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PEER REVIEW

Once upon a time there were:

Three blind peers
Three blind peers
See how they review
See how they review

They all went after a manuscript
They pencilled and cut and rejected it
Have you ever seen a system as severe
As three blind peers?

Almost as vicious as the old nursery rhyme! In academic life one finds oneself either the object of review or the reviewer in many different areas. As such, I should like to reflect on the general characteristics of peer review. Why do we engage in blind peer review? When is it appropriate? When is it essential? When is it fair? And, when is it overkill? I raise these questions particularly in relation to the process of abstract review for the National Nursing Research Conference.

Although in some cases one questions whether or not it refers to a state of pathology, "blind" review refers to a state of anonymity: reviewers are not provided with information about the identity of the author; the author, in turn, does not know the identity of the reviewer. Only in refereed journals is totally blind review really appropriate for the assessment of manuscripts; such is the procedure in this journal.

Other instances involve other types of review that are not blind. Indeed, many of the research grant reviews purposefully ask for evaluation of the investigator's research background and capabilities as part of the overall review process. Certainly reviews involving promotion and tenure are not blind. Why then are abstracts submitted for a national meeting subjected to blind review? Presumably one wishes to eliminate any human bias and judge only the form and content of the work - an operation predicated on the assumption that some abstracts will be rejected. This assumption, to my mind, requires examination.

Most disciplines are anxious to have as many participants as possible at their annual meetings. Abstracts may be solicited but the standards for review of an abstract are different from those for review of a manuscript. That is, one cannot fully judge scientific merit on the basis of 150 words. Criteria for abstract review may include whether or not the research is appropriate in substance, if the meeting is thematic, and some gross

indicators of acceptable methods. Otherwise, the abstracts may be used to organize the sessions of the meeting and, finally, they may be useful in deciding which of the authors should be invited to submit a full manuscript for review, should the organizers plan to publish the proceedings. This process allows more abstracts to be presented and still assures quality in the published work. It is also important to bear in mind that abstracts based on funded research (which should be indicated on the abstract form) have already been peer-reviewed and found acceptable.

In Canada at the present time there is a limited number of nurses engaged in research. Should we not try to foster full participation in our research conferences? I'm not suggesting no abstract review - but an altered approach so that fewer are rejected. Then we can set more rigorous review standards in place for the publication of papers for the proceedings. Should any other considerations, such as space or time, limit the number of abstracts accepted it would indeed be unfortunate: we should guard against such restrictions in future.

We are not large in number and our annual research meeting moves across the country; therefore, I believe some continuity may help. I suggest that the research committee of CAUSN provide this by constituting the scientific planning committee, obviously including other researchers as needed. They could establish consistent standards for review and gain some experience from year to year by which we could learn what is the best way to review abstracts to ensure a scholarly, but full, meeting.

Mary Ellen Jeans

COMITE DE REVISION

Au cours de notre carrière académique, nous avons tous eu l'occasion, à maintes reprises et dans divers domaines, d'être l'objet d'une évaluation ou d'être nous-mêmes l'évaluateur. Regardons de plus près certaines caractéristiques générales d'un processus de révision effectué par des pairs. A quels moments devons-nous nous engager dans un processus de révision par les pairs? Quand cette pratique est-elle appropriée? Quand est-elle essentielle et équitable? et enfin quand est-elle abusive? Je soulève toutes ces questions face au processus de révision des résumés de communication entrepris dans le cadre de la Conférence Nationale de Recherche en Sciences infirmières.

Il est intéressant de souligner le fait que la révision dite "anonyme", où les évaluateurs ne connaissent aucune information sur l'identité de l'auteur, est une procédure utilisée presque exclusivement par les périodiques, tel celui-ci, en vue du choix de leurs manuscripts.

Par ailleurs, il existe d'autres types de révision qui n'utilisent pas le critère de l'anonymat. En fait, de nombreux organismes subventionnaires de recherche, afin de compléter leur processus d'évaluation globale, demandent délibérément des informations sur les antécédents et les réalisations en recherche des investigateurs du projet. D'autres processus d'évaluation tels que ceux reliés à une promotion ou a l'agrégation ne sont évidemmment pas anonymes. Pourquoi donc les résumés de communication soumis en vue d'une Conférence nationale sont-ils sujets à une révision dite "anonyme" par un comité formé de pairs? Présumément pour éliminer toute subjectivité. Ce raisonnement, basé sur le postulat que certains résumés seront réjetes, merite, à mon avis, une analyse.

La plupart des disciplines espèrent avoir le plus de participants possible à leurs assemblées générales. Des résumés de communication peuvent être demandés et soumis mais les critères pour l'évaluation d'un résumé sont différents de ceux utilisés pour un manuscript en vue d'une publication; le fait est que nul ne peut juger du mérite scientifique d'une communication à partir d'un résumé de 150 mots. Parmi les critères de révision d'un résumé de communication devraient figurer, entre autres, si oui ou non il s'agit de recherche, si celle-ci est appropriée quant à son contenu, dans l'eventualité où la conference a une thématique, et si une méthodologie acceptable est employée. D'autres parts, les résumés peuvent être utilisés afin de planifier les différentes sessions de la conférence de même que pour faciliter le choix des auteurs qui pourraient être invités à soumettre un manuscript complet pour révision, lorsque les organisateurs envisagent de publier une partie des actes de la conférence. Ce processus permet à un plus grand nombre de com-

munications d'être présentées tout en assurant la qualité des publications. Enfin, il est important de considérer le fait que les résumés basés sur des recherches subventionnées (ces indications devraient apparaître sur le formulaire de présentation des résumés) ont auparavant été évalués par les pairs et jugés acceptables.

Au Canada, à l'heure actuelle, un nombre restreint d'infirmières sont engagées dans le processus de la recherche. Ne devrions-nous pas encourager la participation de tous dans nos conférences de recherche? Je ne suggère pas d'éliminer la révision des résumés mais plutôt une approche modifiée en vue de réduire le nombre de communications "rejetées" et de mettre en place des critères plus rigoureux pour la publication des actes de la conférence. Advenant le cas où d'autres facteurs, tels que l'espace disponible et le temps, limitent le nombre de résumés acceptés, cette situation est évidemment malencontreuse et nous devrions éviter de telles restrictions dans l'avenir.

Considérant le fait que nous sommes peu et que notre conférence annuelle de recherche tient place à différents endroits à travers le pays, je crois qu'une certaine continuité pourrait nous aider. Je suggère donc que le Comité de recherche de l'ACEUN se charge de cette continuité en constituant le Comité de la planification scientifique, qui devrait inclure évidemment d'autres chercheurs au besoin. Les membres de ce comité pourraient établir des critères uniformes pour l'évaluation des communications et acquérir de l'expérience au fil des ans, expérience qui pourrait nous apprendre quelle est la meilleure façon de réviser des résumés afin de s'assurer d'une assemblée savante mais comble.

Mary Ellen Jeans

ROLE PERSPECTIVES OF JOINT APPOINTEES

Sonia Acorn

A continuing challenge for nursing education and nursing practice is to seek ways to bring the education of students and the clinical practice of nursing closer. The concept of joint academic/clinical appointments in nursing is one method of promoting collaboration and unity between education and practice. The past decade and a half have seen the growth of joint academic/clinical appointments in university nursing faculties, both in Canada and in the United States. The literature describing organizational models and personal experiences of joint appointees is positive, for the most part, although there are some acknowledged problem areas. Little research on the current trend toward joint appointments has been undertaken; there is a need to review the development of joint appointments and their effect on the individuals involved.

The purpose of this study was to provide a descriptive analysis of the role expectations of joint academic/clinical appointees in Canadian university nursing faculties. Role theory was used as the framework from which to review the role expectations of joint appointees who, by virtue of their obligation to report to two organizations, are in a multiple role situation. Relationships among the variables role negotiation skills, perceived congruency and job tension were assessed.

Definition of terms

A joint academic/clinical appointment arises when a school and a clinical agency enter an agreement to appoint persons to positions in both organizations. For the purposes of this study, joint appointments are named according to the agency of primary responsibility. A Faculty-Agency appointment designates a faculty member to a secondary appointment in a service agency. An Agency-Faculty appointment describes the role of a nurse whose primary responsibility is to a service agency, but who has a secondary appointment on the faculty of an educational institution.

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Literature Review

A joint academic/clinical appointment places an individual in a multiple role situation. The individual is responsible to two different organizations: this is reported to place conflicting or unrealistic expectations on the role incumbent (Eschbach, 1983; Kuhn, 1982). Role conflict has been found to be present when an individual fulfills a multiple role (Getzels & Guba, 1954; Rizzo, House & Lirtzman, 1970). Role ambiguity and role overload are additional potential problems for the individual in a multiple role (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964; Lyons, 1971). An individual with highly developed role negotiation skills (role making and role restructuring) will be more successful in handling the demands of a multiple role (Hardy & Hardy, 1988).

McCarthy (1974) conducted a study to describe the roles and responsibilities of joint academic/clinical appointees in baccalaureate nursing programs in university medical centers. McCarthy concluded that an organizational model requiring dual allegiance created internal and external conflicts. This was a result of the individual having to choose between equally desirable alternatives. These inter-role conflicts led to tensions and confusions for the incumbents.

More recently, Anderson and Pierson (1983), conducted an exploratory study in which they compared the responses of faculty members who had a practice component to their roles with those who did not. Findings indicated that conflicting messages were received from schools with regard to the importance of practice: 37% of the respondents reported that their school's written philosophy included faculty practice as a desirable element, while 58% of these respondents' schools did not allot time for this practice. Both students and service agency personnel held a more positive view of faculty practice than did faculty who were not involved in practice.

A survey of Canadian university schools of nursing by Davis and Tomney (1982) reported that ten had joint appointments with service agencies. They cautioned that "each joint appointment must have goals clearly identified by the administration of both institutions" (p. 36). Descriptions of the experiences of Canadian university schools of nursing in joint appointments have, for the most part, been positive (Arpin, 1981; Kergin, 1980; MacPhail, 1987; Malowany, 1981; Royle & Crooks, 1985, 1986). Common features are that faculty have a formal role in both university settings and in health care agencies, and that the purposes of these appointments are to promote inter-organizational communication and cooperation, to enable faculty to gain credibility with students and staff, to improve student learning, to promote a high standard of care and to promote clinical nursing research.

Research Questions

Posed in a framework of concepts relating to the expectations of individuals in multiple roles, this study examined the following questions:

1. How well do joint appointees negotiate certain aspects of their role?
2. What are the joint appointees' perceptions of congruency of role expectations as held by educational institutions and by health care agencies?
3. What is the job tension level of joint appointees?
4. What are the relationships among role negotiation skills, perceived congruency and job tension?

Method

Sample

In the first phase of the study, a survey of the 26 Canadian nursing degree granting institutions found that ten reported the use of joint academic/clinical appointments. A letter was sent to the deans or directors of these ten schools of nursing asking them to identify those faculty members who held joint appointments. They were requested to include both their own faculty who were in joint appointments as well as "Associate Faculty" (joint appointees whose primary responsibility was in a service agency).

The sample consisted of 223 subjects: 76 held Faculty-Agency appointments and 147 held Agency-Faculty appointments. The study was limited to full-time employed nurses who held a joint appointment between the university school of nursing and a service agency. Non-nurse faculty, those employed less than full time and those whose joint appointment was with another faculty or educational institution, were not included. Participation in the study was voluntary and individuals were assured that their anonymity would be maintained. The findings cannot be generalized to other populations because of the sampling technique used, .

One hundred and seventy-seven (79.4%) respondents returned the questionnaire, of which 139 (62.3%) responses were used in the analysis, 39 Faculty-Agency and 100 Agency-Faculty appointees. Questionnaires returned by forty-one respondents were deleted from the study because the faculty member had left the joint appointment, resigned from the university or service agency, returned the questionnaire late or indicated that she or he was not in a joint appointment.

Instrument

The study instrument, a self-administered questionnaire, consisted of five sections:

(1) The Use of Role Negotiation Skills (six items) - designed by the investigator, refers to the reported use of role making (consciously influencing role expectations) and of role restructuring (modifying role expectations of an existing role): for example, "I am able to reach mutual agreement with my supervisor within the service agency on job related issues."

(2) Perception of Congruency (14 items) - designed by the investigator, refers to the subject's perception of congruency in role expectations in the two agencies: for example, "I think that both the university and the service agency understand what is expected of me in each agency."

(3) The Faculty Job Tension Index (18 items) - was patterned after the Kahn et al. (1964) Job Related Tension Index, which was modified by Maurin (1985) to reflect differences between an industrial setting and an academic setting. Subjects were asked to indicate how frequently they felt bothered by work-related happenings: for example, "Feeling that the promotion and tenure criteria are beyond your reach." Subjects were asked to rate themselves on each of the items in the above three sections on a seven-point Likert scale ranging from 1 (low) to 7 (high).

(4) Professional Information: information on length of time in the joint appointment, educational level, teaching experience, tenure status (if applicable), work load and salary source was requested.

(5) The final section of the study instrument consisted of open-ended questions soliciting opinions about joint appointments.

Validity

The Use of Role Negotiation Skills and Perception of Congruency Scales have content and construct validity in two respects. First, the instruments were constructed using the theoretical concepts of multiple roles theory; secondly, all items were assessed and evaluated by experts in higher education and in joint appointments. Validity of the Faculty Job Tension Index had been established by Maurin (1985) using the Index of Content Validity (CVI) as described by Waltz, Strickland and Lenz (1984). Items were examined by independent nurse reviewers, and were retained only when there was 100% agreement that items could suggest adverse working conditions in nursing education.

Reliability

The original instrument of Kahn and associates is a widely-used scale and is reported to be a highly stable indicator of job tension (MacKinnon, 1978). Maurin (1985) refined the instrument and reported a reliability of .86. The reliability ratings, measured with Cronbach's Alpha, for the three scales were: Use of Role Negotiation Skills Scale, .69; Perception of Congruency Scale, .70; and Faculty Job Tension Index, .88.

Data analysis

Descriptive statistics included means, frequencies and percentage distributions. T-tests were used to compare the mean scores of the Faculty-Agency joint appointees' responses with the Agency-Faculty joint appointees' responses. Pearson's correlations were used to test for the existence of relationships among the variables of role negotiation skills, perceived congruency of role expectations and job tension. A factor analysis (oblimin rotation) was performed on the Faculty Tension Index. Content of the open-ended responses was analyzed to reveal common themes.

Findings

Ten (25.6%) of the Faculty-Agency and three (3%) of the Agency- Faculty appointees were doctorally prepared, while 27 (69.2 %) of the Faculty-Agency and 77 (77 %) of the Agency-Faculty held a Master's degree as their highest degree. The length of time in the joint appointment positions was found to be brief, 56% of the Faculty-Agency and 63% of the Agency-Faculty appointees reported being in their joint appointment position three years or less.

Average hours per work week were reported as 46.1 hours for Faculty-Agency joint appointees and 45.8 hours for Agency-Faculty appointees. Thirty-six (92.3%)of the Faculty-Agency appointees were engaged in research activities and spent 6.58 hours per week in these activities; 63 (63%) of Agency-Faculty were engaged in research and reported spending an average of 5.94 hours per week in research.

Research Question 1: How well do joint appointees negotiate certain aspects of their role? Data indicate that both groups of joint appointees have highly developed role negotiation skills (Table 1). Responses to one of the 16 items, "Ability to reach mutual agreement with my supervisor within the university on job related issues," did differ significantly. Agency-Faculty appointees indicated more problems in this area - that they had more difficulty reaching agreement on university job related matters.

Research Question 2: What are the joint appointees' perceptions of congruency in role expectations held by educational institutions and by health care agencies? The perception of congruency in role expectations received from the two agencies was significantly higher for the Faculty-Agency than for Agency-Faculty joint appointees (Table 1). This suggests that either the expectations for Agency-Faculty are not as clearly delineated as they are for Faculty-Agency appointees or that the Agency-Faculty group have a higher need for clarity.

Table 1

Use of Role Negotiation Skills, Expressed Perception of Congruency in Role Expectations and Job Tension Levels By Agency of Primary Responsibility

Scale	Mean Scores: Faculty-Agency Joint Appointees N = 39 x	SD	Agency-Faculty Joint Appointees N = 100 x	SD
Role Negotiation Skills (6 items)	5.89	.91	5.83	.73
Perceived Congruency (14 items)	4.62	.76	4.12*	.30
Job Tension Levels (18 items)	2.88	.66	2.89	.69

Note: Rating scale ranges from 1 = Very Seldom to 7 = Very Frequently
*t = 3.35
p = <.001

Individual perception of congruency items that differed significantly would indicate that both groups had problems with clarity of expectations held by the second institution. This difference was more pronounced for Agency-Faculty appointees, that is, the expectations in the university dimension of their positions (second institution) were not as clear as role expectations for Faculty-Agency appointees for whom the agency dimension of their jobs was secondary.

The perception of adequacy of support services (secretarial assistance, office space) in the second institution also differed significantly. The Agency-Faculty subjects expressed more problems in this area - for example, not receiving adequate support services in the educational institution.

Research Question 3: What is the job tension level of joint appointees? The combined means on the 18-item Faculty Tension Index were low: 2.88 for the Faculty-Agency group and 2.89 for the Agency-Faculty group (Table 1). These findings may indicate that, even though the joint appointees report high work loads and incongruence in role expectations, they are satisfied with their work. Another possible explanation for the low tension levels may be the short period of time that the joint appointees are in the joint role and that, when the negative effects of a multiple role begin to be felt, the individ-

ual leaves the joint role. Responses on three of the eighteen items were found to differ significantly. Agency-Faculty joint appointees expressed feelings of not fitting in well with the faculty group. Perceptions that the job interfered with individuals' personal lives and that time-consuming activities were least significant in performance evaluation were concerns to Faculty-Agency appointees.

Research Question 4: What are the relationships among role negotiation skills, perceived congruency and job tension? A significant positive relationship exists between use of role negotiation skills and perceived congruency in role expectations (Figure 1). This suggests that successful use of role negotiation skills contributes to a perception of congruency in expectations held by the two agencies.

The presence of a negative relationship between perceived congruency in role expectation and job tension levels suggests that when the joint appointees' perceived congruency is threatened, the job tension level increases. The negative relationship between job related tension and role negotiation skills suggests that in situations where the joint appointee does not possess or is unable to use role negotiation skills, the job tension level increases.

Qualitative data from the open ended questions were examined and categorized. Data revealed that the joint appointments were, in many cases, not well planned nor clearly defined. Respondents often expressed the opinion that they did not feel like joint appointees, although they held the title of joint appointee; this was expressed more frequently by the Agency-Faculty group. "My joint appointment is in name only" and "Joint appointments can be developed and have great potential - at present they are in name only" were comments voiced by Agency-Faculty. Lack of clarity in role expectations was an expressed concern. One respondent stated that joint appointments "are not formally developed here. Very poorly defined as an official program."

Statements about being underutilized and not being involved in the affairs of the second institution came more frequently from the Agency-Faculty group. Comments included "I could do more for the university than I do" and "insufficient use of service agency people in faculty areas such as curriculum planning."

Factor analysis

A principal components factor analysis and Oblimin rotation of the 18 items on the Faculty Tension Index Scale yielded five factors, accounting for 66.6% of the variance. Only loadings with absolute values of .3 or greater were used. The five factors were role ambiguity, quantitative role overload,

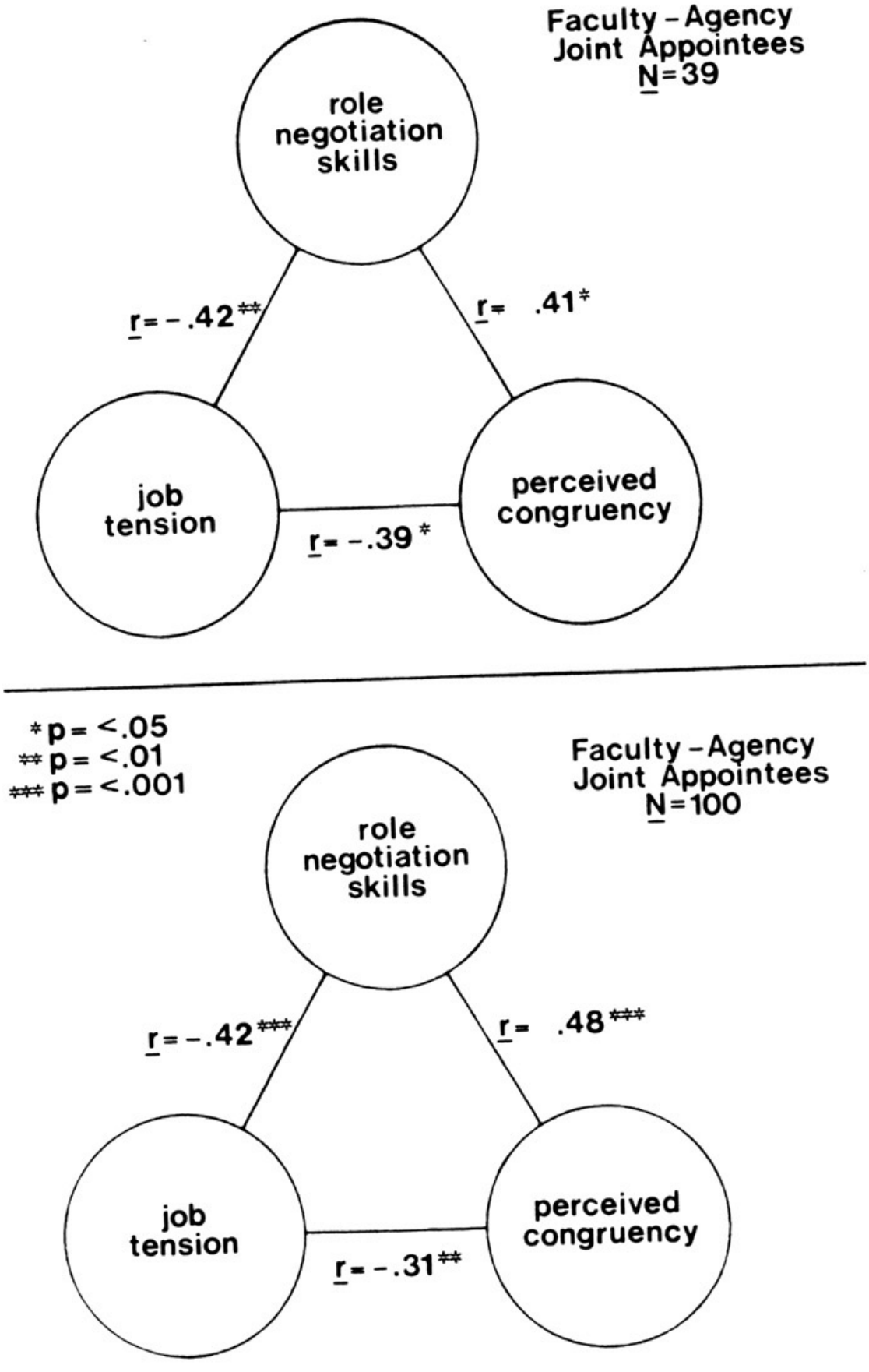

Figure 1

Relationships between role negotiation skills, perceived congruency in role expectations and job tension for joint appointees, by agency of primary responsibility

powerlessness, role uncertainty and quantitative role overload. They provided additional evidence that these concepts are dimensions of job related tension.

Discussion

A limitation of the study was the use of the mailed questionnaire. Although the mailed questionnaire enables the investigator to contact respondents over a wide geographical area, the questionnaire format does not allow the investigator to seek clarification on particular points of the topic under study.

The results provide a description of a particular study population and contribute to an understanding of the present stage of development of joint appointments in Canadian nursing. The joint appointees are employed in both a university and in a hospital setting, are relatively new in the joint appointment and the majority (69.2% of the Faculty-Agency appointees and 77% of the Agency-Faculty) hold a Master's as their highest degree. The average hours worked per week, 46.1 for the Faculty-Agency group and 45.8 for the Agency-Faculty group, are greater than the 44.4 faculty hours reported by Anderson (1986) and are considerably greater than the 37.5 hours per week required of most government and industry employees.

The potential for role overload and role related tension exists in this profile. However, the job related tension levels are relatively low. It is possible that this may be attributed to the short tenure in these positions: joint appointees may find the multiple role too demanding and therefore leave after a relatively short period of time. The constructs of role ambiguity, role uncertainty and role overload were exhibited in the factor analysis. Theoretically, these factors would contribute to a high tension level. One can postulate that the joint appointee leaves the role when role related problems become evident.

The findings demonstrate that joint appointments, in many cases, are not well planned. Some joint appointees indicated that, even though they held the title of joint appointee, they did not consider themselves as such. The Agency-Faculty joint appointees frequently expressed a feeling that role responsibilities in the educational institution were not clearly defined. This is supported by the findings that Agency-Faculty appointees indicated more problems on the item "ability to reach mutual agreement with my supervisor within the university on job-related issues".

The hours devoted to research activities are similar for both groups: 6.58 hours per week for Faculty-Agency joint appointees and 5.94 for Agency-Faculty joint appointees. The high level of research activity reported by Agency-Faculty joint appointees may be related to 26 respondents (26%) reporting their clinical title as either clinical nurse specialist or nurse

researcher, with research a role expectation. The differences in academic qualifications between nurses in academia and those in service agencies has implications for the research expectations placed on Agency-Faculty appointees. There is a need to attract more doctorally-prepared nurses to service agencies to facilitate research activities.

Significant relationships exist among role negotiation skills, perceived congruency in role expectations and job-related tension for joint appointees. The direction of these relationships suggests that the individual with well-developed role negotiation skills will perceive a higher degree of congruity in the role expectations of the two agencies, and will experience a lower level of job tension.

The factors identified in the Faculty Tension Index Scale support the theoretical dimension of the effects that a multiple role has on an individual. The findings add additional evidence that role ambiguity, role uncertainty and role overload are dimensions of job-related tension.

The findings from this study have implications for joint appointees, potential joint appointees and nurse executives. Joint appointments must be well planned, with specific objectives clearly articulated and understood by both agencies. Job responsibilities and accountability must be clear, and availability of administrative support should be examined. Autonomy over time and scheduling is important, as is the availability of office space and secretarial support.

Nurse executives and joint appointees must co-operate in defining the role of the latter group, especially the role of the Agency-Faculty appointees in the educational institution. Individual joint appointees may need assistance in learning to set realistic expectations and being able to say "no" to unrealistic expectations. The many hours of work reported may be acceptable in the short term, but over a long period of time could be viewed as contributing to work-related tension and propensity to leave the joint appointment.

The findings of this study, when considered in relation to the current trend of joint appointments, suggests further areas of investigation:

1. What assistance can be given to potential joint appointees to enable them to function between two organizations successfully?
2. What administrative supports are required to function in a joint appointment (e.g. philosophy, amount of time, amount of resources and services)?
3. Are expected outcomes being achieved? For example, do joint-appointed faculty produce more research than non joint appointed faculty? Do joint appointed faculty have an impact on student learning?

4. An in depth examination of one model, assessing process, organizational structure and outcomes would add to our understanding of joint appointments as they presently exist.

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RÉSUMÉ

Perspectives sur le rôle des titulaires de postes mixtes

Cette étude porte sur les perceptions qu'ont de leur rôle les titulaires de postes mixtes qui les appellent à intervenir en milieu universitaire et clinique, c'est-à-dire dans les facultés de sciences infirmières des universités canadiennes et dans les agences de services correspondantes. Des données recueillies auprès de 39 titulaires de poste mixte enseignement - agence et de 100 titulaires de poste mixte agence - enseignement ont été analysées. Les résultats permettent d'affirmer que les rôles des postes mixtes sont mal définis et moins bien compris que ne le suggèrent les documents à ce chapitre. Les participants ne savent pas très bien quel rôle leur incombe exactement. Des rapports significa- tifs existent entre les différentes variables suivantes: compétences en matière de négociation du rôle, confor- mité des attentes à ce chapitre et tension au travail. Les conséquences de ces résultats sur les titulaires de postes mixtes, sur les personnes susceptibles d'occuper des postes mixtes et sur les infirmières en chef sont également abordées. L'auteur formule par ailleurs des recommandations sur l'orientation que doivent prendre les prochaines recherches à ce chapitre.

OBSTACLES A LA POURSUITE DES ÉTUDES AU NIVEAU UNIVERSITAIRE: PERCEPTION DES INFIRMIERES DU QUÉBEC

André Duquette

Aujourd'hui, la pratique infirmière est largement influençée par de nombreux changements d'ordre économique, technologique et social. La formation continue apparaît comme un moyen privilégié d'adaptation pour maintenir et améliorer la qualité des services offerts à la population.

Au Québec, la presque totalité des infirmières (96%) ont reçu leur formation professionnelle initiale au CEGEP ou à l'hôpital. Or, des statistiques de l'Ordre des infirmières et infirmiers du Québec (OIIQ, 1988) montrent que 67% de la population infirmière n'a pas reçu de formation universitaire santionnée par un certificat ou un baccalauréat. Dans le contexte, tel que recommandé par plusieurs associations professionnelles d'infirmières au Canada, où l'accès à l'exercice de la profession exigera une formation universitaire, il apparaît important de connaître les obstacles qui empêchent les infirmières de poursuivre des études au niveau universitaire.

Les quelques études traitant des obstacles à la formation infirmière continue peuvent être regroupées selon le type d'infirmières interrogées, soit des participantes, des participantes potentielles et des non-participantes.

Dans une étude menée auprès de 40 infirmières du Québec ayant participé à diverses activités éducatives au cours des 12 mois précédant l'enquête, Blais (1983) mentionne que les trois principaux obstacles à une participation éventuelle sont le manque de temps et d'argent de même que les obligations familiales. L'Association des infirmières du Canada, avec un échantillon de 6 493 infirmières, a constaté en 1971, que le manque d'aide financière et les responsabilités familiales apparaissent comme les deux obstacles majeurs à la poursuite des études universitaires. Plus récemment, Witter-Du Gas (1985), qui a interrogé des infirmières ontariennes intéresseées à suivre des cours universitaires crédités, souligne que les responsabilités familiales sont les principales barrières à la formation continue.

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D'autres chercheures se sont surtout adressées à des infirmières considérées comme des non-participantes. Dans une enquête menée auprès de 432 infirmières n'ayant pas suivi d'activités éducatives organisées au cours des cinq années précédant l'étude, Puetz (1980) révèle que les trois principaux obstacles évoqués sont les responsabilités familiales, le manque d'information en regard des activiés offertes, et l'endroit où les activités sont offertes. Parochka (1981), qui a interrogé 41 infirmières n'ayant pas suivi d'activités éducatives organisées au cours des trois années précédant l'enquête, constate que les trois obstacles les plus importants sont les coûts, l'horaire et la pertinence des cours offerts. Enfin Berg (1973), dans une étude comparative menée auprès de 45 participantes et de 57 non-participantes, montre que certains obstacles apparaissent plus influents pour les non-participantes. Il s'agit des responsabilités familiales, des coûts, de la fatigue après le travail, et de la réduction du temps libre.

La recension des écrits amène à constater que les principaux obstacles évoqués concernent avant tout la situation des infirmières, soit les responsabilités familiales, les coûts et le manque de temps. Il faut par ailleurs mentionner que dans la plupart des études examinées, on a proposé aux infirmières concernées une liste d'obstacles souvent plus ou moins exhaustive. Il apparaît aussi qu'il n'existe pas de recherche ayant étudié, à la fois, les obstacles à la formation infirmière continue et les liens d'association avec des variables d'ordre socio-démographique.

La présente recherche se distingue des études antérieures pour plusieurs motifs. Il s'agit de la première étude systématique conduite auprès d'un grand nombre d'infirmières québécoises, francophones et n'ayant pas suivi de cours conduisant à l'obtention d'un diplôme universitaire. De plus, l'instrument utilisé est constitué de 50 énoncés jugés représentatifs de l'ensemble des obstacles à la poursuite des études au niveau universitaire.

Le but de cette recherche était d'identifier les obstacles qui, selon les infirmières québécoises concernées, les ont empêchées de suivre des cours en vue d'obtenir un certificat ou un baccalauréat. Plus précisément, les questions de recherche se présentent comme suit:

1. Quels sont les principaux obstacles qui ont influencé les infirmières à ne pas suivre de cours menant à l'obtention d'un certificat ou d'un baccalauréat?
2. Y a-t-il un lien de dépendance entre les obstacles les plus importants et certaines caractéristiques des infirmières (statut d'emploi, état civil, nombre d'enfants, âge)?

Méthode

Instrument

Cette étude descriptive a été réalisée en utilisant le questionnaire élaboré par Scanlan en 1982 (Deterrents to Participation Scale-DPS). Plusieurs aspects de la validité de cet instrument furent vérifiés et sont décrits dans le texte de Scanlan. Il s'agit d'analyses quant à la validité de contenu, à la validité des concepts et à la validité prédictive.

Il est par ailleurs apparu nécessaire d'adapter le DPS au contexte de la présente recherche selon un cheminement réparti en trois étapes. Le première étape a consisté à traduire de l'anglais les 40 énoncés de Scanlan, puis à vérifier la traduction auprès de deux personnes bilingues et expertes en formatin infirmière continue. A la deuxième étape, un jury, formé de huit expertes en formation infirmière continue, a vérifié la clarté et la pertinence des énoncés. Il en est résulté une nouvelle liste d'énoncés constituée de 50 items: 38 issus de la liste de Scanlan et 12 additionnels. Ceci imposait de procéder à une autre vérification. La troisième phase de vérification s'est effectuée, par entrevue individuelle, auprès de 16 infirmières se rapprochant le plus possible des caractéristiques de celles qui devaient constituer subséquemment la population de recherche. Il en est ressorti une liste de 50 énoncés jugés représentatifs de l'ensemble des obstacles à la poursuite des études au niveau universitaire. Un test de fidélité a été effectué après la collecte des données en utilisant le coefficient alpha de Cronbach ($r = .89$, $N = 1,197$). Une série de questions, portant sur des caractéristiques d'ordre sociodémographique, fut ajoutée au questionnaire.

Les répondantes devaient lire le texte suivant avant de répondre à chacun des 50 énoncés. "Les infirmières et infirmiers se perfectionnent de diverses façons. La plupart font des activités d'auto-formation, plusieurs participent à la formation en cours d'emploi et d'autres suivent des cours. La présente recherche porte uniquement sur les cours crédités menant à l'obtention d'un certificat ou d'un baccalauréat. En vous référant à votre propre situation depuis l'obtention de votre permis (surtout lorsque vous étiez dans l'impossibilité de suivre des cours ou ne vouliez pas en suivre). Veuillez indiquer dans quelle mesure chacune des raisons énumérées ci-dessous vous a influencée à ne pas suivre de cours. (S.V.P., encerclez le numéro qui correspond le mieux à votre situation)". Voici l'exemple d'un énoncé.

	Pas du tout	Un peu	Assez	Beaucoup
Parce que mon employeur ne me fournit pas d'aide financière pour suivre ces cours	1	2	3	4

Population et échantillon

La population de recherche était constituée de 22,494 infirmières francophones, membres actifs de l'OIIQ, employées en nursing, ayant reçu leur formation professionnelle au CEGEP ou à l'hôpital, et n'ayant pas suivi de cours après l'obtention du permis et ce, selon les registres de l'OIIQ au 31 décembre 1984. La population a été subdivisée en plusieurs cellules d'échantillonnages obtenues par deux facteurs de statification: quatre groupes d'âge (moins de 25 ans, de 25 à 34 ans, de 35 à 44 ans, 45 ans et plus) et 13 régions de résidence. Un choix aléatoire simple a permis de prélever 9% des infirmières dans chacune des cellules. Il en est résulté une liste d'échantillonnage de 2,063 noms.

Le premier envoi fut expédié par courrier en février 1985; successivement, à intervalles de trois semaines, trois envois de rappel suivirent. Une lettre de présentation et une enveloppe de retour affranchie et pré-adressée furent incluses dans chacun des envois. Il faut signaler que ces envois postaux furent acheminés par l'OIIQ en raison de la politique de cet organisme de ne pas divulguer l'adresse de ces membres.

Un taux de participation de 80% (n = 1,651) fut obtenu. En raison de nombreux questionnaires invalides, notamment parce que 326 infirmières ont déclaré avoir suivi des cours, un total de 1,197 questionnaires furent analysés.

La taille de l'échantillon, la méthode d'échantillonnage utilisée, le taux de réponses obtenu et une étude des caractéristiques des non-répondantes montrant que six variables socio-démographiques (incluant l'âge et la région de résidence) se distribuent sensiblement de la même façon que celles inhérentes à la population de recherche, autorisent à supposer que les résultats de cette recherche peuvent être généralisés à la population étudiée.

Le profil socio-démographique des 1 197 infirmières retenues se présente comme suit: le plus grand nombre d'entre elles prodiguent des soins aux malades (88%); et oeuvrent dans un centre hospitalier (80%); plus de la moitié travaillent à temps partiel (54%); la plupart des infirmières sont mariées (72%) et ont des enfants de 18 ans et moins (63%); enfin, la majorité d'entre elles ont moins de 35 ans (55%).

Procédures statistiques

Les données furent d'abord compilées sur l'ordinateur de l'Université de Montréal; après avoir vérifié l'exactitude de la compilation, ces données furent traitées à l'aide du programme SPSS. Considérant la nature des questions de recherche, le recours aux statistiques descriptives fut privilégié.

Pour l'analyse des résultats globaux, des moyennes et des écarts-type furent calculés pour l'ensemble des répondantes en considérant les valeurs métriques (1,2,3,4) attribuées à chacun des quatre choix de réponses. En ce qui concerne l'identification des énoncés les plus importants, les catégories de réponses (valeurs nominales) furent analysées d'une façon dichotomique: les classes "pas du tout" et "un peu" indiquant des facteurs peu influents, et les classes "assez" et "beaucoup" indiquant une influence plus marquée. Un tableau de fréquence concernant la répartition des pourcentages des répondantes ayant coché les choix "assez" et "beaucoup" fut alors constitué. Enfin, des tableaux croisés furent dressés et on révélé plusieurs liens de dépendance entre les énoncés les plus importants et les variables socio-démographiques. A ce sujet, la statistique khi-carré a été retenue avec un niveau de signification de $p<.05$.

Résultats

L'analyse des résultats globaux, en considérant la moyenne de chaque énoncé établie à partir des valeurs métriques (1,2,3,4) attribuées aux choix de réponses, a montré que chacun des 50 énoncés représentait un facteur pouvant justifier la décision des infirmières de ne pas suivre de cours. Les moyennes étant par ailleurs peu élevées variant de 1.12 (parce que la crédibilité de l'institution qui offre les cours laisse à désirer) à 2.88 (parce que avec tous mes engagements, je n'ai tout simplement pas le temps).

On a constaté que les dix énoncés ayant obtenu les résultats les plus élevés se distinguent des autres (voir Tableau 1). D'une part, parce qu'ils sont les dix premiers tout autant au point de vue des moyennes que des pourcentages des répondantes ayant coché les choix "assez" et "beaucoup," et d'autre part, parce que l'écart des pourcentages entre le dixième et le onzièmem énoncé est le plus important de toute la distribution. L'étude des résultats a aussi révélé que la variation, dans la perception des répondantes quant à l'importance attribuée à chacun des énoncés, était plus grande pour les items plus influents que pour ceux qui le sont moins.

Kaplan et Fishbein (1969) estiment que le comportement humain est généralement influencé par plusieurs motifs, et que les motifs les plus saillants en seraient les causes déterminantes, parmi les motifs invoqués pour justifier un comportement, tout au plus de six à onze peuvent probablement être considérés comme les plus importants. Il a donc semblé raisonnable de considérer les dix premiers énoncés comme étant, selon l'ensemble des répondantes, les principaux obstacles à la poursuite des études universitaires.

L'analyse des dix énoncés les plus importants montre une grande diversité. Plusieurs concernent le milieu de travail, comme le temps consacré au travail, les libérations du travail, les conditions de travail, et l'épuisement dû

au travail. D'autres énoncés sont davantage liés aux dispositions des infirmières et expriment surtout un manque d'intérêt pour ce type de formation continue (diplôme non nécessaire, temps pour obtenir un diplôme, et pratique satisfaisante). Enfin, des énoncés se rapportent à la situation personnelle des infirmières, comme les engagements nombreux et la vie privée prioritaire. Il faut aussi souligner que le dixième énoncé, "parce que je trouve difficile de suivre des cours à temps partiel," peut concerner certaines contraintes inhérentes tant aux dispositions et à la situation personnelle des infirmières qu'à celles du milieu de travail.

Tableau 1

Les dix énoncés les plus importants selon les pourcentages, les moyennes et les écarts-type obtenus (n = 1,197)

Énoncés	%[a]	X	ET
Parce qu'avec tous mes engagements, je n'ai tout simplement pas le temps	61	2.88	1.19
Parce que je suis satisfaite de ma pratique professionnelle	61	2.78	1.00
Parce qu'il faut trop de temps pour obtenir un diplôme	61	2.67	1.03
Parce que le travail prend beaucoup de mon temps	59	2.70	1.18
Parce que le fait de suivre des cours empiète trop sur ma vie privée	55	2.67	1.10
Parce qu'il est difficile d'être libérée du travail pour suivre des cours	54	2.58	1.20
Parce que les conditions de travail sont devenues tellement difficiles que je n'ai plus le goût de suivre des cours	53	2.58	1.17
Parce que je suis déjà un peu épuisée par mon travail	51	2.57	1.14
Parce qu'il n'est pas nécessaire d'avoir un certificat ou un baccalauréat pour exercer ma profession	50	2.57	1.16
Parce que je trouve difficile de suivre des cours à temps partiel	50	2.50	1.11

[a]Pourcentages des répondantes ayant coché les choix "assez" et "beaucoup".

En vue de faciliter la discussion des résultats, il a semblé opportun de regrouper les dix énoncés les plus importants selon trois thèmes: les énoncés qui concernent le manque de temps, ceux qui sont liés au manque d'intérêt et finalement ceux qui se rapportent aux conditions de travail.

Trois énoncés appartiennent d'une façon plus évidente au manque de temps. Ils concernent à la fois la situation personnelle et la situation de travail.

1. Parce qu'avec tous mes engagements, je n'ai tout simplement pas le temps (61%).
2. Parce que le travail prend beaucoup de mon temps (59%).
3. Parce que le fait de suivre des cours empiète trop sur ma vie privée (55%).

L'analyse des tableaux croisés a révélé des liens de dépendance entre les trois énoncés liés au manque de temps et les caractéristiques des infirmières telles que le statut d'emploi (temps plein et temps partiel), l'état civil (mariée, célibataire, autre), le fait d'avoir ou non des enfants de 18 ans et moins, et l'âge (moins de 25 ans, de 25 à 34 ans, de 35 ans à 44 ans, 45 ans et plus). De façon globale, il en ressort que comparées aux autres infirmières, celles qui travaillent à temps plein, celles qui sont mariées, celles qui ont des enfants de 18 ans et moins, et celles qui ont de 25 à 44 ans, sont significativement ($p<.05$) plus influencées par le manque de temps.

Le manque d'intérêt se rapporte surtout à trois énoncés liés aux dispositions de l'infirmière et à un autre lié aux conditions de travail.

1. Parce que je suis satisfaite de ma pratique professionnelle (61%).
2. Parce qu'il faut trop de temps pour obtenir un diplôme (61%).
3. Parce qu'il n'est pas nécessaire d'avoir un certificat ou un baccalauréat pour exercer ma profession (50%).
4. Parce que les conditions de travail sont devenues tellement difficiles que je n'ai plus le goût de suivre des cours (53%).

Il semble donc que les conditions de travail auraient joué un rôle d'importance dans la manque d'intérêt pour les cours universitaires. Par contre, il est apparu difficile d'identifier des liens de dépendance entre les trois énoncés liés aux dispositions et les caractéristiques socio-démographiques des infirmières. L'examen de la variation a révélé peu de choses à ce sujet.

Enfin, parmi les énoncés les plus importants trois concernent les conditions de travail.

1. Parce qu'il est difficile d'être libérée du travail pour suivre des cours (54%).
2. Parce que les conditions de travail sont devenues tellement difficiles que je n'ai plus le goût de suivre des cours (53%).
3. Parce que je suis déjà un peu épuisée par mon travail (51%).

L'examen de la variation quant à la perception de ces énoncés a permis de dégager certaines tendances. De façon globale, il en ressort que les infirmières travaillant à temps plein, les célibataires, celles qui n'ont pas d'enfant, et celles qui ont plus de 44 ans, sont significativement ($p<.05$) plus influencées que les autres par les énoncés liés aux conditions de travail.

Discussion

L'analyse des résultats a montré que le manque de temps apparaît comme un obstacle majeur à la poursuite des études universitaires. Il n'est pas surprenant de constater que certaines infirmières sont davantage pressées par le temps, celles qui sont marieés, celles qui ont des enfants de 18 ans et moins, et celles qui travaillent à temps plein. En général, ces observations concordent assez bien avec les résultats mentionnés dans les écrits recensés, en particulier en ce qui concerne les responsabilités familiales et le manque de temps.

Il faut par ailleurs souligner que les infirmières qui travaillent à temps partiel (54%), celles qui sont célibataires (18%), et celles qui n'ont pas d'enfants de 18 ans et moins (37%), considèrent les énoncés liés au manque de temps comme des motifs relativement importants, leur ayant attribué 44% pour les choix de réponses "assez" et "beaucoup".

A l'instar de Rubenson (1983), il faut soulever certaines questions quant à l'interprétation du manque de temps. Le manque de temps n'est-il pas, pour plusieurs, une question de choix d'activités pendant les temps libres? Une augmentation du temps libre conduira-t-il nécessairement à une participation accrue aux activités de formation continue? N'y a-t-il pas une différence importante entre vouloir et pouvoir suivre des activités créditées de formation continue? Ces interrogations amènent à discuter du manque d'intérêt.

Les répondants ont clairement exprimé un manque d'intérêt pour les cours universitaires. Il faut noter, que dans les écrits recensés, le manque d'intérêt apparaissait comme un obstacle peu influent. Cette observation constitue un apport original qui invite à étudier plus attentivement l'interaction entre le manque d'intérêt et les situations personnelles et de travail des infirmières en cause.

L'examen de la variation en regard des caractéristiques socio- démographiques a révélé peu de choses à ce sujet. A l'instar de la CEFA (1982), il apparaît raisonnable de croire que certains facteurs d'ordre psycho-social doivent y jouer un rôle d'importance; par exemple, les croyances, les valeurs et les attitudes propres à la condition féminine. En général, dans la société actuelle, les femmes privilégient plus que les hommes les valeurs familiales à celles orientées vers la carrière. Il faut aussi rappeler que 63% des

infirmières interrogées ont des enfants de moins de 18 ans et que 72% sont mariées.

Par ailleurs, outre les facteurs liés aux dispositions personnelles, les conditions de travail des infirmières semblent avoir joué un rôle d'importance en regard du manque d'intérêt pour les cours universitaires. On ne peut ignorer que l'énoncé "parce que les conditions de travail sont devenues tellement difficiles que je n'ai plus le goût de suivre des cours" se classe au septième rang parmi les dix énoncés les plus importants.

Les répondantes ont donc évoqué les conditions de travail comme étant un obstacle majeur à la poursuite des études universitaires. En fait, parmi les dix énoncés les plus importants, trois concernent les conditions de travail.

Au cours des dernières années, les conditions de travail des infirmières ont subi plusieurs modifications. Les restrictions budgétaires, l'alourdissement des clientèles, la rationalisation dans la distribution des soins, les coupures de poste, la croissance des postes à temps partiel au détriment de ceux à temps plein, ont contribué à augmenter la tâche de travail de la plupart des infirmières.

Il était à prévoir que les infirmières travaillant à temps plein subissent avec plus d'ampleur les pressions venant des conditions de travail. Il existe par contre certains liens entre le statut d'emploi, le statut civil et le nombre d'enfants. Proportionnellement, moins d'infirmières mariées travaillent à temps plein (37%) que les autres (67%). Ces faits peuvent, en partie, expliquer que les célibataires et celles qui n'ont pas d'enfant soient davantage influencées par les énoncés liés aux conditions de travail.

Les résultats de la présente recherche amènent donc à constater la diversité et la complexité des principaux obstacles à la poursuite des études universitaires. D'une part, certains obstacles, d'ordre psychologique, concernent les dispositions des infirmières et expriment des attitudes d'indifférence comme le manque d'intérêt pour les cours universitaires. D'autre part, certains obstacles de l'environnement, comme la situation personnelle de l'infirmière et son milieu de travail, traduisent un manque de temps et des conditions de travail difficiles. Une telle connaissance devrait permettre aux intervenants concernés une action plus éclairée.

Les politiques du Gouvernement comme celles des employeurs devraient davantage favoriser tant l'amélioration des conditions de travail que la promotion du perfectionnement des infirmières. On peut notamment penser à des congés d'éducation, des échelles de rémunération valorisant davantage la formation, et plus de flexibilité dans les horaires de travail.

Les organismes professionnels comme l'OIIQ devraient poursuivre les actions entreprises en vue de l'accès à l'exercice de la profession par une formation universitaire. Pour certaines infirmières, ces actions peuvent avoir suscité l'intérêt pour les études universitaires.

Il semble opportun de mentionner que les énoncés qui concernent surtout les milieux d'enseignement, comme l'horaire, la pertinence et l'endroit des cours, n'apparaissent pas parmi les obstacles les plus importants. Cette observation pourrait signifier que les efforts des institutions d'enseignement pour améliorer la qualité et l'accessibilité des cours universitaires ne produiraient pas nécessairement une augmentation importante de la participation. On peut supposer que les barrières liées au milieu d'enseignement deviennent saillantes seulement une fois que la décision de suivre des cours a été prise.

Enfin, les résultats de la recherche amènent à suggérer certaines questions pouvant faire l'objet de recherches subséquentes. Le manque d'intérêt, le manque de temps et les conditions de travail difficiles sont-ils des facteurs liés entre eux et agissant comme des forces cumulatives? Les infirmiers perçoivent-ils différemment des infirmières les obstacles à la poursuite des études universitaires? L'ampleur de l'engagement dans diverses activités éducatives influence-t-elle la perception des obstacles à la formation continue?

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ABSTRACT

Obstacles to university studies: the point of view of Quebec nurses

This research project aimed at identifying obstacles that prevent nurses from taking university courses. Through a random stratified sampling method, we selected 2,063 persons among the 22,494 French speaking nurses of Quebec who worked as nurses and did not take any courses beyond their professional training at the CEGEP level or at the hospital. A 50 statement questionnaire was mailed out and 1,197 questionnaires were returned and reviewed. The ten most important statements were considered under three main themes: lack of time, lack of interest and strenuous working conditions. Statements relating to lack of time and working conditions were dependent upon (X2, $p < .05$) the nurses' situation, i.e. employment status, marital status, number of children and age. Theoretical and practical advice are given to interested nurses.

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THE EFFECT OF PRECEPTORSHIP ON THE CLINICAL COMPETENCY OF BACCALAUREATE STUDENT NURSES: A PILOT STUDY

Florence Myrick and June Awrey

Nursing education has been undergoing major academic changes in the last two decades. In Canada, there has been a widespread change from hospital-based diploma nursing education to college programs. In 1982, a resolution that the baccalaureate degree become the minimum educational preparation for entry into the profession by the year 2000 was ratified by the Canadian Nurses' Association (CNA).

This resolution has significant implications for the nursing profession. By the turn of the century, faculties of university schools of nursing may acquire the exclusive role of preparing registered nurses in Canada. University-based programs will be confronted with a vast influx of students, far exceeding their present capacities. It is currently recognized that existing programs are not equipped for the accommodation of the anticipated increased enrollments (CNA, 1982; French, 1984). Already faculty in schools of nursing are confronted with the problem of new graduates feeling inadequately prepared for the service settings (Shamian & Inhaber, 1985). An increasing disproportion in the ratio of students to faculty will result in an even greater strain on clinical teaching. As a result of these developments the onus is on the nursing profession, in particular nursing education, to explore alternative clinical teaching strategies that will assist in dealing with these difficulties. One such method being proposed in the literature is preceptorship.

Preceptorship may be defined as an "individualized teaching/learning method in which each student is assigned to a particular preceptor...so she can experience day-to-day practice with a role model and resource person immediately available with the clinical setting" (Chickerella & Lutz, 1981, p. 107). While the underlying assumption for the use of preceptorship is that the one-to-one relationship furnishes an effective mechanism for learning, there is little empirical evidence to substantiate that effectiveness (Shamian

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& Inhaber, 1985). The primary purpose of a baccalaureate program is to provide clinically competent beginning practitioners (Bondy, 1984). Therefore, if preceptorship is to be viewed as a viable clinical teaching strategy, it becomes not only necessary but imperative that the question of its relationship to clinical competency be addressed.

Review of the Literature

The change in the academic focus of nursing education from the hospital-based programs to college and university based programs has had little impact on clinical teaching. While it is evident that individual clinical instructors may have modified their style and approach to the teaching of students in the clinical setting, essentially, students in both the diploma and degree programs continue to be taught in much the same manner - albeit they are supervised by a faculty member who directs and scrutinizes their performance while they carry out their nursing care.

During the past 20 years, a variety of instructional techniques have been presented in the literature (Boss, 1985). In each method, there is a claim of increased effectiveness of student learning. While evidence does indicate that organization and presentation can influence or produce a difference in student learning, each method must also relate to a greater goal - that of teaching for clinical competence (Boss, 1985). The challenge for nurse educators is to select appropriate clinical instruction that will provide for that competence. Preceptorship is one such method (Morrow, 1984; Shamian & Lemieux, 1984).

Despite the growing interest in the preceptorship concept, there has been limited research carried out with regard to its use for clinical instruction. Studies conducted by Huber (1981), Marchette (1985) and Olson, Gresley and Heater (1984) determined that there was no significant difference between the performance of student and graduate nurses who were preceptored over that of student and graduate nurses who were not preceptored. However, Shamian and Lemieux (1984) found that the preceptorship model was more effective than the "formal teaching model" (p. 86) in increasing the knowledge base of participating nurses.

Although it is difficult to impute any consistency in the findings of the various studies, it is, nevertheless, apparent that preceptorship is being used frequently as a clinical teaching strategy by a variety of nursing programs throughout Canada and the United States. If this method is to continue to be used as a viable alternative clinical teaching strategy in nursing programs, it is necessary to derive additional substantive evidence to demonstrate the advantages of this model (Shamian & Inhaber, 1985).

Conceptual Framework

Nursing, especially in the acute care setting, has become so complicated that it is becoming increasingly more difficult to "standardize, routinize and delegate much of what the nurse does" (Benner, 1982, p. 402). For years, the influence of nursing care on patient well-being has been underestimated; little or no consideration has been afforded the support of long careers for nurses in the hospital setting (Benner, 1982).

Clearly, nursing practice today mandates on-going career development, especially in light of the evolving complexity of health care and the ever increasing emphasis on the differences between the various levels of nursing - for example the experienced and the novice nurse. The Dreyfus Model of Skill Acquisition has been adapted for nursing by Benner (1984) and provides a very useful method for comprehending those differences. Benner assessed advancement in skilled performance, based upon experience and career progression in clinical nursing. The adaptation, "From novice to expert", was used as a framework for this pilot study.

According to this model, during the process of acquiring and developing a skill, the individual progresses through five phases of proficiency. These include: "novice, advanced beginner, competent, proficient and expert" (Benner, 1984, p. 14). In utilizing this model, it is possible to describe the performance characteristics of each phase of the nurse's development and to identify generally the teaching and learning needs specific to each phase.

The advanced beginner is one who has confronted sufficient situations to acknowledge the recurrent significant aspects of a situation or to have them delineated by a clinical instructor, or preceptor (Benner, 1984). In accordance with this definition, the students who participated in this pilot study were classified as advanced beginners. The expert nurse is one who, based on a vast background of experience, has acquired an instinctive understanding of the situation which permits her or him to focus directly on the problem situation (Benner, 1984). The clinical instructor and the preceptors were classified as experts.

Research Questions

The purpose of this study was to examine the effect of preceptorship on the clinical competency of basic baccalaureate student nurses. Specifically it was to determine if there is a statistically-significant difference in the clinical competency of baccalaureate student nurses who are preceptored and baccalaureate student nurses who are not preceptored.

1. Is there a statistically significant pretest-to-posttest difference in the perceived performance of baccalaureate student nurses who are preceptored

(experimental group) and baccalaureate student nurses who are not preceptored (control group)?

2. Is there a statistically significant difference in the performance of the experimental group and the control group when rated by preceptors and the clinical instructor in the final week of the project?

3. Is there a statistically significant difference in the clinical competency of the experimental and control groups when evaluated by two raters in the final week of the project?

Definition of terms

Preceptorship: An individualized teaching strategy for learning. The baccalaureate student nurse was assigned to one specific preceptor for three weeks of the final clinical experience so that he or she could experience day-to-day practice with a resource person immediately available within the clinical setting (Chickerella & Lutz, 1981).

Preceptor: A registered nurse who is knowledgeable in his or her particular clinical area (Gardiner & Martin, 1985). He or she was a staff nurse who assumed the responsibility for teaching, counselling, acting as role model and resource person and supporting the growth and development of baccalaureate student in the final clinical experience.

Preceptee: A baccalaureate student nurse who was in the final clinical practicum. He or she was responsible for providing professional nursing care to assigned patients, under the supervision of an experienced and prepared registered nurse preceptor.

Clinical competence: The ability to function adequately or to demonstrate sufficient knowledge, judgment and skills while in the clinical setting (Schneider, 1979). This competence was measured by the Slater Nursing Competencies Rating Scale.

Performance: The demonstrated ability to carry out nursing actions in a competent manner while in the clinical setting. Performance was measured by the Six Dimension Scale of Nursing Performance.

Measurement of variables

The independent variable studied was preceptorship. Subjects in the experimental group were each assigned to one specific preceptor for the three-week period of the pilot project. During this time they were provided the opportunity to integrate theoretical concepts within the clinical setting, while assuming patient care responsibilities under the day-to-day guidance of the assigned preceptors. Students in the control group also assumed patient care

responsibilities without the one-to-one guidance of a staff nurse. The clinical instructor was responsible for the supervision of the five students in this group.

The dependent variable under study was clinical competency. This variable was measured by the constructs of leadership, critical care, teaching/collaboration, planning/evaluation, interpersonal relationships/communications and professional development in the Six Dimension Scale of Nursing Performance. The constructs of psychosocial individual, psychosocial group, physical, general, communication and professional implications in the Slater Nursing Competencies Rate Scale (Wandelt & Stewart, 1975) were also examined.

Instruments

Six Dimension Scale of Nursing Performance (6-D Scale):

Composed of 52 items (divided into six subscales), this four point rating scale was designed to obtain self-evaluations of performance, to record supervisor appraisals of performance or to measure perceived adequacy of nursing school performance (Schwirian, 1978). Reliability was determined for each of the subscales by coefficient alpha, with values ranging from .84 for the leadership subscale to .98 for the professional development subscale. Content and construct validity were addressed by the source of the items and the procedure used for development. Criterion validity was acquired in the instrument development. Criterion validity was established in the instrument development study. A factor analysis was conducted on 1501 responses; it indicated six identifiable factors corresponding to the six subscales of the instrument. Cronbach's Alpha was used to measure reliability for each of the six subscales (Schwirian, 1978).

Slater Nursing Competencies Rating Scale (Slater Scale):

This 84-item (divided into six constructs), five-point rating scale was designed to measure the competencies displayed by nurses as they performed nursing actions in providing care to patients (Wandelt & Stewart, 1975). Interrater reliability was estimated using three groups of senior nursing students (n = 74) in three different settings to be .78, .75 and .75. Intercorrelations among items, scales and total scores were computed for a sample of 250 nursing students. The odd-even half-split was .98. A factor analysis was carried out on 71 of the 84 items that had adequate sample size. Cronbach's Alpha analysis yielded .74. Construct validity was established through a factor analysis of 71 inter-item correlations, based on the 250 student sample. Content validity has been sustained through extensive scrutiny by nurse educators and nurse practitioners with expertise in all major clinical areas (Wandelt & Stewart, 1975).

Method

This study was part of a three week pilot project in which a preceptorship program was implemented in the fourth year of the basic baccalaureate program. The pilot project was the first of two pilot projects (incorporation of the preceptor-preceptee relationship), in preparation for curriculum revisions by the faculty of the selected university school of nursing.

Design

A quasi-experimental design was used. Subjects were assigned to the control group or to the experimental group. Random assignment was not feasible because the subjects, themselves, selected the clinical areas for their experience. Whether or not they were preceptored depended solely upon the clinical area selected. Preceptors were provided in five clinical areas only.

Sample

The fourth year basic baccalaureate student nurse population of the university school of nursing was composed of 62 students. Of that number, 52 elected to take the final optional third term experience; 14 of these requested permission to carry out their experience in the institution selected for the study. Twelve students agreed to participate in the pilot project. Seven students who were assigned to preceptors (staff nurses) were included in the experimental group, while the control group comprised five students who were supervised by a clinical instructor (member of the faculty of the university school of nursing). Although it was not possible to match students in the two groups, all were the same sex, approximately the same age and had similar previous clinical experience and academic standing.

Setting

The study was conducted in a 450-bed university teaching hospital in southwestern Ontario. This complex provides nursing services in a variety of specialty areas as well as in general medical-surgical nursing. This institution was selected because of the collaborative involvement of nursing administration and the faculty of the associated university school of nursing in the establishment of a preceptorship program. The areas designated for use in the study included medical, surgical, gynecological, orthopedic and nephrological units; the coronary care unit; the intensive care unit; the operating room; and the emergency room.

Data collection

Subjects in both groups used the Six Dimension Scale of Nursing Performance (6-D Scale) as a self-evaluation in a pretest, upon completion of the

first day of the clinical experience, and again as a posttest three weeks later. The 6-D Scale was also used in the final week of the project, by the clinical instructor and each of the preceptors, to rate the performance of subjects in the control group and the experimental group respectively. In the final week of the project, subjects were randomly assigned to the principal investigator and a research assistant who rated student performances with the Slater Nursing Competencies Rating Scale (Slater Scale). Prior to actual rating with this instrument, a correlation coefficient of .95 of was established for inter-rater reliability.

Results

Four different statistical tests were used to address the research questions. These included the paired t-test, two-tailed t-test, the Mann-Whitney U-test, and the point biserial correlation coefficient.

Results from the paired t-tests indicated that there were statistically significant pretest-to-posttest differences within the groups. Following the three week clinical preceptorship, subjects in the experimental group rated their performance to be significantly ($p<.05$) better in critical care, teaching/collaboration, planning/evaluation, interpersonal relationships/communications and marginally significantly ($p<.10$) better in professional development (Table 1). Subjects in the control group rated their performance as being marginally significantly ($p.<10$) better only in professional development (Table 2). The two-tailed t-test yielded no statistically significant pretest-to-posttest between group differences (Tables 3 and 4).

When the subjects' performance was rated by the clinical instructor and the preceptors, two-tailed t-tests indicated that the subjects in the control group performed significantly better ($p<.05$) than the subjects in the experimental group regarding planning/evaluation and marginally significantly better ($p<.10$) in interpersonal relationships/communications (Table 5). The point biserial correlation coefficient indicated that 47.8 percent of the variance between the groups in the planning/evaluation subscale was attributable to the treatment effect, while in interpersonal relationships/communications, 33 percent of the variance between the groups could be attributed to the treatment effect (Table 5).

Results from the observation of the experimental and control groups by the principal investigator and the research assistant using the Slater Nursing Competencies Rating Scale indicated no statistically significant difference in the performance of the two groups. The mean scores for the experimental group ranged from 0.54 in the psychosocial group subscale to 2.74 in the subscale of professional implications, while the mean scores for the control group ranged from 0.26 in the scale of psychosocial group to 1.40 in the physical scale (Table 6).

Table 1

Self-Evaluation Means, Standard Deviations and t-values as Rated on the Six Dimension Scale of Nursing Performance by the Experimental Group on the Pretest and Posttest (n=7)

	Pretest		Posttest		
	X	S.D.	X	S.D.	t-values
Leadership	2.20	0.67	2.37	1.64	0.36
Critical Care	1.78	0.36	2.98	0.49	7.41**
Teaching/ Collaboration	1.84	0.90	3.20	0.54	2.98**
Planning/ Evaluation	2.34	0.32	3.22	0.35	7.48**
Interpersonal Relationships/ Communications	2.68	0.39	3.61	0.30	4.96**
Professional Development	3.14	0.39	3.57	0.09	3.60*

*p<.10, **p<.105

Table 2

Self-Evaluation Means, Standard Deviations and t-values as Rated on the Six Dimension Scale of Nursing Performance by the Control Group on the Pretest and Posttest (n=5)

	Pretest		Posttest		
	X	S.D.	X	S.D.	t-values
Leadership	2.42	1.24	2.48	1.56	0.06
Critical Care	2.20	0.88	3.16	0.61	2.10
Teaching/ Collaboration	2.24	0.78	3.04	0.35	2.19
Planning/ Evaluation	2.38	0.76	3.18	0.53	2.10
Interpersonal Relationships/ Communications	3.02	0.66	3.64	0.42	2.06
Professional Development	3.32	0.50	3.64	0.37	2.50*

p<.10

Table 3

Self-Evaluation Means, Standard Deviations and t-values as Rated on the Six Dimension Scale of Nursing Performance by the Experimental Group and the Control Group on the Pretest (n=12)

	Experimental Group		Control Group		
	X	S.D.	X	S.D.	t-values
Leadership	2.20	0.67	2.42	1.24	0.40
Critical Care	1.78	0.36	2.20	0.88	1.13
Teaching/ Collaboration	1.84	0.90	2.24	0.78	0.79
Planning/ Evaluation	2.34	0.32	2.38	0.76	0.12
Interpersonal Relationships/ Communications	2.68	0.39	3.02	0.66	1.10
Professional Development	3.14	0.39	3.32	0.50	0.68

Table 4

Self-Evaluation Means, Standard Deviations and t-values as Rated on the Six Dimension Scale of Nursing Performance by the Experimental Group and the Control Group on the Posttest (n=12)

	Experimental Group		Control Group		
	X	S.D.	X	S.D.	t-values
Leadership	2.37	1.64	2.48	1.56	0.12
Critical Care	2.98	0.49	3.16	0.61	0.55
Teaching/ Collaboration	3.20	0.54	3.04	0.35	0.57
Planning/ Evaluation	3.22	0.35	3.18	0.53	0.19
Interpersonal Relationships/ Communications	3.61	0.30	3.64	0.42	0.12
Professional Development	3.57	0.95	3.64	0.37	0.47

Table 5

Evaluation Means, Standard Deviations and t-values as Rated on the Six Dimension Scale of Nursing Performance for the Experimental Group by the Preceptors and for the Control Group by the Clinical Instructor (n=12)

	Experimental Group		Control Group		
	X	S.D.	X	S.D.	t-values
Leadership	2.85	0.41	-	-	-
Critical Care	3.02	0.64	3.30	0.46	0.80
Teaching/ Collaboration	3.01	0.38	3.04	0.48	0.10
Planning/ Evaluation	3.07	0.27	3.64	0.37	3.03**
Interpersonal Relationships/ Communications	3.52	0.18	3.80	0.23	2.22*
Professional Development	3.51	0.30	3.78	0.27	1.55

* p<.10
**p<.05

Table 6

Means, Standard Deviations and t-values as Rated on the Slater Nursing Competencies Rating Scale by the Principal Investigator and Research Assistant (n=12)

	Experimental Group		Control Group		
	X	S.D.	X	S.D.	t-values
Psychosocial Individual	2.37	0.30	2.02	1.13	0.79
Psychosocial Group	0.54	0.55	0.46	0.54	0.26
Physical	2.54	0.58	1.88	1.06	1.40
General	2.54	0.51	2.08	1.16	0.94
Communications	1.87	0.59	1.70	0.98	0.33
Professional Implications	2.74	0.46	2.10	1.20	1.30

Discussion

The pretest-to-posttest differences in the experimental group's self-evaluations indicated that preceptorship may have had a positive impact on the self-evaluation of the students. These findings were similar to those of Walters (1981) who determined that, when senior baccalaureate student nurses were assigned to agency staff who acted as preceptors, they demonstrated an increase in confidence and expertise in their nursing performance. As Benner (1982) indicated, advanced beginners benefit from the guidance of preceptors.

While the lack of pretest-to-posttest differences found in the control group's self-evaluations may have been attributed to the lack of random assignment and the small sample size, it may also have been an indication of the subjects' inabilities to recognize changes in their nursing performances in a three-week period. Walters (1981) found that four to six weeks was usually required for the student to gain confidence and expertise in nursing performance. However, the lack of a perceived change in this group's performance during this three-week period may suggest that the absence of a one-to-one relationship was a contributing factor in developing a sense of confidence in their performance.

The lack of significance between group differences determined in the pre- and posttest self-evaluations may be explained by a number of factors. First, lack of random assignment may have resulted in unequal representation of the subjects. Subsequently, subjects may have differed in areas of self-perception, self-confidence and ability to recognize changes in their performance. Such differences may have affected the self-perceptions of the two groups to a greater extent than did the presence or absence of preceptorship. Secondly, although non-parametric tests yielded similar results to the t-tests, the small sample size may have contributed to the non-significant difference between the two groups' self-perceptions. Finally, the three-week clinical experience may have been too short a time frame for significant changes to have occurred in the performances of the two groups.

The evaluations by the clinical instructor and the preceptors indicated that the control group's performance was significantly better in planning/evaluation and marginally significantly better in interpersonal relationships/communications. The difference seen in planning/evaluation may have been attributed to three factors: 1) the routine emphasis placed on nursing care plans by the clinical instructor may have been reflected in the group's ability to plan and evaluate their nursing care; 2) the nursing care plans may not have been used as extensively in all the units in which the subjects were placed, specifically, the emergency and operating rooms; and, 3) the preceptors may have overlooked certain factors that may have contributed to the

performance of the experimental group. The lower performance scores of the experimental group in the interpersonal relationships/communications category may be attributed to the fact that these students were still adjusting to their role as preceptees in the preceptorship relationship and, as well, may have been directing their interpersonal skills toward socialization into that role. Three weeks may have only permitted them sufficient time in which to become socialized into that new role. Defining the complimentary roles of preceptor and preceptee is of primary importance during this time (Estey & Ferguson, 1985).

Evaluations by the principal investigator and research assistant indicated no significant between group differences. While the small sample size and lack of random assignment may have also contributed to the nonsignificant findings with the Slater Scale, observer presence may have also affected student performance (although measures were taken to prevent this from happening).

Limitations of the study

This pilot study was limited by three factors. First, the sample size was small. "The power of a test increases with sample size" (McCall, 1975, p. 194). Subsequently, the lack of significant difference between the groups' perceptions of their performances may be attributed to low statistical power that results from the small sample size although non-parametric tests yielded similar results to those obtained by the t-tests. Secondly, because random assignment is designed to establish comparability by equalizing the average unit within each treatment group, that is the control group and the experimental group, lack of random assignment may have resulted in those students being unequally represented (Cook & Campbell, 1979). Finally, the study was confined to one baccalaureate nursing program, thus limiting the potential to generalize the results.

Conclusions and Recommendations

Research Question 1: There were no statistically significant pretest-to-posttest between group differences. While there were statistically significant pretest-to-posttest differences in the perceived performance of preceptored students, there were no such differences in the perceived performances of the non-preceptored students.

Research Question 2: When rated by the preceptors and the clinical instructor, there was a statistically-significant difference in the performance of baccalaureate student nurses who were not preceptored over those who were preceptored.

Research Question 3: There was no statistically-significant difference in the clinical competency of subjects in the experimental and control group when

evaluated by two raters in the final week of the project. Baccalaureate student nurses who were preceptored performed no differently than those who were not preceptored.

Conclusions drawn from this study were that the preceptorship program was equally effective with regard to the performance of subjects who were not preceptored in the three week clinical experience. However, there were statistically significant pretest-to-posttest differences in the perceived performance of subjects who were preceptored following the three week clinical experience. It may be concluded that preceptorship does have a positive effect on the self-perception of students. In this study, baccalaureate student nurses who were not preceptored performed significantly better in planning/evaluation than did baccalaureate student nurses who were preceptored, when rated by their immediate supervisors.

These conclusions may contribute to the field of nursing by providing information about the role of nurses in transition to the clinical area. Specifically, preceptorship provides support and guidance to the advanced beginner in the clinical environment. This results in an increase in confidence in perceived performance.

The results of this study are not conclusive in providing evidence that preceptorship is a viable clinical teaching strategy. Therefore, it is recommended that this study be replicated to incorporate a larger sample size, random assignment of subjects and the involvement of more than one baccalaureate nursing program.

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RÉSUMÉ

Rôle de l'enseignement individuel sur la compétence clinique des étudiantes de baccalauréat en sciences infirmières - étude pilote

Cette étude s'inscrit dans le cadre d'un projet pilote de trois semaines aux termes duquel une structure d'enseignement individuel a été mise en place, à la fin de la quatrième année du programme fondamental de baccalauréat. L'échantillon regroupait 12 étudiantes de baccalauréat en sciences infirmières âgées de 22 à 26 ans avec expérience clinique et préparation univer- sitaire identiques. La structure de l'étude reposait sur deux groupes quasi expérimentaux avec format pré- test et post-test. L'évaluation des performances des étudiantes a été effectuée au moyen de la Six Dimension Scale of Nursing Performance et de la Slater Nursing Competencies Rating Scale.

D'après les résultats obtenus, l'existence de cours individuels ne modifie pas de façon significative les performances des sujets ayant bénéficié de ces cours, par rapport à ceux qui n'en ont pas bénéficié. Toutefois, des différences significatives au niveau du pré-test et du post-test, dans les performances des sujets ayant bénéficié de cours individuels, donnent à penser que cette formule peut avoir une influence positive sur la perception que les étudiantes ont d'elles-mêmes dans le domaine clinique.

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THE SOCIAL SUPPORT REQUIREMENTS OF FAMILY CAREGIVERS OF TERMINAL CANCER PATIENTS

Linda S. Nugent

The family, not just the patient, experiences the impact of cancer (Gray-Price and Szczesny, 1985; Lewis, 1983). When the cancer patient becomes terminally ill and is cared for at home, the family bears a considerable burden for the care. The need for support for the family is apparent; yet, limited documentation describing the nature of that support is available. This study examined the social support required by caregivers in the families of terminal cancer patients.

Literature Review

Family caregivers of terminal cancer patients face considerable physical and emotional demands in their caregiving role (Holing, 1986). Although they assume responsibility for the patient's physical care, they often lack knowledge about patient care (Rose, 1976; Welch, 1981; and Wilson, 1975). They experience difficulty obtaining the equipment necessary for the job (Rose, 1976; Wilkes, 1984), and confinement to the home as a result of their duties (Stetz, 1987; Welch, 1981). Enacting family roles also pose demands; for example, child care problems and difficulties with transportation may be experienced (Rose, 1976; and Welch, 1981). Other problems include household help, shopping and finances (Googe and Varricchio, 1981; Stetz, 1987).

Studies (Evernden, 1984; Wilkes, 1984; and Wilson, 1975) suggest that the health of caregivers may be adversely affected by the demands of their situations. In fact, there is evidence that health problems encountered by spouses of terminally-ill patients persist after the death of the cancer victim (Hampe, 1975; Parkes, 1964 and Vachon, 1976).

Social Support is helpful in meeting the demands of various stressful events (Carveith and Gottlieb, 1979; Lin, Ensel, Simone and Kuo, 1979; and Norbeck and Sheiner, 1982). However, no study has actually measured the effect

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of social support in relation to caregivers in families of terminal cancer patients. Some of the gap in this body of knowledge can be attributed to the lack of a consensual definition of social support (Dimatteo and Hays, 1981).

However, there are studies (Evernden, 1984; Ward, 1974) that report on some dimensions of social support with this population. Ward (1974) determined that, amongst chief carers who had regular and substantial help from network members, it was more likely that the terminal cancer patients would be kept at home than in the hospital. One-third of the caregivers in Evernden's (1984) study who perceived themselves as managing the care of the terminal patient well, attributed their success to the availability of support systems.

Before exploring the potential buffering effect of social support on caregivers in families of terminal cancer patients at home, we need to describe the concept of social support more precisely with this population. The purpose of this study was to determine the social support that caregivers in families of terminal cancer patients who are at home require.

Method

Sample

The convenience sample of 24 caregivers in families was obtained with the assistance of visiting nurses in a large metropolitan area and a smaller urban area. Potential subjects were initially contacted by the nurse for permission to release their names and telephone numbers to the investigator. The investigator then contacted them by phone, explained the research protocol as well as the subjects' rights and invited them to participate. Written consent was obtained prior to the interviews which took place in the family caregivers' homes.

Instrument

The Social Support Questionnaire (SSQ), the main instrument for the study, was adapted from Norbeck's Social Support Questionnaire (NSSQ) (Norbeck, Lindsey and Carrieri, 1981) with permission from Dr. Norbeck. The format of NSSQ and the items pertaining to affect, affirmation, aid and loss formed part of the SSQ. Adaptations to NSSQ included changes in the instructions on the face sheet, and the addition of items on the provision of information, additional helpful support, gain in support and changes in the support network. These adaptations were substantiated in clinical practice, and by the literature review and conceptual framework. They were made to reflect the uniqueness of the clinical population under study. Precisely, NSSQ and the SSQ are based on Kahn's conceptualization of social support

(Khan and Antonucci, 1980). These authors suggest that family caregivers' needs for social support may be heightened because of their situations. However, there is no guarantee that their additional needs for support will be met.

An 11-item structured questionnaire, the SSQ is designed to obtain information about the number of people, range (e.g. spouse, friend, health care provider, etc.), and type of network the caregiver is currently involved in and the network she or he would desire. Type of support refers to affect, affirmation and aid. Affect is an expression of liking, admiration, respect or love. Affirmation is an expression of agreement or acknowledgement of the appropriateness of some act or statement by another person. Aid describes a situation in which direct assistance is given, including things, money, information, time and entitlements (Kahn and Antonucci, 1980, pp 267-268).

Most questions measuring type of support ask caregivers to rate (Likert scale with 5 categories) the importance of the help that each network member provides. For example, one item measuring affirmation is, "How much can you confide in this person?" With other, more open-ended questions, the type of support is determined through content analysis. For example, with regard to additional helpful support, caregivers were instructed, "Please tell me the type of support you need and who you feel could provide that support."

The Family Caregiver Profile and the Situational Profile, which were developed by the investigator for the purposes of this study, were composed of caregiver and situational variables that could influence the family caregivers' requirements for social support.

Reliability and validity of the SSQ

Responses to the open-ended questions on the SSQ were content analyzed and assigned to one or more of the categories (affect, affirmation and aid). To increase specificity in the analysis, the components of aid outlined in Kahn's definition (time, things, money, information and entitlement), were also used. A nursing colleague with research and clinical experience in palliative care also categorized the responses. Interrater reliability was established at 100%. In choosing the items for the SSQ, content validity was addressed in that Kahn's social support theory, the literature review and clinical practice guided the selection.

Results

Characteristics of caregivers in families

The family caregivers' sex, marital status, age, household income and sociability are represented in Table 1. The mean age of the subjects was 51.3 years (S.D. 13.9, r 21-71). Of the 13 households with incomes less than $20,000, four had male cancer patients of working age who obviously could not work. Caregivers in three of the other households had resigned full-time jobs because of the patient care demands.

Table 1

Properties of the Family Caregivers

Properties	Categories	Frequency	Percent
Sex	M	4	16.7
	F	20	83.3
Marital Status	married	18	75.0
	divorced or separated	3	12.5
	single	2	8.3
	widowed	1	4.2
Age	18-35 years	4	16.7
	36-65 years	17	70.8
	65 years	3	12.5
Education	1-8 years	2	8.3
	9-12 years	14	58.3
	13-16 years	5	20.8
	17+ years	3	12.5
*Household Income	<$20,000	13	54.2
	$20,000-$39,999	3	12.5
	$40,000+	5	20.8
Sociability	very social	9	37.5
	rather social	13	54.2
	keep pretty much to myself	2	8.3

*3 subjects were uncertain of their household income and did not respond.

All caregivers were related to the cancer patients. Of the 18 married subjects, 16 were spouses of the patient. Caregivers that were not spouses were most often children of the cancer patients (n=6). Caregivers had spent varying lengths of time in their caregiving roles ($\bar{x}$ 7.4 months, S.D. 6.9 months, r 2 weeks - 2.5 years). For one-half of them (n=12), the time did not exceed six months. Most of the family caregivers (n=21) had not had as much previous experience providing patient care at home.

Table 2

Properties of the Situation

Properties	Categories	Frequency	Percent
Sex of patient	M	17	70.8
	F	7	29.2
Age of Patient	<18 years	1	4.2
	18-35 years	0	0.0
	36-65 years	14	58.3
	>65 years	9	37.5
Type of Cancer	digestive	7	29.2
	lung	5	20.8
	central nervous system	4	16.7
	breast	3	12.5
	genito-urinary	3	12.5
	other	2	8.3
Number of other people in household*	0	10	41.6
	1	7	29.2
	2	2	8.3
	3	3	12.5
	4	1	4.2
	5	1	4.2
Dysfunctional score**	0-2	4	16.7
	3-5	12	50.0
	6-8	5	20.8
	9-10	3	12.5

*Besides cancer patient and caregiver

**Calculated by summing the individual ratings on 5 A.D.L. scored as dependent (2), needs assistance (1), independent (0).

Characteristics of the situation

Data for the age and sex of the cancer patient, type of cancer, number of other people residing in the household and measure of dysfunction of the patient are presented in Table 2. Mean age for the cancer patients was 61.5 years (S.D. 16.1, R 5- 91). The dysfunctional score reflected the degree to which the patient depended on his or her caregiver for the performance of five activities of daily living (ADL): bathing, dressing, mobility, toileting and feeding. These scores ranged from 0-10 ($\bar{x}$ 4.9, S.D. 2.6); the higher the score, the more dependent the patient. Patient care demands for family caregivers are obvious in that slightly more than one-half (n=13) of the patients required assistance from or were completely dependent upon their family caregivers for bathing, dressing and at least two of toileting, mobility and feeding.

In ten households, the family caregiver were living alone with the patient. Seven of these caregivers were older female spouses ($\bar{x}$ age 62.3, S.D. 5.12, r 56-70). When other people lived in the household, age seemed to be the critical factor for whether or not they were reported as supportive. Of the seven situations in which they were not considered supportive, most were situations involving children (n=5). Family caregivers in these situations seemed concerned about having enough time to perform both parenting and caregiving roles. One mother commented: "My oldest daughter seems to get the least attention. By the time I look after my husband (patient), the baby and my other daughter, there is little time left for her."

Social support

Social support requirements included the support caregivers were receiving at the time of the interview (current social support), and their expressed need for additional support (desired social support). Since caregivers were selective in their reports of current support, the investigator assumes the support they reported was necessary.

Current social support. Each family caregiver reported 1-15 network members ($\bar{x}$ 7.96, S.D. 3.83) from several range categories: spouse, family, friend, neighbor, (primary group), work/school/church associate, health care provider, clergy, homemaker and other (secondary group). As evident from Figure 1, collectively, more support was provided by the primary group than the secondary group.

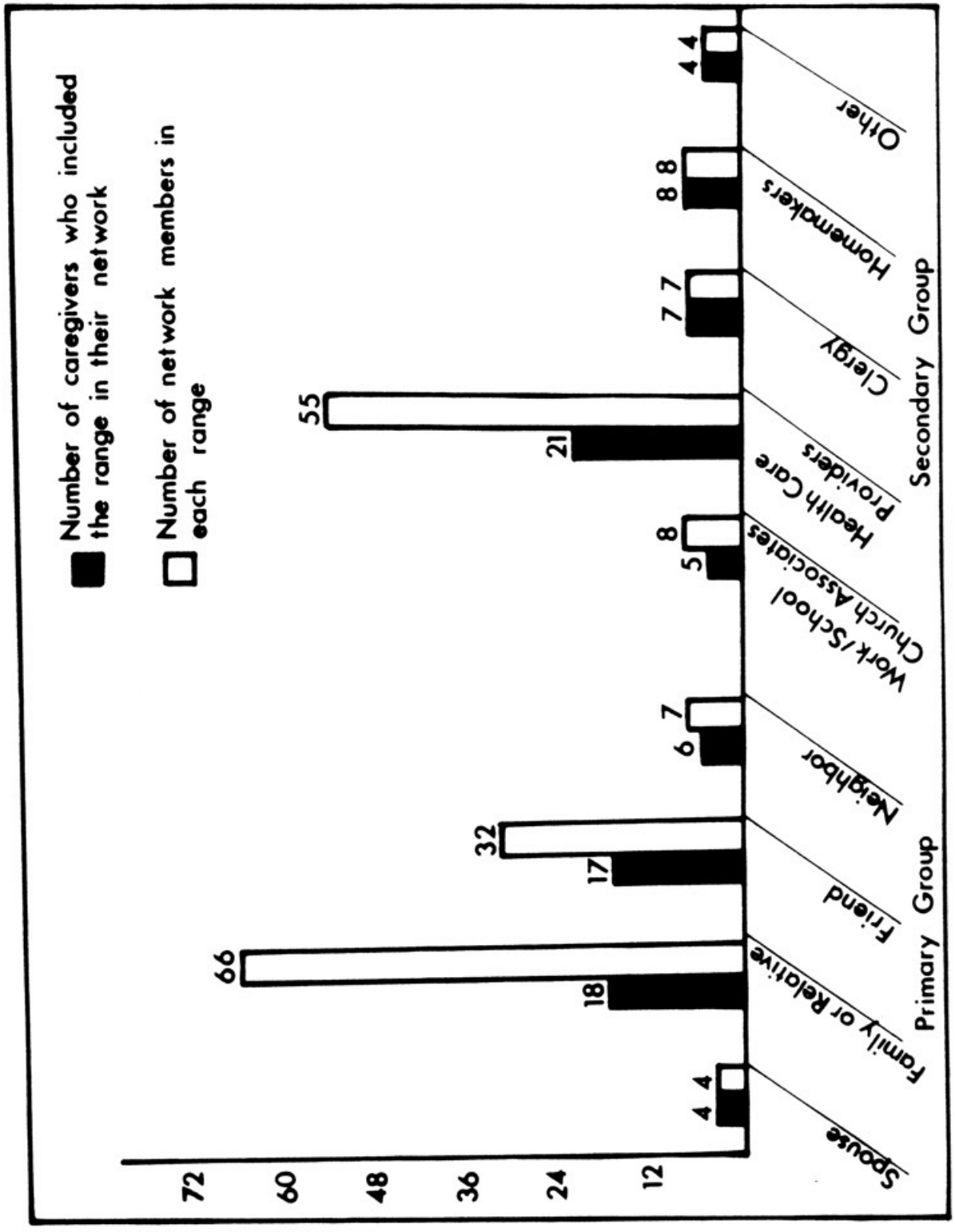

Figure 1

Frequency of the caregivers who identified each range and the network members in each range

The type of support that network members provided varied with the range. Families, health care providers and friends were the major sources of support. When compared to other ranges, the data suggest that families are good confidants; friends support family caregivers' actions or thoughts; and health care providers provide information about the patients' condition or care.

Nurses were the largest subgroup of health care providers. They earned the caregivers' highest score for supporting their actions or thoughts. In praising the nursing services they were receiving, family caregivers' comments (n=9) indicated that the nurse seemed to understand their concerns and behaviours. As one family caregiver commented: "They make me feel that they are as concerned about me as they are about my husband. I can tell them about my feelings, fears, even cry in front of them and that's okay. They are coming in and seeing the day to day situation. I can't say enough about the nurses who come into your home - they are a God-send."

Desired social support. One-third of the sample (n=8) desired more support and collectively identified 11 needs for aid. Five of these caregivers were looking for time; for example, someone to "patient-sit", so that they could get out to bank or shop. Each subject was specific about the time required, their needs ranging from one day every two weeks to an "on call" service. They also recommended that professional nurses, allied nursing personnel or homemakers (secondary group) should provide the service.

Worthy of note is that five caregivers who did not require additional support described the arrangements they had made for time for themselves. Some were taking advantage of the time the homemaker was available; others were relying on friends and relatives. One caregiver identified the purpose of this time: "I need to get out myself, otherwise I get frustrated. When I get frustrated I sometimes take it out on my mom (cancer patient), and that doesn't make me feel very good."

Change in social support

Most caregivers (n= 21) had experienced changes in their social support since assuming the caregiving role. Positive changes - situations in which caregivers received more support from known network members, a gain of a new network member or both - were reported by 19 caregivers. Nearly one-half (n=11) of the caregivers described network members who had become more supportive. Most commonly, families and friends were providing more aid, in terms of time, by calling or visiting more often. Families were also responsible for an increase in the caring or concern (affect) they demonstrated toward the caregivers (n=7).

Nearly two-thirds (n=15) of the sample had gained supportive relationships, ranging from 1 - 7 ($\bar{x}$ 3.4, S.D. 1.72). Aid was the type of support most often

realized from the gain. From the secondary group, the aid was in the form of nursing care, equipment, homemaking services and the provision of information regarding the patient's condition and care. The primary group, generally friends, provided caregivers with time and things: they were available to do "anything", spent time with the caregivers and brought food to their homes. Through their understanding nature, nurses accounted for the greatest gain in affirmation. Most of the 15 caregivers (n=9) attributed "a great deal" of their support to the new network members.

Five caregivers reported a loss of network members (negative change) predominately from the primary group and involving people not visiting, calling or spending time with them (aid). In addition, three caregivers identified network members who were less supportive. The magnitude of these losses was considered to be low. As one caregiver commented: "If they aren't available to you now, then you probably weren't getting that much support from them in the first place."

Discussion

The profile of most caregivers is consistent with that reported by Evernden (1984), Holding (1986) and Stetz (1987): middle-aged female spouses of an older mate. Davis (1980) suggests that females assume the caregiving role more easily than men because it is highly associated with the mothering role, and is consistent with female self-expectations. Female caregivers in this study, and also in Holing's (1986) study, seemed to fit traditional female roles in that most were not working outside the home prior to the patient's illness. The investigator suspects that this profile may change in the future, as younger women today are more career-oriented and may be reluctant to assume full-time caregiving responsibilities.

Caregivers faced considerable demands. Consistent with other studies (Googe & Varricchio, 1981; and Stetz, 1987), the terminal patients in this study required assistance with many of their ADL, yet, 87.5% (n=21) of the caregivers had not had as much previous experience in this role. As indicated earlier, 41.7% (n=10) of the caregivers were living alone with the cancer patient. Fifty percent of the caregivers in Holing's (1986) study also lived alone with the terminal cancer patient. Seven caregivers dealt with parenting responsibilities as well as caregiving responsibilities. Goldstein, Regnery and Wellin (1981) suggest that, for young caregivers, the time and energy demands of caretaking tend to generate conflicts with other family, occupational or social roles and obligations (p.25).

Enabling factors for caregivers

The investigator suspects that several factors influenced the caregivers' abilities to manage the demands of their situations. First, the majority (n=16)

of the caregivers had the support they required. Investigators (Evernden, 1984; and Ward, 1974) have reported that the presence of "supportive others" was helpful in the overall management of terminal cancer patient care at home.

A second influencing factor may be that all families in the study were the recipients of home nursing services. Nurses provided information about the patients' conditions and care; affirmation, through their understanding approach; and nursing care for the terminal cancer patient. Other investigators (Kristjanson, 1986; and Skorupka & Bohnet, 1982) report nurses being helpful to caregivers of terminal patients because of the information they provide. Glaser and Strauss, cited in Hampe (1975), and Wright and Dyck (1984) identify information as being a need in families of terminal patients. The suggestion that visiting nurses provide affirmation to caregivers is supported by findings of Evernden (1984) and of Googe and Varricchio (1981).

A third factor influencing the caregivers' ability to manage may be related to experience in the caregiving role. Mean time in the role was 7.4 months; the caregivers had undoubtedly acquired some degree of caregiving skill over this period, and had had the opportunity to mobilize necessary resources. Five of the eight caregivers who needed additional support were below the mean - in four instances for less than two months. Petrosino (1985), in stressing the need for rapid referrals and well coordinated resources for these families, reports that 76% of the families in her study received hospice services for 2.7 months or less.

Finally, keeping the patient at home allows caregivers to meet some of their own needs. Being with the dying patient and being helpful to him or her are among the needs of grieving spouses which have been identified by Hampe (1975), and supported by Dyck & Wright (1985).

Focus on social support

There were more primary group members than secondary group members among caregivers. MacElveen (1978) and Mitchell and Trickett (1980) have suggested that primary groups are preferred sources of support during stressful situations. In the present study, the unsolicited comments of the caregivers would not lead one to conclude that they had a preference for a particular range category. Each group offered caregivers a different type of support. The value of support from secondary network members is suggested by its importance in meeting additional support needs of caregivers.

Caregivers perceived strong support for their actions and thoughts, particularly from friends and health care providers. It is possible that the significance of support from nurses and other health care providers would be

more important to caregivers because they are professionals who have knowledge and experience in the situation. Results in this study suggest that health care providers were perceived by caregivers to be knowledgeable about the patients' conditions and care.

All reports of desired social support involved aid - usually, a need for time. This fact, coupled with the unsolicited comments of caregivers, gave the investigator an overriding sense of the caregivers' need for time out. In keeping with this finding, one-third of the families of cancer patients in Welch's (1981) study indicated that having no one to patient-sit in the home setting was a problem. In contrast, Evernden (1984) reported that caregivers of terminal cancer patients at home were reluctant to leave the patient alone, even when network members offered to "patient-sit".

Change in support system

Caregivers were receiving more support than they had received prior to assuming the role. No doubt this was a direct response to the heightened need for support that has been identified by Kahn and Antonucci (1980). These authors suggest that most members of a person's convoy are initially connected to that person through the performance of related roles. In fact, new members of the secondary group filled role-related needs - nursing care, equipment, homemaking services and information.

Those caregivers experiencing negative support attributed little significance to the change. It is likely that changes in the circumstances in caregivers' lives had been a motivator in reorganizing their values and priorities. As one subject stated: "It is situations like these that really separate friends from acquaintances. I've found out who is really in my life."

Limitations

Generalization of the findings of this study is limited by the selection of subjects from a convenience sample and by the small sample size. Subjects were interviewed on only one occasion and, therefore, their responses are not representative of the entire terminal stage. Finally, the reliability and validity of the instruments used in the study have not been well established.

Recommendations

Nursing practice

Most caregivers who expressed additional support needs had been in the caregiving role for a shorter time than the total sample. This suggests that nurses should assess caregivers' needs for aid at the onset of their relation-

ships with these families. In particular, nurses should be attentive to what opportunities, if any, the caregivers occasionally have to get out of the home.

Second, nurses should maintain contact with these families, in spite of the fact that caregivers may be managing very well. The nurses in this study were serving a valuable purpose by providing information and affirmation to the caregivers in the home. Caregivers are likely to experience different concerns over time; they might readily share these with a nurse with whom they had established a good relationship.

Nursing research

A tool with dimensions more sensitive to the social support concept should be developed for this population. For example, the aspects of love and admiration, used by Kahn (1979) to describe affect, had little meaning in describing relationships with secondary group members. To facilitate this development, a research design that is more qualitative in nature should be used. Rather than using a structured interview schedule, more open-ended questions, which would afford caregivers the opportunity to describe relevant support indicators, is warranted. As well, a longitudinal study to identify the social support requirements of family caregivers over the course of the cancer patients' terminal illness would be useful. Such a study would provide insight about changes in social support requirements over time and about how these requirements are met.

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RÉSUMÉ

Demandes de soutien social formulées par les aides-familiales qui interviennent auprès des cancéreux en phase terminale

L'objet de cette étude descriptive est de cerner le soutien social que sollicitent les aides-familiales qui interviennent au domiciles des cancéreux en phase terminale. Le concept pluridimensionnel du soutien social de Kahn (1979) sert de base au principal instrument utilisé dans le cadre de cette étude.

La plupart des aides-familiales admettent que des changements positifs sont intervenus au chapitre du soutien dont elles bénéficient depuis la date de leur entrée en fonctions. Au moment où s'est déroulée l'entrevue, deux tiers des aides-familiales affirmaient obtenir le soutien social dont elles avaient besoin. Ce soutien provient de diverses sources et revêt des dimensions aussi tangibles qu'émotives. Les aides- familiales qui souhaitaient obtenir un soutien plus étoffé cherchaient, la plupart du temps, à obtenir un répit.

Des recommandations en matière de soins infirmiers et de recherche sont également formulées.

NURSING RITUALS

Zane Robinson Wolf

Scholars see rituals as part of the fabric of human existence. Rituals serve to express symbolic meanings important to groups of people functioning within a culture or subculture. Words, actions, objects, gestures and relationships are important to ritual performance (Bosk, 1980; Douglas, 1966; Fox, 1979; Malinowski, 1954; McCreery, 1979; Tambia, 1968; Turner, 1969; VanGennep, 1960). Turner (1969) defined rituals as dramas of social events which emphasize the importance of the event they symbolize or represent; rituals are standardized, repetitive dramatizations of social crises, functioning to minimize the effects of crisis. Malinowski (1954) also viewed rituals as being associated with crises — among these, illness, birth, marriage, death and socialization to new roles.

Seldom have nursing practices and procedures been studied for ritual content. Nurses who have described and criticized rituals within the context of professional nursing see rituals as valueless and often condemn them. Huey (1986) considered some nursing rituals to be cherished beliefs in need of abandonment. She called on nurses to save time and money and to expose and replace unnecessary practices with more scientific actions. Huttmann (1985) equated nursing rituals with time-honored, time wasting practices. According to Huttmann, nurses who use these routines are on "automatic pilot". Both Huey and Huttmann consider rituals to be obsessive, repetitive, traditional tasks, without meaning.

Another nurse, Walker (1967), found that the ritualistic behaviours used by nurses satisfied individual needs rather than organizational goals. Ritual behavior was considered dysfunctional and anxiety-relieving. However, she identified latent functions and beneficial aspects of nurses' ritualistic practices. Schmahl (1964) determined that rituals served no purpose, were non-therapeutic and were automatic. She described ritual as an unnecessary form or routine employed to avoid facing new goals, thereby associating rituals performed by nurses with their anxiety.

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Research Questions

In order to explore nursing rituals from another perspective, the definition of ritual identified by DeCraemer, Vansina and Fox (1976) was used during an ethnographic study: ritual is patterned, symbolic action that refers to the goals and values of a social group. Using this definition of ritual, it was possible to examine the beliefs, values and patterns of rituals present in a group of nurses working on a medical unit.

The research questions of this ethnographic study were the following.

1. What actions, words and objects make up nursing rituals?
2. What are the types of nursing rituals demonstrated by nurses caring for adult patients on a hospital unit?
3. What explicit or manifest meanings and implicit or latent meanings do these rituals have for nurses, patients, families, physicians and other hospital personnel?
4. How are nurses, patients, families, physicians and other hospital personnel involved in these rituals?
5. How do nursing rituals emerge in the context of the routines, procedures and reports of the nursing unit?

The following nursing practices and procedures were examined as situations in which nursing rituals may occur: post-mortem care; medication administration; admission to and discharge from the hospital; change of shift report; and, the bath and other medical aseptic practices. The study's conceptual orientation justified investigating these nursing practices and procedures as situations in which nursing rituals could be present. It was assumed that nursing rituals did not necessarily function positively, negatively or neutrally for nurses (Wolf, 1986; Wolf, 1988).

Method

This study of nursing rituals was conducted on a 32-bed medical unit of a large urban American hospital. Participant observation, event analysis and semi-structured interviews were the major data collection methods. Nursing staff, patients, family members and other hospital personnel were the informants of the study. The study was reviewed by the institutional review board of the hospital and was approved following an expedited review. Informants signed consent forms.

Data collection extended over a 12-month time period. Data were collected during the day, evening and night shifts. The investigator was an outsider to the setting. Field notes were kept by the researcher; these notes were analyzed and indexed. Shift reports were audiotaped and included in the field notes, after being transcribed verbatim. Three nursing staff who were key

informants reviewed the results of the study and attested to the validity of the description.

Descriptive Analysis

Investigating nursing rituals illuminated aspects of the nursing subculture that had been not been fully explored and described previously.

Post-mortem care: Therapeutic nursing ritual

Post-mortem care, the hands-on care that nurses gave to their dead patients, was embedded in the context of the events preceding death. Patients' deaths were influenced by the "do not resuscitate" (DNR) or "resuscitate" (code) status of each patient and resuscitation decisions were shared among nurses, patients, family members, physicians and other hospital personnel. The technological equipment used in cardiopulmonary resuscitation added to the pressures surrounding death events.

Description and analysis of pre-death events revealed four code categories used by nurses and others as they cared for dying patients. A "no code" classification meant that the patient was categorized as a DNR (do not resuscitate) and no resuscitation efforts were to be initiated. "Almost no code" suggested to the staff that the patient's family had given verbal DNR permission; however, resuscitation efforts would be initiated. The category of "slow code" indicated that the patient's family refused to give hospital staff "do not resuscitate" permission. However, because of the hospital staff's misgivings about prolonging life, the code call was delayed and slow-paced resuscitation efforts were begun. "Full code," also called "regular code," meant that the family or the patient refused to grant the DNR permission, or the hospital staff had not yet been able to, or thought to, ask the patient or family for a code status. "Full codes" were characterized by energetic efforts on the part of the staff. Notwithstanding the fact that hospital policy and procedures mandated that there were two code categories, "no code" and "full code," nurses and other hospital staff used four code options.

Post-mortem care was given by nurses who usually knew their patients well. Nurses did not merely care for dead bodies after death. They cared for dying patients, returning day after day as they witnessed their suffering. They rejoiced in peaceful deaths, glad that these patients escaped the resuscitation drama.

Neophytes used resuscitation and post-mortem care as a sort of "proving ground" of their ability to handle death. More experienced nurses checked the inexperienced to see how they performed the techniques and procedures of resuscitation, the influx of hospital personnel at the code, the aftermath of death or survival and post-mortem care.

After death, as nurses gave post-mortem care, it was clear that the patient was seen as still present, surrounded by spirit and requiring care. They cared for dead patients in a respectful manner, aware of patients' humanness. Nurses touched these patients gently, as they washed away and removed evidence of previous suffering. They tacitly insisted that the patient's body was respectfully treated.

Clearly, post-mortem care was more than a step-by-step procedure. Instead of consulting the hospital's policy and procedure manual, nurses shared beliefs, values and information about after death care as they demonstrated how to perform post-mortem care. Working as a group during post-mortem care, nurses helped each other ease the realities of death. Their washing of the patient and straightening of the hospital room represented, on a latent level, the purification of the patient and the room. Thus, some of the soil and profanity of death was removed.

The post-mortem care that nurses gave their dead patients was a private event, one seldom witnessed by other hospital staff and family. Post-mortem care ended, almost officially, their tenure of moral responsibility for the patient. Post-mortem care was a therapeutic nursing ritual. Nurses performed symbolic healing actions that improved the condition of patients, removing the traces of suffering, even after death.

Admission to and discharge from the hospital: *Patient ritual*

As patients needing hospitalization were separated from their usual home environment, were incorporated within the hospital environment, were healed or became stabilized and left the hospital for home, certain nursing rituals could have been evident. However, no nursing beliefs and values specific to admission and discharge emerged from the descriptive data.

Admission and discharge procedures contained themes that suggested that patient rituals could be included within these incorporation and separation routines. Nurses efficiently greeted patients, helped them change into hospital clothing or their own bedclothes and gathered information about current illnesses, previous hospitalizations, surgical procedures and prescribed over-the-counter medications. As hospital rules were imposed on patients by nurses during admission routines, patients admitted their feelings of vulnerability and awaited diagnostic studies, medical treatment or surgery.

Patients' vulnerability and lack of privacy were emphasized in the hospital setting. Removing patients' street clothes and wearing hospital clothes confirmed this. Explicitly, patient clothes made it easier for nurses to care for ill patients. As patients' conditions improved, they often exchanged hospital clothes for their own bedclothes. Differences in dress helped the staff distin-

guish patients from hospital personnel. Patients dressed like patients; wearing patient clothes was equated with the symbolic taking on of the patient role.

Procedural and task-oriented in their approach, nurses efficiently prepared patients for discharge from the hospital. They taught patients and their families about drugs they would take while at home, gave last minute treatment instructions and made medical and radiology appointments.

Discharge from the medical unit and hospital was a relief for patients. Patients eagerly asked nurses to cut off identibands prior to discharge, or borrowed nurses' scissors in order to do this for themselves. As identibands and bedclothes were removed, and street clothing put on, the association of these symbols with anonymity, vulnerability, illness and patienthood was evident. With a change of clothing and their usual roles assumed, patients became less vulnerable.

Nurses valued the procedures and customs associated with discharge. When patients evaded these procedures, leaving the unit without instructions from nurses and physicians, nurses were surprised. However, admission and discharge procedures and practices did not contain strongly held beliefs and values for nurses. Admission and discharge procedures may once have been associated with nursing rituals, but seemed more symbolically significant to patients.

Medication administration: *Therapeutic nursing ritual*

Medication administration was a highly visible and time-consuming part of nursing care, and was classified as a therapeutic nursing ritual. Medications were healing substances, given to improve patients' conditions.

Explicitly, nurses viewed medications as a high priority nursing function. Interestingly, the vague possibility that hospital staff other than nurses might some day administer medications to patients aroused fear in nurses. Implicitly, nurses regarded medication administration as a serious trust, shared with physicians. This trust was embedded in the value or therapeutic goal that the nurses held about the care of their patients: do good and avoid harm. Medication administration represented nursing's emphasis on the reciprocal relationship between patient trust and nursing responsibility.

Nurses classified the therapeutic actions of medications in the following manner. Stabilizing medications were given to maintain function; curing medications removed the signs and symptoms of disease; preventive or prophylactic medications slowed or stopped the onset of disease and kept patients from becoming ill; and placebo medications were given to placate patients - the drugs would do no harm and might do some good.

Nurses used shortened, ethnocentric language when communicating among themselves and with physicians as they gave medications. This special language was intended to reduce the time needed in discussions concerning medications. It, as well as the recording style for chart and kardex notation, served to maintain an aura of secretiveness and preserve the territoriality that marked the nursing function of administering medications.

The ritual aspects of medication administration were obvious as nurses relied on the "three-time check" to insure that the correct medication was given to the right patient. This practice, used to prevent nurses from making medication errors, has persisted for years in nursing literature dealing with giving medications (Groff, 1896).

Nurses continued using supplies, such as the small paper souffle cup, in a manner that seemed inefficient. Souffle cups were often stuffed to overflowing with unit-dose medications, still in their identifying package. Some nurses said that the drugs were left in the packaging and placed in souffle cups so that drugs could be reviewed immediately before giving them to patients, and in order that nurses could review actions and side effects with patients.

Medication administration was a clearly identifiable, visible nursing function. Many hospital staff shared in the work of medications. Many hospital forms were used to record this public nursing function. At the same time that medication administration was public, it was also somewhat parochial. New graduate nurses were gradually initiated into the special knowledge needed for medication administration.

The seriousness and moral concern with which nurses viewed medication administration emerged when they made medication errors. They openly, yet hesitatingly, admitted their own and each other's guilt in the arenas of staff meetings, change of shift report and incident reports. These open admissions of guilt served a latent function. Through public confession, the nurses were able to share both the error and guilt of their medication-related mistakes. In this manner, the guilt, blame and punishment were shared by nurses in a corporate or group way. They often blamed medication errors on failure to follow procedure, on other staff and on problematic events. However, medication errors symbolized failure of responsibility and patient trust, of inadvertently doing harm to those who needed their help.

The bath and other medical aseptic practices: *Therapeutic nursing ritual*

Within the broad area of medical aseptic practices, three specific hygienic practices were examined as sources of nursing ritual: the bed bath; methods of handling excreta; and methods of handling the products of infection.

Nurses comforted and improved patients' conditions by means of the bath; as such, the bath was a therapeutic nursing ritual. Patients were helped to remain or become clean through "self," "partial," or "complete" baths. Bathing patients and keeping them clean through other means, including changes of bed linens, were clearly the nurses' domain. Seasoned nurses discussed and demonstrated some of the finer points of the bath when patients' conditions necessitated modifications and special considerations.

Failing to keep patients clean violated a nursing norm. When emergencies such as codes or other problems delayed bathing activities, nurses apologized. Avoiding giving baths to patients was considered a violation of patients' and families' wishes.

On an explicit level, the bath was used as an opportunity for cleansing, checking patients' skin and assessing general condition. It also provided an opportunity to listen to, talk with or teach patients. The value of "good" personal hygiene for patients was internalized. Thus, nurses resisted changing the daily baths on the day shift to bathing patients every other day. On an implicit level, bathing patients was a nursing ritual because it represented purification, care of the patient by the laying-on-of hands and the opportunity to heal by washing away disease, or at least some of its traces.

There were opportunities for repeated bathings during each 24-hour cycle of nursing time. On day shift the daily bath was given; on the evening shift, P.M. care again provided a bathing opportunity. During the night shift, A.M. care was another scheduled time for patients to be washed. The timing of bathing activities gave structure and organization to the nursing work of each shift, and implicitly served to impose order on the easily disordered events of the patient unit. Nurses took comfort in the fact that their patients' baths were completed.

Nurses were in close, personal contact with their patients and commonly handled excreta and secretions. They feared infection from patients who had or were suspected of having communicable diseases. At times, their fear of infection overrode their scientific knowledge. Handwashing, wearing gloves and using other medical aseptic practices helped them to protect themselves and others and to prevent the spread of infection. When in doubt as to the handling of infected patients, they consulted more experienced nursing staff instead of the infection control manual (a source of scientifically-based techniques).

Nurses responded to their contacts with profane materials in a matter-of-fact manner, with humor, complaining, tolerance and magical thinking. At times they expressed a fearlessness about handling infected materials, demonstrating a strong sense of responsibility, bravery or denial. For the

most part they accepted personal risks, but openly acknowledged their fear of carrying infection to their families.

Nurses were experts at keeping the clean and the dirty separate. More than other hospital personnel, they cared directly for infected patients and handled their bodily products. Despite fear of infection, most upheld the standard that they were responsible for all patients, and that even infected patients deserved care that was respectful.

Change of shift report: *Occupational nursing ritual*

Change of shift report was a occupational nursing ritual, or ritual of socialization; the interactions among the nursing staff facilitated the transition of the neophyte graduate nurses into their professional role. Shift report was used as a testing ground for them. During report, graduate nurses were evaluated, shaped, taught and corrected. They learned what it meant to be a nurse.

Shift report was a challenging arena for new as well as seasoned nurses. Standards of nursing care were set, repeated and checked from shift to shift. They warned each other to watch for situations in which error could take place. They also openly acknowledged and shared errors as they occurred. Change of shift report served as a major forum for accountability and responsibility for patient care.

Change of shift report was clearly the domain of the registered nurse, although contributions of licensed practical nurses and nursing assistants were also valued. While explicitly concerned with the passing of information about patients, report served as a sacrosanct time. They tolerated some interruptions during the hallowed time of report. Those that were more favorably viewed were directly related to nurses' work with patients. Physicians' interruptions were seldom graciously endured.

As nurses interacted, exchanging information during report, they used hospital-bound, nursing-specific language. The language kept the meaning of report somewhat secret and was intelligible only to those who were initiated into nursing life in the hospital.

Nurses used shift report as a place to complain, and to express humor and concern. This enabled them to diffuse some of the difficulties of the nursing role. For example, anger at a difficult patient was openly discussed with others during report. They helped each other and tried to resolve shared patient and professional problems.

During change of shift report, nurses were temporarily able to freeze time in order to focus on the events of the previous shift and to anticipate those of

the on-coming shift. Those working on the next shift were able to begin work from an orderly perspective. Professional behavior was demanded during change of shift report.

The fact that nurses helped each other complete unfinished business after shift report emphasized the shared responsibility they felt toward their work. The continuous coverage commitment and responsibility toward their patients was symbolically portrayed during the transfer of patient ownership at change of shift report. Other means of guaranteeing patient coverage and assuming the burden of patient care were in place on the medical unit. Shift report, however, functioned as the principal occupational ritual where nursing responsibility to patients was taught, tested and reinforced by the group. Clinical knowledge, standards of care and values were transmitted shift to shift among the nurses.

Discussion and Implications

Nursing rituals coexisted with science, technology and procedure as nursing staff cared for their patients. Nurses' work combined elements of the sacred and the profane aspects of human life, as it incorporated the extreme contrast of the mysteries of death and suffering and the handling of the gross products of excretion and infection. Nursing rituals helped nurses to reaffirm some of the beliefs and values of nursing, such as doing good and avoiding harm. Furthermore, nurses passed on their subcultural knowledge by word of mouth and by demonstration.

Rituals have received negative reactions from nurses as being purposeless practices or as procedures to be discarded. However, they are worth examining from the perspective of the definition used. Rituals are patterned symbolic actions that refer to the goals and values of a social group (DeCreamer, Vansina, & Fox, 1976, p. 469). A system of nursing rituals exists in hospital nursing, with latent and manifest levels of meaning. These rituals enable nurses to carry out caring activities for patient who are acutely or chronically ill, old and dying.

The embedded and hidden aspects of nursing rituals and of nurses' work illuminate the fact that much of our work may be largely unknown to the public. The personal, profane and sacred nature of part of the work may obscure our contribution to health care. Many fail to realize what we do, emphasizing technical and physical functions. Disclosing part of the hidden work of nursing by investigating nursing rituals may encourage different public reactions to nursing care.

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RÉSUMÉ

Rituels et soins infirmiers

Cette recherche se fonde sur une méthode eth- nographique dont l'objet est de décrire et d'analyser les rituels propres aux soins infirmiers sur lesquels il existe par ailleurs peu de documents. Les soins post- mortem, les procédures d'admission et de congé, l'administration des médicaments, le bain et les pratiques d'aseptisation ainsi que les changements d'équipes sont examinés en fonction des rites qui peuvent s'y rattacher. L'étude s'est déroulée dans un service pour adultes de 32 lits d'un grand hôpital urbain. Les observations des participants, l'analyse des événements et la tenue d'entrevues semi-structurées constituent l'essentiel des méthodes utilisées pour réunir des données à ce chapitre. Le personnel infirmier, les patients, les membres de leur famille ainsi que d'autres membres du personnel hospitalier ont participé à cette étude. Les résultats comprennent une description eth-nographique des cinq catégories de rites. Les soins post-mortem, l'administration des médicaments et le bain sont des rituels propres aux soins infirmiers thérapeutiques ou des actes symboliques visant à améliorer l'état des patients. Les changements d'équipe, rituel professionnel ou rituel de sociali- sation, sont empreints de gestes symboliques qui facilitent la transition du statut de néophyte à celui de professionnel. L'admission et le congé des patients sont assimilés à des rites qui relèvent exclusivement des patients.

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