor pay in nursing'), and two 'out' without clarification.

When broken down into grades of staff, of the seven pupil-enrolled nurses, six plan to continue in nursing, and one gave no answer. Thirty students hope to remain in nursing, six out, and one gave no answer. For staff nurses, 14 plan to continue in nursing, four out, and two gave no answer, and of the ward sisters, nine plan to continue in nursing, nine out (four for retirement, two to marriage, one a non-nursing career, and two did not specify); the percentage loss will be greatest at the ward sister level.

The reliability analysis of the categories for the six sentence completions, with three independent judges, yielded the following agreement levels:

1. "I chose nursing as a career because ..." 92%
2. "A day on the ward is satisfying to me when ..." 62% (coding for relationships)
3. "A day on the ward is satisfying to me when ..." 72% (coding for kind of work)
4. "A well run ward is one ..." 97%
5. "The greatest problem in nursing today is ..." 100%
6. "Five years from now I hope to be ..." 100%

**Summary**

The role of nurse appeals to nurses for the opportunity of helping and working with people, and also for the personal satisfaction derived from nursing work. In
nursing practice, 50% of the nurses mention satisfactions related to being with patients, and 54% mention self-oriented satisfactions. Completion of tasks is very important to nurses. Three-fourths of the nurses like to work on a ward which is well organised. Shortage of staff is of primary concern to nurses in the small and medium sized hospitals, but in the large teaching hospital, where recruitment of students was no problem, nurses were more concerned with education, specialisation, administration and communication. Seventy-one per cent of the nurses interviewed planned to continue in nursing, but only 25% of all the nurses hoped to be doing full time hospital nursing five years from now.
References:


4. Lentz, E. and Michaels, R. (1959) "Comparisons Between Medical and Surgical Nurses" Nursing Research Vol. 8 No. 4 Fall, 192-197.


All students of nursing are taught that basic care of patients includes both physical and emotional assistance. Therapeutic techniques for interacting with patients are taught to psychiatric nurses, but in recent years, problems of communications have been recognised in general hospitals as well. Barnes (1) feels that all institutions have serious communication problems, but in the hospital it has become acute, and needs urgent solution.

Ley and Spelman (2), in an attempt to have a factual basis for determining the causes of communication failures, investigated the relative effectiveness of various methods of communicating information to patients. Strong frightening arguments, for example, were found to have a negative effect on patients carrying out advice.

Revans (3) felt that a hospital's internal communications affected the length of stay of patients, and their satisfaction with nursing care.

Dudgeon (4) reported that 34% of the patients felt there was a lack of information about their illness, tests and treatments. In Hugh-Jones (5) study, two out of five patients were not satisfied with the medical information given to them. Cartwright (6) reported 61%, and McGhee (7) 65% of their respondents mentioning communication problems.

**Purpose of Communications in Nursing**

Communication is not an end in itself, but a way to fulfill the purpose of nursing; the meeting of patient needs. Interviewing in nursing is useful for obtaining information, giving information, health teaching, and allowing for the expression of feelings (8). Personnel who have no training in interviewing skills may unwittingly hamper
the patient's progress by using non-therapeutic techniques of rejection, making stereotyped comments, and introducing unrelated topics (9). Robinson (10) points out that the role of the nurse is to relieve the patient who is suffering anxiety, loneliness and pain. The patient who is frightened, depressed, disoriented, demanding, or dying all require special help from the nurse.

**Nurse-Patient Contacts**

Wooldridge (11) felt that nurses often prefer to ignore the social-psychological areas of patient care, and purposefully restrict contact with patients; instead they define their responsibilities almost entirely in terms of performing various physical and medical-technological services for the patient.

Of the 74 nurses who were asked to indicate how well the nurse gets to know a patient, in Reissman's study (12), 10 felt 'very well', 33 'fairly well', 11 'very little' and 20 said 'it depends' or 'very few contacts'. By job categories, staff nurses and nurse's aides generally became better acquainted with patients than others. Reissman found it hard to separate whether nurses prefer the gap that exists, or would actually like to get to know patients better.

In the present study, nurses and patients were asked to complete the sentence:

"Nurses' tasks are such that:

a. it is impossible for them to get to know a patient;
b. they get to know a little about the patient;
c. they get to know a patient very well."

**Nurse Views of Nurse/Patient Contacts**

Only in the small hospital were there a few nurses who felt it was impossible to get to know patients.
About half of the nurses felt they can get to know patients a little, and half very well. Some of the additional comments nurses made were that they were too busy to get to know patients well, that on surgery patients were in and out too quickly for the staff to get to know them well, and that the patient's condition will affect how much contact the nurse has with him. Some felt it depended on the personalities involved, and others thought it depended on the ward's assignment system. On one ward where they were experimenting with patient assignment, the staff felt that they had a better opportunity to get to know patients well. See Table 35 for nurse views.

### Table 35

Nurse views of nurse/patient contacts; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 22)</th>
<th>Medium Hospital (No. 24)</th>
<th>Large Hospital (No. 37)</th>
<th>Average (No. 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can't know patient</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Know patient a little</td>
<td>41</td>
<td>50</td>
<td>57</td>
<td>49</td>
</tr>
<tr>
<td>Know patient well</td>
<td>50</td>
<td>46</td>
<td>43</td>
<td>46</td>
</tr>
<tr>
<td>No answer</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Among the different grades of staff, there was no statistically significant variation. The pupil-enrolled group had a slightly larger per cent who felt they got to know the patient well (57%), whereas the students, staff, and ward sisters had less than one-half of their group who felt they got to know patients well; (42% of the students, 45% of the staff, and 45% of the ward sisters). Ward variations did not reflect satisfaction with care or noticeable differences among staff or patients.

**Patient Views of Nurse/Patient Contacts**

A larger percentage of the patients felt that the nurse cannot get to know them at all. See Table 36.
Patient views of nurse/patient contacts; comparison of hospitals, and average, by percent

<table>
<thead>
<tr>
<th>Per cent</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can't know patient</td>
<td>14</td>
<td>8</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Know patient a little</td>
<td>40</td>
<td>58</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>Know patient well</td>
<td>34</td>
<td>33</td>
<td>56</td>
<td>41</td>
</tr>
<tr>
<td>No answer</td>
<td>12</td>
<td>2</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

In the large hospital, over half the patients felt the nurse got to know the patient well, and a smaller percentage than the nurses felt she knew them a little, with 13% (as compared to no nurses) feeling it was impossible for the nurse to get to know the patient at all. In the additional comments section, the patients also suggest that it depends on the personality of the individual patient and nurse, the length of the patient's hospitalisation, the number of staff, how often they were shifted from ward to ward, etc. A few suggested that the nurse needs to remain detached from her patients, so a superficial knowledge was all that was required.

Patient Opinions of What Upsets Patients

The number and type of worries a patient has while in hospital can give the nurse clues to improving nurse/patient communications. Haywood et al (13) found that over one-half their patients admitted to being upset or afraid in hospital. Sometimes it was over their own condition; sometimes about other patients, or their families. A few mentioned features of the ward and its staff. Their worries were classified as preventable, possibly preventable, and not preventable. Many of their fears and upsets could have been prevented.
In this study, patients were asked to complete the sentence:

"Patients get upset when ..."

One-fifth of the patients deny that anything upsets them. Of these, 73% came from the highly satisfied group. A second group have complaints of a physical nature. They are upset because of pain, vomiting, drugs that don't come on time, lack of rest from noise, bedpans that are cold, wet or unavailable, or their general needs are neglected. The third group suffer some form of emotional discomfort, caused by boredom, communication problems, domestic worries, staff who are discourteous, other patients who are dis-oriented or dying, visitors who wear the patient out, or don't come when expected. Many of the patients feel their upset originates from their own personal fears, loneliness and confusion. Some patients mention both physical and emotional upsets, giving totals of more than 100% to Table 37.

| TABLE 37 |
| Patient views of what upsets them in hospital; comparison of hospitals, and average, by per cent |

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deny</td>
<td>24</td>
<td>13</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Emotional</td>
<td>62</td>
<td>77</td>
<td>59</td>
<td>66</td>
</tr>
<tr>
<td>Physical</td>
<td>14</td>
<td>29</td>
<td>28</td>
<td>24</td>
</tr>
</tbody>
</table>

Communication problems are mentioned by 12 patients. "There is a lack of information. You don't know when you'll be able to get up, or go out of hospital." Twenty-eight patients refer back to themselves. "Patients get upset because they fear they can't co-operate, and they are worried about their condition." Nineteen patients mention other patients as upsetting. "Patients get upset when other patients are very ill or die." Eighteen patients mention 'general others'. "Patients get upset when they make you wait unnecessarily, for instance, for a national
health certificate." Thirteen patients make reference specifically to nurses; "when the nurses are mean or sadistic" or when "nurses are unkind, and you can't hit back".

**Nurse Opinions of What Upsets Patients in Hospital**

Nurses, in response to this same sentence completion, almost all mention some form of emotional discomfort. See Table 38.

**TABLE 38**

<table>
<thead>
<tr>
<th>Nurse views of what upsets patients in hospital; comparison of hospitals, and average, by per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Hosp.</td>
</tr>
<tr>
<td>Deny</td>
</tr>
<tr>
<td>Emotional</td>
</tr>
<tr>
<td>Physical</td>
</tr>
</tbody>
</table>

Over half the nurses in the large hospital felt that communication problems were the main reason that patients got upset. "Procedures are not explained properly." "They feel they do not know what is wrong, or are not being told the truth." "They are not secure for things are not explained fully to them." Only two nurses mentioned that nurses might upset patients because they were 'disinterested', or "talked in front of them about something which might be frightening to them". In the medium sized hospital, however, seven nurses mention other nurses who are 'rude', 'impatient', 'have a poor attitude', etc.

Nurses in all three hospitals seem to be fully aware of the problems that cause upset to their patients.

**Nurse Views of Reference Group for Patient Worries**

Haywood et al (14) asked their patients in whom they confided if they had personal worries. Nearly one-half the patients expressed confidence in sister, or charge nurse. Twenty-six per cent mentioned the almoner, and 7%
In this study, patients and nurses were asked to complete the sentence:

"When a patient is worried, he should ..."

All the nurses felt that the action to be taken is to talk about it. A few mentioned the social worker, a few the doctor, with the largest number referring to the 'nurse', 'sister', or just 'someone'. Several gave multiple reference groups. See Table 39.

**TABLE 39**

Nurse views of reference group for patient worries; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>42</td>
<td>65</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>13</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>5</td>
<td>54</td>
<td></td>
</tr>
</tbody>
</table>

An interesting number of students, pupil nurses, and enrolled nurses answer that the patient should be 'reassured'. The experienced nurse is more apt to give a therapeutic response such as "be able to talk about his worries", "consult someone who is sympathetic" etc.

**Patient Views of Reference Group for Patient Worries**

Not all the patients feel they should consult someone with their worries. Fifteen per cent of the patients feel they should either keep it to themselves, keep busy, relax, or forget it. The other 85% have a large reference group, mentioning visitors, relatives, the secretary, the chaplain, the physiotherapist, other patients, and the psychiatrist, in addition to the general 'someone', nurse, doctor and social worker. See Table 40.
TABLE 40
Patient Views of reference group for patient worries; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hosp.</th>
<th>Medium Hosp.</th>
<th>Large Hosp.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>38</td>
<td>48</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Doctor</td>
<td>16</td>
<td>27</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td>Soc. Worker</td>
<td>24</td>
<td>2</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>'Someone'</td>
<td>26</td>
<td>19</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

In the small hospital, with its larger number of social class IV and V patients, one-fourth of the patients mention the almoner (or welfare people or social worker). As the size of the hospital increases, and there are more housemen and other doctors on the wards, a larger percentage of patients mention the doctor in their reference group.

Matters Requiring the Additional Attention of the Nurse:

Nurse Views

Another question dealing, in part, with communications, was the multiple choice:

If qualified nurses had more time, they could devote it to:

a. explaining things to patients;

b. the teaching of students and other staff;

c. improving the facilities of the ward;

d. (any other) .....................................

In the nurse's questionnaire, 'd' was not left open but was:

d. assisting the doctor.

Among the nurses, the majority felt that additional time should be spent teaching students and other staff, as mentioned in Chapter 9. Only one nurse mentioned assisting the doctor, and few felt that extra time should be devoted to the improvement of ward facilities. Although instructions
asked for the circling of one answer, several circled both 'a' and 'b' as being of equal importance. See Table 41.

**TABLE 41**

Nurse views of matters requiring the additional attention of the nurse; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explaining to Patients</td>
<td>36</td>
<td>13</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Teaching Students</td>
<td>91</td>
<td>92</td>
<td>78</td>
<td>87</td>
</tr>
<tr>
<td>Improving Facilities</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Assisting Doctor</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Matters Requiring the Additional Attention of the Nurse: Patient Views

Twelve per cent of the patients felt unable to answer this question. The teaching of students and staff was seen as quite important, but the patients used the open answer to introduce other subjects. One-fifth of the patients in the small hospital said that more individual attention should be given to patients. Some patients felt that if the nurse had more time, she should use it for more recreation or rest, taking an eight hour straight shift instead of a 12 hour split-shift. In addition to explaining things to patients, many felt the nurse should spend extra time talking to the elderly, or generally socialising. See Table 42.

As the hospitals increased in size, there was a small increase in the percentage of patients who felt more time could be devoted to explaining things to patients.

Nurse Views of Ways of Improving Care on the Wards

The last multiple choice question for nurses was:
"Nursing care on this ward could be improved if:

a. there were more nurses;
b. communications were better among the staff;
c. there was better equipment with which to work;
d. other (specify) ..................................

The problem of recruitment of student nurses in the small hospital is reflected in the answers to this question. Over half the staff in the medium sized hospital also mention shortage of staff. Other things mentioned were the need for more ancillary staff, better administrative organisation, more time for the trained staff to teach and supervise student nurses, and avoidance of personality problems between ward sisters and their staff. In the large hospital, communication problems superceded staffing concern. See Table 43.

**TABLE 42**

Patient views of matters requiring the additional attention of the nurse; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explaining to Patients</td>
<td>24</td>
<td>29</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Teaching Students</td>
<td>40</td>
<td>37</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>Improving Facilities</td>
<td>4</td>
<td>12</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Individual Attention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to Patients</td>
<td>20</td>
<td>8</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>More time for Nurses</td>
<td>8</td>
<td>10</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>No Answer</td>
<td>14</td>
<td>8</td>
<td>15</td>
<td>12</td>
</tr>
</tbody>
</table>

The reliability analysis of the categories used for the two sentence completions in this chapter, with three independent judges, yielded the following agreement levels:

1. Patients get upset when ... (from patient questionnaire) 90%
2. Patients get upset when ...(from nurse questionnaire) 93%

TABLE 43
Nurse views of ways of improving care on the ward; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>More staff</td>
<td>77</td>
<td>58</td>
<td>24</td>
<td>53</td>
</tr>
<tr>
<td>Better communications</td>
<td>14</td>
<td>13</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>Better equipment</td>
<td>27</td>
<td>4</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>25</td>
<td>14</td>
<td>13</td>
</tr>
</tbody>
</table>

Summary
Half the nurses feel they can get to know patients a little, and half feel they get to know them well. Among the patients, however, 12% feel it is impossible for the nurse to know her patients, 41% feel the nurse knows them a little, and 41% that she can get to know them well. Twenty per cent of the patients deny that anything upsets them while in hospital. The rest of the patients relate many of their upsets to emotional causes (66%), and 24% to physical discomforts. The nurses primarily feel patients are upset by emotional situations (93%), and 18% mention physical discomforts. All the nurses feel the patient should consult someone if he has worries, but 15% of the patients feel they should keep it to themselves. Communication problems were particularly mentioned in the large hospital.
References:


The 'additional comments' section gave nurses and patients the opportunity to express themselves on any subject relevant to the hospital situation.

From the nursing staff, student problems were voiced the most frequently. There were fewer overall comments from the nursing staff in the large hospital than from the other two hospitals.

The statements have been quoted verbatim, and are included under the following headings: students, pupil nurses, part-time nurses, agency nurses, staff nurses, ward sisters, tutors, ancillary staff, patients, and general problems.

Additional Comments by Nursing Staff

A. STUDENTS

1. Students should spend more time in school in their first year, so they can cope better when they get on the wards, and not be lost.

2. Students shouldn't be used as a pair of hands.

3. Practicals should be done in our own hospital, not among strangers.

4. The difference between the first year student with NO responsibility other than basic care, and the second year is too dramatic a change. It is frightening not to have been prepared for it. More classroom teaching is necessary.

5. A second year student is given too much responsibility on night duty. First year students are not treated with sufficient maturity. New students feel lonely; there are not enough facilities provided.
6. Students need more teaching from staff about procedures such as dressings. They also need more time to talk with patients without being made to feel guilty about doing this activity.

7. There should be more lectures on basic psychology, so staff recognise that patients are affected by their environment, and the nurse may need to recognise that their outside lives are affecting their hospitalisation.

8. The hospital cares only about patients, and should be more concerned with the needs of students. For example, if a nurse is sick, no one seems to care; if she has family problems, or is ill, she has to work anyway. Students should not have to make excuses to get humane care.

9. Student nurses shouldn't have to clear up dishes and do other domestic work. Sister should be given a special time to take her students for teaching.

10. Foreign students are not much good to us; they spend three years training, and then they go back home, and we have no trained staff as a product.

11. On a few occasions we have language difficulties, and an underlying homesickness when girls come from abroad.

12. Junior nurses feel they get the brunt of things. Just because it was done that way to the senior nurses, they carry it on too. They should not bully, and there should be better team work.

13. This hospital is so absorbed with new advances in medicine and surgery, that the more common surgery is hardly ever encountered. This would, I imagine make transfer to a smaller hospital very frustrating.

14. I think that most students are not staying in nursing today because of the treatment you receive from those in authority who show off their authority, and there is prejudice among the races.

15. The student nurse training scheme needs to be re-organised. There is much dissatisfaction among the students.
B. PUPIL NURSES

1. The students and SRN's make the pupil nurse feel inferior, and this attitude is an extremely serious problem resulting in pupil nurse dropout. This attitude prevails among everyone and discourages enrolled nurses.

2. There are too many bosses for the pupil nurse. There is not enough time to study and you are too tired to do it.

3. The treatment of pupil nurses is deplorable.

C. PART-TIME NURSES

1. There should be a system to return part-time staff. That is, there should be a nursery, and flexible hours, etc.

D. AGENCY NURSES

1. I don't like agency nurses. They are too much interested in the money aspect.

E. STAFF NURSES

1. The staff nurse is not treated as a registered nurse. There is no time to read notes, and the notes are poor. We should be allowed to talk to nurses more, and this is looked down on. The person in charge of the ward should allow nurses to talk to patients without feeling they shouldn't.

F. WARD SISTERS

1. I feel very pressured and dissatisfied. There is no time to teach, no time to take care of patients properly, or take two days off in a row. I am currently without a ward clerk, and have no SRN. There is too much responsibility on this ward, and they present me with such problems as the keys to the drugs which can't be left with an enrolled nurse or student.
2. If sisters would treat nurses according to their merit rather than their personal feelings, there would be less unhappiness.

G. TUTORS
1. Some students are put off from nursing by their tutor.
2. We need tutors who can encourage nurses to study; to keep up with it even if the student gets tired.
3. We need more adequate teaching on the wards; lectures from both medical and nursing staff, and more up to date teaching from tutors in some areas.

H. ANCILLARY STAFF
1. We need more domestics and more clerks.
2. I think training for the auxiliary nursing staff would help.
3. The lack of staff on wards could be improved by the use of ancillary staff, and household staff. The nursing staff have to do too many non-nursing duties which take up valuable time, such as cleaning and dusting, messages and face shaves for men.

I. PATIENTS
1. Patients need more things to do on the ward.
2. There should be some sort of waiting room for patients who are waiting to come on the wards.

J. GENERAL PROBLEMS
1. The big city hospitals attract more nurses and are therefore better staffed than the provincial ones, when in fact many of the provincial ones give equally good training. Could publicity help?
2. The shortage of nursing is not only a question of money. We need to plug nursing more in the schools, which tend to run nursing down.
3. Staffing is a big problem at present. The split shift and long hours put off staff.

Additional Comments from Patients

There were numerous comments from patients praising nurses for their excellent care, dedication, kindness, courtesy, helpfulness, understanding and patience.

"The nurses have been marvellous".

"The nurses are personable and helpful".

"The nurses are dedicated, but overworked".

"We have outstanding night staff".

"The food is marvellous, and everyone is perfect".

Criticisms have been summarised (not quoted) under the following headings: general environment, nursing staff, medical staff and patients.

A. GENERAL ENVIRONMENT

1. Food: Cold, poor, wasted, poorly served, lack of choice
   - Lack of tea and sugar
   - Drinks served in cracked cups

2. Sanitation:
   - Poor disinfection between patients
   - Poor cleaning of the wards
   - Orderlies sweeping while patients eating
   - Dirty bathrooms

3. Bedpans and Bathrooms:
   - Bedpans given only on rounds, not when needed
   - Handrails needed by toilet
   - Insufficient toilets and washing facilities for large ward
   - No toilet paper

4. Noise: Too much activity and noise and visiting on the open ward for a very sick patient
Vibration of ripple beds keep other patients awake at night

5. Linens: Shortage of
6. Space: More space needed between each bed on the ward
7. Maintenance:
   Nurse reports plumbing problem, but no one comes to repair
8. Transportation:
   Delays and long waits between ward, X-ray, and other departments in the hospital

B. NURSING STAFF
1. Division of nursing tasks results in no one taking time to talk with patients
2. Administration should come around and find out what is troubling patients
3. Nurses today are unfamiliar with diets for diabetics
4. Sister is intolerant of her junior nurses
5. Students need time for more schooling
6. Some nurses are irritable, abrupt, discourteous, temperamental, sarcastic, prejudiced, mean, sadistic, 'scatterbrained'
7. Nurses rotate wards too often; changing staff is upsetting to patients
8. Language problems between English speaking patients and foreign nurses and doctors
9. Night staff too 'thin'
10. Nurses have too many non-nursing jobs; there should be more domestics and ancillary staff
11. General management treats nurses poorly
12. Understaffing creates nursing care problems
13. No one keeps the patient posted as to what will happen, or what is going on
MEDICAL STAFF

1. Housemen don't explain things well (why catheter was in, how long patient would remain in hospital)
2. Superiority attitudes of doctors; they should assume the patient has more intelligence

PATIENTS

1. Need volunteers to talk with patients and take care of flowers, etc.
2. Very disturbing to patients to have deranged, or psychiatric patients on an open ward
3. Older patients don't get enough attention
4. Because of shortage of staff, patients have to learn to do for themselves
5. Drug system is poor; nothing is written down, and nurses don't remember to give drugs
6. It is hard to find a nurse when you need something for pain
7. There is no regular time for dressings, you just have to wait until they have time for you
8. Patients are not kept in hospital long enough
9. Boredom is a problem for patients
10. A patient's need for privacy is underestimated by nurses
11. Having a seriously ill patient on the ward is frightening to other patients
12. The seriously ill patient should have a buzzer or light to get the nurse, rather than having to shout
13. It is bad to put a young person on a ward where everyone is elderly
14. Nurses should be more aware of patient's emotional problems: depression, loneliness etc.
In order to develop a practical tool for nurses to use for rating patient satisfaction with care, each patient questionnaire was analysed for comments about nursing practices, communication problems, shortage of staff, environmental problems, nurse/patient interpersonal conflicts, and the generalised comment of 'inadequate attention'.

The largest number of critical comments came under the heading of 'communications'. Many patients did not feel this was only a nursing problem, however, and many thought it was a matter of shortage of staff. The second largest number of problems mentioned were about the hospital environment, and included those areas which Raphael (1) has discussed in depth: food, noise, sanitation, etc.

Shortage of staff was implied in many comments made by patients, but was only counted as such when it was specifically stated by the patient.

Poor nursing practices included comments about dressings, medications, diets, and the general deterioration of technical nursing.

Nurse/patient interpersonal problems included opinions about nurses who the patients thought were mean, rude, cold, sadistic, rough, sarcastic or temperamental.

Sometimes patients were not specific about whether the problems were related to nursing practices or attitudes, yet they commented about a general lack of attention to their needs. These comments were grouped under the heading 'inadequate attention'.

Comparison of Highly Satisfied Patients with Less Satisfied Group

Criticism came from both the highly satisfied
group of patients, and those who were less satisfied. However, almost all of the patients who made no critical comments were from the highly satisfied group. Table 44 compares the comments of the two groups. The less satisfied group were more critical in all areas, but particularly about communications, and nursing practices.

### TABLE 44
Types of critical statements made by patients; comparison of highly satisfied group with less satisfied group, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Highly Satisfied (No. 104)</th>
<th>Less Satisfied (No. 52)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>41</td>
<td>77</td>
</tr>
<tr>
<td>Environment</td>
<td>36</td>
<td>48</td>
</tr>
<tr>
<td>Nursing Practices</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>Interpersonal Problems</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>Inadequate Attention</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Shortage of Staff</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>No Criticism</td>
<td>23</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the three patients who considered care to be poor, all had criticism of the personalities of nurses, two commented on poor nursing practices, communication problems and general lack of individual attention, one about the environment, and none about shortage of staff.

Comparison of Critical Statements
Made in Three Hospitals

Table 45 compares the critical statements made by patients in each hospital. As has been found throughout the study, patients in the large hospital had fewer comments to make about shortage of staff, and inadequate attention. Communication problems were similar in all three hospitals, as were interpersonal problems.
TABLE 45
Types of critical statements made by patients; comparison of hospitals, and average, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 50)</th>
<th>Medium Hospital (No. 52)</th>
<th>Large Hospital (No. 54)</th>
<th>Average (No. 156)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>56</td>
<td>56</td>
<td>48</td>
<td>53</td>
</tr>
<tr>
<td>Environment</td>
<td>22</td>
<td>48</td>
<td>48</td>
<td>40</td>
</tr>
<tr>
<td>Nursing Practices</td>
<td>20</td>
<td>21</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Interpersonal Problems</td>
<td>20</td>
<td>13</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Inadequate Attention</td>
<td>48</td>
<td>33</td>
<td>22</td>
<td>34</td>
</tr>
<tr>
<td>Shortage of Staff</td>
<td>24</td>
<td>12</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>No Criticism</td>
<td>18</td>
<td>10</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

Comparison of Wards

When comparing wards with relatively high satisfaction with wards with low satisfaction, the average number of criticisms tend to increase. On the four wards with 86% - 90% high satisfaction among its patients, there were 1.5 criticisms per patient. The six wards with 30% - 57% high satisfaction averaged 2.1 criticisms per patient. No one area consistently reflected high or low satisfaction with care on any ward, however. A ward's problems may be the product of shortage of staff which affects the amount of individual attention the patient feels he receives. A ward may be well staffed but have a poor communication system. The patients may be dissatisfied because the night nurse is short tempered with patient requests for a bedpan. See Table 46.

Using the number of criticisms as an indicator of ward problems, 36% or more of the patients on wards 4A and 4D comment about shortage of staff. Thirty-eight percent or more of the patients on ward 4C and 3E speak of interpersonal problems with nurses. On ward 4C and 2E, 40% or more of the patients comment about the nursing practices.
Over 60% of the patients complained about the environment on wards 2B, 2C, 3B and 3F. Over 60% of the patients on wards 4A, 4B and 3F mentioned a lack of individual attention, and on wards 2B, 2C, 2D and 3E, over 70% of the patients were concerned with communication problems.

### TABLE 46

**Number of critical statements made by patients; comparison of wards in descending order of high satisfaction**

<table>
<thead>
<tr>
<th>Ward</th>
<th>High Sat. (%)</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>Total Criticisms</th>
<th>Pt. No.</th>
<th>Average/ Pt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4B</td>
<td>90</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>1.5</td>
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<tr>
<td>4E</td>
<td>88</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>3</td>
<td>3</td>
<td>11</td>
<td>8</td>
<td>1.4</td>
</tr>
<tr>
<td>3D</td>
<td>88</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>8</td>
<td>1.4</td>
</tr>
<tr>
<td>3E</td>
<td>86</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>12</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>2F</td>
<td>78</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>12</td>
<td>9</td>
<td>1.3</td>
</tr>
<tr>
<td>2C</td>
<td>75</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>17</td>
<td>8</td>
<td>2.1</td>
</tr>
<tr>
<td>3D</td>
<td>75</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>3A</td>
<td>73</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>17</td>
<td>11</td>
<td>1.5</td>
</tr>
<tr>
<td>3C</td>
<td>73</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>16</td>
<td>11</td>
<td>1.5</td>
</tr>
<tr>
<td>2A</td>
<td>70</td>
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<td>1</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>18</td>
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<td>2D</td>
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<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>8</td>
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<tr>
<td>4C</td>
<td>57</td>
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<td>3</td>
<td>3</td>
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<td>1</td>
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<td>1</td>
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</tr>
<tr>
<td>4A</td>
<td>55</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>20</td>
<td>11</td>
<td>1.8</td>
</tr>
<tr>
<td>4D</td>
<td>55</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>27</td>
<td>11</td>
<td>2.5</td>
</tr>
<tr>
<td>2B</td>
<td>50</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>7</td>
<td>23</td>
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<td>2.3</td>
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<td>30</td>
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<td>4</td>
<td>4</td>
<td>1</td>
<td>17</td>
<td>10</td>
<td>1.7</td>
</tr>
</tbody>
</table>

**Key:** Column Letters
- A - Shortage of Staff
- B - Interpersonal Problems
- C - Nursing Practices
- D - Environment
- E - Inadequate Attention
- F - Communications

Based on these findings, the following questionnaire is suggested for use.
Questionnaire for Patients About Nursing Care

Instructions: Draw a circle around 'Yes' if your answer is yes, and around 'No' if your answer is no. If a question does not apply to you, draw a circle around 'N.A.' (not applicable). By each group of questions, there is a space in which we hope you will write explanations and suggestions.

<table>
<thead>
<tr>
<th>Questions:</th>
<th>Answers</th>
<th>Explanations and Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>About Physical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Were you able to wash often enough to keep clean?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>2. Did you get enough rest and sleep?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>3. Was a bedpan or bathroom available when you needed it?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>4. Were you assisted to a comfortable position in and out of bed?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>5. Was your food satisfactory for your appetite and/or diet?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>6. Did you get enough to drink?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td><strong>About Your Treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Did you get your medicines properly?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>8. Were your treatments done as necessary?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>9. Were you kept reasonably free of pain?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>Questions</td>
<td>Answers</td>
<td>Explanations and Suggestions</td>
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<tr>
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</tr>
<tr>
<td>10. Did you feel you had enough individual attention?</td>
<td>Yes No N.A.</td>
<td>About Your Well Being</td>
</tr>
<tr>
<td>11. Did you feel there was enough to keep you occupied? (books, radio, visiting etc.)</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>12. Did you feel you had adequate privacy?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>13. Were any of the nurses unkind or abrupt with you?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>14. Did you feel nurses were interested in you?</td>
<td>Yes No N.A.</td>
<td>About Information</td>
</tr>
<tr>
<td>15. Did the nurses take enough time to find out what you wanted to know?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>16. Did the nurses explain to you about your medicines and treatments?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>17. Did the nurses explain things to your family?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>18. Do you feel you have been prepared for going home?</td>
<td>Yes No N.A.</td>
<td>About Ward Staffing</td>
</tr>
<tr>
<td>19. Do you feel there were enough nurses on the ward during the day?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
<tr>
<td>20. Do you feel there were enough nurses on the ward during the night?</td>
<td>Yes No N.A.</td>
<td></td>
</tr>
</tbody>
</table>
Questions: Answers

21. Were the accommodations good? (bed, lights, sanitation, heat, space, noise.) Yes No N.A.

22. Would you describe the nursing care on this ward as - (tick one)

very good? ( )
adequate? ( )
poor? ( )

Additional Comments:

This type of survey can be used to give patients the opportunity to express themselves about the nursing care. Administration can be guided by the responses for the staffing of wards, the revision of nursing practices, or the improvement of communication techniques. The questionnaire also allows information to be gathered on the effect of any changes introduced to a ward; for instance, satisfaction with care before and after patient assignment is introduced.
CONCLUSION: SOME SUGGESTIONS FOR CONSIDERATION

In the hospitals used for this study, nursing care was essentially patient centred, and nursing staff were giving most of the bedside care. Satisfaction with care among the patients was high. For those who were dissatisfied, however, there was no opportunity to express their feelings to those in an administrative position.

Recruitment and Staffing

Shortage of staff was an acute problem in one of the hospitals. More active recruitment schemes for boys and girls in secondary schools should be instigated. Grammar school students should have more information about university and experimental schemes available in Great Britain. Temporary shortage of staff problems on any given ward might be helped by the use of 'floating nurses'. More adequate staffing at night might be gained by using higher pay for those willing to work on a permanent night shift. Since some of the students in the large hospital felt they were not doing 'typical bedside nursing', they might be rotated through some of the smaller hospitals, thereby improving the variety of their learning experience, and at the same time alleviating the student nursing shortage there.

Improving Individual Attention

On wards where patients feel the need for more individual attention, the ward sister might change from assigning her staff by tasks to the patient assignment system. There might also be introduced to these wards volunteers to assist with feeding of the elderly, writing letters, arranging flowers, distributing nourishment, and general chatting with patients. Bedpans should be more readily available for bedridden patients.
Wards which require a large amount of administrative work should have clerks to free the ward sister for an increased role in teaching, supervision, and improving communications.

Communications

Patients should be given the opportunity to ask questions during routine nursing rounds. Tutors should stress the importance of explaining procedures to patients when teaching students. Visitors should be given every opportunity to gain information from the staff during visiting hours, or when making enquiries by telephone. Physicians should keep the ward sister informed as to their patients' treatments, teaching needs, and length of hospitalisation, so that nursing staff can be adequate intermediaries.

Interpersonal Relations

When there are serious interpersonal conflicts between a nurse and her patients, or between a nurse and other members of the staff, there should be provision for an alternate job in the hospital structure, where the nurse's capabilities may be more effectively used.

The Environment

Hospitals (and nursing staff) should seek better ways to keep food hot for serving, offer an alternative to meat, potatoes and vegetables (salads and sandwiches), and make tea and coffee available throughout the day. The use of ripple beds on the open wards should be questioned. Disoriented patients on an open ward can be a serious problem from both the psychological aspect, and the physical viewpoint of preventing adequate rest for the other patients. All patients who are bedridden should have some method (bell or buzzer) for getting the attention of the staff. Nurses on night duty should be reminded frequently that loud voices are disturbing to sleep. Ancillary personnel should have in-service training in sanitation, and should be closely supervised by nursing staff.
Nursing Practices

There should be written routines on each ward for the giving of medicines, the checking of special medical diets, and various procedures. At ward sister meetings, any complaints about nursing practices should be openly discussed, and suggestions for change put into action.

Student Nurse Training

Students of nursing should have a course in psychology designed to help them cope with the emotional needs of their patients. The ward sister should encourage her staff to devote time to the psychological aspects of nursing care. Student nurses should have some managerial training prior to attaining staff rank.

The Enrolled Nurse

There should be clarification of what the enrolled nurse is expected, and forbidden to do.

Nurse-Doctor Collaboration

Better co-operation between nurses and physicians needs to be developed to increase the effectiveness of their work as a team. Informal discussions and presentation of each profession's problems to each other might be planned.

Summary

This portion of the study has investigated the role conceptions of nurses and patients about themselves and relevant others in the hospital situation. Suggestions have been made for the improvement of nursing care, and a questionnaire about nursing care has been devised for presentation to patients.
PART II:

MEDICAL STAFF VIEWS OF THE ROLE OF THE NURSE
STUDIES ABOUT MEDICAL VIEWS OF THE ROLE OF THE NURSE

It has been pointed out in Chapter 1 of this study that the nurse's role is determined, not only by her self-expectations, but also by the expectations of her colleagues. In some of the reports from the United States, the doctor saw the nurse in a subordinate role, as his assistant, following his orders and routines.

In Great Britain, there is a dearth of information about medical views of the role of the nurse, particularly in the general hospital. Miss Hockey's (1) survey included 306 general practitioners who gave their views of the district nurse. Eighty per cent of the doctors expressed unreserved satisfaction with care given by district nurses, but most doctors were ignorant of their qualifications, and the help they were capable of giving.

In a discussion of the triangular relation of doctor-nurse-patient, Conran (2) felt that the traditional roles paralleled the father-mother-child relationship. With accelerating technological intervention within hospitals, however, there has been a negative effect on this relationship, and a corresponding devaluation of the hospital nurse. Doctors tend to depreciate her suggestions. It is thought that doctors and nurses no longer speak the same language.

The Lancet took up this theme in an editorial (3). It pointed out that the doctor justifies his work quantifiably, and tends to disregard those aspects of his work that cannot be expressed statistically; therefore he underrates the traditional duties of the nurse.

ISSUES AFFECTED BY THE DOCTOR'S OPINIONS

What are some of the issues affected by the
attitudes of the doctor toward the role of the nurse? One of the most prominent is the education of the nurse. If the physician sees the nurse's role from a non-scientific vantage, he will be against her education in an academic system, and block all but the continuation of apprentice schemes. If he sees nurses as 'do' people rather than 'think' people, training for skills will be the sole emphasis. Another question is whether nursing is seen by physicians as a true profession, with the acceptance of independent judgements for the occupants of the role of nurse. A third issue is the expanding role of the nurse, with increased delegation of tasks by doctors, resulting in the 'blurring' of roles. It is also important to understand medical views of the sex role in nursing, concepts of team relationships, the career structure in nursing, and how the nurse is seen in research.

To explore these issues, a questionnaire was devised to present to physicians in general hospitals. It is felt that the role of the nurse is now, and will be in the future, strongly affected by medical staff attitudes.

The Research Setting

It was decided to attempt to interview doctors in the same general hospitals used to research nurse-patient expectations and role perceptions. Letters were sent to the four hospitals where the pilot and main studies were carried out. Co-operation was obtained from the Medical Staff Committees of the three hospitals used in the main study, but not from the hospital where the pilot study was done. Since the pilot study was to be used primarily to test the adequacy of the new questionnaire, it was felt that another hospital could be used for this purpose.

The Sample

The sample consisted of male and female doctors on medical and surgical wards. They included medical students, house officers, registrars and consultants. The
hospital where the pilot study was done was the only teaching hospital where the views of medical students could be obtained.

The Method of Research

The questionnaire was devised so that it could be used for a structured interview, or for self-completion by the doctor. This technique was used to allow the doctor a freedom of choice, in consideration of his time limitations. In this way, the researcher hoped to avoid a high non-response rate.

Lists were obtained of the medical staff working on the wards where nurses and patients had been interviewed. A letter was sent to each doctor explaining the research project (see Appendix D). This was followed by letter and telephone contacts for the purpose of arranging a time and place for interview. Interviews were carried out on the wards, at out-patient departments, on Harley Street, at home, in the consultant's lounge etc. When a doctor cancelled an appointment, two follow-up appointments were attempted; if these were unsuccessful, no further attempt was made to interview the doctor.

The Research Instrument

The questionnaire consisted of four parts:

Part 1 was the ranking of ten nursing activities, and was the same as that asked of patients and nurses, for comparative purposes.

Part 2 consisted of nine completion sentences about their general expectation of the role of the nurse, the role of the ward sister, the Salmon Nursing Structure, team relationships, male nurses, the shortage of nurses, the education of nurses, and general problems in nursing.

Part 3 asked the doctor to express his opinion (agree/disagree) about six statements concerned with nursing as
a profession, research into nursing problems, the education and personality of nurses, subordination in the nursing role, and the importance of the ward sister on a round.

Part 4 gave a list of activities; the doctor had to decide which of these activities the nurse could initiate without a doctor's order, which she should carry out only with a doctor's order, and which she should not carry out at all.

From these, it could be seen if the doctor felt the nurse's role included teaching, using psychotherapeutic techniques, preventive methods, prescriptive authority, and various complex technical procedures.

The variables included were age, country where medical education was obtained, specialty and present position.

As in the first part of the research, much of the analysis of data from the survey of medical views of the role of the nurse consisted in its summarisation by percentages in table form. An average rank order was calculated for the ranking of the 10 nursing activities. Reliability analysis was used for the coding of the sentence completions. In Part 4, each doctor was given a nurse initiation score. For each activity that he ticked in column A (indicating that he thought the nurse could initiate the procedure without a doctor's order), a score of two was given. If the activity was ticked under column B (the nurse should carry out the procedure only with a doctor's order), a score of one was given. For column C (where the doctor felt the nurse should not carry out the procedure at all), no score was given. With 22 activities listed, the highest possible score was 44. Doctors who scored 35-44 were considered to have high nurse-initiative concepts. Scores of 25-34 gave nurses a medium amount of initiative, and scores of 15-24, low initiative. These scores were related to the variables of age, specialty, position, and country of medical education.

Questionnaire 3 has been reproduced in Appendix C.
References:


CHAPTER 18

THE PILOT STUDY

Since permission to interview medical staff was not obtained in the hospital where nurses and patients were interviewed for the first pilot study, a fifth hospital was used for the second pilot study. This was undertaken in an 850 bed teaching hospital. Nineteen volunteers were included in the survey: five medical students, four house officers, five registrars, and five consultants. All were men, and all had their medical training in England. Nine were on surgical wards, five on medical wards, and five were at the medical school. Ten were 20-29 years of age, seven were 30-39 years of age, and two were 40-49 years of age.

A summary of the pilot findings appears in Tables I - XVI in Appendix C.

In Part I, 18 of those who were interviewed completed the ranking of nursing activities. Their average rank order:

1. (1.9) Giving medicines and doing treatments.
2. (2.7) Talking with patients to provide reassurance and support.
3. (4.3) General basic care (baths, beds, bedpans).
4. (4.6) Taking temperature, pulse, respiration and blood pressure.
5. (5.3) Answering patient and family questions.
6. (5.4) Assisting doctors with technical procedures.
7. (6.2) Attending on medical staff.
8. (6.7) Reporting and receiving report on change of shift.
9. (8.6) Preparing and distributing meals and drinks.

Doctors placed the five types of activities in the following order:

1. (3.3) Technical care.
2. (4.0) Emotional support.
3. (5.9) Doctor's assistant
4. (6.5) Basic care
5. (8.0) Administrative duties.

When compared to the responses of patients and nurses in the main study, there are few major differences. The doctors place the answering of patient and family questions in a slightly more important position, and the preparing and distributing of meals in ninth place, and nurses and patients put this in eighth place. When considering the five types of activities, doctors are most concerned with the technical aspects of the nurse's tasks, as were both nurses and patients. All placed administrative duties last. However, the doctor places doctor assistant duties in third place as being more significant than basic care duties, and this was reversed for nurses and patients, (see Part I: Tables 2 and 3).

General basic care is more important to the younger doctors and medical students (3.2) than to those registrars and consultants in the 30-39 and 40-49 year old range, (5.8 and 5.0).

Medical students give a relatively low priority to attending on medical staff (7.4); house officers move it up one position (6.8), and registrars place it fourth after treatments, talking to patients, and taking vital signs (4.8).

Consultants and house officers consider the nurse's answering of patient and family questions to be comparatively more important (4.2) than do the registrars (6.0) or the medical students (6.6).

There were no major differences noted when comparing the responses of medical specialists with those of the surgical specialties.

The range of responses among the 18 doctors was smaller for those activities placed in first and second position and eighth, ninth and tenth position, than for the
middle five activities. This narrower range is indicative of better agreement for those activities they consider most and least important.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Giving medicines and doing treatments</td>
<td>1-5</td>
</tr>
<tr>
<td>2. Talking with patients to provide reassurance and support</td>
<td>1-5</td>
</tr>
<tr>
<td>3. General basic care</td>
<td>1-8</td>
</tr>
<tr>
<td>4. Taking temperature, pulse, respiration and blood pressure</td>
<td>2-8</td>
</tr>
<tr>
<td>5. Answering patient and family questions</td>
<td>2-9</td>
</tr>
<tr>
<td>6. Assisting doctors with technical procedures</td>
<td>1-9</td>
</tr>
<tr>
<td>7. Attending on medical staff</td>
<td>3-9</td>
</tr>
<tr>
<td>8. Reporting and receiving report on change of shift</td>
<td>4-9</td>
</tr>
<tr>
<td>9. Preparing and distributing meals and drinks</td>
<td>5-10</td>
</tr>
<tr>
<td>10. Clerical/reception duties</td>
<td>5-10</td>
</tr>
</tbody>
</table>

**General Expectations of the Role of Nurse**

When the doctor was asked what was the main thing he expected of a nurse, a small number mentioned personality factors (that she be sympathetic, thoughtful, kind, etc.), a large number mentioned technical competence (efficiency, skilled observance, carry out doctor's orders), and many gave an answer that combined her technical ability with emotional support of the patient. See Table I. The most common word used was efficient, and next most often used was sympathy.

**Expectations of the Role of the Ward Sister**

A good ward sister is considered by 53% of the doctors to have managerial abilities, by 68% to be technically competent, and by 68% to have certain personality traits (to be imaginative, sensitive, cheerful, firm, kind, flexible). Two doctors mentioned that she should have the ability to teach. See Table II.
Recruitment of Nurses

Medical views about the type of student who should be recruited into nursing were categorised in three ways: educational background (and level of intelligence), personality factors of compassion, kindness, cheerfulness, and a general commitment to nursing (which included a desire to help people). There was a fairly even distribution of these categories mentioned by the respondents. Some stress one qualification and deny the significance of another:

"Schools of nursing should recruit students who are interested in people without necessarily requiring a vigorous academic training."

Forty-seven per cent of the doctors mention intelligence, a little over half discuss personality characteristics, and 58% want a student because she is keen to nurse. See Table III.

Training for Nurses

When discussing the best type of training for nurses, all doctors mention the practical aspects. Thirty-two per cent of the respondents felt that the training should be essentially practical, and 63% suggested that the practical training should be combined with an academic grounding. One response could not be coded. See Table IV.

Men in Nursing

Male nurses seem to be well accepted by doctors, and are seen as particularly helpful on genito-urinary male wards, in theatre, casualty, where strength is needed, in administration, on orthopaedics, and with difficult patients. Fifty-eight per cent of the doctors see them positively in the role of nurse. Forty-two per cent express some ambivalence.

"Male nurses are very good on men's wards, genito-urinary surgery, or any kind of male ward; they are vital in casualty to deal with drunks."
"Male nurses are useful for heavy work, but probably not as satisfactory from the patient's point of view."

"I've had very little experience with male nurses. I'm prejudiced a bit against them. So much of a nurse's job is sympathy, and women are more sympathetic."

See Table V.

The Shortage of Nurses

More than half the doctors mention poor pay as a cause of the shortage of nurses. A few speak of long, bad, or strange hours, non-nursing duties, and the poor public image of nursing. Several suggest the shortage is perpetuated by inflexible administrators, and others mention the hierarchical career structure and poor career prospects. See Table VI.

The Nurse/Doctor Relationship

When asked how the nurse/doctor relationship could be improved, a few doctors felt there was no essential problem, but rather a question of individual personalities. Several felt there should be better team concepts involving improved communications. Others felt the doctors should make more of an effort to understand the work of nurses, and involve them in their teaching, and ward rounds. One doctor wished nurse attitudes would change, so that they did not feel the doctors "were trying to use them as slaves". See Table VII.

The Salmon Nursing Structure

Although two consultants expressed general approval of the Salmon nursing scheme, many of the younger doctors said they were not familiar with it, and 47% of the doctors were critical of it. The most common feeling was
that the ward sister can only achieve status and promotion by removing herself from clinical nursing into administration. One doctor objected to the overly detailed job descriptions, and many felt there were large numbers being used unnecessarily in executive positions. See Table VIII.

Nursing Today

When asked what is the worst thing about nursing as it is today, poor pay and bad hours are again mentioned. One felt the high academic standard required to enter nursing was "at complete variance with the moronic standard of teaching on the whole". Others felt the nursing wastage was in part caused by inflexible administration who would not fit the married nurse into hospital nursing. Also mentioned was the ambiguity of the role of nurse, the number of inexperienced ward sisters, the amount of non-nursing duties, and the fact that "nurses appear to be trained as miniature doctors rather than nurses". See Table IX.

Part III of the Pilot Study

The doctor was asked to comment on six statements made about nursing, nurses, their training, and some aspects of work in the general hospital. The first statement: "Nursing is a profession" was designed to see if nursing was thought to be an art transferred by non-intellectual processes, a sub-profession, or a full profession. It is interesting that 79% of the respondents agreed with the statement that nursing is a profession, and the few who did not agree with the statement gave equivocal responses, such as:

"Not for all nurses."

"Not at the moment, but it ought to be."

"Essentially correct, though this does not imply extensive academic knowledge."

"It should be; however a religious avocation still exists which is unrealistic and impractical."
The second statement was: "Research into nursing problems is best done by social scientists". Most felt research could be carried out by nurses, doctors, or whoever can formulate the questions best. Some felt social scientists could be doing nursing research if they had nursing or medical experience. The term 'social scientist' produced some adverse reactions! One felt social scientists might be the most impartial observers, but they would have to 'lean on' nurses and doctors. See Table XI.

When asked if the apprentice system is the ideal way to train nurses (statement 3), most felt that apprentice training is necessary, but it must be closely associated with theoretical grounding. One doctor used this statement to say that the three year university course is poor because it is without practical work. Another felt apprenticeship was good, but that the system should be adapted if outmoded in some ways. Some felt it was a good system, just as it is for the doctors. See Table XII.

Statement 4 was: "A good nurse has an inborn understanding of people". A few flatly rejected this statement.

"There is no such thing as inborn; whether it is acquired through life in response to all sorts of things, it may also be taught in training"

Thirty-two per cent of the doctors agree that it is an inborn quality. Thirty-seven per cent qualify their response, and 32% disagree that understanding people is an inborn characteristic. See Table XIII.

Statement 5 was: "All orders on a ward should emanate from the doctor (activity, diet, medications, etc.)". Some agreed completely since "it's a question of legal responsibility; one person has to make the decisions who carries the responsibility; the physician is that person". Others felt that sisters and staff nurses should be capable of many directives. Others felt it varied with the degree of specialty on the ward, the experience of the ward sister,
and whether the matter was trivial or not. One said "All orders should emanate from a team, not a single person, as in a democracy." Another respondent claimed that "No-one should give anyone an order; management should emanate from everybody including patients and cleaners." See Table XIV.

The last statement was "Under normal circumstances, the ward sister or her deputy must accompany the doctor on a ward round." Agreement was 95%. It was considered important because "nursing staff should take an active part in the decision making process", and because "it is vital for communications". Many saw it from a 'give and take' viewpoint. Some felt that the decisions taken by the doctor are then handed on to sister without being lost. Only one felt "it is a waste of time". See Table XV.

**Establishing the Doctor/Nurse Borders**

Part IV consisted of a list of activities, and the doctor was asked to decide if it was something that the RN can initiate without a doctor's order, can carry out with a doctor's order, or should not be doing at all. The activities included various technical procedures, giving of medications, using psychotherapeutic techniques, ordering and carrying out diagnostic tests, teaching and explaining.

The only activity which all agreed can be initiated by the nurse was measuring the blood pressure. All but one doctor felt the nurse can encourage a patient to discuss his worries.

In addition, the following activities are those which over 50% of the doctors felt the nurse can do without a doctor's order:

1. Give booster inoculation of tetanus toxoid.
2. Teach diabetic self-care.
3. Give psycho-social advice to an obese patient, or a geriatric patient.
4. Give the following medicaments: vitamins and aperients.

5. Discuss pending procedure with patient.

There were no activities where a majority of the doctors felt they should only be carried out by the medical staff. Forty-seven per cent of the doctors felt that the nurse should not order X-rays; 42% that she should not administer local anaesthetics by injection, and 37% that she should not start an intravenous infusion. See Table XVI.

In addition, each doctor was given a total score depending on how many ticks he placed in each column. There were three doctors with high nurse initiative scores. All were surgeons; two were consultants and one was a registrar. None were under 30; two were 30-39 years of age, and one was 40-49 years of age.

There were five doctors with low initiation scores; four were 20-29, and one was between 30-39 years of age. Two were medical students, two house officers, and one a registrar. One was a surgeon, and the other two were on medical wards.

From these small numbers it would seem that consultants were more confident of nursing abilities than the younger students and house officers, and surgeons were more inclined to allow the nurse to initiate than were physicians.

The doctor's view of the nurse's role included explaining procedures to patients, teaching them how to care for themselves, giving emotional support, doing a procedure that will allow her to report changing conditions, and deciding to administer drugs for prevention of disease, or for the prevention of constipation.

Summary

The pilot study was used to test the adequacy of the questionnaire. All four parts were found to be
understandable to the respondent. Only one doctor found part I impossible to rank. The doctors' average ranking can be compared to that of patients and nurses since it was presented to them in exactly the same way. The greatest amount of time for the structured interview was spent on the sentence completion section of part II. A few doctors had difficulty summarising their main expectations of a nurse, but all completed all nine sentences. The answers lend themselves to a coding system that can be checked by reliability analysis in the main study. The six statements presented in part III can be readily analysed for the per cent who agree, the per cent who disagree, and those who qualify their response. Part IV is also easily tabulated into the per cent who tick each column, giving a medical picture of the nurse/doctor borders, and how each doctor views the nurse's role in terms of decision making.

No changes were made in the questionnaire for use in the main study. The interview time was from 20 - 60 minutes, depending upon the amount of discussion the sentence completion section provoked. In sharp contrast to what the researcher anticipated, doctors seemed very interested in this piece of nursing research, and many expressed the desire to review the completed study.
THE MAIN STUDY

The Setting and Sample

The setting for the main study was the same as that described in Chapter 5 of the first section of this study. The distribution of the variables for the doctor sample was as follows:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 29</td>
<td>5</td>
<td>7</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>30 - 39</td>
<td>3</td>
<td>6</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>40 - 49</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>50 +</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>2. Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>14</td>
<td>19</td>
<td>38</td>
<td>71</td>
</tr>
<tr>
<td>Women</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3. Country of Medical Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>10</td>
<td>18</td>
<td>26</td>
<td>54</td>
</tr>
<tr>
<td>Ireland</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>India</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Egypt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Greece</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>South Africa</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Australia</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mexico</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ceylon</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sudan</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Sixty-eight per cent of the doctors were 20-39 years of age, and most were men. Seventy-two per cent were from the United Kingdom, and the rest were from 10 foreign countries. Thirty-nine per cent were house officers, 25% registrars, and 36% consultants. About half were medical specialists and the other half were surgeons.

Of the 93 doctors contacted, 75 doctors completed the questionnaire, giving a response rate of 81%. Of these, four completed the survey by themselves, and 71 were interviewed by the researcher. Interview time was usually about 20 minutes, but varied from 15 minutes to over an hour.

### Ranking of Nursing Activities

The doctors were asked to rank, in order of importance to them, the activities on which nursing staff spend their time. Sixty-eight doctors completed this section: 13 in the small hospital, 19 in the medium sized hospital, and 36 in the large hospital. Table 47 gives the ranking for each hospital, and the total average ranking of nursing activities by doctors.

In all three hospitals, the doctors consider the giving of medicines and treatments the most important nursing activity, and clerical duties the least important. In the medium sized hospital, doctors ranked talking with patients in sixth place, and the other two hospitals ranked it second in importance.
TABLE 47

Average ranking of nursing activities by doctors: comparison of three hospitals, and total

<table>
<thead>
<tr>
<th>Activity</th>
<th>Small (No.13)</th>
<th>Medium (No.19)</th>
<th>Large (No.36)</th>
<th>Total (No.68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(5) 5.2</td>
<td>(3) 4.4</td>
<td>(5) 4.8</td>
<td>(5) 4.8</td>
</tr>
<tr>
<td>Medicines and Treatments</td>
<td>(1) 2.6</td>
<td>(1) 2.6</td>
<td>(1) 2.6</td>
<td>(1) 2.6</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(2) 4.1</td>
<td>(6) 5.0</td>
<td>(2) 4.4</td>
<td>(3) 4.5</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(3) 4.2</td>
<td>(2) 3.7</td>
<td>(3) 4.7</td>
<td>(2) 4.2</td>
</tr>
<tr>
<td>Report</td>
<td>(8) 7.0</td>
<td>(8) 6.6</td>
<td>(7) 5.6</td>
<td>(8) 6.4</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(7) 5.9</td>
<td>(7) 6.3</td>
<td>(8) 5.8</td>
<td>(7) 6.0</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(6) 5.9</td>
<td>(5) 4.8</td>
<td>(6) 5.4</td>
<td>(6) 5.4</td>
</tr>
<tr>
<td>Meals</td>
<td>(9) 7.3</td>
<td>(9) 7.8</td>
<td>(9) 8.1</td>
<td>(9) 7.7</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(4) 4.3</td>
<td>(4) 4.6</td>
<td>(4) 4.7</td>
<td>(4) 4.5</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 8.5</td>
<td>(10) 9.2</td>
<td>(10) 8.8</td>
<td>(10) 8.8</td>
</tr>
</tbody>
</table>

As in the first part of the study, the 10 activities were classed under five headings (technical care, basic care, emotional support, doctor's assistant and administrative duties). Doctors placed the five types of activities in the following order: technical care, doctor's assistant, emotional support, basic care and administrative duties. See Table 48 for comparison of the three hospitals and the total average.

Comparison of Responses

With Those Given by Nurses and Patients

There are three main differences between the doctors' ranking as compared with nurses and patients. Doctors rank basic care lower (fifth place) than do nurses (first place) and patients (second place). The doctors place attending on consultants much higher (fourth place) than do nurses (ninth place), and nurses rate report higher (fifth place) than do doctors (eighth place) or patients (ninth place). See Figure 3.
When comparing the ranking of types of nursing activities, doctors place technical care first, as do patients and nurses, and administrative duties last. The major difference is that doctors rate nurses as assistant to the doctor in second place, whereas nurses place this fourth. Patients place basic care second, and doctor's assistant fourth, and the doctors reverse the order.

The Spearman rank-order correlation between the average ranking of nursing activities by doctors and nurses was .62. This is less than that between nurses and patients (.73). It is significant at the 5% level, but not at 1% for 10 activities.

TABLE 48
Average ranking of types of nursing activities: comparison of three hospitals, and total

<table>
<thead>
<tr>
<th></th>
<th>Small (No.13)</th>
<th>Medium (No.19)</th>
<th>Large (No.36)</th>
<th>Total (No.68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Care</td>
<td>(1) 3.4</td>
<td>(1) 3.1</td>
<td>(1) 3.7</td>
<td>(1) 3.4</td>
</tr>
<tr>
<td>Basic Care</td>
<td>(4) 6.3</td>
<td>(4) 6.1</td>
<td>(4) 6.5</td>
<td>(4) 6.3</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>(3) 5.0</td>
<td>(3) 5.7</td>
<td>(3) 5.1</td>
<td>(3) 5.3</td>
</tr>
<tr>
<td>Doctor's Assistant</td>
<td>(2) 3.4*</td>
<td>(2) 4.7</td>
<td>(2) 5.0</td>
<td>(2) 4.4</td>
</tr>
<tr>
<td>Administrative</td>
<td>(5) 7.3</td>
<td>(5) 7.9</td>
<td>(5) 7.2</td>
<td>(5) 7.6</td>
</tr>
</tbody>
</table>

*Note: When two types of nursing activities ranked the same, the averages were taken to the nearest .01 to determine position.

Comparison of Medical Views by Age, Staff Position, Specialty, and Country of Medical Education

Since there were less than five women in the sample of doctors, no comparison was made between men and women in the sample. Table 49 compares medical views of the ranking of nursing activities by age.
FIGURE 3

Comparison of rank order of ten nursing activities by doctors with patients and nurses.
Older doctors consider it more important that the nurse attend on consultants than do younger doctors. This difference could be seen most strongly between the responses of consultants and registrars. The consultants place it in second place (3.4), and the registrars consign it to seventh place (6.0). The house officers ranked it in fourth place (4.6). Talking with patients is emphasised more by the house officers who place it first (3.7) than do registrars or consultants who rank it fifth (4.8 and 5.3). The registrars, however, consider answering patient and family questions fairly important in third place (4.7), whereas the house officers and consultants rank it seventh (6.5 and 6.1). Assisting the doctor decreases in importance from house officer (fifth place (4.8)) to registrar (sixth place (5.3)), to consultant (eighth place (6.2)). See Table 50.

There are few differences in ranking between medical and surgical specialists. Attending on consultants is placed second in importance (4.1) by surgeons, and in fifth place (5.3) by medical specialists. See Table 51.

When comparing the responses of foreign trained doctors with those trained in the United Kingdom, there
are three main differences. Talking with patients is ranked second by those who trained in the U.K. (4.3), but placed in the fifth position (5.1) by foreign trained doctors. Attending on consultants is third in importance (4.3) and assisting doctors sixth (5.7) in importance as ranked by those trained in the United Kingdom, and these activities are reversed by foreign trained doctors. See Table 52.

### TABLE 50

**Doctors' ranking of nursing activities:**
**comparison by staff position**

<table>
<thead>
<tr>
<th>Activity</th>
<th>House Officers (No. 29)</th>
<th>Registrars (No. 18)</th>
<th>Consultants (No. 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(6) 5.1</td>
<td>(4) 4.7</td>
<td>(4) 4.6</td>
</tr>
<tr>
<td>Medicines &amp; Treatments</td>
<td>(2) 3.9</td>
<td>(1) 1.8</td>
<td>(1) 3.0</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(1) 3.7</td>
<td>(5) 4.8</td>
<td>(5) 5.3</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(3) 4.2</td>
<td>(2) 4.2</td>
<td>(3) 4.4</td>
</tr>
<tr>
<td>Report</td>
<td>(8) 6.6</td>
<td>(8) 7.2</td>
<td>(6) 5.7</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(7) 6.5</td>
<td>(3) 4.7</td>
<td>(7) 6.1</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(5) 4.8</td>
<td>(6) 5.3</td>
<td>(8) 6.2</td>
</tr>
<tr>
<td>Meals</td>
<td>(9) 8.0</td>
<td>(9) 7.7</td>
<td>(9) 7.3</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(4) 4.6</td>
<td>(7) 6.0</td>
<td>(2) 3.4</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 8.8</td>
<td>(10) 8.8</td>
<td>(10) 9.1</td>
</tr>
</tbody>
</table>

### TABLE 51

**Doctors' ranking of nursing activities:**
**comparison by specialty**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Medical (No. 33)</th>
<th>Surgical (No. 35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(3) 4.5</td>
<td>(5) 5.0</td>
</tr>
<tr>
<td>Medicines and Treatments</td>
<td>(1) 2.2</td>
<td>(1) 2.9</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(4) 4.7</td>
<td>(4) 4.5</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(2) 4.1</td>
<td>(3) 4.2</td>
</tr>
<tr>
<td>Report</td>
<td>(8) 6.7</td>
<td>(8) 6.3</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(7) 6.2</td>
<td>(7) 6.0</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(6) 5.9</td>
<td>(6) 5.1</td>
</tr>
<tr>
<td>Meals</td>
<td>(9) 7.0</td>
<td>(9) 8.0</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(5) 5.3</td>
<td>(2) 4.1</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 8.5</td>
<td>(10) 8.9</td>
</tr>
</tbody>
</table>
TABLE 52
Doctors' ranking of nursing activities: comparison by country of medical education

<table>
<thead>
<tr>
<th></th>
<th>Trained in United Kingdom (No. 48)</th>
<th>Foreign Trained (No. 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>(5) 4.7</td>
<td>(4) 5.0</td>
</tr>
<tr>
<td>Medicines &amp; Treatments</td>
<td>(1) 2.4</td>
<td>(1) 2.9</td>
</tr>
<tr>
<td>Talking with Patients</td>
<td>(2) 4.3</td>
<td>(5) 5.1</td>
</tr>
<tr>
<td>TPR and BP</td>
<td>(4) 4.4</td>
<td>(2) 3.5</td>
</tr>
<tr>
<td>Report</td>
<td>(7) 6.1</td>
<td>(8) 7.4</td>
</tr>
<tr>
<td>Answering Questions</td>
<td>(8) 6.3</td>
<td>(7) 5.4</td>
</tr>
<tr>
<td>Assisting Doctors</td>
<td>(6) 5.7</td>
<td>(3) 4.3</td>
</tr>
<tr>
<td>Meals</td>
<td>(9) 7.8</td>
<td>(9) 7.8</td>
</tr>
<tr>
<td>Attending Consultants</td>
<td>(3) 4.3</td>
<td>(6) 5.3</td>
</tr>
<tr>
<td>Clerical Duties</td>
<td>(10) 9.0</td>
<td>(10) 8.4</td>
</tr>
</tbody>
</table>

Summary
In all three hospitals, doctors consider the giving of medicines and treatments the most important nursing activity, and clerical duties the least important. Doctors placed the five main divisions of work in the following order: technical care, doctor's assistant, emotional support, basic care and administrative duties. When comparing their responses to those of nurses and patients, the doctors rank basic care lower than do nurses and patients, and attending on consultants higher than do nurses; nurses rate report higher than do doctors or patients. When comparing medical views by age, staff position, specialty and country of education, the following differences were found: older doctors consider it more important that the nurse attend on consultants than do younger doctors; the difference was greater between consultants and registrars. Medical specialists consider it less important than do surgeons, and those trained in the United Kingdom consider it more important than do foreign trained doctors. Talking with patients is very
important to house officers, and to those trained in the United Kingdom. Assisting the doctor decreases in importance from house officer to registrar to consultant; foreign trained doctors consider it more important than do those trained in the United Kingdom.
CHAPTER 20

EXPECTATIONS OF THE ROLE OF NURSE

General Expectations of the Role of the Nurse

What the doctor expects of a nurse was categorised from the sentence completion:

"The main thing a doctor expects of a nurse is ..."

The answers were classified as to whether they mentioned:

1. Technical competence: medical knowledge, skilled observance, general efficiency, caring or looking after patients, carrying out doctors' orders, being liaison between doctor and patient, assisting the doctor with exams and procedures, doing routine tasks, and reporting to the doctor

2. Personality characteristics: the nurse is reliable, has common sense, is kind, understanding, sympathetic, considerate, punctual, humane, able to get along with people

3. Technical competence and personality characteristics combined.

One-fourth of the doctors mention both technical competence and personality characteristics. Of the remaining 75%, 71% emphasise technical competence. The doctors in the medium sized hospital were the most technically oriented. See Table 53.

<table>
<thead>
<tr>
<th>TABLE 53</th>
</tr>
</thead>
</table>

General expectations of the nurse as viewed by doctors: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Competence</td>
<td>64</td>
<td>81</td>
<td>69</td>
<td>71</td>
</tr>
<tr>
<td>Personality Characteristics</td>
<td>7</td>
<td>0</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Technical Competence &amp; Personality Characteristics</td>
<td>29</td>
<td>18</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>
The main expectation for many doctors is the proper care of the patient.

"The main thing a doctor expects of a nurse is to put the patient at ease, be a psychological uplift to him, receive the patient politely, and make him as comfortable as possible; take a good history; be thorough and punctual, and keep everything ready for the doctor."

Reporting of observations is often mentioned.

"... she must translate the medical instructions into reality at the bedside, and observe any unusual reaction on the part of the patient, and report it."

Some of the doctors make no mention of the patient, but are concerned with the nurse carrying out orders, and assisting the doctor.

"The main thing a doctor expects of a nurse is to listen to instructions and to ask questions if they are not sure what to do," and

"... be assistant to whatever the surgeon is proposing to do; she needs training to fit in with the doctor's requirements. She needs intelligence, training in medical care, and the mental make-up for the right approach," or

"... one who comes forward when you come on the ward, and has a certain amount of self-confidence."

Comparison of Medical Responses with those of Nurses and Patients

When compared to the responses given by patients and nurses (Chapter 8), it can be seen that doctors express less concern for the emotional support of the patient than do nurses or patients. Kindness and understanding were the words most often used by nurses and patients. Doctors stress the word efficiency, and next most commonly used were the words reliable and sympathetic.
Table 54 compares medical views of the role of the nurse by age, staff position, specialty and country of medical education.

**TABLE 54**

Comparison of medical views of the role of the nurse by age, staff position, specialty and country of medical education, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Technical Competence</th>
<th>Personality Characteristics</th>
<th>Tech. Comp. &amp; Personality Char.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Age:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 39</td>
<td>71</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>40 - 50+</td>
<td>71</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td><strong>2. Staff Position:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House Officer</td>
<td>83</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Registrar</td>
<td>47</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td>Consultant</td>
<td>74</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td><strong>3. Specialty:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>82</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Surgical</td>
<td>59</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td><strong>4. Country of Medical Education:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>72</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Foreign</td>
<td>67</td>
<td>0</td>
<td>33</td>
</tr>
</tbody>
</table>

There were no major differences between doctors because of age or country of medical education. Surprisingly the medical specialists were more technically oriented than were the surgeons, who often mentioned both technical competence and personality characteristics for the role of the nurse. Registrars were less technically oriented than were house officers or consultants.

**The Role of the Ward Sister**

The role of the ward sister is seen as having
many of the same characteristics as the general role of
nurse, but in addition over 60% of the doctors include a
need for managerial skills. Often the doctor mentions
all three categories, wanting the ward sister to be a good
administrator, technically proficient, and sympathetic
and able to get along with people. How the doctor saw the
role of the ward sister was explored by their completion of
the sentence:

"A good ward sister is one who ..."

and coding of their responses was: technical competence,
personality characteristics, and managerial skills. Two
responses could not be coded because they were vague:
"She is a very important person" and "She is the centre
of the hospital".

Technical competence included knowing how to
nurse, reporting, observing, treating in emergencies,
carrying out the doctor's orders, efficiency, ability to
teach, communication abilities, being able to explain
things to junior housemen, and being well trained in her
specialty.

Personality characteristics included that she be
kind, have sympathy, be polite, helpful, understanding,
pleasant, consistent, with common sense, reliable, cheer­
ful, enthusiastic, honest, good humoured, co-operative and
able to get along with everyone.

Some aspects of her managerial skills were that
she was a good organiser, had the capacity for leadership,
promoted a sense of team work, ran the ward well, was able
to delegate, supervise, plan ward routines, control the
nurses and patients, liaise, take decisions, and use her
authority.

See Table 55 for medical expectations of the ward
sister.

Eighty-one per cent of the doctors in the medium
sized hospital mention more than one category in describing
the role of the ward sister; 67% in the large hospital, and 50% in the small hospital.

TABLE 55
Medical expectations of the ward sister; comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Competence</td>
<td>79</td>
<td>72</td>
<td>72</td>
<td>74</td>
</tr>
<tr>
<td>Personality Characteristics</td>
<td>29</td>
<td>59</td>
<td>51</td>
<td>46</td>
</tr>
<tr>
<td>Managerial Skills</td>
<td>57</td>
<td>72</td>
<td>54</td>
<td>61</td>
</tr>
<tr>
<td>Not Coded</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

Typical of the doctors who mentioned all three categories is:

"A good ward sister is a good administrator, a good nurse, and has a pleasant personality."

"... is essentially reliable with a keen sense of observation, with an adequate sense of responsibility to take decisions."

"... a good sister bothers about dressings, teaching, giving a good report. She has a certain amount of discipline, can delegate well, and is able to make everything work. A rigid time table is o.k. if she sets a good pattern (routine) for the day; this also includes nurses knowing their off-duty in advance."

One doctor felt that the expectations of the ward sister varied with the position of the doctor.

"... for the houseman, he wants a ward sister to assist him; the registrar hopes she will find him an empty bed, and be conscientious about getting treatments done, or will see that the nurses get them done; the consultant wants efficiency for his ward round."
Another doctor wanted the ward sister to "have the ward completely under her control. The patients have confidence in her authority; she inspires confidence in her nurses, and teaches them well; the doctor can rely on her knowledge and experience." One doctor sees her in a similar role to the junior houseman: "A good ward sister is one who is able to take over from a junior house surgeon. She is capable of putting up drips, doing electrolytes, etc." One consultant suggests that she "regard her position as the most important in the nursing structure, and act accordingly."

Comparison of Medical Responses with those of Patients

When comparing the doctors' expectations of the ward sister with the patients, the doctors are more technically oriented than are the patients. As the hospitals increased in size, there was an increasing number of comments by patients about the ward sister's managerial role, with a decreasing number of comments about her technical role. No such relationship was found for the doctors; managerial skills were mentioned most often by the doctors in the medium sized hospital.

Comparison of Medical Views by Variables

Of the 22 doctors who responded with only one category, a comparison of their answers shows no major differences because of age, staff position, specialty or country of medical education.

The reliability analysis of the categories for the two sentence completions discussed in this chapter, with three independent judges, yielded the following agreement levels:

"The main thing a doctor expects of a nurse is..." 87%

"A good ward sister is one who..." 89%
Summary

For the general expectations of the role of nurse, doctors stress technical competence. The doctor wants the nurse to be efficient, reliable, and sympathetic to the patient. The medical specialists were even more technically oriented than were the surgeons, but the registrars mentioned technical competence less often than did house officers or consultants.

In addition to technical competence and giving emotional support to the patient, the ward sister is seen by 60% of the doctors as requiring managerial skills. A good ward sister needs to be a good administrator, a good teacher, able to meet different expectations for house officer, registrar and consultant, and be capable of taking over many of the technical activities required of housemen. Her position is considered by the doctor to be very important in the hospital nursing structure.
CHAPTER 21

THE PROFESSIONALISATION OF NURSING

Literature about Professions

Sociologists have focused on the analysis of those occupations which aspire to full professional status, but have not yet fully established this claim (teachers, nurses and social workers, for example). They call the group semi-professions, sub-professions, pseudo-professions or heteronomous professions. Etzioni (1) feels there is no need for this middle group to break out of their semi-professional status because there is little basis for them to be considered fully professional. They are not free to innovate, have short training, and female employment is often not compatible with professional goals. To develop into a profession, Katz (2) argues that nurses would need a corpus of knowledge and colleagueship with physicians. Acceptance of nurses as professionals would require drastic rearrangement of the social roles in the hospital. The nurse's assistance of the doctor, for instance, might be replaced by medical students, freeing the nurse to concentrate on tasks of patient care. The semi-professions discussed are also of a bureaucratic control pattern, and this is thought to be related to the prevalence of women in them. Women are less committed to work than men, are less likely to maintain a high level of specialised knowledge, tend to defer to men as a cultural norm, base their career less on scholarly attractions than on temporary work prior to marriage, and have a desire for pleasant social relations on the job.

Wilensky (3) suggests the following steps by which a semi-profession is transformed into a recognised profession:

1. full time activity at the task
2. establishment of university training
3. a national professional association
4. a redefinition of the core task, so as to give the 'dirty work' over to subordinates

5. competition between the new occupation and the neighbouring ones

6. political agitation in order to gain legal protection

7. a code of ethics

Goode (4) rejects this, for he says many semi-professions have tried most of these without recognition as a profession. He feels the generating traits of professionals are high income, prestige and influence, high educational requirements, professional autonomy, licensure, commitment of members to the profession, a desire to remain in the profession, a code of ethics, cohesion of the professional community, monopoly over a task and intensive adult socialisation experience for recruits. The two main core traits are a basic body of abstract knowledge, and the ideal of service.

Carr-Saunders and Wilson (5) said the term 'profession' stands for a complex of characteristics, and law and medicine exhibit all, or most of these features; many other vocations approach this position more or less closely. The characteristics are:

1. The practitioners have acquired a technique through prolonged and specialised intellectual training, which enables them to render a specialised service to the community;

2. they develop a sense of responsibility for the technique which they manifest in their concern for the competence and honour of the practitioners as a whole;

3. they build up associations to impose tests of competence and enforce certain standards of conduct;

4. techniques may be scientific or institutional or both; they are founded upon a basic field of enquiry.
MacGuire (6) says that in England, nursing stands isolated from all other professions as using apprenticeship as the sole method of preparing aspirants for their professional role. The drive towards increasing professionalisation brings nurses into conflict with physicians and hospital administrators.

Reissman (7) points out that the fact that the physician refuses to give the nurse more than perfunctory recognition of her professional aspirations rubs sorely with those in leadership. As nursing shifts from an art (which is learned by imitation, observation and practice, where talents are thought to be inborn, and the art is transferred by non-intellectual processes) to a profession, the consequences may produce conflicts between the two groups.

Doctors are undisputed in their professional status. Their ability to make a diagnosis comes as the result of prolonged systematic training and experience. Although university training fell into disuse after it had been acquired in the 19th century, it was recaptured and has since remained attached to medicine. Nursing can claim professional characteristics to a less marked degree than medicine. Schlotfeldt (8) sees the following differences in nursing:

1. it lacks a body of knowledge;
2. it does not recognise the university as having responsibility for its development;
3. it does not regard itself as an intellectual discipline;
4. it is rewarded fewer privileges and rewards for its services;
5. nursing students learn to 'do' rather than 'to know', remaining in servitude;
6. it has few leaders who would hasten the movement of nursing education into higher institutions.

In addition, teachers of nursing seldom have
specialty preparation, or are scholars. In response to society's demand for additional practitioners, nurses have yielded to pressures even where there is a lack of appropriately prepared faculty. Learning is not directed toward developing powers of critical thinking.

Spalding and Notter (9) point out that, whereas the physician has unlimited license to provide all services to the sick, the professional nurse is specifically forbidden to diagnose, prescribe, or order therapeutic measures.

Norris (10) feels that direct access to a patient or client is mandatory for a profession, and the nurse has little direct access to her patient. The physician acts as the gatekeeper of the health care system, and he alone controls entry into, and passage through the system. The patient may thus be deprived of the services of other health professionals.

Glaser (11) discusses how work changes as an occupation professionalises. The menial tasks are delegated and an independent area of competence is sought. In the case of nursing, the menial physical care of patients has moved to practical nurses, housekeeping to auxiliaries, clerical work to ward clerks, etc. The independent area of competence has included the emotional support of patients, health teaching, family guidance, etc. With professionalisation, there will also be the exclusion of the subprofessionals from the colleague group (for example, the formal, distant relationship between the practical nurse and the university nurse in the USA).

Davis (12) mentions still another problem of professionalisation in nursing, the importance of a lifetime commitment to the field. One-third of those qualified to practice as professional nurses choose not to practice in the United States.

Kovacs (13) represents the professionalisation of nurses in a triangle arrayed in a continuum extending from the simple mother-type activities at the base of the
pyramid, to the highly complex tasks associated with the full professional role at the apex. Intellectual skills are emphasised for the professional role, and manual skills for the base of the pyramid. To use her professional skills, nurses are developing clinical specialist programmes (in Canada and the U.S.) so that administration will not be the only way up the career ladder.

Medical Views about Nursing as a Profession

Because the drive toward professionalisation brings nurses into conflict with doctors, it was thought that this aspect of the nursing role should be investigated.

Doctors were asked how they felt about the statement:

"Nursing is a profession."

A large number agreed that nursing is a profession. Those who commented made it clear that the term profession is used in a great number of ways, and means different things to different people:

"Yes, if a profession is to create."

"Yes, as opposed to going to college first."

"Yes, rather than a trade; the term is too ambiguous."

"Yes, she does it for the sake of the job rather than what she gets out of it."

"Yes, because medicine is a profession, and the same with nursing; it is studied as a profession."

"Yes, in as much as law and medicine are a profession."

"Agreed, and equally a vocation."

"Yes, it is by the basic definition."

"Yes, I agree it is a profession dealing with people rather than things (that is, rather than being machine oriented)."

"Yes, because it needs specialised training; now that we're changing the structure of nursing, she
can eventually do a degree. As long as the opportunity is present, you can get a good recruit, because there is no dead end that way."

Only one doctor who agreed used education as a deciding factor.

Of the 15% who did not feel nursing was a profession, comments were:

"Not really; it is a job."

"No, for most people it is a training."

"It is a profession in that it is a life calling, but not in the sense that it needs a university education."

"It is a paramedical profession under the doctor's orders."

"It should be; it isn't now."

"No, it has more aspects than a profession."

"No, it has no future in it today."

"No, nurses are a group with special training and esprit; the nurse is a professional, but nursing is not a profession."

As the hospitals increase in size, there is an increase in the per cent of doctors who see nursing as a profession. In the small hospital, some of the doctors gave no clear response, so their answer could not be coded. See Table 56.

**TABLE 56**

Medical staff views about nursing as a profession: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing - a profession</td>
<td>64</td>
<td>86</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>Nursing - not a profession</td>
<td>21</td>
<td>14</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Not Coded</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
In addition, doctors were asked to comment on the statement:

"A good nurse has an inborn understanding of people."

Forty-three per cent of the doctors agree with this statement completely. Another 30% agree, but qualify their answer in some way:

"Yes, I'm sure that is right. Lectures, though do help."

"It is a combination of nature and training."

"A vocation can be stifled or encouraged, but certain persons will make a good nurse, and others will never."

"A bit of both. You take a girl you feel can do it; then she wants training to deal with people and things."

"It is mainly inborn, but it can be improved on with training."

Twenty-eight per cent disagree, feeling it is acquired.

"I disagree totally; it can be acquired."

"It is not an inborn quality; one can learn and improve."

"I'm not happy with the use of the word 'inborn'. It is something which can be developed."

See Table 57.

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 25)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree: Inborn</td>
<td>43</td>
<td>59</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>Response Qualified</td>
<td>14</td>
<td>32</td>
<td>44</td>
<td>30</td>
</tr>
<tr>
<td>Disagree: Acquired</td>
<td>43</td>
<td>9</td>
<td>31</td>
<td>28</td>
</tr>
</tbody>
</table>
Since 80% of the doctors describe nursing as a profession, obviously many of these same doctors feel nurses are 'born' not 'made'.

When comparing medical views by age, staff position, specialty and country of medical education, there are no major differences among those who agreed that a good nurse has an inborn understanding of people.

**Literature about the Education of Nurses**

In 1965 the American Nurse's Association took the position that all preparatory nursing programmes should be located within institutions of higher education. This position created a tremendous stir among nurses and doctors who objected to the replacement of hospital schools of nursing by collegiate institutions. Five years later the National Commission for the Study of Nursing and Nursing Education attempted to evaluate both sides, and concluded that the gradual relocation of nursing programmes within institutions of higher learning followed the natural evolution of education within our culture, and recommended the continuation of this trend.

Reinkemeyer felt that Great Britain was in an active stage of transformation, and her research attempted to explore why higher education was both wanted and rejected. She found that the British nurse was aloof to higher education because she felt that nursing was a vocation requiring dedication rather than education. Reinkemeyer suggested that with students the main labour force over the past 100 years, very few changes or innovative attempts have been made. The London and provincial teaching hospitals set their own higher minimal requirements which attract well-qualified candidates from the higher social classes, and the matrons in these hospitals do not want to lose this group to universities. In exploring the British nursing value systems as insight into the problems of British nursing's hesitation with the university link-up, she suggested that British academicians feel the university is for the cultivation of the mind and
the liberalisation of the personality. Nurses (with the exception of the few in experimental programmes) do not attach any significance to intellectual aims, and are concerned with the practical implications. The term 'academic' was taken by nurses to mean armchair teaching and the learning of useless abstractions, and therefore a contradiction for nursing. Nursing, Reinkemeyer suggests, can only be an academic subject if one abandons the glorification of the practical, and emphasises the quality of teaching, learning, developing theory, formulating a systematic body of knowledge, and using research and experimentation. She said the few experimental programmes were oversubscribed with applicants, so the high qualifications were anything but a deterrent; high intelligence and high educational qualifications are fully compatible with a strong vocational interest in nursing. She felt that the university nurse would have to be seen in the unique role of 'creative thinker', as an 'idea' person rather than a much overeducated 'do' person.

Ensing (16) pointed out that it is becoming evident that nurses of different levels of intelligence, aptitude and skills are needed. The student nurse of today expects to develop as a whole person, having interests outside her career, using an enquiring mind, and accepting discipline only for the right reasons.

Dr. Pellegrino (17) outlined the rationale for nursing education in the university. He said the future of nursing as a profession, and its ultimate effectiveness as a social instrument, are contingent upon the degree to which it establishes contact with the many university disciplines requisite to its growth. The university would provide a more substantial base in general education, more emphasis on problem solving and dealing with unknowns, give the nurse a better understanding of the language used by various university disciplines as a way of keeping up to date with those who discover new knowledge. He also felt it was the first step toward graduate education programmes to cultivate master degrees in the clinical specialties for teachers and workers in the health team.
The university would also benefit from the feedback from nurses to clinical medicine, biologists, sociologists, economists, engineers, etc.

Glaser (18) felt that the discipline of the old Nightingale system was out of step with the new trend in patient care that required relaxed patient relationships. He also said that the changing status of women in England and the changing content of medicine necessitated revisions in the educational methods.

In reviewing the training of the nurses of the future, Brian Watkins (19) suggested that a proportion of nurses would require a balance of relatively advanced scientific and technological training with human relation skills. This would help to prepare nurses for renal dialysis units, intensive care units, transplant surgery units, etc. In addition, nursing education would require a strong bias toward rehabilitation and the medicosocial aspects of disease. He felt that a nurse's ability to work in a team will only be possible when she trains with members of other health professions in a common school, sharing relevant lectures and practical experience.

This comprehensive education was put forth in a report by Sir Harry Platt, Lord Morris and Sir Ronald Tunbridge in 1963 (20). Within the polytechnic, there could be a B.Sc. degree for all medical students and students of other disciplines (physiotherapy, nurse education, administration and management) to allow for people of different abilities to hive off from professional education into practical work. The programme would allow for greater emphasis in community nursing.

How do doctors feel about the education of nurses? In a study of the image of the graduate nurse in Columbia, South America, Dr. Easton (21) found that graduate nurses are gradually being seen as a product of an academic system, but this is largely by doctors who are university based. Private practitioners, on the other hand, make no clear cut differentiation in the role of
aides, practical nurses and graduate nurses. From his findings, he suggests that university doctors are satisfied with the result of delegating medical tasks to graduate nursing personnel, reflecting a more favourable change in role image of the university based graduate nurse by the university physician.

Medical Views about the Training of Nurses

In the present study, only one doctor had trained where there were university nurses (in Edinburgh), and he approved of this method of training. Many of the other doctors reject the concept of a theoretically trained nurse.

Doctors were asked to express their feelings about the training of nurses by completing the two sentences:

"Schools of nursing should recruit students who are..."

"The best type of training for nurses is..."

They were also asked to comment on the statement:

"The apprentice system is the ideal way to train nurses."

Their responses to the type of person who should be recruited into nursing were categorised into the following three areas:

1. Personality and Physical factors: Someone who is kind, responsible, gregarious, fit, strong, active, with common sense, with high morals, mature, enthusiastic, sympathetic, hardworking, conscientious.

2. Educational Background: Certain level of intelligence, with O and A levels, with certain language ability, well educated, willing to learn and able to learn, good general education.

3. Commitment: Keen to nurse, desire to help people, with a vocational bias, interested in nursing, motivated to nurse, realistic notion of nursing, interested in clinical nursing.
Many stress one characteristic while negating the importance of others:

"Schools of nursing should recruit students who have common sense rather than intelligence. She should be willing to help the doctor and have a kind personality."

"... practical aptitude rather than any striking intellectual achievement. It is a farce to expect A levels. It should be a desire to care for people."

"... an initial motivation to nurse is the wrong reason to recruit. There should be a minimum level of intelligence (five O levels and two A levels). Even technicians in hospitals have a higher required standard."

"... an average intelligence. They should be interested and devoted to nursing. They don't need to go to university; they're good for administrators and instructors."

"... personality is more important than academic standing. Special jobs require academic ability."

Many doctors bring out all three characteristics:

"... must have a basic intelligence, common sense (nous) and practical, have rapport with people, and very much want to nurse."

"... of high intellectual standards, high moral ideals, and with a sense of vocation."

One doctor points out that ideally one wants someone who is educated and sympathetic, but in actuality they recruit who they can get. Another doctor suggests a split into a dual level of instruction, using intelligent girls for the technical aspects of nursing, and a lower level of girl for the menial tasks. In the small hospital, dedication is stressed over educational background, and this is reversed in the other two hospitals. See Table 58.

It is interesting that of the doctors who mentioned ONLY commitment to nursing as the factor for
recruiting nurses, 45% of the doctors were from the small hospital, which has a serious student nurse shortage.

TABLE 58
Medical views of the type of student one should recruit into nursing: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality or Physical Factors</td>
<td>29</td>
<td>50</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>Educational Background</td>
<td>50</td>
<td>72</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>Commitment</td>
<td>71</td>
<td>45</td>
<td>51</td>
<td>56</td>
</tr>
</tbody>
</table>

The responses to the best type of training for nurses was coded into:

1. Essentially practical: apprenticeship training, all teaching on the ward, with no mention of academics, or denial of its value.

2. Combination of practical with theory: the block system, experience and regular lectures, not all done by the bedside.

About one-fourth of the doctors suggest that the best type of training for nurses is essentially practical. There is an increase in per cent as the hospitals increase in size. See Table 59.

TABLE 59
Medical views of the best type of training for nurses: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical</td>
<td>14</td>
<td>27</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>Theory &amp; Practical</td>
<td>86</td>
<td>72</td>
<td>69</td>
<td>76</td>
</tr>
</tbody>
</table>
Doctors who felt training should be essentially practical said:

"The best type of training for nurses is entirely oriented around the ward; that is, entirely practical with tutorials on the ward for academics, and perhaps ward rounds to explain conditions. I doubt if it is very good to have classroom lectures."

"... the old fashioned training which is bedside orientated. I'm saddened by their making the training too academic."

"... to work under a first class sister."

"... nurses have swung too much from practical matters which shouldn't be neglected; there is too much dominance of theory."

Those who felt that the training needs to combine practical with theory:

"... combination of practical training, academic training and a training in the humanities, to know what motivates people."

"... 60% practical, 40% academic."

"... practical backed up with theory; they should know why they are doing things, not just how."

"one that co-ordinates nursing procedures with the medical reason for doing them."

"combine some theory, but highly trained nurses can be frustrated, since the doctor is ultimately responsible. The nurse interprets, but makes no bedrock decisions."

"... an initial formal training in biology and basic sciences; the rest essentially practical."

"... rather like doctors; practical and theory combined, with theory for a start. They need time to learn. Junior nurses are treated like a dog's body, with bedpans, etc. instead of learning about drugs and drips. They are overworked with menial tasks."
"practical experience coupled with regular lectures relevant to the experience. There should be one hour of lecture to each ten hours of work (instead of the present 1:14)."

"... St. Bart's nurses. They must have theoretical training, but basically practical and ground work. They should not try to be little doctors."

Of the 20 doctors who suggested that training for nurses should be essentially practical, nine were consultants, seven were registrars, and four were house officers (a larger proportion of consultants and registrars than in the total sample). There were no major differences relating to age or country of medical education. There was a slightly greater per cent who were medical specialists (60%) than surgeons (40%).

In discussing the apprentice system for training nurses, some of the doctors pointed out inadequacies in the system:

"... any professional group needs apprenticeship; you learn by example. But it mustn't be the whole of training, certainly not for promoting any new ideas concepts."

"No, they are thrown into everything with very little knowledge to help. Thereby there is a large waste in the initial months or year."

"Nursing is not a strictly manual thing; apprenticeship is unsuitable without academics too."

"No, all those controlling wards, particularly the older generation, aren't particularly good teachers. The authoritarian approach is outdated."

"I'm not sure about that. It is a method of cheap labour."

A large number agree unresexedly that the apprentice system is the ideal way to train nurses. The four doctors who thought it was basically a poor system were young, three house officers and one registrar. See Table 60.
As the hospitals increase in size, there is an increase in the per cent of doctors who approve of apprenticeship training for nurses. This is similar to the increase noted in Table 59.

In comparing medical views about the education of nurses with nurse views, no similar questions were posed to the nurses in the first section of the study. However, nurses voiced their opinions about the education of nurses in the additional comments section, and in a multiple choice question:

"If qualified nurses had more time, they could devote it to

a. explaining things to patients
b. the teaching of students and other staff
c. improving the facilities of the ward
d. assisting the doctor."

Eighty-seven per cent of the nurses felt that more time should be devoted to teaching students. Many complained that a large number of students are used as a pair of hands, don't spend enough time in school, have too much responsibility before they have had adequate classroom teaching, do too many menial tasks, and feel that they could use more medical and nursing staff lectures on the ward. It is obvious that nurses do not agree that their training has become too theoretical.
The reliability analysis of the categories for the two sentence completions discussed in this chapter, with three independent judges, yielded the following agreement levels:

"Schools of nursing should recruit students who are ..."  93%

"The best type of training for nurses is ..."  100%

**Summary**

Eighty per cent of the doctors feel that nursing is a profession. Their views do not seem to be related to professionalism as it is associated with education in a university, length of training, or level of specialised knowledge, but rather because the nurse is dedicated to her work. Forty-three per cent of the doctors suggest that a good nurse has an inborn understanding of people, and 24% of the doctors think that the best type of training for nurses is essentially practical. Sixty-four per cent approve of apprenticeship training for nurses. Many of these terms seem to have different meanings to different people.
References:


2. Katz, F.E. in Etzioni, A. (ed.) op cit, Ch. 2.


15. Reinkemeyer, Sister Mary Hubert (1966) "The Limited Impact of Basic University Programmes in Nursing: A British Case Study" Manuscript of dissertation from the Univ. of California, Berkeley.


17. Pellegrino, E.D. (1968) "Rationale for Nursing Education in the University" American Journal of Nursing, 1006-1009.


THE SEX ROLE IN NURSING

Literature about the Sex Role in Nursing

It has been pointed out in various chapters of this study that nursing is strongly affected by the fact that it is essentially a female profession. It has bearing on relationships with co-workers, the status and authority system, the work norms, the economic complex, etc.

As Glaser mentions (1), there are certain institutional mechanisms which make occupations sex-linked. If a given society encourages its male religious orders to care for its sick, then the men will receive training in skills and attitudes which are appropriate for the nursing work in that society. For women to become nurses, conditions must be such that it is proper for them to work outside the home with non-relatives, and the society considers it appropriate for them to receive training and skills in nursing. In most countries nursing is essentially a female profession. In Saudi Arabia, however, nursing is inappropriate for women. In medieval Europe and some of contemporary Asia, nursing is legitimate for both sexes.

Some of the recent research in England and America reveals pronounced role strains for men in nursing. Barriers against entry into nursing by men include such attitudes as, it is 'unmanly' to nurse the sick, remuneration does not satisfy family obligations, and nursing a female patient may be threatening to the women and degrading to the male nurse.

Any society that is heterogeneous may, of course, have sub-groups from which male nurses can be recruited. Therefore, in England and America, recent migrants may find nursing an appropriate career.

Not only does the sex role affect recruitment, but Glaser suggests it also affects the way nurses perform
their work. Accepted feminine characteristics will have a bearing on the nurse's willingness to supervise, do research, do 'dirty work', and give and take orders from men. In countries where women's emancipation movements are active, nursing has attempted to acquire the same prerogatives as prestige male professions, such as medicine.

The entry of men into nursing is thought by many to be beneficial because it helps reduce the turnover rate, and hastens the economic and role changes needed to strengthen the profession (2).

Brown and Stones (3) felt that men would fit particularly well into the 'technical' role of nursing in modern hospitals. However, in their survey of male pupil and student nurses, they found the 'good nurse' was more often described in the 'comfort' role than in the 'technical' role. The male entrants did have a more 'down to earth' image of nursing than women, and more often they remain working in hospital after registration (82% of men as compared to 44% of women two and a half years after registration). They are also less likely to oppose moving upwards into managerial positions along Salmon lines. In addition, most planned to remain in England.

Despite the obvious advantages of increasing the number of men in nursing, resistance comes not only from societal attitudes, but also from women within the profession. Claire Wallace (4) ominously warns us that male nurses are infiltrating Florence Nightingale's domain, and have got into nursing by false pretences. She says women have meekly let them in, and the final insult will probably be they will seek a higher rate of pay than their feminine colleagues. She considers them to be inferior nurses, and worries that some day a male home sister may be appointed.

Ensing (5) says that the number of men in nursing is small, and the majority work in mental hospitals, but an increasing number are working in industrial medical departments, in domiciliary nursing, operating theatres, administration and teaching.
Spalding and Nettter (6) report that some male nurses think that one of the major problems of male nurses revolves around the acceptance of the qualified male nurse by the medical profession. Physicians confuse men nurses with untrained attendants, and do not give them proper recognition.

In using the term 'sex role' in nursing, there is the presumption that it refers to the fact that nursing is seen as a feminine occupation. However, Olesen and Whittaker (7) told of the misinterpretation of the term by dental students who spoke of the sex role in a different context. They felt that marriage had helped them work harder in their professional studies. One is also aware that one uses one's 'sex' to affect nurse/patient, nurse/doctor relationships.

Medical Views about Men in Nursing

In the present study one doctor pointed out that when he is talking to a male nurse, he automatically assumes extra medical comprehension, and speaks on a higher plane to him than to female nurses. To avoid confusion with terminology, the doctors were simply asked to complete the sentence:

"Male nurses ..."

and their answers were coded as to whether the doctor expressed unqualified approval of men in nursing, or whether some ambivalence was felt. Most doctors see men in some nursing roles, but only 34% found them completely acceptable, in the same positions as women, without limitations on the role. When the doctor used the term especially good on certain wards, this was taken to be a positive view; when the doctor said the male nurse should be used only on a given ward, this was interpreted as giving him a limited role. See Table 61.

As the hospitals increased in size, unqualified approval increased.
TABLE 61
Medical views about men in nursing: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unqualified Approval</td>
<td>21</td>
<td>36</td>
<td>44</td>
<td>34</td>
</tr>
<tr>
<td>Ambivalence Expressed</td>
<td>79</td>
<td>64</td>
<td>56</td>
<td>66</td>
</tr>
</tbody>
</table>

The roles that men were seen in, and the number of doctors who mentioned them are given below:

- On male wards: 20
- Psychiatric and mental: 15
- Urology: 13
- Orthopaedics: 8
- Theatre: 7
- For heavy work: 7
- Casualty: 4
- Geriatrics: 4
- Administration, or in Charge: 4
- With difficult patients: 3
- Surgical wards: 2
- Out-patient department: 1
- Medical wards: 1
- Intensive care unit: 1
- Paediatrics: 1

Unqualified approval included such statements as:

"I don't think there is any difference, just as there are female doctors."

"A good male nurse is better than a female nurse on a urological ward without exception; they are first class, and good for discipline."

"They are splendid; I've had some very good ones. I see them in the same role as female nurses, in the senior grades especially. They administer women better than women do themselves."
"... are extremely useful; too bad there aren't more of them."

"In general the good ones are even better than female nurses because they come in with motivation and dedication."

"I approve of them; as a matter of fact, I tend to assume that they are more intelligent, and give them an extra explanation, treating them man to man."

"I'm biased about male nurses; they are all fantastic."

Some doctors recognise that their reaction to male nurses is an emotional rather than an intellectual one.

"Intellectually I feel they are equally good at their jobs as female nurses, but I have a separate emotional reaction against male nurses."

Ambivalent remarks by doctors included:

"Male nurses are very good people in theatre and orthopaedic units. They have a bad record as queers (floppy individuals) among the English people; not so much with those from abroad."

"I prefer female nurses and I think patients do."

"They are jolly useful on male wards for catheterisation etc. If I were sick, I would personally prefer to be looked after by a female."

"They have a great role in theatre, and as mental nurses. I am opposed to male midwives."

"... not in the same role as females; have to choose the jobs. It is wrong to use them in psychiatry, but should be used in paediatrics. Even so, one does wonder why men enter nursing."

"I don't see them as an alternative to females. They are greatly inferior without exception. Can be on male genito-urinary and violent psychiatric wards, but the female should be in authority over him. In general nursing, the female is far superior."
"... not in the true sense of a nurse when dealing with patients; when I think of nursing, I have the concept of femininity."

"... often very good as theatre sisters; I would not like to see any increase though."

"... in certain situations - psychiatric hospital with male and difficult patients; in casualty where they are likely to deal with violent patients. In general wards, there is not a great need for male nurses; the male orderly does."

**Comparison of Medical Views by Variables**

When comparing medical views by age, staff position, specialty, and country of medical education, no major differences were found among those who gave unqualified approval of men in nursing.

**Summary**

Thirty-four per cent of the doctors expressed unqualified approval of men in nursing. Most of the other doctors limited their role to male wards, psychiatric units, urology, orthopaedics, theatre, and jobs requiring heavy work. As the hospitals increased in size, the percent of doctors giving unqualified approval to male nurses increased.
References:


Kogan et al (1) have looked into working relationships within the British hospital service. They described the authority attached to a role as the right to act at one's discretion, as sanctioned by the institution. The working relationships depend on there existing both clearly defined roles in which there is authority, and on there being in the roles people who have adequate power to make their authority work. The roles and authority need to be clear to those who occupy the roles, and to those with whom relationships are maintained. They feel that the starting point of organisation of the executive hierarchy is the relationship between superior and subordinate, since it is this relationship which carries the dynamics of accountability, and so ensures that effective performance exists in each role. One of the ways A is accountable for B's work is if he can decide what tasks B may NOT carry out; he needs to be able to write reports on B's performance, decide if B is unacceptable to him, and be able to have him removed from under him. When applied to the doctor/nurse relationship, it can be seen that the doctor often feels ultimately responsible for everything that happens to the patient, but compared to years ago, is less and less the nurse's teacher, writing reports on her performance or able to control whether she works on a given ward or not. Carrying the analogy further, Kogan et al suggest that A expects B to use judgement in doing the work, so that A does not have to specify and prescribe every bit of B's work. If the doctor has to specify everything that he wants the nurse to do, he loses much of the help of having a subordinate. The degree of freedom which A gives B reflects the extent to which A feels confident that B can cope.

For effective hospital services today, there is
more of a need for collateral relationships. Under Salmon, the CNO is set up as collateral to the Group Secretary or House Governor roles, and not subordinate to them. This has established the nursing hierarchy as independent of the administrative hierarchy; it has possibly also caused fragmentation in the system. The medical staff are thought to have a considerable and idiosyncratic degree of power (as distinguished from their sanctioned rights), a personal or professional ability to influence other individuals. This personal power is well known in hospital circles, and can be a source of conflict.

The authors also point out that doctors have treatment/prescribing authority. This includes the authority to evaluate the standard of treatment given to patients, and the authority to take action to rectify the treatment. Even though a highly skilled nurse may give treatment outside the expertise of the prescribing doctor, ultimately it all emanates from the doctor's authority to prescribe. The consultant's relationship with nursing staff is in a treatment/prescribing relationship; however, the nursing staff also give services to the consultants not immediately related to prescribed treatment. For example, in the large teaching hospital, she may be involved in research tasks. Occasionally this also causes conflict, as the nurse may see it as being outside her normal role.

The Salmon report (2) was a survey of opinions, and fact finding through visits to British hospitals. The committee was to advise on the senior nursing staff structure (ward sister and above), the administrative functions of the respective grades, and the methods of preparing staff to occupy these grades. They felt that status was to be established by the kinds of decisions the top management made, rather than the number of beds controlled. They used the term 'nursing officers' because it is useful for male and female personnel. They proposed a broad scheme of systematic education and training for promotion upwards, with accent upon progressive increasing of managerial skills. They described the job of ward sister (grade 6) as essentially one of organisation, assigning
jobs to the team under her control. She herself is under the control of the Matron (structural authority) yet acting in accordance with the directions of the medical staff (sapiential authority, described as the right invested in a person, to be heard by reason of expertness or knowledge). By being able to distinguish between structural and sapiential authority, she could more easily deal with her job and all people related to her job. Relief of non-nursing duties was recommended for each grade. Grade 7 was a post for employing a nurse's special clinical abilities, and increased administrative abilities. Grade 8 had less of the professional element, the emphasis being on the deployment of staff and on personnel work. Top management was to have as its primary objects high quality care for patients, and the training of nurses in accordance with professional requirements, by reconciling these two objects in a practical plan. Salmon also looked into the separation of midwifery, psychiatry and nurse education, and suggested integrated control for the future. It was also suggested that there were too many nursing committees, and they could be reduced by means of more informal consultation, plus the combining of some functions. They also recommended that nursing administration should begin at the student nurse level with some formal management instruction.

In this study, the completion of the sentence "My personal view of the Salmon Nursing Structure is ..." brought forth some vehement reactions to the working relationships within the hospital which doctors feel is the product of introducing the Salmon structure.

Some of the answers suggest that the doctor is reflecting the ward sister's dissatisfaction with the system. A fairly large number of the young and foreign doctors are totally unfamiliar with it. The main theme of the responses was that it takes the ward sister off the ward, and out of nursing. A few suggest it is simply a matter of replacing one title for another one. Many feel it creates a top heavy pyramid of administration for nursing. The few who basically approved often qualified their remarks.
"My personal view of the Salmon nursing structure is the same as Mr. Salmon. It was a theoretical exercise which should never have been implemented. The Salmon arrangements have been a disaster."

"... classification is needed, and it is good."

"... gradings are often unfair to the senior nurse. It also makes no allowance for higher qualifications; I know a principal tutor who is a grade 7."

"I know little about it. I hear it from the nurses, and they think it is a mistake, and the previous system was better, because of the move toward administration."

"... I don't like it at all. It gives people different names. You can't call them by number. It may be a convenient method for administration, but it's not for me. Also Grade 7 is a difficult grade to accept. Unless she is tactful, knowledgeable, and so forth, she becomes a nuisance to everyone. Her duties are not clear to me."

"... the Salmon type of nursing takes the nursing out of the nurse. The real intelligent nurse is given paper work, and real nursing is passed to the auxiliary."

"I think the fact that the ward sisters stay at 6 is bad; 7 and up is only useful in a large establishment."

"... a calamity. It is top heavy with senior nursing people. Jobs once requiring two or three now require five or more people. The matron doesn't run her own hospital any more. It is a more costly system. It has divorced the ward sister from the hierarchy; she has to deal with lesser people, and number 8 doesn't hear of her problems. Matron is not seen on the wards any more which is poor for the morale. The ward sister is the biggest tragedy. She can't advance if she wants to remain in bedside nursing."

"... it is better now with this structure. Nursing is too technical for one person to handle, and it will attract better people to stay in nursing."
"... it is terrible, mainly because expert sisters can only get promotion by going into administration, and it is top heavy with administrators. A doctor has to find the right administrator to sort out any problems when once you had one person you would go to."

"... it is perhaps a bit early to judge it; there are some favourable points. I think its principal fault is it removes some of the authority of the ward sister."

The responses to the sentence completion were coded as to those who generally approve of it (most of the comments were good), those who generally disapproved of it (most of the comments were bad), and those who were not familiar with it, or whose answers were not clear, or were equivocal. See Table 62.

### TABLE 62

Medical views of the Salmon nursing structure:
comparison of three hospitals and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basically approve</td>
<td>7</td>
<td>14</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Basically disapprove</td>
<td>71</td>
<td>72</td>
<td>64</td>
<td>69</td>
</tr>
<tr>
<td>Unfamiliar with it, or answer unclear</td>
<td>21</td>
<td>14</td>
<td>28</td>
<td>21</td>
</tr>
</tbody>
</table>

Even though the doctor claims to object to administration for nurses, a large number wanted the ward sister to be a good organiser (see Table 55).

Of the seven doctors who approved of Salmon, five were consultants and two were house officers, four were English and three were foreign trained doctors, four were surgeons and three were physicians.

The Shortage of Nurses

The problems of the career structure in nursing
were again mentioned when doctors were asked to complete the sentence:

"The shortage of nurses is caused by ..." but the majority felt that poor pay and living conditions were the main contributory causes. Some felt it was not only that pay was poor, but that other groups were now competing for women in jobs where the work was less arduous, and the pay considerably better. Many blame the shortage on nurse wastage caused by inflexible administrators with authoritarian views who are unwilling to fit the married nurse into the general hospital scheme. Some suggest that it is a poor public image of nursing as a difficult life, when in fact the job is better than the image of it. Some simply feel that the young people of today are selfish, and not of a dedicated type. One doctor suggested that local girls are deterred from recruiting when a large number of the recruits are coloured. Another felt it was a matter of politics:

"... there are no votes to be gained from spending money on nurses. They merely give lip service to their difficulties. In essence, then, the patient doesn't matter. This doesn't apply to private clinics where the patients do matter."

The doctors' responses were coded into five categories:

a. Poor pay and living conditions (which included having to live in while training)

b. Hours (night duty, split shift, long hours)

c. Authoritarian attitudes, which included doctors, nurses and administrators, students who were treated badly, rigid rules and regulations

d. Type of work and general career structure: poor prospects, poor pension, non-nursing tasks, menial tasks, low status, having to leave nursing for marriage and children

e. Other: Poor public image, poor recruiting techniques,
increasing need for nurses, other jobs less demanding, more competition from other jobs, the young people of today not interested in serving others or working hard, etc.

The reliability analysis yielded less than 85% agreement (60%) on the coding for this sentence completion; therefore the percentages quoted in Table 63 are the researcher's interpretation of the responses, and as such, are not meant to have statistical meaning.

TABLE 63
Doctors' opinions of the cause of the shortage of nurses: comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor pay and living</td>
<td>57</td>
<td>45</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours</td>
<td>7</td>
<td>32</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Authoritarian attitudes</td>
<td>21</td>
<td>18</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Nursing work &amp; structure</td>
<td>29</td>
<td>23</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
<td>54</td>
<td>36</td>
<td>47</td>
</tr>
<tr>
<td>Not coded</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

There were many multiple responses by the doctors.

Nursing as it Exists Today

Many of these same problems were again discussed when the doctor was asked to complete the sentence:

"The worst thing about nursing as it is today is ..."

The doctor mentioned the general shortage of nurses, the working conditions for nurses, the rigid attitudes, the Salmon structure, the poor public image, etc. In addition, a few doctors objected to the type of nurse now coming into
nursing, to the way they are educated, their attitudes about helping the doctor, to problems of communication, and to the lack of devotion to the job.

"The worst thing about nursing today is the terrible wastage occurring with marriage or maternity leave. Few hospitals provide nurseries, so we wouldn't lose them."

"... too few nurses, and not intelligent enough; badly deployed, and foreign. The profession is unattractive to native girls both in terms of conditions of service and rewards of labour."

"... the situation where a nurse can earn three times as much as a private agency nurse than the same job if she contracted as a staff nurse in the same hospital."

"... the nurse's shifts. Nobody knows about the patient. They've either just come on or just gone off. This becomes a communication problem where no one is able to tell the doctor anything."

"... the terribly limited horizons of the average nurse (the result of their authoritarian training and type of education). An example of this is - the operating room nurse has lists, and the surgeon can't deviate from the established routine without upsetting the nurse terribly."

"... nurses do many things that are non-nursing. Then, in out-patient, you can't get them to do dressings, work with the patient, or work with the doctor. The X-rays and notes are left to the housemen. Nurses should do this for the doctor."

"... it is wrong to give a university type of education before a nurse undertakes her vocational training. She is 21 when a nurse gets out of university, and she has a concept that she can't dirty her hands. What I would like is post-graduate courses for qualified nurses who are going to take up a lifelong career in nursing, and give her the education. I advocate a university degree IF the work matches the work of any other group at the university."
"... too much theoretical training and not enough practical training. The emphasis is not on the prevention of bed sores as it once was."

"... nowadays they are not well selected; standards are going down. The older nurses seem to have come from a different group."

"... having nurses of different nationalities in the same ward causing great difficulties." (foreign doctor)

"... nurses who don't stay on duty until the job is finished; the trade union thing - they are busily watching their watches."

Although nursing perceptions of the doctor's expectations of her became increasingly negative as the size of the hospitals increased (see Chapter 11), medical views about the nurse's approach to her job were not significantly different among the three hospitals. See Table 64.

The responses of the doctors were categorised in the following ways:

a. Working conditions: pay, hours, living conditions, competition from other higher paying jobs.

b. Training and academic aspects: poor teaching, not enough practical experience, not enough medical understanding, trained to act like doctors, not bright enough to be in nursing.

c. Shortage of nurses.

d. Career structure of nursing and rigid administrative practices: Salmon, the general nursing structure, rigid attitudes about married nurses, etc.

e. Approach to nursing: civil service approach to nursing, non-devoted nurses, regarding nursing as a job rather than a vocation, traditional practices, selfish attitudes of nurses.

f. Other: attitude of public to nursing, poor communications, the flux of nurses, the number of foreign nurses, etc.
Not Coded: "nothing came to mind."

**TABLE 64**

Medical views about the worst thing in nursing today; comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total Hospital (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working conditions</td>
<td>29</td>
<td>9</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Training &amp; academic aspects</td>
<td>14</td>
<td>14</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Shortage of nurses</td>
<td>21</td>
<td>18</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Career structure &amp; rigid administration</td>
<td>36</td>
<td>14</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Approach to nursing</td>
<td>7</td>
<td>27</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>18</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Not coded</td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

**Team Relationships**

The theme of the deterioration of the nurse/doctor relationship has been discussed by social scientists, nurses and doctors. Peplau (3) hopefully suggests that there was a period of disintegration which has been replaced by reintegration along healthier lines. At the beginning of the century, nurses depended on the doctor for education, advice, guidance and approval. Doctors knew nurses personally and selected them to care for their private patients. In the period preceding the Second World War, there was an overabundance of nurses, and medical students and residents often replaced the student nurse as the doctor's trainee and helper. Since 1945, students have been less vulnerable to hospital exploitation, and are less responsive to unquestioning obedience. In the U.S.A., doctors have sometimes been resentful of the further education of nurses, their use of nurses as their teacher, and their focus on clinical nurses with independent ideas.
Communication problems can be created by the doctor’s lack of understanding of terms currently being used by nurses, such as ‘dependent’ and ‘independent functions’, 'nursing diagnosis', 'nursing rounds', 'clinical nursing research', etc. (4).

Dr. Stein (5), a psychiatrist, says that the underlying attitudes which demand that the interactional framework between doctor and nurse fit a game model, is unfortunate, creating serious obstacles to meaningful communications. If the nurse offers a suggestion, she often makes it appear to be initiated by the doctor, so that she is the passive participant in their game. He feels the doctor carries into his interpersonal professional relationship a defence mechanism against the possibility of error, and develops attitudes of omnipotence which makes accepting advice from a nurse highly threatening. All this inhibits effective dialogue which is both stifling and anti-intellectual. He suggests that both professions take steps to change the attitudes which breed such a game.

Dr. Jacobs (6) also discusses the nurse/physician relationship from a depth-psychological point of view. The doctor builds a barrier against the scientification of nursing in order to avert imminent independence of nurses, which might alter the male/female relationship of regarding the woman as a servant rather than a partner. He feels doctors should recognise and consciously accept the conflict of authority traced back to averted father/daughter relations. Medical students might be instructed to give doctor’s orders a different sound and meaning.

Conran (7) feels it is essential for the doctor and nurse to share an unassailable feeling of mutual respect and interdependence in order that any innovation be introduced to a ward. Specialised units such as renal dialysis and intensive care depend upon a particular esprit de corps in which the nurse has recovered some equality of status. In these units, there seems to be a restoration of the therapeutic triangle where nurses and doctors have
a closer understanding of each other's needs as it relates to patients. Conran recommends a weekly seminar or discussion group to investigate doctor/nurse relations which might help stem some of the falling recruitment and wastage of nurses.

Parry-Jones (8), in his human relations training sessions, found that the problems of communications between nurses and doctors centred on the doctor's lack of recognition of the role of the nurse, or her need for a real sense of interdependence. He says the nurse's humility and traditional subservience to both the profession of nursing and to the doctor is poor.

Reissman (9) mentions a particular problem for medical students in their relationship with nurses. Nurses are familiar with the hospital environment, and the insecure student sees the nurse as someone he needs but resents; he builds up a negative image of the nurse in his early training years, and this has a lasting effect on his attitudes.

In the present study, doctors were asked to complete the sentence

"The nurse/doctor relationship could be improved if ..."

The responses were coded in the following ways:

a. Both interacting by improved communications, team attitudes, having an opportunity to meet and talk; both nurses and doctors change in some way.

b. Doctors change by giving more respect to nurses, listening to nurses, trying to understand their problems, helping them with better instructions.

c. Nurses change by being less bureaucratic, not trying to act like doctors, accept criticism, be more willing to ask questions, get a better education.

d. No problem seen, or essentially a problem of individual personality differences.
The following are examples of responses where the doctor felt both groups need to interact:

"The nurse-doctor relationship could be improved if there was a closer worker relationship; the attitude that there is a big difference between them shouldn't be."

"... we can have some meetings at liberal times; the nurses should have lunch in the same dining room as doctors."

"... product of the complexity of modern medicine with people drifting apart. Both require education into each other's problems; there is also a tendency for nurses to drift away from clinical nursing resulting in problems."

"... in the large teaching hospital, the relationship is beginning to suffer from too many nurses having to relate to too many doctors."

"... it varies with hospitals; you need team attitudes like in theatre for a relaxed atmosphere."

Doctors thought they themselves might change by:

"appreciating what the nurses do, and not expecting to be treated as gods. The fault is mostly on the medical side."

"... doctors gave more informal teaching of nurses, and recognised the problems nurses had in their training, with material problems, etc."

"... more awareness in the medical student's training of the role of the nurse."

"... by better understanding and co-operation. The doctor should tell the nurse what he expects; describe the condition and tell her why he needs her to do various procedures."

Nurses, on the other hand, should make some changes:

"... if the nurse is not up to standard, and the
doctor tells her, the nurses get upset. There are differences in working methods and in approach. It would be best if the sister in charge discussed the various procedures with the new doctors."

"... nurses would not try to be doctors, but stick to nursing the patient and giving them comfort."

"Better understanding by nurses of medical problems, of how to integrate nursing and medical care, and that a doctor needs a nurse to assist him."

"... sometimes the nurses make decisions that should be left to doctors, especially in teaching hospitals; there are many foreign doctors here, and they all feel this way."

"... possibly by giving more responsibility to the nurses and closing the professional gap between medical and nursing staff."

"... as a surgeon, the most crucial place is in the theatre, where you need the nurse to be bright and good humoured; a scrub nurse who sulks puts the patient's welfare at stake; you want a more mature personality in theatre. In out-patient, you want a receptionist-type nurse, so you can use unskilled people there. In the ward, different levels of nurses are needed. For the doctor and sister, communications are the main relationship, and you want the nurse to be reliable and conscientious. How the nurses could be made happier by the doctors: resentment is partially over the pay differential; a few have odd grievances because they would like to be doctors, and try to make medical decisions instead of getting on with nursing work."

Those who felt there was no real problem in the nurse/doctor relationship:

"... by and large relations are very good and better than years ago where the old fashioned ward sister didn't let the doctor on the ward until she decided to."
"... it depends on local circumstances; the relationship here on the whole is good."

"... it is pretty good; personality differences is all, and you can't change these things."

### TABLE 65

Medical views of how the nurse/doctor relationship could be improved; comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both interacting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for change</td>
<td>29</td>
<td>32</td>
<td>38</td>
<td>33</td>
</tr>
<tr>
<td>Doctors change</td>
<td>14</td>
<td>14</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Nurses change</td>
<td>43</td>
<td>27</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>No problem seen</td>
<td>14</td>
<td>32</td>
<td>28</td>
<td>25</td>
</tr>
</tbody>
</table>

In the small hospital, more doctors felt that a problem existed, and 43% suggested that the nurses needed to make some changes. The percentage of doctors who thought that nurses needed to make changes to improve the relationship decreased as the size of the hospital increased.

When comparing medical views by age, staff position, specialty and country of education, the only major difference was that 75% of the doctors who felt the doctor should make changes to improve the relationship were physicians, whereas of those who felt that nurses should change, 76% were surgeons.

### Ward Rounds

Ward rounds is often a time for communication between the doctor and nurse. The importance to a doctor of having a nurse on a ward round was ascertained by asking the doctor to comment on the statement:
"Under normal circumstances, the ward sister or her deputy must accompany the doctor on a ward round."

All but one doctor felt it was essential that the nurse do so; he qualified his statement by saying:

"I don't think so. She has hard work enough. If it is a particularly difficult patient, she goes with them. With chronic patients, it takes up too much time. ICU, yes."

Many doctors felt that the nurse should be present because both can contribute information to each other. Others saw it as a time when the doctor gave his instructions to the nurse. A few suggested that it was good for the patients to see the ward round as a team effort. Some felt it could be used as a teaching session, and others mentioned that on a female ward, it is necessary to have the nurse there to assist with the physical. See Table 66.

### TABLE 66

Doctors' views about the importance of having a nurse accompany the doctor on a ward round; comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential to accompany</td>
<td>100</td>
<td>100</td>
<td>97</td>
<td>99</td>
</tr>
<tr>
<td>Unnecessary to accompany</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Some of their additional comments included:

"... they must invariably (and they never do) so everyone knows what is going on."

"Yes, to bring the senior nursing staff and junior medical staff into discussion on the case. Consultants have passed the age where they simply give orders; everyone contributes. He doesn't see himself
as Kingpin, but has help from others."

"Very much so; as a teaching session, and also the accompanying nurse acts as an intermediary and often as a buffer. The sympathetic nurse allays the patient's anxiety."

"Yes, otherwise she doesn't know what is happening to the patient. Now she is often off duty, and can't do this."

"Yes, as a vital time of day (should be twice a day) when there is integration and exchange between each patient, staff nurse and doctor, and all three have to be present. The problems of the patient come out; observations of staff nurse come out (she is in the ward all day), and orders can be discussed and given. The whole thing is communication which is vital."

"Agree: the staff nurse with the house officer and the sister with the consultant. Sister gives her views on the home situation, reactional situation. In the formal round, the patient knows that the people are coming."

"Yes, and she should want to!".

In the additional comments that doctors made, it was apparent that when the ward sister did not accompany the doctor on ward rounds, the doctors felt quite antagonistic about it. One house officer stated that this problem was being taken to administration by his consultant, and another regretted that the ward sister was often off duty during ward rounds.

The reliability analysis of the categories for the four sentence completions used in this chapter, with three independent judges, yielded the following agreement levels:

1. My personal view of the Salmon nursing structure is ... 87%

2. The shortage of nurses is caused by ... 80%
Summary

Many foreign and young doctors are unfamiliar with the Salmon nursing structure. Most of the remaining doctors disapprove of it because they feel it takes the ward sister out of nursing, stresses administration and uses numbers instead of names. The majority of doctors feel the shortage of nurses is caused by poor pay and living conditions; other reasons include the hours nurses work, authoritarian attitudes, the career structure, the poor public image, the increased need for nurses, and competition from other jobs. Many of these problems were again discussed when the doctor was asked about the worst thing in nursing as it exists today; in addition he mentioned the type of nurses being recruited into nursing, the way they are educated, their attitudes about helping doctors, their lack of devotion to the job, and problems of communication. One third of the doctors felt the nurse/doctor relationship could be improved if both groups made an effort to work as a team. In the small hospital, over 40% of the doctors felt the nurses should change in some way. About one-fourth of all doctors felt there was no problem in the nurse/doctor relationship. Almost all doctors feel it is essential that the nurse accompany the doctor on a ward round in order to facilitate exchange of information, for teaching, and in order that the doctor may have her assistance.
References:


2. Salmon, B. (Chairman) (1966) "Report of the Committee on Senior Nursing Staff Structure" H.M.S.O.


CHAPTER 24

THE EXPANDED ROLE OF THE NURSE

Literature about the Expanded Role of the Nurse

Brown (1) tells us that it is dangerous for nurses to ignore the pervasiveness and power of social trends; nursing may find itself out of step by stoutly maintaining its right to practice in ways it had once deemed appropriate and desirable.

There is a current tendency in the re-organisation of medical and nursing practice to give nurses many of the general practitioner's jobs; these include initial assessment of medical problems for referral, family health counselling, concern for preventive and rehabilitative aspects of disease and disability, etc. Within the general hospital, Dilworth (2) describes nurses who have taken on many of the traditional tasks of the doctor (in the United States). In a medical outpatient department, nurses assess the needs of chronic ambulatory patients in an all-nurse clinic. She also describes a prenatal clinic where nurses take a history, order laboratory work, and do a routine examination. The nurses are also running well-child clinics, giving adolescents care, and doing gynaecological exams.

When discussing the expanded role of the nurse, the crucial argument seems to be that overqualification is wasteful and unproductive. A task which is performed by a person who has much more skill and background knowledge than is needed to perform the particular procedure adequately may be wasting valuable time. For example, the highly specialised paediatrician might be better used in diagnosing and treating seriously ill children, leaving a highly qualified trained nurse the task of counselling the mother of a well-baby. Sheps and Bachar pursue this argument (3).

Peplau (4) asks us to consider the fact that the
critically ill in hospital require a well-organised, equipped, expensive science centre in which medicine is the primary, authoritative profession. Thereafter, patients require a less costly nursing science centre in which professional nursing is the primary discipline. She feels this two-step delivery system is both effective and economical.

Dr. Wilbur (5) says there are three ways we can fulfill our need for more health professionals at levels below the physician. We can educate a group of less sophisticated doctors, and thus create two levels of medical education, develop a completely new professional group with fewer years of education than the physician, or we can raise the educational level of existing professionals (nurses, pharmacists, etc.). He believes the third choice is the best, and the AMA approved the training of 75,000-100,000 nurses as physician's assistants practicing on a fee for service basis to care for the well-baby, as obstetric nurse practitioners, making home visits, etc. In a survey of university trained nurses, McCormack and Crawford found that a majority of these nurses considered an expanded role for nurses to be highly desirable (6).

Mauksch (7) feels that within the hospital, there are no really independent functions of nurses and doctors, but interdependent functions. Because of this, the person in charge must share his plans and objectives. As the core of nursing practice moves from pseudo-mother to clinical specialist, the synthesis of accumulated functions may cause strain. The nurse stays in her unit, and as a result the role of the nurse is profoundly affected by her obligation to represent continuity of time and place. This saddles her with the function of coordinating those who come and go. Mauksch asks if the co-ordination of the patient care system is inevitably the nurses?

Asplund (8) suggests that the contradictions of the nurse's role are caused by the fact that basic nursing care is now a matter of supervision and administration,
with many of the diagnostic and therapeutic functions of the doctor delegated to the nurse. Seivwright (9) feels that role is not static, and may change by expansion of functions, and creation of subsidiary or satellite roles. There is also contraction or displacement of functions, the original role becoming obsolete.

Strauss (10) summarises the current relations between physicians and nurses in the U.S.A. by stating that nurses working with doctors in the hospital or office seldom challenge the superordinate position, but nurses in public health and in university schools of nursing establish an equal-partner relationship.

In addition to assuming these various nursing roles, the nurse is also taking on the function of research into nursing problems. H. Marjorie Simpson (11) outlines the early research which helped to identify factors which influence unsatisfactory conditions, studies of work load, use of non-nursing personnel, centralised services, mechanisation of work, improved equipment, and conservation of nursing skills. Nurses will have to deal in basic research to establish facts, in applied research to improve patient care and help alleviate the nursing shortage, and to enrich curriculum, increase recruitment, and improve the organisation of nursing service. This may require a certain number of nurses to be trained in research methods.

Medical Views about Nursing Research

In the present study, doctors were asked to comment on the statement:

"Research into nursing problems is best done by social scientists" to investigate who the doctor felt should be doing nursing research. The term 'social scientists' provoked such comments as:

"No social scientist should EVER be allowed to carry out a research project that could influence the lives and activities of the society. They are a curse on our society. Research should be done by the Royal
College of Physicians, Surgeons, Nurses in concert with the GNC."

"Yes, better done by someone not involved. However, social scientists are not scientists."

"Keep clear of them; they are the barnacles on the backside of the health service."

Some agreed that the social scientists were the best group because they are most likely to be objective, and because 'it is an academic bit'. Others felt it was better to have nurses doing it if they had special training in research methods, or had assistance from social scientists or nursing organisations such as the RCN or GNC. One doctor felt the nurse should be "adequately qualified; a degree course in nursing is a good idea." Another doctor said: "Research is unnecessary". Several doctors wanted the research to be done only by groups within the hospital - medical staff, administration and nursing personnel. See Table 67.

<table>
<thead>
<tr>
<th>Agree: Social scientists only</th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree: Nurses only or nurses with social scientists</td>
<td>21</td>
<td>63</td>
<td>26</td>
<td>37</td>
</tr>
<tr>
<td>Disagree: Group within hospital alone, or with social scientists</td>
<td>50</td>
<td>9</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Not Coded: no clarification or no answer, or research unnecessary</td>
<td>0</td>
<td>14</td>
<td>18</td>
<td>11</td>
</tr>
</tbody>
</table>

Twenty-three per cent of the doctors felt that nurses alone were the ones to do research into nursing
problems (one in the small hospital, nine in the medium sized hospital, and seven in the large hospital). Sixty per cent of the doctors suggest that the nurse should be involved in the nursing research.

**Medical Views about Orders on the Ward**

Decision making was analysed by asking the doctor to comment on the statement:

"All orders on the ward should emanate from the doctor (activity, diet, medications, etc.)."

A large number of doctors disagree with this, suggesting that nurses also can make decisions, and can initiate activities. Those who agree with the statement feel that the doctor is ultimately responsible for everything.

"... the danger is that things may happen that the doctor is not aware of, and he is ultimately responsible."

"Yes, it must come from one person, not two."

"Yes, otherwise you might find a nurse hasn't understood the problem."

Those who disagree usually mention the ward sister as taking responsibility for some decisions on activity, aspirin, how beds are made, diet, enemas, blanket baths, bed sores, sleeping drugs, etc. Several mention that the ward sister often has more practical experience about these matters than the junior housemen. One worries that "Now, though, they seem to be taking decisions AWAY from the ward sister." Another said: "Rubbish; but this will soon happen unless the status of the ward sister returns to its former level." See Table 68.

The doctors in the small hospital are more likely to retain responsibility for decision making than the doctors in the larger hospitals. There were no major differences when comparing medical views by age, staff position, specialty or country of medical education.
TABLE 63

Doctors' views of decision making on the ward; comparison of three hospitals, and total, by per cent

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 22)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor responsible</td>
<td>43</td>
<td>14</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Nurse makes some decisions</td>
<td>57</td>
<td>86</td>
<td>72</td>
<td>72</td>
</tr>
</tbody>
</table>

Medical Views about Nurse Initiation of Activities

As described in the pilot study, doctors were given a list of activities, and they were asked if the activity was something the SRN can initiate without a doctor's order, can carry out with a doctor's order, or should not be doing at all.

There were two activities which over 90% of the doctors felt could be initiated by nurses: measuring the blood pressure, and encouraging a patient to discuss his worries. In addition, the following activities are those which over 50% of the doctors felt could be initiated by the nurse without a doctor's order:

1. Dress wounds arising from injuries.
2. Teach diabetic self-care.
3. Give psycho-social advice to the obese patient and the geriatric patient.
4. Give the following medicament: aperients.

There were two activities which 49% or more of the doctors felt should only be carried out by the medical staff: administering local anaesthetics by injection, and ordering X-rays. See Table 69.

When comparing the responses of doctors in the three hospitals, there were three activities where there
<table>
<thead>
<tr>
<th>Activity</th>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Measure blood pressure</td>
<td>90</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>2. Start intravenous infusion</td>
<td>16</td>
<td>45</td>
<td>39</td>
</tr>
<tr>
<td>3. Give booster of tetanus toxoid</td>
<td>35</td>
<td>59</td>
<td>7</td>
</tr>
<tr>
<td>4. Local injection of anaesthetics</td>
<td>10</td>
<td>41</td>
<td>50</td>
</tr>
<tr>
<td>5. Measure haemoglobin level</td>
<td>42</td>
<td>49</td>
<td>10</td>
</tr>
<tr>
<td>6. Syringe an ear</td>
<td>30</td>
<td>64</td>
<td>6</td>
</tr>
<tr>
<td>7. Dress wounds</td>
<td>55</td>
<td>42</td>
<td>2</td>
</tr>
<tr>
<td>8. Teach diabetic self-care</td>
<td>63</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>9. Obese patient psycho-social advice</td>
<td>58</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Geriatric patient psycho-social advice</td>
<td>63</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Alcoholic patient psycho-social advice</td>
<td>43</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>10. Suture wounds</td>
<td>17</td>
<td>56</td>
<td>28</td>
</tr>
<tr>
<td>11. Give vitamins</td>
<td>45</td>
<td>51</td>
<td>4</td>
</tr>
<tr>
<td>Give analgesics</td>
<td>48</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>Give aperients</td>
<td>61</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Give indigestion remedies</td>
<td>46</td>
<td>52</td>
<td>2</td>
</tr>
<tr>
<td>12. Give intra-gastric feeding</td>
<td>32</td>
<td>66</td>
<td>3</td>
</tr>
<tr>
<td>13. Order X-rays</td>
<td>6</td>
<td>46</td>
<td>49</td>
</tr>
<tr>
<td>Order physiotherapy</td>
<td>14</td>
<td>59</td>
<td>27</td>
</tr>
<tr>
<td>Order change in diet</td>
<td>15</td>
<td>58</td>
<td>26</td>
</tr>
<tr>
<td>14. Discuss procedures with patient</td>
<td>46</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>15. Discuss patient worries</td>
<td>93</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

**Explanation of Columns**

A - SRN can initiate the activity without a doctor's order
B - SRN can carry out the activity only with a doctor's order
C - SRN should not carry out the activity at all

Total: No. 74 (one doctor in the medium sized hospital did not complete this section)
### TABLE 70
List of activities, and per cent of doctors ticking each column; comparison of three hospitals

<table>
<thead>
<tr>
<th>Activity</th>
<th>Column A</th>
<th></th>
<th>Column B</th>
<th></th>
<th>Column C</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Small</td>
<td>Medium</td>
<td>Large</td>
<td>Small</td>
<td>Medium</td>
<td>Large</td>
</tr>
<tr>
<td>1. Measure blood pressure</td>
<td>93</td>
<td>86</td>
<td>92</td>
<td>7</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>2. Start an intravenous infusion</td>
<td>24</td>
<td>14</td>
<td>10</td>
<td>43</td>
<td>38</td>
<td>54</td>
</tr>
<tr>
<td>3. Give booster of tetanus toxoid</td>
<td>57</td>
<td>38</td>
<td>31</td>
<td>57</td>
<td>57</td>
<td>62</td>
</tr>
<tr>
<td>4. Local injection of anaesthetics</td>
<td>64</td>
<td>52</td>
<td>41</td>
<td>43</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>5. Measure haemoglobin level</td>
<td>57</td>
<td>19</td>
<td>49</td>
<td>43</td>
<td>67</td>
<td>36</td>
</tr>
<tr>
<td>6. Syringe an ear</td>
<td>29</td>
<td>19</td>
<td>41</td>
<td>71</td>
<td>76</td>
<td>46</td>
</tr>
<tr>
<td>7. Dress wounds</td>
<td>50</td>
<td>52</td>
<td>64</td>
<td>43</td>
<td>48</td>
<td>36</td>
</tr>
<tr>
<td>8. Teach diabetic self-care</td>
<td>64</td>
<td>67</td>
<td>59</td>
<td>29</td>
<td>29</td>
<td>36</td>
</tr>
<tr>
<td>9. Obese patient psycho-social advice</td>
<td>70</td>
<td>67</td>
<td>51</td>
<td>14</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Geriatric patient psycho-social advice</td>
<td>64</td>
<td>67</td>
<td>59</td>
<td>14</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Alcoholic patient psycho-social advice</td>
<td>36</td>
<td>52</td>
<td>41</td>
<td>29</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>10. Suture wounds</td>
<td>14</td>
<td>24</td>
<td>13</td>
<td>57</td>
<td>48</td>
<td>62</td>
</tr>
<tr>
<td>11. Give vitamins</td>
<td>36</td>
<td>52</td>
<td>46</td>
<td>57</td>
<td>48</td>
<td>49</td>
</tr>
<tr>
<td>Give analgesics</td>
<td>36</td>
<td>57</td>
<td>51</td>
<td>57</td>
<td>43</td>
<td>49</td>
</tr>
<tr>
<td>Give aperients</td>
<td>64</td>
<td>57</td>
<td>62</td>
<td>36</td>
<td>43</td>
<td>38</td>
</tr>
<tr>
<td>Give indigestion remedies</td>
<td>43</td>
<td>43</td>
<td>51</td>
<td>50</td>
<td>57</td>
<td>49</td>
</tr>
<tr>
<td>12. Give intra-gastric feeding</td>
<td>43</td>
<td>19</td>
<td>33</td>
<td>57</td>
<td>76</td>
<td>64</td>
</tr>
<tr>
<td>13. Order X-rays</td>
<td>0</td>
<td>10</td>
<td>8</td>
<td>50</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td>Order physiotherapy</td>
<td>0</td>
<td>24</td>
<td>13</td>
<td>71</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>Order change in diet</td>
<td>7</td>
<td>29</td>
<td>10</td>
<td>64</td>
<td>52</td>
<td>59</td>
</tr>
<tr>
<td>14. Discuss procedures with patient</td>
<td>57</td>
<td>43</td>
<td>38</td>
<td>14</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>15. Discuss patient worries</td>
<td>93</td>
<td>86</td>
<td>100</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

**Explanation of Columns**

A - SRN can initiate the activity without a doctor's order

B - SRN can carry out the activity only with a doctor's order

C - SRN should not carry out the activity at all

<table>
<thead>
<tr>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 14</td>
<td>No. 21</td>
<td>No. 39</td>
<td>No. 74</td>
</tr>
</tbody>
</table>
was major disagreement about nurse initiation of activities. In the medium sized hospital, only 19% of the doctors felt she should measure the haemoglobin level, syringe an ear, or give intra-gastric feeding, and in the other two hospitals, a greater per cent of doctors felt she could initiate these activities. See Table 70.

From the doctor's point of view, the role of the nurse includes initiation of some technical procedures, giving emotional support to patients, teaching, and giving medicaments. The nurse's role included (with the doctor's orders) most of the activities presented on the list, with the exception of ordering X-rays and giving local anaesthetics by injection. Over half the doctors feel the nurse should be capable of starting an intravenous infusion, and suturing wounds.

Each doctor was given a total score depending on the number of ticks he placed in each column. Of the 74 doctors completing this section, 25 had low nurse initiation scores, 40 had medium scores, and nine had high nurse initiation scores. See Table 71.

<table>
<thead>
<tr>
<th></th>
<th>Small Hospital (No. 14)</th>
<th>Medium Hospital (No. 21)</th>
<th>Large Hospital (No. 39)</th>
<th>Total (No. 74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low initiation</td>
<td>29</td>
<td>33</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Medium initiation</td>
<td>57</td>
<td>57</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>High initiation</td>
<td>14</td>
<td>10</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

The doctors' scores were similar in all three hospitals.

Among those with low nurse initiation scores, there were no major differences because of age, specialty or country of medical education. There was a larger per
cent from the house officer group, and a relatively lower per cent from the registrar group. Among those with high nurse initiation scores, this was reversed. Fifty-six per cent were from the registrar group, and 22% were house officers. Also 44% of those with high nurse initiation scores were doctors trained in a foreign medical school (as compared with a total sample of 28%).

When comparing doctors' nurse initiation scores with their responses to nurses making some decisions (Table 68), no differences were found. The average score for those doctors who felt all orders should emanate from the doctor was 27, and the average score for those who felt nurses were capable of making some decisions was 28.

**Summary**

Sixty per cent of doctors include nurses in a research role. Seventy-two per cent of the doctors see the nurse as capable of making decisions about the patient's activity, diet, and medications. In the small hospital, fewer doctors suggest the nurse can make decisions as compared with doctors in the other two hospitals. Most doctors feel a nurse can measure the blood pressure and encourage a patient to discuss his worries without having a doctor's order to do these activities. Over half the doctors also felt she could initiate the dressing of wounds, teaching of diabetic self-care, giving of aperients, and giving psycho-social advice to obese and geriatric patients. Twelve per cent of the doctors feel the nurse can initiate a large number of activities on the list presented to them; over half of these doctors were from the registrar group.
References:


CONCLUSION: SOME SUGGESTIONS FOR CONSIDERATION

As a result of exploring doctors' views of the role of the nurse, it was found that the doctor is most concerned with the technical aspects of the nurse's work. This should cause no great concern for the nurse, as she, too, considers it to be of primary importance. However, they do differ in two major areas; basic care, and assisting the doctor. Although the doctor stresses practical nursing when he talks about the role of the nurse, he gives relatively low priority to tasks of bathing, making beds, and distributing food. Although the student must learn to do all these things effectively, she probably will not be spending a significant portion of her time with these jobs once she is a staff nurse. Many of the technical tasks cannot be done by ancillary staff, so it is logical that the training of student nurses emphasise technical competence.

Unless there are major changes made in ward communication techniques, nurses attendance on ward rounds will continue to be of major importance to doctors, and should not be downgraded by nurses. On a ward having patients with conditions requiring care by consultants in several sub-specialties, the ward sister may find it difficult to make ward rounds with everyone; she should then delegate this responsibility to a staff nurse or senior student, being sure they are adequately informed about the patients included in the round. The substitute should keep a summary of decisions made to 'feed back' to the ward sister. In turn, this would provide an excellent opportunity for the doctor to contribute to the education of the nurse by communicating to her his rationale of treatment, and giving her the chance to ask for clarification of obscure points.

The nurses rate reporting and receiving reports higher than do the doctors. Report should be recognised as a time when important communications are passed from one
group of nurses to another, and as such, is as important
to the doctor as it is to the nurse, so that his orders
will be effectively transmitted. The doctor should also
understand that the ward sister often uses this time to
teach student nurses.

Assisting the doctor with technical procedures
was particularly important to foreign doctors and junior
housemen. Ward sisters should try to be more sympathetic
to the problems of both of these groups of doctors, and
attempt to 'ease' their feelings of strangeness and lack
of familiarity with ward routines by formal introductory
lectures, informal explanations, emotional support, and
appropriate assistance with various procedures.

Nurses must not stress technical competence at
the expense of continuing to give patients the emotional
support that is so strongly needed, as evidenced by patient
comments. Therefore the training of nurses (and doctors)
should include methods of dealing with the emotional
problems of hospitalised patients. It is quite probable
that lectures in this area could be combined for the medi­
cal and nursing profession.

The doctor feels that a good ward sister has to
be a good organiser, yet regrets that present day nursing
stresses administration. He must realise that the nurse
is committed to learning management techniques, since she
is currently being used as the person who assigns jobs,
and co-ordinates the activities of the various groups who
have business on the ward. If, on the other hand, nurses
and doctors are found to believe this should NOT be the
ultimate responsibility of a ward sister, other people
will have to be found for this work (non-nursing admini­
strative people, or mature women with a previous nursing
background, for example). Then instead of training ward
sisters in management, post-graduate clinical courses might
be implemented to place the ward sister in a position
analogous to the consultant.

Doctors blame the introduction of the Salmon
nursing scheme for the present emphasis of administration
for nurses. It is more likely that over the years, as hospitals became more complex, supervision of the tremendous number of personnel involved with patient care was thrust on the nurse by default. The basic question is not whether Salmon is good or bad, but whether it is inefficient to train nurses in tasks that are not used once she reaches grade 6. If the management of a ward could be handled better by non-nurses, then administrative tasks should be removed from the role of the nurse, and she should be returned to clinical work. This is something that doctors and nurses must explore together.

If nurses are to improve their professional status, doctors will have to understand that a percentage of university trained nurses are needed for teaching, research, and upgrading clinical nursing. It would be most beneficial if doctors recognised the potential use of nurses with degrees. It is the author's belief that very few nurses in fact have the desire to be doctors, but rather wish to be more effective nurses with sound theoretical backgrounds. Nurses can be good practical people while at the same time acquiring an understanding of the principles needed for technical competence, as is the case with doctors. It would be helpful if the doctor recognised some of the deficiencies of the apprenticeship system for training nurses, and tried to upgrade the student nurses' education by trying to link all of their studies with their practical experience. Student nurses should have full student status, and not be used only as a source for staffing wards. Modern medicine requires high quality nursing, and students with O and A levels should not be lost to the profession because of lack of opportunity for advanced education.

The medical approach to the problem of the shortage of nurses was similar to the nurses, and suggestions for change have already been considered in Chapter 16.

The rapid turnover of ward sisters has contributed to problems in the nurse/doctor relationship. Informal discussions at coffee time of each other's professional problems
might help counteract this, and combined teaching sessions (introductory ward lectures by the ward sister to the student nurses and junior housemen; also teaching sessions for both groups by the consultant) might serve to improve understanding.

If the role of the nurse is to be expanded to include such tasks as starting intravenous infusions, suturing wounds, giving dangerous drugs, teaching patients self-care, giving psychological support, then it is important for those who teach the student nurse to include these tasks in their practical instruction and theoretical understanding. Doctors and nurses must decide what technical activities are to be included in the nurse's role, and how best to utilise the nurse's qualifications.

This portion of the study dealt with medical staff views of the role of the nurse. Doctors seem to be interested in the issues confronting the nursing profession, and should be approached as partners in attempting to solve problems of improved patient care, education of tomorrow's nurse, and clarification of the borders between the doctor's and nurse's roles.

Although this research is primarily descriptive, it is hoped that it may provide a basis for further studies of an experimental nature, using the questionnaire devised as a tool for measuring patient satisfaction with nursing care. It is also hoped that this thesis has not only communicated the results of the study, but will be instrumental in stimulating those in positions of authority to institute changes based on its recommendations.
APPENDIX A

PILOT STUDY OF NURSE/PATIENT EXPECTATIONS AND ROLE PERCEPTION

1. Questionnaire 1 - (Patients)

A research project "the study of nursing care" is being conducted at the Royal College of Nursing. This portion of the study is concerned with what the patient expects of a nurse and how the nurse sees her role.

Your responses on the questionnaire will be anonymous, so don't sign your name. Do not ask others about the questions. We are interested in your ideas. Do not omit any item, since a complete questionnaire from each person is essential. Thank you for your time and co-operation.

PART 1 Would you answer the following questions? If you do not know the different types of ward personnel, simply state this, and go on to the next question.

1. Would you explain the difference between a pupil nurse and a student nurse in terms of uniform, years of training and types of duties?
2. Can you tell me how you identify the staff nurse, and what are her main duties?
3. How would you say the ward sister spends most of her time?
4. What other types of personnel work on the ward, and what do they do?

PART 2 Complete the following sentences. There are no right or wrong answers, so put the first ideas that occur to you.

5. A nurse should always ____________________________
6. A good nurse is one who ____________________________
7. Years ago, nurses ________________________________
8. Today, nurses ____________________________

9. A good patient is one who _______________________

10. When a patient is worried, he should _____________

11. Patients get upset when _______________________

12. The main thing a patient expects of a nurse is ___

PART 3 Following are some statements made about nurses.
You are asked to express your own agreement or
disagreement with each statement. Circle letter
(a) if you strongly agree, letter (b) if you
agree, (c) if you disagree and letter (d) if you
strongly disagree about each statement.

13. In general, the quality of nursing service has im­
proved over the past ten years:–
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree

14. Nurses today seem more concerned with their own
   problems than with the care of patients:–
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree

15. Nurses spend too much time away from the patient, and
   not enough time doing bedside nursing.
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree

16. Nurses are careful to respect the dignity of the
    patient.
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree
17. Nurses tend to be cold and disinterested in patients.
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree

18. Nurses don't take enough time to talk to patients and answer their questions.
   a. strongly agree
   b. agree
   c. disagree
   d. strongly disagree

PART 4 Following are some activities on which ward staff spend their time. Will you please read all of these, and decide which tasks are the most important to you. Then rate them from most important (1) to least important (10).

( ) Preparing and distributing meals and drinks to patients.

( ) Attending on consultants and other medical staff visiting ward.

( ) Taking and recording temperature, pulse, respiration and blood pressure.

( ) Clerical/reception type duties such as filing, completing case notes, etc.

( ) Giving general basic care to patients such as washing, making beds, giving bedpans.

( ) Talking with patients to provide reassurance and support.

( ) Giving medicine, injections, dressing wounds, and doing other treatments.

( ) Reporting, and receiving reports on change of shift.

( ) Assisting doctors with technical procedures.

( ) Answering the questions of patients and their families.
PART 5 Below are some incomplete sentences. Each is followed by some alternatives. Circle the letter preceding the statement that seems to complete the sentence best.

19. When a patient is worried about his illness, he usually talks about it to:—
   a. the doctor
   b. the nurse
   c. the other patients
   d. a member of his family
   e. a minister of religion
   f. no one

20. Nurses' tasks are such that:—
   a. it is impossible for them to get to know a patient
   b. they get to know a little about the patient
   c. they get to know a patient very well

21. When a patient needs some information relating to his illness, he can turn to:—
   a. the doctor
   b. the nurse
   c. another patient
   d. other ward personnel

22. A good ward sister is one who:—
   a. has a great deal of skill and knowledge
   b. manages the ward with efficiency
   c. carries out the doctor's orders properly
   d. is kind and understanding to patients

23. If qualified nurses had more time, they could devote it to:—
   a. talking with patients
   b. the teaching of students and other staff
   c. improving the facilities of the ward
   d. assisting the doctor with procedures

24. I feel that nursing care on this ward is:—
   a. highly satisfactory; it could not be better
b. satisfactory; most of the things that are done are fine, but a few things can be improved

c. poor; some of the services are adequate but the majority could be better

d. very poor; everything needs to be improved.

Additional Comments:

Personal Information Sheet

SEX: Male Female

AGE: Under 20 20-29 30-39 40-49 50-59 60-69 over 70

MARITAL STATUS: Single Married Divorced Separated Widowed

COUNTRY OF BIRTH: ___________________

RELIGION: R.C. C.of E. no affil. Jewish Other

NUMBER OF PREVIOUS HOSPITALISATIONS: 0 1 2 3 or more

JOB DESCRIPTION: ___________________

self-employed employee employer
retired student other

If married woman, and not working:
Former employment ___________________
Husband's occupation ___________________

EDUCATION:

a. Primary
b. Grammar Secondary Comprehensive
c. GCE CSE City and Guilds
   0 Levels
   A Levels
d. University

DIAGNOSIS: ___________________
APPENDIX A

2. Questionnaire 1 - (Nurses)

A research project, "the study of nursing care", is being conducted by the Royal College of Nursing. This portion of the study is concerned with what the patient expects from a nurse, and how the nurse sees her role.

Your responses on the questionnaire will be anonymous, so don't sign your name. Do not ask others about the questions. We are interested in your ideas. Do not omit any item, since a complete questionnaire from each person is essential. Thank you for your time and co-operation.

PART 1 Complete the following sentences. There are no right or wrong answers, so put the first ideas that occur to you.

1. A nurse should always ____________________________
2. A good nurse is one who __________________________
3. Years ago, nurses ________________________________
4. Today, nurses ________________________________
5. A good patient is one who __________________________
6. When a patient is worried he should ________________
7. Patients get upset when __________________________
8. The main thing a patient expects of a nurse is __________
9. The pupil nurse ________________________________
10. Doctors expect nurses to __________________________
11. Visitors usually ________________________________
12. I chose nursing as a career because __________________
13. Staff nurses usually ______________________________
14. The hospital expects the nurse to __________________
15. Student nurses learn from __________________________
16. I like patients who ______________________________
17. A well run ward is one ______________________________
18. The greatest problem in nursing today is _________

19. Five years from now, I hope to be ________________

20. When I have spent a satisfying day on the ward, the things that have made it that way include _________

PART 2 Following are some activities on which ward staff spend their time. Will you please read all of these and decide which tasks are the most important (1) to least important (10).

( ) Preparing and distributing meals and drinks to patients.

( ) Attending on consultants and other medical staff visiting ward.

( ) Taking and recording temperature, pulse, respiration and blood pressure.

( ) Clerical/reception type duties such as filing, completing case notes, etc.

( ) Giving general basic care to patients, such as washing, making beds, giving bedpans.

( ) Talking with patients to provide reassurance and support.

( ) Giving medicine, injections, dressing wounds, and doing other treatments.

( ) Reporting, and receiving reports on change of shift.

( ) Assisting doctors with technical procedures.

( ) Answering the questions of patients and their families.

PART 3 Below are some incomplete sentences. Each is followed by some alternatives. Circle the letter preceding the statement that seems to complete the sentence best.

21. When a patient is worried about his illness, he usually talks about it to:--
a. the doctor  
b. the nurse  
c. the other patients  
d. a member of his family  
e. a minister of religion  
f. no one

22. Nurses' tasks are such that:-
   a. it is impossible for them to get to know a patient  
   b. they get to know a little about the patient  
   c. they get to know a patient very well

23. When a patient needs some information relating to his illness he can turn to:-
   a. the doctor  
   b. the nurse  
   c. another patient  
   d. other ward personnel

24. A good ward sister is one who:-
   a. has a great deal of skill and knowledge  
   b. manages the ward with efficiency  
   c. carries out the doctor's orders properly  
   d. is kind and understanding to patients

25. If qualified nurses had more time, they could devote it to:-
   a. talking with patients  
   b. the teaching of students and other staff  
   c. improving the facilities of the ward  
   d. assisting the doctor with procedures

26. Nursing care on this ward could be improved if:-
   a. there were more nurses  
   b. communications were better among the staff  
   c. there was better equipment with which to work  
   d. other (specify) ________________________

Additional Comments:
Personal Information Sheet

SEX: Male Female


MARITAL STATUS: Single Married Divorced Separated Widowed

COUNTRY OF BIRTH: __________________________

PRESENT POSITION: Ward Sister Staff Nurse Enrolled Nurse
Student Nurse (1,2,3,4) Pupil Nurse (1,2)

PREVIOUS EMPLOYMENT: (Begin with first job after training school. Please include nursing and non-nursing jobs)

<table>
<thead>
<tr>
<th>Position</th>
<th>Organisation</th>
<th>Number of years Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EDUCATION:

a. Grammar Secondary Comprehensive (Single sexed or mixed)

b. Route of entry into nursing school:
   GCE General Nursing Council Entry Test

c. Scholastic achievement:
   GCE CSE City and Guilds
   O Levels Subjects:
   A Levels Subjects:

d. SRN RMN RSCN RNMS
   SCM Part 1
   Part 2
   SEN Assessment
   Seniority

e. Post Registration Courses (Please specify whether nursing or non-nursing) Administration:
   Academic:
## TABLE A

Per cent of highly satisfied patients by age, sex, number of previous hospitalisations, social class, length of stay in hospital and type of patient

<table>
<thead>
<tr>
<th></th>
<th>Per Cent of High Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE:</strong></td>
<td></td>
</tr>
<tr>
<td>16 - 39</td>
<td>33</td>
</tr>
<tr>
<td>40 - 59</td>
<td>40</td>
</tr>
<tr>
<td>60+</td>
<td>76</td>
</tr>
<tr>
<td><strong>SEX:</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>67</td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
</tr>
<tr>
<td><strong>NO. OF PREVIOUS HOSP.</strong></td>
<td></td>
</tr>
<tr>
<td>0 or 1</td>
<td>67</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>3 or more</td>
<td>44</td>
</tr>
<tr>
<td><strong>SOCIAL CLASS:</strong></td>
<td></td>
</tr>
<tr>
<td>I or II</td>
<td>49</td>
</tr>
<tr>
<td>III</td>
<td>62</td>
</tr>
<tr>
<td>IV or V</td>
<td>78</td>
</tr>
<tr>
<td><strong>LENGTH OF STAY IN HOSP.:</strong></td>
<td></td>
</tr>
<tr>
<td>up to 1 month</td>
<td>69</td>
</tr>
<tr>
<td>1 - 2 months</td>
<td>33</td>
</tr>
<tr>
<td>over 2 months</td>
<td>25</td>
</tr>
<tr>
<td><strong>TYPE OF PATIENT:</strong></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>74</td>
</tr>
<tr>
<td>Surgical</td>
<td>42</td>
</tr>
</tbody>
</table>

No. 45
TABLE B
Patient expectations of the nurse, by per cent*

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Technical Care</th>
<th>Emotional Support</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The main thing a patient expects of a nurse is</td>
<td>67</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>A good nurse is one who</td>
<td>42</td>
<td>67</td>
<td>4</td>
</tr>
<tr>
<td>A nurse should always</td>
<td>29</td>
<td>69</td>
<td>4</td>
</tr>
</tbody>
</table>

* Several patients gave more than one category of response, and totals are more than 100%.

No. 45.

TABLE C
Patient self-role conceptions, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Passive</th>
<th>Co-operative</th>
<th>Independent</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good patient is one who</td>
<td>49</td>
<td>40</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

No. 45

TABLE D
Patient discomforts, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Emotional</th>
<th>Physical</th>
<th>Deny or Not Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients get upset when</td>
<td>67</td>
<td>27</td>
<td>13</td>
</tr>
</tbody>
</table>

No. 45
### TABLE E
Reference group for patient worries, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Nurse</th>
<th>Doctor</th>
<th>Someone</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a patient is worried, he should (talk to)</td>
<td>81</td>
<td>43</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

No. 42

### TABLE F
Nurse self-role conceptions, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Technical Care</th>
<th>Emotional Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>The main thing a patient expects of a nurse is</td>
<td>82</td>
<td>59</td>
</tr>
<tr>
<td>A good nurse is one who</td>
<td>48</td>
<td>76</td>
</tr>
<tr>
<td>A nurse should always</td>
<td>68</td>
<td>32</td>
</tr>
</tbody>
</table>

No. 22

### TABLE G
Nurse conceptions of the role of patient, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Passive</th>
<th>Cooperative</th>
<th>Independent</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good patient is one who</td>
<td>18</td>
<td>68</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>I like patients who</td>
<td>5</td>
<td>68</td>
<td>18</td>
<td>9</td>
</tr>
</tbody>
</table>

No. 22
TABLE II
Nurse views of patient discomforts, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Emotional</th>
<th>Physical</th>
<th>Deny or Not Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients get upset when</td>
<td>82</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

No. 22

TABLE I
Nurse reference group for patient worries, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Nurse</th>
<th>Doctor</th>
<th>Someone</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a patient is worried, he should (talk to)</td>
<td>59</td>
<td>23</td>
<td>36</td>
</tr>
</tbody>
</table>

No. 22

TABLE J
Nurse concepts of a well run ward, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Organisation</th>
<th>Happy Atmosphere</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A well run ward is one</td>
<td>50</td>
<td>45</td>
<td>9</td>
</tr>
</tbody>
</table>

No. 22

TABLE K
Nurse conception of hospital expectations, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Positive</th>
<th>Negative</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital expects the nurse to</td>
<td>77</td>
<td>23</td>
<td>0</td>
</tr>
</tbody>
</table>

No. 22
**TABLE L**

Nurse views of visitors, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Positive</th>
<th>Negative</th>
<th>Personal Needs</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visitors usually</td>
<td>23</td>
<td>45</td>
<td>27</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 22

**TABLE M**

Nurse views of doctor expectations, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Carry Out Orders</th>
<th>Assist Doctor</th>
<th>Nursing Competence</th>
<th>Impossible Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors expect nurses to</td>
<td>36</td>
<td>14</td>
<td>23</td>
<td>27</td>
</tr>
</tbody>
</table>

No. 22

**TABLE N**

Nurse conceptions of the role of staff nurse, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Like a Sister</th>
<th>Help Gen. Nursing Duties</th>
<th>Too Much Respons.</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurses usually</td>
<td>36</td>
<td>18</td>
<td>27</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 22
### TABLE 0
Nurse views of student learning, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Experience</th>
<th>Nurses</th>
<th>Tutors</th>
<th>Doctors</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurses learn from</td>
<td>32</td>
<td>54</td>
<td>18</td>
<td>9</td>
<td>27</td>
</tr>
</tbody>
</table>

No. 22

### TABLE P
Nurse views of the pupil nurse, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
<th>No Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pupil nurse</td>
<td>41</td>
<td>50</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>

No. 22

### TABLE Q
Reasons for entering nursing, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Help People</th>
<th>Be Useful</th>
<th>Like People</th>
<th>Personal Satisfaction</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I chose nursing as a career because</td>
<td>45</td>
<td>5</td>
<td>18</td>
<td>32</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 22

### TABLE R
Nursing satisfactions and relationships, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Reference to</th>
<th>Patient</th>
<th>Self</th>
<th>Staff</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I have spent a satisfying day on the ward, the things that made it that way include</td>
<td>86</td>
<td>54</td>
<td>41</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
TABLE S
Nurse views of problems in nursing, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Shortage</th>
<th>Wages</th>
<th>Hours</th>
<th>Non-nursing</th>
<th>Other duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>The greatest problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in nursing today is</td>
<td>36</td>
<td>18</td>
<td>14</td>
<td>14</td>
<td>36</td>
</tr>
</tbody>
</table>

No. 22

TABLE T
Future plans of nurses, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>In Nursing</th>
<th>Out of Nursing</th>
<th>Not Clear or No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five years from now, I hope to be</td>
<td>68</td>
<td>9</td>
<td>23</td>
</tr>
</tbody>
</table>

No. 22
A research project, "the study of nursing care", is being conducted by the Royal College of Nursing. This portion of the study is concerned with what the patient expects of a nurse and how the nurse sees her role.

Your responses on the questionnaire will be anonymous, so don't sign your name. Do not ask others about the questions. We are interested in your ideas. Do not omit any item, since a complete questionnaire from each person is essential. Thank you for your time and co-operation.

Personal Information

SEX: Male Female

  over 70

MARITAL STATUS: Single Married Divorced Separated Widowed

COUNTRY OF BIRTH: ____________________________

NO. OF HOSPITALISATIONS: 1 2 3 or more

JOB DESCRIPTION: ____________________________

EDUCATION: None until 14 until 16 until 18 University

REASON FOR HOSPITALISATION: ____________________________

LENGTH OF HOSPITALISATION: 4-7 days 1-2 weeks 2-4 weeks
  1-2 months over 2 months

NUMBER OF DAYS ON THIS WARD: ____________________________

PART 1 Following are some activities on which nursing staff spend their time. Will you please read all of these, and decide which tasks are the most important
to you. Then rate them from most important (1) to least important (10).

( ) Preparing and distributing meals and drinks to patients.
( ) Attending on consultants and other medical staff visiting ward.
( ) Taking and recording temperature, pulse, respiration and blood pressure.
( ) Clerical/reception type duties such as filing, completing case notes, etc.
( ) Giving general basic care to patients such as washing, making beds, giving bedpans.
( ) Talking with patients to provide reassurance and support.
( ) Giving medicine, injections, dressing wounds and doing other treatments.
( ) Reporting and receiving reports on change of shift.
( ) Assisting doctors with technical procedures.
( ) Answering the questions of patients and their families.

PART 2 Following are some statements made about nurses. You are asked to express your own agreement or disagreement with each statement.

1. In general, the quality of nursing service has improved over the past ten years:
   a. agree
   b. disagree

2. Nurses are careful to respect the dignity of the patient:
   a. agree
   b. disagree

3. Nurses don't take enough time to talk to patients and
answer their questions:
  a. agree
  b. disagree

4. Nurses tend to be cold and disinterested in patients:
   a. agree
   b. disagree

5. Nurses spend too much time away from the patient and not enough time doing bedside nursing:
   a. agree
   b. disagree

6. Nurses today seem more concerned with their own problems than with the care of patients:
   a. agree
   b. disagree

PART 3 Complete the following sentences. There are no right or wrong answers, so put the first ideas that occur to you.

1. The main thing a patient expects of a nurse is ______
2. A good patient is one who __________________________
3. When a patient is worried, he should _____________
4. A good ward sister is one who _______________________
5. Patients get upset when ____________________________
6. A nurse should always ____________________________

PART 4 Below are some incomplete sentences. Each is followed by some alternatives. Circle the letter preceding the statement that seems to complete the sentence best.

7. If qualified nurses had more time, they could devote it to:
   a. explaining things to patients.
   b. the teaching of students and other staff.
   c. improving the facilities of the ward.
   d. (any other) ___________________
8. Nurses' tasks are such that:
   a. it is impossible for them to get to know a patient.
   b. they get to know a little about the patient.
   c. they get to know a patient very well.

9. I feel that nursing care on this ward is:
   a. highly satisfactory; it could not be better.
   b. satisfactory; most of the things that are done are fine, but a few things can be improved.
   c. poor; some of the services are adequate but the majority could be better.

Additional Comments:
APPENDIX B

2. Questionnaire 2 - (Nurses)

A research project, "the study of nursing care", is being conducted by the Royal College of Nursing. This portion of the study is concerned with what the patient expects of a nurse, and how the nurse sees her role.

Your responses on the questionnaire will be anonymous, so don't sign your name. Do not ask others about the questions. We are interested in your ideas. Do not omit any item, since a complete questionnaire from each person is essential. Thank you for your time and co-operation.

PART 1 Following are some activities on which nursing staff spend their time. Will you please read all of these, and decide which tasks are the most important to you. Then rate them from most important (1) to least important (10).

( ) Preparing and distributing meals and drinks to patients.

( ) Attending on consultants and other medical staff visiting ward.

( ) Taking and recording temperature, pulse, respiration and blood pressure.

( ) Clerical/reception type duties such as filing, completing case notes, etc.

( ) Giving general basic care to patients, such as washing, making beds, giving bedpans.

( ) Talking with patients to provide reassurance and support.

( ) Giving medicine, injections, dressing wounds, and doing other treatments.

( ) Reporting, and receiving reports on change of shift.
( ) Assisting doctors with technical procedures.
( ) Answering the questions of patients and their families.

PART 2 Complete the following sentences. There are no right or wrong answers, so put the first ideas that occur to you.

1. A nurse should always _____________________________
2. When a patient is worried he should ________________
3. Patients get upset when ___________________________ 
4. The main thing a patient expects of a nurse is _____
5. The pupil nurse _________________________________
6. Doctors expect nurses to __________________________
7. Visitors usually __________________________________
8. I chose nursing as a career because ________________
9. Staff nurses usually ______________________________
10. The hospital expects the nurse to _________________
11. Student nurses learn from _________________________
12. I like patients who ______________________________
13. A well run ward is one __________________________
14. The greatest problem in nursing today is _________
15. Five years from now, I hope to be ________________
16. A day on the ward is satisfying to me when ________

PART 3 Below are some incomplete sentences. Each is followed by some alternatives. Circle the letter preceding the statement that seems to complete the sentence best.

17. Nurses' tasks are such that:-
   a. it is impossible for them to get to know a patient.
   b. they get to know a little about the patient.
   c. they get to know a patient very well.
18. If qualified nurses had more time, they could devote it to:
   a. explaining things to patients.
   b. the teaching of students and other staff.
   c. improving the facilities of the ward.
   d. assisting the doctor.

19. Nursing care on this ward could be improved if:
   a. there were more nurses.
   b. communications were better among the staff.
   c. there was better equipment with which to work.
   d. other (specify) _________________________

Additional Comments:

Personal Information Sheet

SEX: Male Female


MARITAL STATUS: Single Married Divorced Separated Widowed

COUNTRY OF BIRTH: _________________________

PRESENT POSITION: Ward Sister Staff Nurse Enrolled Nurse
                   Student Nurse (1,2,3,4) Pupil Nurse (1,2)

LENGTH OF TIME ON THIS WARD: _________________________

PREVIOUS EMPLOYMENT: (Begin with first job after training school. Please include nursing and non-nursing jobs)

<table>
<thead>
<tr>
<th>Position</th>
<th>Organisation</th>
<th>Number of years Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FATHER’S OCCUPATION: _________________________
EDUCATION:

a. Elementary  
b. Technical

c. Grammar Secondary Comprehensive (Single sexed or mixed)

d. Route of entry into nursing school:
   GCE General Nursing Council Entry Test

e. Scholastic achievement:
   GCE CSE City and Guilds

   O Levels _____ Subjects: _______________________
   A Levels _____ Subjects: _______________________

f. SRN RMN RSCN RNMS
   SCM Part 1
       Part 2
   SEN Assessment
       Seniority

g. Post-Registration Courses (Please specify whether nursing or non-nursing)

   Administration:
   Academic:
Dear Sister/Nurse,

"The Study of Nursing Care"

As you may have already been informed, your matron has agreed to take part in a research project which is looking into the relation between what a patient expects of a nurse, and how the nurse sees her role. This project forms part of a larger study of nursing care which has been sponsored by the Department of Health.

In connection with this, I shall be visiting your ward for a day or two, talking with patients, and asking ward sisters, staff and student nurses to complete a questionnaire. This information is completely confidential, and no names will be attached to your replies.

It will be a great help to my study if you will complete a questionnaire, which should take about fifteen minutes of your time. This can be done either off duty by yourself, or during an interview period with me.

I look forward to meeting you.

Yours sincerely,

Mrs. E. R. Anderson, R.N.
Research Assistant
APPENDIX C

PILOT STUDY OF MEDICAL STAFF VIEWS
OF THE ROLE OF THE NURSE

1. Questionnaire 3 - (Doctors)

A research project, "the study of nursing care", is being conducted by the Royal College of Nursing. One of several studies undertaken investigated role conceptions of nurses and patients about themselves and relevant others in the hospital situation. This survey is concerned with medical staff views of the role of the nurse.

Your responses to this questionnaire will go forward anonymously. Please do not omit any item. Thank you for your time and co-operation.

PART 1 Following are some activities on which nursing staff spend their time. Will you please read all of these and decide which tasks are the most important to you. Then rate them from most important (1) to least important (10).

( ) Preparing and distributing meals and drinks to patients.
( ) Attending on consultants and other medical staff visiting ward.
( ) Taking and recording temperature, pulse, respiration and blood pressure.
( ) Clerical/reception type duties such as filing, completing case notes, etc.
( ) Giving general basic care to patients, such as washing, making beds, giving bedpans.
( ) Talking with patients to provide reassurance and support.
( ) Giving medicine, injections, dressing wounds, and doing other treatments.
Reporting, and receiving reports on change of shift.
Assisting doctors with technical procedures.
Answering the questions of patients and their families.

PART 2 Briefly complete the following sentences. Please put the first idea that occurs to you.

1. The main thing a doctor expects of a nurse is ______
2. Schools of nursing should recruit students who are __
3. The best type of training for nurses is _____________
4. A good ward sister is one who _____________________
5. Male nurses _________________________________
6. The shortage of nurses is caused by _____________
7. The nurse/doctor relationship could be improved if ___
8. My personal view of the Salmon Nursing Structure is _______________________________
9. The worst thing about nursing as it is today is ___

PART 3 What do you, as a physician, feel about the following statements?

1. Nursing is a profession.
2. Research into nursing problems is best done by social scientists.
3. The apprentice system is the ideal way to train nurses.
4. A good nurse has an inborn understanding of people.
5. All orders on a ward should emanate from the doctor (activity, diet, medications, etc.).
6. Under normal circumstances, the ward sister or her deputy must accompany the doctor on a ward round.
PART 4

Following is a list of activities. Please tick (✓) Column A if you feel an SRN (with additional in-service training) can initiate the activity without a doctor's order, Column B if you feel the nurse should carry out the activity only with a doctor's order, or Column C if you feel the nurse should not carry out the activity at all.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

1. Measure blood pressure.
2. Start an intravenous infusion (not by cutting down).
4. Administer local anaesthetics by injection.
5. Measure the haemoglobin level.
6. Syringe an ear.
7. Dress wounds arising from injuries.
8. Teach diabetic self-care.
9. Give psycho-social advice to
   - an obese patient
   - a geriatric patient
   - an alcoholic patient
10. Suture wounds arising from injuries.
11. Give the following medicaments:
    - vitamins
    - analgesics (not DDA)
    - aperients
    - indigestion remedies
13. Order X-rays
    - physiotherapy
    - change in diet
14. Discuss pending procedure with patient
    - (lumbar puncture, thoracentesis, paracentesis, biopsy).
15. Encourage a patient to discuss his worries.

Other activities you consider controversial:

Additional Comments:

Personal Information:

Sex: Male ___ Female ___
Age: 20-29 ___ 30-39 ___ 40-49 ___ over 50 ___
In which country did you obtain your medical education?

Present position: Medical Student
House Officer
Registrar
Consultant

Specialty: Medical
Surgical
2. **Pilot Study Tables I - XVI**

**TABLE I**  
**Doctor expectations of the nurse, by per cent**

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Technical Care</th>
<th>Emotional Support</th>
<th>Both Tech. Care &amp; Emotional Support</th>
<th>Not Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>The main thing a doctor expects of a nurse is</td>
<td>47</td>
<td>11</td>
<td>37</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 19

**TABLE II**  
**Doctor expectations of the ward sister, by per cent**

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Manager</th>
<th>Technical Competence</th>
<th>Personality Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good ward sister is one who</td>
<td>53</td>
<td>68</td>
<td>68</td>
</tr>
</tbody>
</table>

No. 19

* Several doctors gave more than one category of response, and total is more than 100%

**TABLE III**  
**Medical views about the type of student to be recruited in nursing, by per cent**

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Committed to Nursing</th>
<th>Intelligent</th>
<th>Personality Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schools of nursing should recruit students who are</td>
<td>58</td>
<td>47</td>
<td>53</td>
</tr>
</tbody>
</table>

No. 19

* Several doctors gave more than one category of response, and total is more than 100%
## TABLE IV
Doctors' views of nurse training, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Essentially Practical</th>
<th>Practical Combined with Theoretical</th>
<th>Not Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>The best type of training for nurses is</td>
<td>32</td>
<td>63</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 19

## TABLE V
Medical views about men in nursing, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Positively Seen in Nursing Role</th>
<th>Ambivalence Expressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male nurses</td>
<td>58</td>
<td>42</td>
</tr>
</tbody>
</table>

No. 19

## TABLE VI
Doctors' opinions about the cause of the shortage of nurses, by per cent *

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Poor Hours</th>
<th>Rigid Admin.</th>
<th>Poor Career Structure</th>
<th>Other</th>
<th>Not Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>The shortage of nurses is caused by</td>
<td>58</td>
<td>16</td>
<td>32</td>
<td>26</td>
<td>11</td>
</tr>
</tbody>
</table>

No. 19

* Several doctors gave more than one category of response, and total is more than 100%
### TABLE VII
Medical opinions about improving the nurse/doctor relationship, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Better Team Efforts</th>
<th>Doctors Change</th>
<th>Nurses Change</th>
<th>No Problem in Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nurse/doctor relationship could be improved if</td>
<td>42</td>
<td>32</td>
<td>5</td>
<td>21</td>
</tr>
</tbody>
</table>

No. 19

### TABLE VIII
Medical views of the Salmon nursing structure, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Basically Approve</th>
<th>Basically Disapprove</th>
<th>Lack Familiarity With Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>My personal view of the Salmon Nursing Structure is</td>
<td>11</td>
<td>47</td>
<td>42</td>
</tr>
</tbody>
</table>

No. 19

### TABLE IX
Medical views about nursing as it is today, by per cent *

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Working Conditions</th>
<th>Academic Shortage</th>
<th>Rigid System of Nurses</th>
<th>Admin.</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>The worst thing about nursing as it is today is</td>
<td>32</td>
<td>16</td>
<td>16</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

No. 19

* One doctor gave more than one category of response, and total is more than 100%
### TABLE X
Views of doctors concerning nursing as a profession, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing is a profession</td>
<td>79</td>
<td>21</td>
</tr>
</tbody>
</table>

No. 19

### TABLE XI
Views of doctors about research into nursing problems, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Agree</th>
<th>Disagree: Nurses only</th>
<th>Disagree: Anyone</th>
<th>Not Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research into nursing problems is best done by social scientists</td>
<td>5</td>
<td>32</td>
<td>53</td>
<td>11</td>
</tr>
</tbody>
</table>

No. 19

### TABLE XII
Medical views about the apprentice system for training nurses, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Unqualified Agreement</th>
<th>Qualified Agreement</th>
<th>Disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The apprentice system is the ideal way to train nurses</td>
<td>37</td>
<td>58</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 19
**TABLE XIII**
Medical views about nurses and their understanding of people, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Unqualified</th>
<th>Qualified</th>
<th>Disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agreement</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>A good nurse has an inborn understanding of people</td>
<td>32</td>
<td>37</td>
<td>32</td>
</tr>
</tbody>
</table>

No. 19

**TABLE XIV**
Doctors' views of decision making on the ward, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>All orders on a ward should emanate from the doctor (activity, diet, medications, etc.)</td>
<td>32</td>
<td>53</td>
<td>16</td>
</tr>
</tbody>
</table>

No. 19

**TABLE XV**
Medical views of the importance of a ward sister on a round, by per cent

<table>
<thead>
<tr>
<th>Categories of Response</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under normal circumstances, the ward sister or her deputy must accompany the doctor on a ward round</td>
<td>95</td>
<td>5</td>
</tr>
</tbody>
</table>

No. 19
<table>
<thead>
<tr>
<th>Activity</th>
<th>A*</th>
<th>B*</th>
<th>C*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Measure blood pressure</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Start an intravenous infusion</td>
<td>5</td>
<td>58</td>
<td>37</td>
</tr>
<tr>
<td>3. Give booster innoculation of tetanus toxoid</td>
<td>53</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>4. Administer local anaesthetics by injection</td>
<td>11</td>
<td>47</td>
<td>42</td>
</tr>
<tr>
<td>5. Measure the haemoglobin level</td>
<td>42</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>6. Syringe an ear</td>
<td>21</td>
<td>68</td>
<td>11</td>
</tr>
<tr>
<td>7. Dress wounds arising from injuries</td>
<td>37</td>
<td>63</td>
<td>11</td>
</tr>
<tr>
<td>8. Teach diabetic self-care</td>
<td>63</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>9. Give psycho-social advice to an obese patient</td>
<td>58</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Give psycho-social advice to a geriatric patient</td>
<td>53</td>
<td>32</td>
<td>16</td>
</tr>
<tr>
<td>Give psycho-social advice to an alcoholic patient</td>
<td>32</td>
<td>47</td>
<td>21</td>
</tr>
<tr>
<td>10. Suture wounds arising from injuries</td>
<td>16</td>
<td>63</td>
<td>21</td>
</tr>
<tr>
<td>11. Give the following medicaments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vitamins</td>
<td>53</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>analgesics (not DDA)</td>
<td>47</td>
<td>53</td>
<td>0</td>
</tr>
<tr>
<td>aperients</td>
<td>63</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>indigestion remedies</td>
<td>47</td>
<td>53</td>
<td>0</td>
</tr>
<tr>
<td>12. Give intra-gastric feeding</td>
<td>16</td>
<td>79</td>
<td>5</td>
</tr>
<tr>
<td>13. Order X-rays</td>
<td>5</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>physiotherapy</td>
<td>21</td>
<td>53</td>
<td>26</td>
</tr>
<tr>
<td>change in diet</td>
<td>32</td>
<td>47</td>
<td>21</td>
</tr>
<tr>
<td>14. Discuss pending procedure with patient</td>
<td>74</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>15. Encourage a patient to discuss his worries</td>
<td>95</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

* Explanation of each column:

A - SRN can initiate the activity without a doctor's order
B - SRN can carry out the activity only with a doctor's order
C - SRN should not carry out the activity at all
Letter to Doctors

Dear

A research project "The Study of Nursing Care" is being conducted by the Royal College of Nursing. One of the studies undertaken investigated role conceptions of nurses and patients about themselves and relevant others in the hospital situation.

Your hospital participated in this survey. The second part of this study is concerned with medical staff views of the role of the nurse. The Chairman of the Medical Committee has agreed to take part in this research project.

It will be a great help to the study if you will complete a questionnaire, which should take about fifteen minutes of your time. This can be done during an interview period with me, or by yourself. The interview will of course be arranged at your convenience.

I am sure you will agree that the doctor's opinion about the role of the nurse is of the utmost importance. I therefore hope you will be willing to share your views with me.

Yours sincerely,

Evelyn R. Anderson, B.A., M.N.,
Doctoral Candidate - University of Surrey.