TERRITORIAL IDENTITIES IN NURSING

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CHAPTER I

INTRODUCTION

Territoriality has been recognized as a major drive that determines, in part, human behavior. Territorial behavior is the acquisition and defense of an area claimed by individuals and groups. Pluckhan (1972) has discussed this behavior as it extends into professional practice.

Nursing has not been deemed a specific territory and this is a salient factor in the question of nursing's professionalism. A well defined area of practice is needed to provide a group psychology, cohesiveness, recognition of the group's services, and protection of the group's services from other occupations and professions (Ardrey 1970; Goode 1970).

The professionalization of nursing is inhibited by a lack of autonomy. First, nursing has traditionally been subordinated to hierarchies of authority: physicians and the bureaucratic system. Secondly, legislation has restricted the authority of nurses in implementing independent judgments, and has defined nursing in vague and general terms (Monnig 1975). Consequently, nurses identify with various systems, functions, and values. Multi-identities in nursing may result in conflicts between nurses. For example, nurses in administrative roles may believe that

the enforcing of hospital policies and insuring that the system runs smoothly are more important than providing personalized patient care. A staff nurse, on the other hand, may only implement hospital rules that are in the best interest of the patients. Nurses in various roles may also disagree with the significance of conducting nursing research and continuing education for the promotion of knowledgeable care.

This study, therefore, attempted to determine if staff nurses, clinical nurse specialists, and nursing supervisors identify with humanitarian services, professionalism, and/or bureaucracy as territorial areas in nursing. Determining significant differences among nurses' identities is the first step toward cohesiveness and a well defined area of practice.

Statement of the Problem

Do nurses identify with professionalism, humanitarian services, and/or bureaucracy as territorial areas in nursing?

Statement of the Purposes

The purposes of this study were to:

1. Determine if staff nurses, nursing supervisors, and clinical nurse specialists identify with bureaucracy, humanitarian services, and/or professionalism as territorial areas in nursing

2. Determine the relationship among bureaucracy, humanitarian services, and professionalism in nursing

Theoretical Framework

The study is based on the theory of territoriality as described by Ardrey (1966). Territoriality is defined as an innate need which involves the acquiring and defending of an area against others of the same species. The concept was initially studied in animal behavior. Ardrey (1966) asserted that humans also possess the inherent need to claim and defend a territory. This need is displayed by such things as "no trespassing" signs, fences, and patriotism.

Territorial behavior deals with open programs of instinct (Ardrey 1960). "A territory is innate. The command to defend it is likewise innate. But its position and borders will be learned" (Ardrey 1966, p. 24). In human beings, the greatest portion of the open instinct is learned rather than innate. Territorial behavior is determined by social tradition and individual experience (Ardrey 1966).

Ardrey (1970) expanded the concept of territoriality to a human space time continuum which is protected by an individual or cohesive group. Jobs, licensure laws, roles, areas of practice, departments in an organization, and spheres of political influence are as closely guarded as one's own home or property (Ardrey 1970).

The possession of a territory satisfies three of man's basic needs: (1) identity, (2) stimulation, and

(3) security (Ardrey 1970). "There are few exceptions to the rule that the need for identity is the most powerful and most pervasive among all species" (Ardrey 1966, p. 335). As groups or individuals delineate the boundaries of their territory, identity with the territory becomes established. Individuals within a specified territory are differentiated from others and acknowledged or identified by the boundaries and the context of the area they possess (Ardrey 1966). Ardrey (1966) described the "castle-and-border" phenomenon of territory to explain how security and stimulation are satisfied. The territorial heartland, "castle," is delineated by "territorial stakes" and within these "territorial stakes," security is provided. Just as important as the "castle" is the region that borders the castle. The territorial periphery provides stimulation. Individuals from different territories challenge one another at the border region.

Territorial behavior is both protective and aggressive. In the "castle," individuals protect the territory from outsiders. Peripherally, aggressive behavior is displayed as individuals attempt to expand control over a specified area. The drive to conquer, grow, and master life's tasks are the basis of aggression. "Aggressiveness is the principle guarantee of survival. As no population could survive without sufficient numbers sufficiently aggressive" (Ardrey 1970, p. 258 and 259).

Territoriality as a genetically based behavior is accepted by most who have studied the concept. The main criticism addressed to Ardrey's theory is that it is theoretically derived with paucity of scientific research conducted (Pluckhan 1972). The assumptions inherent in the theory are: each person is an open system in contact with the environment, and territoriality is innate (Ardrey 1966).

Background and Significance

One of the main problems that faces nursing today is the inability to acquire professional status (Lysaught 1971). Being without a well defined territory, nursing is described by vague and general terms. Brown (1970) stated that although there are those who feel nursing is essential to the health needs of society, nursing is "undifferentiated in character and performed by interchangeable persons" (p. 122). An old saying is that nursing is defined by what needs to be done (Lysaught 1971).

Delineating a territory involves the setting up of "territorial stakes" or "identity pegs" (Lyman and Scott 1967). Within the territorial stakes, identity with a stable content of mechanisms develops (Pluckhan 1972). The stable content of mechanisms may include functions, behaviors, and attitudes. Lyman and Scott (1967) explained that most people are affected by the encroachment of their territory to some degree. Certain groups of people in

society are especially deprived: women, blacks, and youths. Nursing composed primarily of women has been deprived of a territory. Without a well defined territory, nurses are incapable of protecting an area of practice from intruders. Factors that contribute to nursing's lack of a delineated territory are nurses' diverse educational preparations, the performing of functions within the medical framework, lack of research conducted, and the employment status.

Kliengartner (1967) stated that employment of a professional person in a large organization impinges upon professional autonomy more than the other aspects of professionalism. Autonomy embodies the whole concept of professionalism. Professionals profess to know better than others the nature of certain matters. This is the essence of the professional claim (Hughes 1963). Without autonomy, open doors for development and expansion of the profession's self-chosen ends are closed. The incorporation of nurses into a large-scale organizational system increases nurses' administrative and technical duties. This, in turn, erodes the nurses' earlier personalized patient-oriented care.

Characteristics of bureaucracy in hospitals are the heavy reliance on policies, rules, and hierarchial demands (Johnson 1971). The hospital hierarchy describes nursing as a set of routines and standardized procedures (Mauksch 1966). Nurses have often been expected to conform to traditional static situations within the hospital setting

(Brown 1948). People who function well in static situations are passive and obedient (Brown 1948). Traditionally, characteristics of a good nurse included obedience, the spirit of self-sacrifice, conservatism, dependability, stability, patience, and conscientiousness (Brown 1948; Saunders 1954; and Davis, Olesen, and Whittaker 1966).

Dominance, initiative, and mastery of one's environment are constructive forms of aggressiveness (Brooks 1967). Aggression is necessary to maintain and acquire control of one's territory (Ardrey 1970). Since the employment of nurses, aggressiveness and a desire for change was admonished in nursing (Saunders 1954). With aggression admonished, nurses have exercised only minimal control over the practice of nursing. The development of a group identity is inhibited when nurses are dominated by others' decisions in the bureaucratic system (Bowman and Culpepper 1974). The employment status facilitates identity with the institution and the bureaucratic process (Mauksch 1966). Consequently, nurses have been religated to a position of subservience, ordertaking, or semi-professional status. Nurses have denied themselves the practice of nursing as self-generated autonomously guided service to people (Mauksch 1975). Today, nursing is highly diversified. Nurses undertake various tasks and function in a wide range of situations which lack commonalities and denies nurses a group identity (Saunders 1954). The fact that the American

Nurses' Association represents only a fourth of the practicing registered nurses (Kushner 1974) indicates nursing's deprivation of unity.

In contrast to the characteristics that describe the territorial functions of bureaucracy, characteristics of a profession are: (1) intellectual operations necessitating extensive individual responsibility, (2) research constantly conducted, (3) implementation of practical aims, (4) a specialized educational discipline, (5) self-organized with group consciousness, and (6) more responsive and concerned about the public than isolated individuals (Flexner 1915). The right and responsibility of nurses to define and control the practice of nursing conflicts with the position of hospital employment (Jacox 1969). The bureaucrat is specialized in some phase of administrative routine which stresses efficiency, rules, and authority. The professional is primarily concerned with a vast expanding body of knowledge which is applied for the welfare of the clients (Taves, Corwin, and Haas 1963; Johnson 1971). When the nurse cannot realistically conform to both the professional and bureaucratic expectations, the nurse may abandon one and cling to the other, attempt to compromise between the expectations, or withdraw psychologically or physically from both (Taves, Corwin, and Haas 1963).

In terms of the conflict between the territorial activities of a profession and that of a bureaucracy, the

expectations of a nursing supervisor are particularly affected. On the one side is the nursing supervisor's staff and patients; on the other side are the bureaucratic hierarchial demands. Kinlein (1977) stated that many nurses in administration are guardians of bureaucracy. These nurses convey, implement, and occasionally enforce the mandate of the hospital administration (Mauksch 1966). Territorial conflict between professional goals and bureaucratic demands appear to be resolved by abandoning the expectations of a profession.

The highest function of a nurse is to give compassionate, tender, personal, and technically competent care to patients (Saunders 1954). As student nurses complete their education and accept staff nurse positions, bureaucratic policies and efficiency are practiced at the expense of the professional ideals that were taught in school (Saunders 1954). Staff nurses' activities are frequently determined by external pressures rather than by scientific knowledge (Lysaught 1971). Although the employee status facilitates identity with the institution, there is no reason why the staff nurse must internalize the values of the bureaucratic system (Taves, Corwin, and Haas 1963). The bureaucratic or health care system is frequently the cause of nurses leaving nursing (Lysaught 1971). The staff nurse may identify with bureaucracy, remain loyal to

the professional ideals, or seek identity with other professionals.

Nursing has been exploring the clinical nurse specialist role which is a return to patient care. Christman (1970) has warned that unless a clinical posture is adopted, nurses will not keep pace with the advancement of other health professions nor will nurses be able to stop the fragmentation of health care. The education of the clinical nurse specialist for total, personalized patient care is recognized by the American Nurses' Association and the National League for Nursing (Claus and Bailey 1977). The clinical nurse specialist may assess health needs, formulate nursing care plans, institute preventive measures, refine nursing techniques, and provide emotional support and guidance (Bates 1974; O'Shaughnessy 1967; and Georgopoulos and Christman 1973). The clinical nurse specialist independently sees patients, refers them to other health professionals, and has limited or no functions with management (Georgopoulos and Christman 1973).

In conclusion, clinical nurse specialists, staff nurses, and nursing supervisors may experience professional-bureaucratic conflicts. Researching the identity of these nurses with bureaucracy, professionalism, and humanitarian services may determine the degrees of the conflict and assist nurses in acquiring a territory that is a self-generated autonomously guided service to people.

Hypotheses

The hypotheses of the study were:

Ha_1--There will be a statistically significant difference in the identity of staff nurses, nursing supervisors, and clinical nurse specialists with professionalism, bureaucracy, and humanitarian services as territorial areas in nursing

Ha_2--There will be a statistically significant, positive correlation between professionalism and humanitarian services

Ha_3--There will be a statistically significant, negative correlation between professionalism and bureaucracy

Ha_4--There will be a statistically significant, negative correlation between humanitarian services and bureaucracy

Definition of Terms

The following terms in this study were defined:

Clinical nurse specialist--a clinician with a high degree of knowledge, skills, and competence in a specialized area of nursing. These skills are made directly available to the public through provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. This nurse holds a master's degree in nursing with an emphasis in clinical nursing (American Nurses' Association 1974)

Staff nurse--a registered nurse working on a hospital ward

Nursing supervisor--a registered nurse in a position of authority to support, assist, evaluate, and constructively criticize staff nurses

Territorial area--dominance over an area which may include skills, people, application of knowledge, or an institution. It satisfies the three innate needs of identity, security, and stimulation

Territoriality--"the drive to gain, maintain, and defend the exclusive right" to an area (Pluckhan 1968, p. 389) which includes components of bureaucracy, humanitarian services, and professionalism in nursing

Bureaucracy--an organized system which is characterized by "impersonality, rigid routine, task orientation, and increasing administrative duties" (Corwin 1960, p. 101)

Professionalization--a "dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of 'profession'" (Vollmer and Mills 1966, p. vii, viii)

Professionalism--"an ideology and associated activities that can be found in many and diverse occupational groups whose members aspire to professional status" (Vollmer and Mills 1966, p. viii)

Humanitarian services--services "characterized by loyalty to the patient as a unique human being whose

emotions, attitudes and feelings are an important focus" (Corwin 1960, p. 204)

Limitations

No attempt was made to control the following limitations:

1. the continuing educational courses the subjects had taken
2. the type of hospital in which the subjects practiced
3. the subjects' major area of practice

Delimitations

In this study the delimitations included:

1. clinical nurse specialists will have at least one year of experience, a master's degree in nursing, and presently working full time
2. staff nurses will be employed full time with no less than one year of experience
3. nursing supervisors will be employed full time with no less than one year of experience
4. all nurses will belong to the American Nurses' Association
5. all nurses' basic level of education will be a Bachelor of Science in Nursing

Assumptions

The study was based on the following assumptions:

1. the basic function of nursing is to provide humanitarian services

2. professional and humanitarian values are desirable in all of nurses' roles

3. territoriality is innate with its borders learned (Ardrey 1966)

4. each person is an open system in contact with the environment

Summary and Overview

Chapter I presented the statement of the problem, statement of the purposes, the theoretical framework, background and significance, hypotheses, definition of terms, limitations, delimitations, and assumptions. The hypotheses were deduced from the theory of territoriality.

The background and significance explained that nurses' territory may be determined by functions, attitudes, and behaviors. The functions some nurses perform may be part of the territory of bureaucracy. Nurses who acquire functions from another territory may identify with that territory. Nurses who remain loyal to professionalism which includes humanitarian services may have little in common with nurses who are bureaucratic. Multi-identities may result in conflicts and prevent cohesiveness and a group psychology. Furthermore, multi-identities in nursing

may inhibit the acquisition and expansion of a strong knowledge base for the welfare of the clients. Determining conflicting identities in nursing is therefore imperative for the professionalization of nursing.

As an overview, Chapter II consists of the review of the literature which documents previously conducted studies on staff nurses, nursing supervisors, and clinical nurse specialists in relationship to professionalism, bureaucracy, and humanitarian services. A description of the setting, sample, human rights, instrument, data collection, and treatment of the data is included in Chapter III. Analysis of the data collected is presented in Chapter IV through the use of tables and explanations. Finally, Chapter V presents a summary, the conclusions, implications, and recommendations for further research in relationship to this thesis.

CHAPTER II

REVIEW OF LITERATURE

The review of literature discusses the territorial areas of bureaucracy, professionalism, and humanitarian services in relationship to the staff nurse, nursing supervisor, and clinical nurse specialist. Nurses who are employed may experience conflicts over the disparities of the activities required in an institution and the ideals of the practice of nursing. This chapter is divided into four sections: (1) the territorial areas of professionalism, bureaucracy, and humanitarian services; (2) the staff nurse; (3) the nursing supervisor; and (4) the clinical nurse specialist. Studies conducted on staff nurses, nursing supervisors, and clinical nurse specialists in relationship to these territorial areas are described.

Territorial Areas of Professionalism Bureaucracy, and Humanitarian Services

A territory may include areas of practice, an institution, roles, and/or departments in an organization (Ardrey 1970; Pluckhan 1972). Identity, stimulation, and security are the three basic needs satisfied by the possession of a territory (Ardrey 1970). Identity is the most powerful of these three basic needs (Ardrey 1966).

Employed nurses delineate their territory according to the functions they perform within an institution. As these nurses "stake out" the boundaries of their territory, identity with the territory becomes established (Ardrey 1966). Identity with bureaucracy, professionalism, and humanitarian services may result in conflict. Since humanitarian services are encompassed within the definition of a profession (Flexner 1915), no conflict is expected. However, bureaucratic activities may be deterrent to professionalism and humanitarian services, as well as, professionalism and humanitarian services deterrent to the efficiency of a well organized system.

In this increasingly specialized world, nurses are asking, "What...is the unique identity of the practice of nursing?" (Treat and Kramer 1972, p. 20). Corwin (1960) stated that nursing does not have an independent body of knowledge from which nursing principles and theories can be derived and applied therapeutically. An independent body of knowledge is essential for professional autonomy and the establishment of nursing's territory (Mauksch 1966).

Behind the search for nursing's unique identity are the conflicts between professionalism and the actual work situation. Hospital control remains a basic factor in nursing's inability to gain power and freedom (Kreheler 1976). Nurses are responsible and accountable to the hospital bureaucracy (Christman 1970; Corwin 1960). In a

study conducted by Kramer and Schmalenberg (1976), various conflicts in nursing were identified. The conflict identified most frequently was the conflict between professionalism and bureaucracy. This conflict, according to Corwin (1960), involved nurses' perceptions of what nursing should be, which in turn provides for professional self-integrity, and the requirements of the actual work situation within the hospital's bureaucratic framework. The main characteristics of bureaucracy as described by Corwin (1960) are:

> (1) a set of hierarchically organized offices defining specialized duties; (2) the intention to maximize efficiency; (3) an emphasis on abstract rules and records to insure continuity of the organization; (4) impersonal organization; and (5) a career orientation (p. 111).

Three models of bureaucracy described by Litwak (1961), are Weber's model, human-relations model, and professional bureaucracy. First, Weber's model deals with uniform events, impersonal social relations, and consists of a hierarchy of authority that adheres to specified rules and regulations. This model has a high degree of efficiency and is capable of predicting future events. Because nurses' functions and decisions must be made according to the uniqueness of each patient's situation, Weber's model is difficult to apply. Second, the human-relations model deals with non-uniform events. Six characteristics of this model are:

> ...horizontal patterns of authority, minimal specialization, mixture of decisions on policy and on administration, little a priori limitation of duty and privileges to a given office, personal rather than impersonal relations, and a minimum of general rules (Litwak 1961, p. 179).

The third model is that of the professional bureaucracy. This model deals with both uniform and non-uniform events. In other words, both routine tasks and social skills may be conducted within this bureaucratic framework. Hospitals and other health care agencies function according to this model.

Much of nursing is controlled and organized according to the Weberian concept of bureaucracy. Nursing has an hierarchy of authority and is considered by hospital administrators to consist of a set of routines and standardized procedures. In addition, nursing is responsible to the hospital bureaucracy. The incorporation of nursing into Weber's model of bureaucracy requires nurses to be task oriented, have loyalty to the hospital, and to be subordinated to the routines and regulations (Corwin 1961). As nurses become bureaucratized, their relationships with patients become routine and impersonal (Corwin 1960). Saunders (1954) stated that bureaucracy "acts as a mold into which occupational groups must be made to fit" (p. 1096). In performing therapeutic tasks for patients, hospital policies generally limit nurses' ability to provide individual patient care (Glover 1967). Consequently, nurses become increasingly dependent on lay

authorities who regulate the bureaucratic organization. The exploitation of nurses to meet the bureaucratic demands has impinged upon the professionalization of nursing and the nurses' acquisition of dignity and respect (Kushner 1974).

In contrast to the bureaucratization of nursing, professionalization encompasses personalized patient care, loyalty to the national association, autonomy, independent judgments, and an expanding body of knowledge (Corwin 1961). Nursing as an art, involves the whole patient--both body and mind. Through teaching and therapeutic skills, nurses promote and maintain mental and physical health for the family, community, and the individual (Brown 1948). According to Orem (1971):

> Nursing is the complex ability to accomplish or to contribute to the accomplishment of the patient's usual and therapeutic self-care by compensating for or aiding the patient in overcoming the conditions or disabilities that cause him (1) to be able to act for himself, (2) to refrain from acting for himself, (3) to act ineffectively in caring for himself (p. 47).

The humanitarian services as outlined by Orem (1971) and Brown (1948) will contribute to changing nursing from an occupation to a profession (Brown 1948). However, the professionalism of nursing which includes the pursuing of nursing research, advanced education, independent judgments, personal responsibility, and self organization is necessary before nurses can readily provide humanitarian services. Professional nursing can not only be measured by how well

the physical care was performed, but also by the nurses' therapeutic interactions with patients, and the scientific principles and theories upon which individualized care is based.

Essentially, the goals of professionalism and bureaucracy conflict. The hospital organization which focuses nursing activities on specific functions and policies inhibits nurses' decisions and activities in providing individual care. On the other hand, the professionalization of hospital nurses infringes on the established territory of bureaucrats who control and regulate health care agencies (Corwin, Taves, and Haas 1961; Jacox 1969). Promoting the ideology and autonomy of nursing, challenges administrative and medical personnel who now direct many of the activities nurses perform (Corwin, Taves, and Hass 1961; Jacox 1969). Professional nursing would replace an authoritarian hierarchy with a colleague-peer authority system of management (Johnson 1971). The colleague-type relationship would involve responsibility that is personal in nature, rather than responsibility that is placed on the structure of the organization.

Staff Nurse in Relationship to the Territorial Areas

Staff nurses are those nurses who provide care at the patient's bedside in an assigned area of the hospital. According to Mauksch (1975), these nurses have the lowest

prestige level. Staff nurses have become the incumbents of a dependent, directed practice which thus decreases the value of their work. Staff nurses' ability to provide patients with respect and individualized care while oppressed is questionable (Berger, Rennert, George, and Schwartz 1972). This section will, therefore, address studies conducted about staff nurses in relationship to bureaucracy, professionalism, and humanitarian services.

Six hundred general-duty nurses in thirty-seven hospitals in Minnesota were surveyed by Mayo and Lasky (1959) regarding job satisfaction. Among the reasons given for low satisfaction, 50 percent of the nurses identified being confused about their professional identity. The nurses surveyed felt that there was a discrepancy between the institution's expectations and the nurses' professional and humanitarian self-concepts. Corwin (1961) found that staff nurses with a Bachelor's of Science in Nursing (B.S.N.) developed a relatively low identity with the hospital and maintained a relatively high professional identity. The length of time the subjects were staff nurses when the study was conducted is unknown. However, in studying staff nurses with a diploma or B.S.N. and student nurses, Corwin (1960) found that student nurses identified with professionalism and humanitarian services significantly more than the staff nurses. Employment, therefore, was considered the

determining factor which lead to an increase in bureaucratic values by the nurses.

A longitudinal study conducted by Kramer (1966) utilized a similar theoretical framework as Corwin. Kramer sampled seventy-nine graduates at three California State College baccalaureate nursing programs. The subjects were administered the Corwin's instrument at graduation to obtain baseline values of professionalism and bureaucracy. Three months and six months after graduation, the sample was given the Corwin's instrument again and a standardized tape recorded interview was conducted. The conclusions disclosed a significant increase in identity to bureaucracy after employment and a significant decrease in professional values. There was also a significant increase of role deprivation three months after graduation. Those nurses who left nursing, returned to school, or changed jobs due to dissension, indicated significantly greater role deprivation than graduates who remained on the same job for six months. In a follow-up study two years later, the nurses displayed a further decrease in professional values.

Findings from a study by Kramer (1970) categorized baccalaureate nurses from thirty-seven medical centers in "highly successful," "average successful," and "less successful" groups as determined by the director of nursing. No criteria for "success" was given. All nurses in the study were employed for at least nine months. Corwin's

instrument and a standard interview were used to collect data. The staff nurses occupied the "average" and "less successful" groups more than the "highly successful" group. The majority of the "less successful" group disclosed high professional-low bureaucratic values. Kramer speculated that these nurses could be change agents in altering the out-moded bureaucratic system of the hospital to a human-relations model of bureaucracy.

A survey from 1968 to 1970 to obtain data regarding what nurses perceived as important in their practice was conducted by Treat and Kramer (1972). Through the use of interviews, questionnaires, and attitude scales, the data were collected and analyzed. The study concluded:

> ...that the system has socialized the nurse to the awareness that 'keeping things running' is the area about which she will be questioned and correspondingly the criterion by which her effectiveness will be evaluated (Treat and Kramer 1972, p. 250).

To determine if baccalaureate graduates perceived hospital bureaucracy as an interferring factor in implementing their conception of nursing practice, Harrington and Theis (1968) conducted a study at three hospitals. One of the hospitals chosen was the Loeb Center, which emphasized the human-relations model of bureaucracy. In contrast, the other two hospitals had the Weberian principles of bureaucracy accentuated. These two hospitals were considered "typical" bureaucratic hospitals.

Responses from the nurses at the Loeb Center were compared to the nurses' responses at the other two hospitals. The findings from this study revealed that the attitudes and expectations of the administrative personnel, the quality and quantity of the work assignment, and the communication between health workers were the major factors that impinged upon the baccalaureate graduates to perform perceived nursing practice at the "typical" hospitals. Baccalaureate nurses at the Loeb Center did not find these factors deterrent. The investigators described the nurses from the "typical" bureaucratic hospitals as frustrated, unchallenged, and passive. At the Loeb Center, on the other hand, the nurses were considered satisfied, enthusiastic, and self-directing.

The results of the studies presented, and the review of the literature conducted by Hughes et al (1958), concluded that the nurses' status, recognition, and assignment fitting to meet the needs of the bureaucratic system may be what nurses dislike most about their job. In addition, incorporation of nurses into the hospital bureaucracy decreases many nurses' professional values which are replaced with bureaucratic values. Nurses who are responsible for managerial functions in the area of practice and are restricted by a job description within the nursing hierarchy will have difficulty in initiating new

ideas and improving communications for the welfare of the patients (Oselladore 1978).

Nursing Supervisor in Relationship to the Territorial Areas

The nursing supervisor's position exists between the director of nursing service and head nurse in the hierarchy of nursing. Nurses advance to the supervisory position after being promoted through the ranks of nursing within the bureaucratic structure (Falls 1970; Ellsberry 1972). This results in a loss of prestige for nursing care carried out at the patient's bedside, while the performing of activities related to the maintainance and promotion of the organization is most rewarded (Elsberry 1972). The middle management nurse assists and controls many administrative functions. Nursing supervisors are knowledgeable about budgetary needs, the number of professional health workers needed, and the amount and type of supplies and equipment utilized (Falls 1970). Corwin (1960) stated that a position in nursing which is defined by the bureaucratic hierarchy and follow administrative orders according to the bureaucratic rules and regulations demands loyalty to that administration rather than to the ideology of nursing.

According to Mauksch (1975), nurses who aspire to upward mobility in the managerial hierarchy, abandon patients in favor of the institution. Georgopoulos and Christman (1970) stated that utilizing the nurse as a

manager minimizes the therapeutic and personal care functions that are basic to the professionalism of nursing. Appraising most nursing service departments may well disclose the difference between the professed goals and the goals actually practiced. Nurses in management go through a process, whereby the instrumental goals which are the rules and regulations of the system, become most valued (Corwin 1960). Cleland, an activist in nursing, stated that directors of nursing are often preventing nurses from acquiring authority and autonomy. These nurses inhibit collective bargaining, grievance procedures, and written contracts at the request of bureaucratic administrators (Kushner 1974).

Johnson (1971) conducted a study concerning nursing supervisors' identity with professionalism and bureaucracy. The study was conducted in three midwestern hospitals by fourteen supervisors. Analysis of the data indicated that the majority of nursing supervisors experienced territorial conflict. On a questionnaire, these nurses inconsistently chose between a professional or bureaucratic response. The study, therefore, concluded that the hierarchy of nursing should be reexamined to enhance the professionalism of nursing.

The study conducted by Kramer (1970) which categorized nurses into three groups--"highly successful," "average successful," and "less successful"--reported that

there were more administrative nurses in the "highly successful" group than the other two categories. This group disclosed high professional-high bureaucratic values. From the findings of this study, Kramer speculated that there is some pressure within the organization for retention of high professional values. A significant difference between this study and the one conducted by Johnson (1971) is that Johnson's study only included diploma nurses and Kramer's subjects were all baccalaureate nurses.

Due to nursing supervisors' lack of influence on personalized patient care, Lysaught (1972) stated that the position of nursing supervisor may have been dysfunctional from the beginning. Gabrielson (1970) concurs with Lysaught and commented that the traditional nursing supervisor role may become obsolete in the future. At Veterans Administration Hospital, Becksville, Ohio, Towner (1968) described the reorganization of the usual nursing hierarchy. The reorganization consisted of three main changes: deletion of the nursing supervisor's office on all shifts, an increase in supervisory and clerical responsibilities for the head nurse, and the establishment of the clinical nurse specialist's position. Implementation of these changes brought about greater work satisfaction for the staff and head nurses, a decline in personal problems with nonprofessional personnel, and greater emphasis on patient care.

At Veterans Administration Hospital at Brockton, nursing supervisors on the evening and night shift were deleted (Dahlstein and Flood 1970). Evening and night supervisors' jobs at this hospital mainly consisted of administrative and clerical work. These positions were, therefore, eliminated with the supervisors reassigned to positions that involved direct patient care. Eight months after the reorganization of the nursing hierarchy, a survey was conducted to determine the effects of these changes. The sample consisted of thirty-four randomly selected registered nurses and nurses' aides from the evening and night shift. Twenty-eight of the subjects responded: twelve registered nurses and sixteen nurses' aides. Analysis of the data revealed four significant conclusions: (1) the supervisors can be deleted, (2) professional performance by the individual nurses was enhanced, (3) the nurses were free of many nonnursing duties, and (4) the nurses developed closer interrelationships because they depended on one another for help when emergencies occurred.

At ten large hospitals, Lyons (1970) conducted a study to determine nursing supervisors' influence on the pattern of staff nurses' turnover. Lyons discovered that nursing supervisors were insignificant in affecting the job satisfaction of staff nurses. Management theories, however, have considered supervisors important in facilitating organizational effectiveness. Five reasons were suggested

for the results of this study. First, the supervisor may have minimal influence on staff nurses' behavior and attitudes due to the multi-interactions that the subordinates experience, limiting the significance of the supervisors' relationship with the staff nurses. Second, the nursing supervisor may lack clinical skills which frequently prevents them from assisting staff nurses. Third, differences between the supervisors' and the staff nurses' values on clerical tasks may have caused a lack of common interest. Fourth, supervisors have limited power or utilize their power poorly, presenting an appearance of the "powerless messenger for higher level supervisors" (Lyons 1970, p. 80). Finally, many staff nurses converse with their supervisors on a limited basis.

In conclusion, the supervisor position may have been an error from the beginning. Nurses who occupy this position appear to identify with the organization more so than with their profession and are being rewarded for their loyalty to the hospital rather than for their services to humanity. As stated by Lysaught (1972):

> ....only when promotion, reward, and responsibility lead to more encompassing and enhanced patient care--rather than away from the patient--can nursing begin to become an unambiguous profession (p. 23).

Clinical Nurse Specialist in Relationship to the Territorial Areas

The last role in nursing to be discussed is the clinical nurse specialist. In 1958, the American Nurses'

Association established formal recognition of clinical expertise in nursing (Pask 1977). The clinical nurse specialist may perform various nursing activities: provide direct nursing care, act as a change agent, expand nursing's knowledge through research, educate staff nurses, and serve as an internal source of consultation (Georgopoulos and Christman 1970; Baker and Kramer 1970; Yokes 1966; Simms 1966; Reiter 1966; Pohl 1965; Nielson 1965; and Towner 1968). A characteristic common to all clinical nurse specialists is the ability to make a high degree of discriminative judgment in planning, assessing, setting priorities, and identifying nursing measures for the benefit of the patient (Kinsilla 1973). The nurse specialist position differs from traditional positions in nursing in that the nurse specialist has unrestricted geographical work areas, flexible work hours, self-delineation of a job description, self-selection of patients for care, and de-emphasis or deletion of the managerial components (Baker and Kramer 1970; Little 1967; and Georgopoulos 1970). The clinical nurse specialist performs direct and indirect patient care.

There is great disparity in nurses' attitudes about what the clinical practice of nursing includes (Baziak 1968). Two main views exist: the accepting of tasks which were formerly within the physician's territory and the developing and expanding of independent activities

based on nursing's foundation of knowledge. Lenburg (1970) stated:

> Nursing can only come into its own profession in a knowledge-oriented (as opposed to a task-oriented) environment--that is, in a setting in which the nurse is expected to utilize the knowledge shehas acquired and not simply to wait for directions from others (p. 21).

As nurses apply nursing knowledge and continue to expand nursing knowledge through research, certain areas of health which nurses will be most competent to care and treat will be identified. Nuckolls (1972) proposed, "professional status will follow professional performance" (p. 376). Hughes (1950) further contended, "the process of turning an art and an occupation into a profession often includes the attempt to drop tasks to some other kind of worker" (p. 295).

Research conducted to identify the success of the clinical nurse specialist in regards to the specialist's influence on patient care is sparse. Stevens (1976), while addressing the clinical nurse specialist role, stated, "no other movement [clinical specialism] in nursing has contributed so much, so rapidly, to the attempts to professionalize nursing and to substantiate its existance as an independent profession" (p. 30). Stevens continued, "nevertheless, that does not change the fact that clinical specialism is structurally ill-adapted to the typical bureaucratic management system" (p. 30). Edwards (1968) stated that the lack of success of the clinical nurse specialist role within a hospital may be related to the

rigidities of the bureaucratic hospital structure. Furthermore, nursing has not established evaluative measurements to determine the effectiveness of the clinical nurse specialist (Edwards 1971).

The study conducted by Kramer (1970) which categorized nurses into "highly successful," "average successful," and "less successful" groups concluded that there was significantly more clinically promoted nurses, including the clinical nurse specialist, in the "highly successful" group. This group disclosed high professional-high bureaucratic values. The result of this study may be explained by Corwin (1960) when he stated, these nurses may be oriented to bureaucracy, but also seek recognition from colleagues and are therefore oriented to both bureaucratic and professional values.

Baker and Kramer (1970) studied thirty-seven medical centers in the United States to determine if the position of the clinical nurse specialist existed and if so, the job description for it. Data were collected by standardized interviews with the director of nursing or her delegate and six nurses whose generic program was baccalaureate. Supplementary data were also collected by conducting interviews with the clinical nurse specialists and by evaluating job descriptions, inservice and orientation schedules, and organizational charts. During each interview, the director of nursing was asked a series of questions to determine the presence of the clinical nurse specialist's role, the

functions of that role, and the difficulties and successes arising from the role. Analysis of the data concluded that twenty-two of the thirty-seven medical centers had one to fifteen nurse specialists with the median four. The existance of the position ranged from newly formulated to four years in length. From the analysis of the data, Baker and Kramer concluded that no well defined expectations of clinical nurse specialists existed. Furthermore, eight of the directors of nursing had difficulty in implementing the nurse specialist within the hospital bureaucratic system. All directors unanimously believed that the clinical specialist should improve patient care and act as a role model for the staff nurses. Other health workers had problems accepting the very existance of the role. Baker and Kramer concluded that a clear-cut description of the clinical nurse specialist's job is necessary for acceptance and success of the role.

In an experimental study conducted by Georgopoulos and Jackson (1970), the clinical nurse specialist's affect on staff nurses' behavior in writing nursing kardexes was determined. In this study, each kardex was a compilation of clinical data, medical orders, and nursing goals and plans on an individual patient. Analysis of the kardex data was utilized to determine nursing activity and performance. The sample included three clinical nurse specialists and three head nurses. The study took place

in six--twenty-five bed medical units in a modern general hospital. Three units were under the leadership of a head nurse and three units under a clinical nurse specialist in the position of team leader. All six units were under the direction of the same nursing supervisor, had similar staffing, and similar staff to patient ratio. Over a thirteen month period, the kardexes were collected three different times for analysis: prior to the study, midway into the study, and during the final two months of the study. In terms of both quantitative and qualitative nursing information noted on the kardexes, the general hypothesis--nursing practice under the leadership of a clinical nurse specialist will be superior to nursing practice under the leadership of a head nurse--was accepted.

To test whether the clinical nurse specialist, while functioning in the traditional staff nurse role, could favorably affect the course of patients' illnesses, a research study at the University of Washington was conducted for two and one-half years (Little 1967). The sample included four nurses who had completed the University of Washington's graduate program in psychiatric nursing. The study took place on a fifty-four bed unit, in a four hundred bed sanitorium where the patients were being treated for pulmonary tuberculosis. The clinical nurse specialists' nursing activities were compared to the activities of the staff nurses by using the Arnstein's method (U.S. Public

Health Service 1954). Initially the results concluded no significant differences between the clinical nurse specialists' and staff nurses' activities. The ward organization was therefore changed. The changes included the transferring of the head nurse to another unit, the introduction of a ward manager, elimination of some housekeeping and dietary activities, dictaphones provided to reduce charting by the nurse specialist, the availability of conference rooms and office space, and the administering of treatments in the treatment room for ambulatory patients. With all the above changes, the clinical nurse specialist did not function to the degree originally anticipated. The final change implemented, was the addition of a staff nurse on days and one on evenings. In the final stage of the study, the nurse specialists did function as originally perceived and did favorably affect patient care during the study. Little (1967) commented, with all preparations, problems arose generally in relationship to "tradition," "hospital policy," and legal considerations.

At the University of Wisconsin in May 1971, during a two day symposium, the activities and pressures experienced by clinical nurse specialists were identified (Aradine and Denyes 1972). The sample included twenty-eight nurse specialists from the Midwest United States. From the analysis of the data, twelve categories of activities and four pressure areas were identified. The

data revealed that the nurse specialist initially, within the first year, focused on patient care and personal growth. After the first year, the clinical nurse specialist activities expanded to include education, consultation, and community functions. The pressure categories identified were: self, system, role, and other. The most frequently identified pressures were within the self pressure category, such as, self-expectations too high, acceptance of failure, and setting limits, during the first year. After three years of experience, these nurses experienced system pressures most frequently. System pressures included such things as: administration policy, lack of feedback, resistance by the staff and doctors, and money.

The role of the clinical nurse specialist was examined in relationship to nursing service and the total health care system by Backsheider (1971). The study included twenty-five nurse specialists that had or were about to receive their master's degree in nursing. Common to all the clinical nurse specialists' role was flexibility in working hours and freedom from assigned tasks and functions that were not related to clinical nursing care. Other functions undertakened by the clinical nurse specialist included education, consultation, and planning patient care.

In summary, studies conducted on clinical nurse specialists disclosed that these nurses have been both

successful and unsuccessful in enhancing humanitarian services and professionalism. Although the nurse specialist has limited or no bureaucratic functions, Kramer (1970) found that nurse specialists disclosed high professional-high bureaucratic values. The lack of research conducted on the clinical nurse specialist's position and because the position is still in the experimental stage, nurse specialists' influence on the professionalization of nursing is yet to be determined.

Summary

The persistence of competing identities in nursing signifies that nurses have not developed unified goals. Unity is necessary to attain stability and provide effective nursing care (Bowman and Culpepper 1974). To facilitate an environment that alleviates stress and provides the patient with security, privacy, and self-esteem, nurses must come to terms with their own identity (Vochon 1976). Nurses in various roles of nursing need to identify with one practice of nursing that can be defined, defended, and expanded through a strong knowledge base. This practice of nursing should be recognized by nurses and the public as independent, unique, and necessary.

Various studies in the review of literature were presented. Studies conducted on staff nurses indicated that the bureaucratic system infringes on the practice of nursing. Bureaucratic demands have resulted in job

dissatisfaction and/or the relinquishing of professional ideals. Although the clinical nurse specialist theoretically offers nursing the greatest opportunity to acquire professional status, minimal research has been conducted to validate this belief. The influence of the nursing supervisor in enhancing or impinging on quality patient care also lacks scientific data. However, from the data collected, the nursing supervisor appears to display insignificant influence on patient care.

Reiter (1973) stated, "the ultimate criterion by which any profession can be judged is the worth of the practice each of us makes available to the public" (p. 18). Therefore, if nursing is to acquire professional status and provide quality care, the ideology of nursing must be maintained and the realities of the work situation altered (Berkowitz 1968). If nurses recognize the existance of conflict and encourage constructive resolution, the professionalization of nursing will be facilitated (Kramer and Schmalenberg 1976).

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

This chapter presents the circumstances under which this descriptive correlational study (Polit and Hungler 1978) was conducted. Included in the chapter are the setting, sample, human rights, instrument, data collection, and treatment of the data.

Setting

The study took place throughout the United States. The setting included hospitals which varied in size from less than one hundred beds to greater than a thousand beds. The hospitals may have been located in a metropolitan or rural area. Both private and government supported hospitals may have been included in the study. There were no delimitations on the various departments within the hospital from which the sample was obtained.

Sample

The target population included staff nurses, clinical nurse specialists, and nursing supervisors who met the following criteria:

1. employed full time
2. practiced within a hospital
3. had one year of experience under their present title
4. had a Bachelor of Science in Nursing

In addition, the clinical nurse specialists were master's prepared.

The American Nurses' Association was contacted for lists of clinical nurse specialists, nursing supervisors, and staff nurses. Computerized digit randomization was utilized to select one hundred subjects in each role.

A total of 160 subjects returned the questionnaire. However, only forty-one staff nurses, thirty nursing supervisors, and thirty-four clinical nurse specialists met the delimitations of the study as determined by the demographic data collected (Appendix B). Thus a total of 105 nurses contributed data used in the study.

Human Rights

Authorization to conduct the study was obtained from Texas Woman's University Human Research Review Committee and the American Nurses' Association. The subjects were mailed a brief description of the study and a requisition for their consent to participate in the study (Appendix A). The subjects' anonymity was assured in that no identity was requested on the instruments. In addition, two envelopes were included; each subject was informed to

return the consent form in one envelope and the instruments in the other. The subjects were informed that they were in no way obligated to participate and were free to withdraw at any time. The possibility of risks, which was improper release of data, was stated in the brief description of the study. If the subjects had any questions regarding the study, they were encouraged to contact the researcher.

Instrument

Corwin's questionnaire was used to obtain nurses' identity with professionalism, bureaucracy, and humanitarian services. Corwin (1960) developed and utilized the questionnaire in his study: "Role Conception and Mobility Aspiration: A Study in the Formation and Transformation of Bureaucratic, Professional, and Humanitarian Nursing" (Appendix C). The instrument consists of three Likert-type scales that provide indices of identity to these three variables. Each question is a hypothetical situation. The sample was asked to indicate the degree to which they concurred with the question, by circling one of the following responses: "Strongly Agree," "Agree," "Undecided," "Disagree," and "Strongly Disagree."

There are six items in the bureaucratic scale, eight items in the professional scale, and seven in the service scale. An item in the service scale was excluded, initially there were eight items. The item excluded was:

"Some graduate nurses believe that the professional nurses who should be rewarded most highly are the ones who regard nursing as a calling in which one's religious beliefs can be put into practice." This item was eliminated to separate religious beliefs from the practice of nursing. Another alteration in the instrument was the substitution of registered or registered nurse for graduate. Graduate can be interpreted as a registered nurse who has just completed nursing school or a nurse who has not passed the state board examination. This was therefore changed to eliminate any confusion.

In Corwin's study, the original questionnaire was distributed to approximately 150 nurses. The results of this pre-test were analyzed for internal consistency through the method developed by Sletto (Corwin 1960), and on the basis of the respondents' comments. The final questionnaire was then constructed from the revisions obtained through these analyses.

Kramer utilized Corwin's tool in her dissertation in 1966, and in a study in 1970, to study role conception and role conflict. Kramer (1966) validated Corwin's tool against "known groups." The critical ratio between the mean scores on the three scales concluded satisfactory validity (significant at p less than 0.05 level). Kramer (1966) also conducted test-retest studies to obtain

reliability coefficients. The coefficients were greater than 0.80 on all three scales.

Attached to Corwin's instrument was a demographic sheet. The demographic data collected was used to describe the sample and to insure that the delimitations of the study were met (Appendix B).

Data Collection

The American Nurses' Association was contacted for a list of one hundred nurses in each role: nursing supervisor, clinical nurse specialist, and staff nurse. This list included nurses who were selected throughout the United States by digit randomization. This was done to assure a minimum sample of thirty nurses in each role. The subjects were mailed a brief description of the study, a requisition for their consent to participate, a demographic sheet, and Corwin's instrument. The subjects were informed that they were in no way obligated to participate and free to withdraw at any time. A total of 160 nurses answered the questionnaire. However, only 105 subjects met the delimitations of the study. Although the nurses randomly selected were categorized into these three roles according to the American Nurses' Association, many participants were nurse educators or held various other titles. Also, many nurses were not employed by a hospital.

Treatment of Data

The statistical treatment of the data consisted of analysis of variance, Newman-Keuls Multiple Comparisons, and the Pearson Product Moment (Pearson-R). All hypotheses were measured at the 0.05 level of significance. The first hypothesis was measured through the use of analysis of variance and the Newman-Keuls Multiple Comparisons. These statistical tools determined if the sample identified with bureaucracy, professionalism, and/or humanitarian services. The second, third, and fourth hypotheses were measured through the use of the Pearson-R. The Pearson-R described the correlation among professionalism, bureaucracy, and humanitarian services.

Summary

The study was conducted with the use of Corwin's instrument. Validity and reliability of the tool were assessed by Kramer (1966). The sample included staff nurses, clinical nurse specialists, and nursing supervisors who met the delimitations of the study. The sample was obtained from the American Nurses' Association and selected throughout the United States by digit randomization. The subjects were contacted by mail and informed about the study, the risks, and their rights. Analysis of variance, Newman-Keuls Multiple Comparisons, and the Pearson Product Moment were employed to test the hypotheses:

Ha_1--There will be a statistically significant difference in the identity of staff nurses, nursing supervisors, and clinical nurse specialists with professionalism, bureaucracy, and humanitarian services as territorial areas in nursing

Ha_2--There will be a statistically significant, positive correlation between professionalism and humanitarian services

Ha_3--There will be a statistically significant, negative correlation between professionalism and bureaucracy

Ha_4--There will be a statistically significant, negative correlation between humanitarian services and bureaucracy.

CHAPTER IV

ANALYSIS OF DATA

Introduction

A descriptive correlational design was employed to answer the question: do nurses identify with professionalism, humanitarian services, and/or bureaucracy as territorial areas in nursing? The purposes of the study are to determine: if staff nurses, nursing supervisors, and clinical nurse specialists identify with bureaucracy, professionalism, and/or humanitarian services as territorial areas in nursing; and the relationship among bureaucracy, professionalism, and humanitarian services in nursing. The sample was obtained from the American Nurses' Association and contacted by mail. Forty-one staff nurses, thirty nursing supervisors, and thirty-four clinical nurse specialists who met the delimitations, participated in the study. The subjects were asked to complete a demographic questionnaire in addition to the twenty-one questions on Corwin's tool. The tool consisted of three scales which measured indices of identity to bureaucracy, professionalism, and humanitarian services. The nurses' indices of identity were determined by analyses of variance and the Newman-Kuels Multiple Comparisons. Correlation among bureaucracy,

professionalism, and humanitarian services was then analyzed by the Pearson Product Moment.

The chapter is presented in three sections. The first section describes the sample. The second section presents the nurses' identity with bureaucracy, professionalism, and humanitarian services as territorial areas in nursing. Finally, the third section describes the correlation among bureaucracy, professionalism, and humanitarian services.

Description of the Sample

A total of 160 nurses from the three hundred nurses contacted answered the demographic sheet and Corwin's instrument (53.3 percent). However, fifty-five of the participants did not meet the delimitations. These nurses were not clinical nurse specialists, staff nurses, or nursing supervisors; not employed at a hospital full time; or occupied their present position for less than one year. All subjects who met the delimitations were employed at a hospital full time, had one year of experience under their present title, and had a Bachelor of Science in Nursing. In addition, all clinical nurse specialists held a master's degree in nursing. Thus a total of 105 nurses (35 percent) contributed data that were analyzed for this study.

Thirty-four nurse specialists participated and met the delimitations of the study. The clinical nurse specialists ranged in age from twenty-five to fifty-nine

with the mean age of thirty-six. All clinical nurse specialists were females. The majority of these nurses practiced medical-surgical nursing (56 percent), were Caucasian (91 percent), and worked in hospitals with greater than four hundred beds (44 percent). Table 1 below displays the demographic data collected from the clinical nurse specialists.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF CLINICAL NURSE SPECIALISTS*

Variables	Race	Sex	Age Range	Area of Practice	Size of Hospital
White	31				
Black	2				
Japanese-American	1				
Female		34			
Male		0			
20-29			5		
30-39			19		
40-49			8		
50-59			2		
> 60			0		
Medical-Surgical				19	
Mental Health				14	
Maternal-Child				1	
Less than 100 beds					3
100-200 beds					6
200-400 beds					10
> 400 beds					15

* N = 34

A total of thirty nursing supervisors who met the delimitations participated. These nurses ranged in age from twenty-three to sixty-five years with the mean age of forty. All supervisors were female, except one. Also, all supervisors were Caucasian, except one. The majority of the supervisors practiced medical-surgical nursing (63.3 percent) in hospitals with greater than four hundred beds (33.3 percent). Table 2 displays the demographic data collected from the nursing supervisors.

Forty-one staff nurses participated and met the delimitations of the study. These nurses ranged in age from twenty-one to fifty-eight years with a mean age of twenty-six. All staff nurses were female, except one, and Caucasian, except two. The majority of the staff nurses practiced medical-surgical nursing (68.3 percent) and worked in hospitals with greater than four hundred beds (49 percent). Table 3 displays the demographic data collected from the staff nurses.

Nurses' Identity with Bureaucracy, Professionalism, and Humanitarian Services

This section addresses the first hypothesis: Ha_1--There will be a statistically significant difference in the identity of staff nurses, nursing supervisors, and clinical nurse specialists with professionalism, bureaucracy, and humanitarian services as territorial areas in nursing.

TABLE 2

DEMOGRAPHIC CHARACTERISTICS OF NURSING SUPERVISORS*

Variables	Race	Sex	Age Range	Area of Practice	Size of Hospital
White	29				
Oriental	1				
Female		29			
Male		1			
20-29			9		
30-39			8		
40-49			5		
50-59			3		
> 60			5		
Medical-Surgical				19	
Mental Health				4	
Maternal-Child				5	
Other				2	
Less than 100 beds					7
100-200 beds					5
200-400 beds					8
> 400 beds					10

* N = 30

Each of the dependent variables are presented separately: professionalism, bureaucracy, and humanitarian services. The hypothesis was accepted at the 0.05 level of significance.

Professionalism

There were eight items in the professional scale of Corwin's tool. Nurses' attitudes representing identity

TABLE 3

DEMOGRAPHIC CHARACTERISTICS OF STAFF NURSES*

Variables	Race	Sex	Age Range	Area of Practice	Size of Hospital
White	39				
Mexican-American	1				
Japanese	1				
Female		40			
Male		1			
20-29			35		
30-39			5		
40-49			0		
50-59			1		
> 60			0		
Medical-Surgical				28	
Mental Health				5	
Maternal-Child				6	
Other				2	
< 100 beds					2
100-200 beds					2
200-400 beds					17
> 400 beds					20

* N = 41

with the professionalism of nursing included such characteristics as a commitment to knowledge, implementation of independent judgments, membership to professional associations, and the promotion of professional standards. The items within this scale pertained to these characteristics.

The sample size of the staff nurse, clinical nurse specialist, and nursing supervisor and the mean scores and standard deviations obtained from these nurses are listed below in Table 4.

TABLE 4

MEAN SCORES AND STANDARD DEVIATIONS FOR PROFESSIONALISM

	Sample Size	Mean Scores	Standard Deviations
Staff Nurse	41	29.83	3.84
Clinical Nurse Specialist	34	32.00	3.93
Nursing Supervisor	30	29.50	4.70

$F = 3.65$
2 and 102 df
$P < 0.03$

Statistical testing with analysis of variance resulted in a F value of 3.65 with 2 and 102 degree of freedom, yielding a p value of less than 0.03. The employment of the Newman-Keuls Multiple Comparisons determined that clinical nurse specialists identified significantly more with professionalism than staff nurses and nursing supervisors. There was no statistically significant difference between staff nurses' and nursing supervisors' identity with professionalism.

Bureaucracy

There are six items in the bureaucratic scale of Corwin's tool. Nurses' attitudes representing identity with the hospital bureaucracy included such characteristics as punctuality, rule-following, record-keeping, loyalty to hospital authorities, tenure, and secrecy about disagreeable hospital procedures. The items within this scale pertained to these characteristics.

The sample size of the staff nurse, clinical nurse specialist, and nursing supervisor and the mean scores and standard deviations obtained from these nurses are listed below in Table 5.

TABLE 5

MEAN SCORES AND STANDARDS DEVIATIONS FOR BUREAUCRACY

	Sample Size	Mean Scores	Standard Deviations
Staff Nurse	41	16.98	2.66
Clinical Nurse Specialist	34	16.62	2.85
Nursing Supervisor	30	18.50	2.50

$F = 4.41$
2 and 102 df
$p < 0.015$

Statistical testing with analysis of variance resulted in a F value of 4.41 with 2 and 102 degrees of freedom, yielding

a p value of less than 0.015. Newman-Keuls Multiple Comparisons determined that nursing supervisors identified significantly more with bureaucracy than staff nurses and clinical nurse specialists. There was no statistically significant difference between staff nurses' and clinical nurse specialists' identity with bureaucracy.

Humanitarian Services

There are seven items in the humanitarian scale of Corwin's tool. Nurses' attitudes representing identity with the patient included such characteristics as compassion, personal interests in the patient, and individualized care. The items within this scale pertained to these characteristics.

The sample size of the staff nurse, clinical nurse specialist, and nursing supervisor and the mean scores and standard deviations obtained from these nurses are listed in Table 6. Statistical testing with analysis of variance resulted in a F value of 5.44 with 2 and 102 degrees of freedom, yielding a p value of less than 0.006. The employment of Newman-Keuls Multiple Comparisons determined that clinical nurse specialists identified significantly more with humanitarian services than staff nurses and nursing supervisors. There was no statistically significant difference between staff nurses' and nursing supervisors' identity with humanitarian services.

TABLE 6

MEAN SCORES AND STANDARD DEVIATIONS
FOR HUMANITARIAN SERVICES

	Sample Size	Mean Scores	Standard Deviations
Staff Nurse	41	26.56	2.80
Clinical Nurse Specialist	34	28.59	2.66
Nursing Supervisors	30	26.67	3.22

F = 5.44
2 and 102 df
P < 0.006

Correlation Among Bureaucracy, Professionalism, and Humanitarian Services

This section addresses the second, third, and fourth hypotheses. Each hypothesis was accepted or rejected at the 0.05 level of significance and tested with the Pearson Product Moment (Pearson-R).

Ha_2--There will be a statistically significant, positive correlation between professionalism and humanitarian services. The correlation coefficient between professionalism and humanitarian services was 0.447 with a p value less than 0.001. Thus the hypothesis was accepted.

Ha_3--There will be a statistically significant, negative correlation between professionalism and bureaucracy. The Pearson-R correlation coefficient between

professionalism and bureaucracy is -0.131 with a p value less than 0.183. Although the correlation was negative, there was no statistically significant correlation with the data available. Thus, the hypothesis was rejected.

Ha_4--There will be a statistically significant, negative correlation between humanitarian services and bureaucracy. The Pearson-R correlation coefficient between professionalism and bureaucracy was -0.199 with a p value less than 0.0423. Thus, the hypothesis was accepted.

Conclusion

The first hypothesis was accepted at the 0.05 level of significance. Ha_1--There will be a statistically significant difference in the identity of staff nurses, nursing supervisors, and clinical nurse specialists with professionalism, bureaucracy, and humanitarian services as territorial areas in nursing. In comparing the three groups: clinical nurse specialists identified with professionalism and humanitarian services; nursing supervisors identified with bureaucracy; and staff nurses showed no strong identity toward professionalism, bureaucracy, or humanitarian services. Acceptance of the hypothesis gave support to Stevens' (1976) statement, "no other movement [clinical specialism] in nursing has contributed so much, so rapidly, to the attempts to professionalize nursing and to substantiate its existance as an independent profession" (p. 30). The high bureaucratic values of nursing supervisors also

supported the belief that nursing supervisors abandon the ideology of nursing for the bureaucratic system as indicated by Kinlein 1977; Corwin 1960; Mauksch 1975; and Lysaught 1972.

The second and fourth hypotheses were also accepted at the 0.05 level of significance. Ha_2--There will be a statistical significant, positive correlation between professionalism and humanitarian services. Ha_4--There will be a statistically significant, negative correlation between humanitarian services and bureaucracy. Acceptance of the second hypothesis supported the belief that humanitarian services are included within the professionalism of nursing, and as such, both encompass one territory. Acceptance of the fourth hypothesis provided further support for the belief that rigid bureaucratic policies are deterrent to humanitarian services (Kreheler 1975; Glover 1967; Mayo and Lasky 1959; Harrington and Theis 1968; and Oselladore 1978). Bureaucratic goals and humanitarian goals belong to two separate conflicting territories. As stated by Bowman and Culpepper (1974), the persistence of competing identities in nursing signifies that nurses have not developed unified goals. Unity is necessary to attain stability and provide effective nursing care.

The third hypothesis was rejected at the 0.05 level of significance. Ha_3--There will be a statistically significant, negative correlation between professionalism

and bureaucracy. Rejection of the hypothesis indicated that professional nursing, excluding humanitarian services, can be conducted within bureaucratic regulations. Professionalism, such as membership to professional associations, nursing research, promotion of professional standards, and advanced education, may be more compatible with bureaucratic rules than humanitarian services.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

The descriptive correlational approach was employed to investigate two purposes. First, the identity of clinical nurse specialists, nursing supervisors, and staff nurses was determined. Second, the correlation among bureaucracy, humanitarian services, and professionalism was determined.

The sample was obtained from the American Nurses' Association. Digit randomization according to the zip codes of the nurses' addresses was utilized by the computer to select one hundred staff nurses, one hundred clinical nurse specialists, and one hundred nursing supervisors. All nurses who belonged to the American Nurses' Association; classified as a nursing supervisor, staff nurse, or clinical nurse specialist; had a Bachelor of Science in Nursing; and employed full time, had an equal opportunity to be chosen as subjects in the study. Many of the subjects who answered the questionnaire, however, did not meet the delimitations of the study. They were not employed by a hospital, were nursing educators, held various other titles, or did not occupy their position for at least a year.

Although a total of 160 nurses answered Corwin's instrument, only 105 participants (~~35~~ 66% percent) actually contributed data to the study.

The theory of territoriality was employed to determine nurses' identity toward the territorial areas of bureaucracy, professionalism, and humanitarian services. Ardrey (1966) asserted that humans possess the innate need to claim and defend a territory. Territorial behavior deals with open programs of instinct and satisfies the basic need of identity (Ardrey 1960). Therefore, nurses claim, defend, and delineate the borders of nursing by social tradition and individual experiences (Ardrey 1966). Nurses who have a statistically significant different identity from other nurses, regarding the practice of nursing, may be in conflict.

The review of literature addressed the staff nurse, clinical nurse specialist, and nursing supervisor, in relationship to professionalism, bureaucracy, and humanitarian services. Previous studies concluded conflicts between the institution's and staff nurses' expectations, values, and functions of nursing (Corwin 1960; Mayo and Lasky 1959; Harrington and Their 1968). Several sources stated that nursing supervisors abandon the ideology of nursing for the bureaucratic system (Kinlein 1977; Corwin 1960; Mauksch 1975; and Lysaught 1972). Also, several investigators (Dahlstein and Flood 1970; Lyon 1970; and

Towner 1968) determined that nursing supervisors were unnecessary for the practice of nursing within the hospital setting. There was no conclusive evidence indicating that clinical nurse specialists were more professionally oriented than staff nurses or nursing supervisors, however, studies conducted by Georgopoulos and Jackson 1970; and Little 1967, disclosed that nurse specialists fostered humanitarian services.

The data collected from the 105 subjects were first analyzed by the three, one way analysis of variance and the Newman-Keuls Multiple Comparisons. These statistical tests concluded a significant difference between the territorial identity of staff nurses, clinical nurse specialists, and nursing supervisors with professionalism, bureaucracy, and humanitarian services. Thus, the first hypothesis was accepted.

The data were also analyzed by the Pearson-R. Interpretation of the data yielded a statistically significant, positive correlation between professionalism and humanitarian services; no statistically significant, negative correlation between professionalism and bureaucracy; and a statistically significant, negative correlation between bureaucracy and humanitarian services. Thus, the second and fourth hypotheses were accepted, and the third hypothesis was rejected.

Conclusions

Based upon the results of the study, the following conclusions were drawn:

1. Clinical nurse specialists identify more with professionalism and humanitarian services as territorial areas in nursing than staff nurses and nursing supervisors

2. Nursing supervisors identify more with bureaucracy as a territorial area in nursing than clinical nurse specialists and staff nurses

3. Staff nurses show no strong identity toward professionalism, bureaucracy, or humanitarian services when compared to nursing supervisors and clinical nurse specialists

4. Nurses who identify with professionalism also identify with humanitarian services

5. Nurses who identify with bureaucracy are not likely to identify with humanitarian services

6. Professionalism and humanitarian services are components of one territory in nursing

7. Bureaucracy is a separate and conflicting territory to humanitarian services

Implications

The study has implications for nursing supervisors, staff nurses, and clinical nurse specialists within the hospital setting and for nursing in general. Nursing care should be personal and based on scientific principles.

Professionalism and humanitarian nursing promote this type of quality care. Bureaucracy, on the other hand, is impersonal and routine. Clinical nurse specialists, therefore, need to be aware that they are more humanitarian and professionally oriented than nursing supervisors and staff nurses. Awareness of this difference can assist clinical nurse specialists in introducing new ideas and changes. Clinical nurse specialists will also need to assist nursing supervisors and staff nurses in becoming more humanitarian and professionally oriented. Both staff nurses and nursing supervisors need to evaluate their priorities in implementing nursing care, their goals as nurses, and their philosophy of nursing.

Nursing is presently defined in vague and general terms (Brown 1970; Lysaught 1971). If nursing is to acquire a territory that can be defined, defended, and expanded through a strong knowledge base, nurses must come to terms with their own identity (Vochon 1976). The persistence of a bureaucratic identity by some nurses impinges upon the professionalization of nursing. Competing identities imply the lack of a group psychology and cohesiveness. Recognition of nurses' services and protection of nurses' services from other occupations and professions is not possible until nurses develop unified goals.

Recommendations

The recommendations resulting from the study were to:

1. Compare nurses who are employed at a hospital to nurses who are employed at other health care agencies to determine the relationship among various bureaucratic systems and nurses' indices of identity with professionalism, bureaucracy, and humanitarian services as territorial areas in nursing

2. Investigate if other variables affect nurses' identity with professionalism, bureaucracy, and humanitarian services, such as the size of the hospital, nurses' age, area of practice, and continuing educational courses which may result in conflict between nurses and prevent unified goals in nursing

3. Compare employed nurses to independent nurse practitioners to determine if the lack of employment within a bureaucratic system discloses a decrease in bureaucratic values and enhances professionalism and humanitarian values

4. Assess the reliability, validity, and clarity of Corwin's instrument, due to the age of the instrument and based on the participants' comments

5. Compare nurses who are members of the American Nurses' Association to nurses who are not, so that, conflicting identities between these nurses may be determined

6. Determine of a line position fosters identity with bureaucracy in comparison to a staff position of the clinical nurse specialist

APPENDIX A

Brief Explanation of the Study

I, Rita Holl, am a graduate student at Texas Woman's University. I am conducting a study regarding nurses' attitudes toward various functions and behaviors within the practice of nursing. It is hoped that the results of the study will assist nurses in identifying conflicts between nurses.

Your participation in the study will be greatly appreciated. The study will take approximately 15 minutes of your time and involves answering two questionnaires. Anonymity will be provided in that there is no identity, such as, your name or social security number, required on the questionnaires. Two envelopes are provided: one for your consent, the other one for the questionnaires. You are in no way obligated to participate and are free to withdraw at any time. No risks or discomforts are anticipated. The is, however, always the possibility of improper release of data, but great effort will be taken to prevent this.

If you agree to participate, please read and sign the attached consent form which will be kept on file by the investigator. The results of the study will be available to you by checking the appropriate space on the bottom of the consent form. If you have any questions regarding the study, please contact me at: 1810 Inwood Road #306
Dallas, Texas 75235

Thank you for your time and consideration.

Sincerely,

Rita Holl, R.N.

TEXAS WOMAN'S UNIVERSITY

(Form A - Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

(The following information is to be read by the subject)

1. I hereby authorize Rita Holl, R.N. to perform the following procedures:

   Administer two questionnaires that will take approximately 15 minutes.

2. The procedure of investigation listed in Paragraph 1 has been explained to me by Rita Holl, R.N. (The brief explanation of the study given in written form)

3. I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts:

   No discomfort is anticipated from filling out the questionnaires. A potential risk includes the possibility of improper release of data. However, great care will be taken to prevent this. Also the scores will be reported as group scores, not individually, adding protection of anonymity.

4. I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

   It is hoped that the results of the study will assist nurses in identifying conflicts between different roles in nursing.

5. An offer to answer all my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

_____ _____

Subject's signature Date

I do_____do not_____want a copy of the results of the study.

APPENDIX B

DEMOGRAPHIC SHEET

This information will be used to describe the participants in the study.

Age_____

Sex_____

Race_____

Job Title (check one):

Nursing supervisor_____

Staff nurse_____

Clinical nurse specialist_____

Nurse practitioner_____

Other (please state)_____

Highest level of nursing education (check one):

Bachelor of Science in Nursing_____

Master's_____

Doctorate_____

Number of years you have been a nurse_____

Number of years you have had your present job title_____

Employment status (check one): Full time_____Part time_____

Area of Practice (check one):

Mental health_____

Community health_____

Medical-surgical_____

Maternal-child_____

Other (please state)_____

Size of hospital where you are employed (check one):

Less than 100 beds_____

100 to 200 beds_____

200 to 400 beds_____

Greater than 400 beds_____

Other (please state)_____

APPENDIX C

Corwin's Instrument

The following questions measure different attitudes in nursing. There are no right or wrong answers. Each question should be answered as to how you honestly feel. Please do not omit any question. There are five possible responses to each question:

SA--Strongly agree
A--Agree
UD--Undecided
D--Disagree
SD--Strongly disagree CIRCLE ONE RESPONSE

1. One registered nurse, who is an otherwise excellent nurse except that she is frequently late for work, is not being considered for promotion, even though she seems to get the important work done.

   Do you think this is the way it should be in nursing?

   SA A UD D SD

2. A head nurse at one hospital insists that the rules be followed in detail at all times, even if some of them do seem impractical.

   Do you think this is the way it should be in nursing?

   SA A UD D SD

3. A registered staff nurse observes another registered staff nurse, licensed practical nurse, or aide who has worked the hospital for months violating a very important hospital rule or policy and mentions it to the head nurse or supervisor.

   Do you think that this is what registered nurses should do?

   SA A UD D SD

4. When a supervisor at one hospital considers a registered nurse for promotion, one of the most important factors is the length of experience on the job.

   Do you think this is what supervisors should regard as important?

   SA A UD D SD

SA--Strongly agree
A--Agree
UD--Undecided
D--Disagree
SD--Strongly disagree

5. In talking to acquaintances who aren't in nursing, a registered nurse gives her opinions about things she disagrees with in the hospital.

   Do you think this is what registered nurses should do?

   SA A UD D SD

6. A registered nurse is influenced mainly by the opinions of hospital authorities and doctors when she considers what truly "good" nursing is.

   Do you think this is what registered nurses should consider in forming their opinions?

   SA A UD D SD

7. One registered nurse tries to put her standards and ideals about good nursing into practice even if hospital rules and procedures prohibit it.

   Do you think that this is what registered nurses should do?

   SA A UD D SD

8. One registered nurse does not do anything which she is told to do unless she is satisfied that it is best for the welfare of the patient.

   Do you think that this is what registered nurses should do?

   SA A UD D SD

9. All registered nurses in a hospital spend, on the average, at least six hours a week reading professional journals and taking refresher courses.

   Do you think this should be true of all nurses?

   SA A UD D SD

10. All registered nurses in a hospital are active members in professional nursing associations, attending most conferences and meetings of the association.

    Do you think this should be true of all nurses?

    SA A UD D SD

SA--Strongly agree
A--Agree
UD--Undecided
D--Disagree
SD--Strongly disagree

11. Some nurses try to live up to what they think are the standards of their profession, even if other nurses on the ward or supervisors don't seem to like it.

    Do you think that this is what registered nurses should do?

    SA A UD D SD

12. Some registered nurses believe that they can get along very well without a lot of formal education, such as required for a B.S., M.S., or M.A. college degree.

    Do you think that this is what registered nurses should believe?

    SA A UD D SD

13. At some hospitals when a registered nurse is considered for promotion, one of the most important factors considered by the supervisor is her knowledge of, and ability to use, judgement about nursing care procedures.

    Do you think this is what supervisors should regard as important?

    SA A UD D SD

14. Some hospitals try to hire only registered nurses who took their training in colleges and universities which are equipped to teach the basic theoretical knowledge of nursing science.

    Do you think this is the way it should be in nursing?

    SA A UD D SD

15. At one hospital registered nurses spend more time at bedside nursing than any other nursing task.

    Do you think this is the way it should be in nursing?

    SA A UD D SD

16. Head nurses and doctors at one hospital allow the registered nurse to tell patients as much about their physical and emotional condition as the nurse thinks is best for the patient.

    Do you think this is the way it should be in nursing?

    SA A UD D SD

SA--Strongly agree
A--Agree
UD--Undecided
D--Disagree
SD--Strongly disagree

17. A doctor orders a patient to sit up in a wheel chair twice a day, but a registered nurse believes that he is not emotionally ready to sit up; the doctor respects her opinion and changes the treatment.

    Do you think this is the way it should be in nursing?

    SA A UD D SD

18. Doctors and head nurses at the hospital respect and reward nurses who spend time talking with patients in an attempt to understand the hostilities, fear, and doubts which may affect the patient's recovery.

    Do you think this is what doctors and head nurses should regard as important?

    SA A UD D SD

19. A registered nurse believes that a patient ought to be referred to a psychologist or a public health nurse and tries to convince the doctor of this, even though he is doubtful.

    Do you think this is what registered nurses should do?

    SA A UD D SD

20. At one hospital the nurse's ability to understand the psychological and social factors in the patient's background is regarded as more important than her knowledge of such other nursing skills as how to give enemas, IV's, or how to chart accurately.

    Do you think this is the way it should be in nursing?

    SA A UD D SD

21. At some hospitals the registered nurses who are most successful are the ones who are realistic and practical about their jobs, rather than the ones who attempt to live according to idealistic principles about serving humanity

    Do you think this is the way it should be in nursing?

    SA A UD D SD

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