NURSING PAPERS

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QUEBEC CCUSN RESPONDS TO THE CASTONGUAY REPORT

ADAPTING SOCIAL MEASUREMENT FOR SPECIAL POPULATION GROUPS

PERCEIVED ROLE DIFFERENCES AND DISCREPANCIES AMONG NURSING SUPERVISORS

Volume 3, No. 1

EDITORIAL QUESTIONS AND PROBLEMS

CRITIQUE OF RESEARCH ARTICLES

Nursing papers functions without a formal editorial board relying on the responses of readers to provide critical assessment of articles and a continuing dialogue on the issues involved. This ideal state involving reader response has not been realized and therefore an alternate proposal is in order. We would welcome your comments on the following suggestion:

> The research article or original paper as submitted would be forwarded to one or two persons for their critical appraisal, then the article along with the critiques would be published. Each university school might forward a list of persons to assess research projects noting for each his or her field of competence. At the moment, two or three names from universities offering graduate programs in nursing, and possibly one or two from other university schools would suffice. This editorial policy would require three copies of each paper submitted for publication.

PUBLICATION OF POSITION STATEMENTS

In recent issues we published the report of the CCUSN, Quebec Region, to the Task Force Study on the Cost of Health Services and the response of Miss E. Logan, Director of the School for Graduate Nurses, McGill University, to Recommendation 5:1 (preparation of personnel for public health nursing) of the Canadian Public Health Association. In the present issue we have included the response of the Quebec Region of CCUSN to the Castonguay Report on the study of Health and Social Welfare in Quebec.

What does the CCUSN both national and regional, as well as the university schools of nursing, think of this policy to publish position statements made by CCUSN or by individual schools to the critical issues confronting us?

In the meantime, we would be pleased to publish such statements from across the country.

RESEARCH REPORTS ON NURSING FROM OTHER DISCIPLINES

You will note in this issue a research paper on nursing supervisors submitted by Dr. Larry Moore, Associate Professor of Organizational Behaviour, the University of British Columbia. Have you comments on whether we would publish such articles and, if so, to what extent? If the policy to have two critiques of the research paper published along with the article is acceptable, we would follow the same procedure for the researcher in another field; however, we might have to pay for the critique.

ADVERTISING

To increase the small operating budget of Nursing Papers, i.e. $860.00 from contributions and subscriptions for a three-year period, we are considering advertising by university schools of nursing and by book publishing companies. We could offer the university school one half page for $70 or one page for $125 per year (2 issues). In this way we could bring in from $1540 to $2750 annually. Advertising by book publishing companies would augment this sum a good deal.

Your responses to these four problems would be most helpful. I would also ask that contributing authors include a short curriculum vitae for inclusion along with their article in Nursing Papers.

Our contributors in this issue include:

Ruth Mackay (Ph.D. University of Kentucky), Associate Professor of Nursing, Queens' University, Kingston,
and
Larry F. Moore, (D.B.A., University of Colorado), Associate Professor of Industrial Administration and Director of Graduate Studies, Faculty of Commerce and Business Administration, University of British Columbia.

Mémoire du Comité de l'Association Canadienne des Ecoles Universitaires de Nursing*, région du Québec, chargé d'étudier le rapport de la Commission d'Enquête sur la Santé et le Bien-Etre Social, 1971.

* Jusqu'en novembre 1970, cet organisme était connu sous le nom de Conférence canadienne des écoles universitaires d'infirmières.

RECOMMANDATIONS

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, recommande:

I. Que le terme infirmière clinicienne soit utilisé pour désigner l'infirmière préparée au niveau du premier cycle.

II. Que le terme infirmière spécialiste soit utilisé pour désigner l'infirmière préparée au niveau du deuxième cycle.

III. Qu'une nouvelle catégorie de travailleurs de la santé (assistant médical) ne soit pas créée, mais qu'une étude de l'élargissement du rôle de l'infirmière universitaire et de sa formation soit entreprise conjointement par les écoles universitaires de nursing et les facultés de médecine d'une part, et les corporations professionnelles concernées d'autre part, notamment l'Association des Infirmiers et Infirmières de la Province de Québec et le Collège des Médecins et Chirurgiens de la Province de Québec.

IV. Qu'à l'intérieur des CEGEP, des facilités de recyclage soient prévues afin que les infirmières techniciennes désireuses d'entreprendre des études universitaires puissent obtenir la formation pré-universitaire requise pour l'admission à l'université.

V. Que l'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, soit représentée par un de ses membres au sein du Conseil de la recherche sur la Santé, dont la création est recommandée par la Commission.

VI. Que des professeurs des écoles universitaires de nursing de la province de Québec fassent partie de tout comité de recherche, approuvé par les organisme governementaux, dont le but est d'étudier les problème de santé touchant directement ou indirectement le nursing.

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, comprend les corps professoraux des écoles de nursing des universités Laval, McGill et de Montréal. Ces écoles universitaires forment des infirmiers et des infirmières* au niveau du

* Seul le terme infirmière est employé par la suite dans le texte. Ce terme comprend les deux appellations infirmier et infirmière.

premier et du deuxième cycle. Le programme du baccalauréat est orienté vers une formation générale en nursing tandis que le programme de maîtrise offre une formation spécialisée. Les programmes (théorie et pratique) sont entièrement sous le contrôle des universités responsables. Les diplômés de ces écoles sont, pour de multiples raisons, trop peu nombreux.

La publication du Rapport de la Commission d'Enquête sur la Santé et le Bien-Etre Social a suscité chez les professeurs des écoles universitaires le désir d'en étudier sérieusement le contenu et de prévoir les modalités de la mise en application de ses recommandations. C'est dans cet esprit que l'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, vous fait part de ses préoccupations et vous soumet ses recommandations concernant quatre aspects de la profession d'infirmière.

Ces quatre aspects sont:

1) l'infirmière universitaire: sa formation, ses fonctions (infirmière clinicienne, assistant médical);
2) l'enseignement continu;
3) la recherche;
4) les relations entre l'université, les centres de santé et le CEGEP.

Les professeurs sont d'accord avec la philosophie, les objectifs généraux et les priorités mentionnés dans le rapport.

L'infirmière universitaire

Les écoles universitaires appuient, en général, les principes énoncés par la Commission concernant la formation des infirmières au premier cycle. Cependant, nous tenons à apporter des précision relatives à certaines modalités de leur formation au premier et au deuxième cycle.

La Commission exprime les opinions suivantes:

. . . La formation du premier cycle permet une spécialisation progressive . . . (cf. 1371, tome IV, volume IV).

La polyvalence du premier cycle des sciences de la santé offre divers programmes d'études qui se différencient progressivement et à l'intérieur desquels il est possible d'offrir des options de spécialisation dans un secteur particulier de la discipline. (cf. 1372, tome IV, volume IV).

Au cours de leur dernière année en vue de l'obtention d'un baccalauréat en sciences de la santé, les étudiantes en sciences infirmières choisissent une orientation clinique qui leur assure une compétence dans une spécialité: pédiatrie, gériatrie, obstétrique, psychiatrie, médecine communautaire. (cf. 1387, tome IV, volume IV).

Nous concevons que le mot "option", au premier cycle, signifie une

concentration orientée vers une spécialité, qui assure un minimum de compétence dans cette spécialité. L'option favoriserait une meilleure préparation aux études spécialisées du deuxième cycle. Les professeurs acceptent l'idée de concentration de cours au niveau du premier cycle, mais croient que la spécialisation qui assure la "compétence clinique essentielle" (cf. 1389, tome IV, volume IV) n'appartient qu'au deuxième cycle universitaire.

Le terme "infirmière clinicienne", tel qu'utilisé tout au long du rapport, est ambigu et doit être explicité. Dans le contexte nord-américain, le terme "clinical nurse specialist" ou infirmière clinicienne, est utilisé, en général, pour désigner l'infirmière préparée dans une spécialité au niveau du deuxième cycle. ([1], [2], [3])

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, recommande:

I. Que le terme "infirmière clinicienne" soit utilisé pour désigner l'infirmière préparée au niveau du premier cycle.

D'après sa formation, cette personne est une praticienne qui connaît l'ensemble des dimensions du nursing. Le champ d'action de l'infirmière clinicienne pourrait être situé dans les trois types de centres de santé (CLS, CCS et CHU). Nous croyons qu'elle est particulièrement bien préparée pour donner des soins généraux de qualité et exercer le leadership dans ce domaine.

Les écoles universitaires de nursing appuient la position de l'Association des Infirmiers et Infirmières de la Province de Québec au sujet du rôle et des fonctions de l'infirmière universitaire.([4])

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, recommande:

II. Que le terme "infirmière spécialiste" soit utilisé pour désigner l'infirmière préparée au niveau du deuxième cycle.

L'infirmière spécialiste possède un haut degré de compétence dans une spécialité de nursing. ([5], [6]) Elle exécute des fonctions d'enseignement et de recherche; elle est, de plus, habilitée à agir comme expert consultante à tous les niveaux de planification, d'administration et de distribution des soins infirmiers. Son champ d'action se situe aussi dans les trois types de centres de santé. A cause de sa préparation en recherche, en enseignement et en soins spécialisés, elle joue un rôle primordial au CHU.

Les professeurs se prononcent contre la création d'une nouvelle catégorie de travailleurs de la santé, actuellement appelés assistants médicaux, mais préconisent une revision de la formation de l'infirmière bachelière de façon à élargir son rôle. L'Association des Infirmières Canadiennes s'est prononcée dans le même sens.([7])

Au chapitre XI du volume IV, la Commission exprime l'avis que les infirmières cliniciennes devraient jouer le rôle d'assistantes médicales (cf. 1383, p. 72). Nous ne sommes pas en faveur de l'appellation "assistante médicale" pour nommer l'infirmière clinicienne. Il est inutile d'augmenter la confusion déjà existante en ajoutant une nouvelle catégorie aux travailleurs de la santé.

Les professeurs croient, tel que l'énonce la Commission, que: "la formation des infirmières de niveau universitaire à l'intérieur d'un complexe des sciences de la santé contribue à la revalorisation de leur rôle." (cf. 1386, tome IV, volume IV).

La Commission ajoute:

"Elles peuvent exercer dans les centres de santé un certain nombre de tâches actuellement réservées à la profession médicale et notamment dans plusieurs endroits, aux assistants médicaux, si leur entraînement leur assure la compétence nécessaire, si elles travaillent au sein d'une équipe et si la loi les autorise à effectuer ces tâches. (cf. 1386, tome IV, volume IV).

Il est important de s'assurer que le transfert des tâches médicales à l'infirmière clinicienne soit reconnu légalement et accepté par les deux professions. Nous croyons que le transfert de certaines tâches, actuellement réservées à la profession médicale, ne revalorisera les infirmières qu'à condition que ces dernières soient considérées par les médecins comme des collègues et non comme des assistantes.

Des modifications devront être apportées aux programmes universitaires afin de préparer l'infirmière à de nouvelles tâches et responsabilités. Les écoles universitaires de nursing, désireuses de s'assurer que ce nouveau rôle satisfera les besoins de santé de la société, ont déjà commencé des démarches pour discuter avec la profession médicale des implications de l'élargissement de ce rôle. De plus, les écoles universitaires sont disposées à développer des projets pilotes avec des médecins afin de metre sur pied des programmes appropriés à cette nouvelle formation.

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, recommande:

III. Qu'une nouvelle catégorie de travailleurs de la santé (assistant médical) ne soit pas crée, mais qu'une étude de l'élargissement du rôle de l'infirmière universitaire et de sa formation soit entreprise conjointement par les écoles universitaires de nursing et les facultés de médecine d'une part, et les corporations professionnelles d'autre part, notamment l'Association des Infirmiers et Infirmières de la Province de Québec et le Collège des Médecins et Chirurgiens de la Province de Québec.

Il est à noter que l'Association des Infirmières Canadiennes poursuit présentement une enquête afin de déterminer dans quelle mesure les infirmières ont déjà commencer à assumer un rôle plus large que celui qui leur est officiellement reconnu.(8)

L'enseignement continu

Nous sommes d'accord avec la recommandation de la Commission à l'effet

"Que l'enseignement continu soit la responsabilité des universités, des CEGEP ou des écoles polyvalentes, selon le niveau de formation des professionnels auxquels il s'adresse." (rec. 4.XI. 209, tome IV, volume IV)

Nous croyons que les ressources humaines et financières nécessaires doivent être mises à la disposition des responsables à chacun des niveaux de formation.

Les écoles universitaires sont prêtes à développer des programmes de deuxième cycle suffisamment souples pour répondre aux besoins des professeurs de techniques infirmières au CEGEP, qui possèdent déjà un baccalauréat.

Il est non seulement nécessaire que les écoles universitaires de nursing se préoccupent davantage du développement et du perfectionnement de leurs professeurs, mais de plus, qu'elles soient encouragées et soutenues financièrement dans ce sens par leurs universités et les organes décisionnels gouvernementaux.

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, est également préoccupée par la situation des infirmières techniciennes, diplômées du CEGEP ou de l'école d'un hôpital, qui désirent poursuivre leurs études en vue de l'obtention d'un degré universitaire mais qui ne remplissent pas les conditions requises pour l'admission au programme universitaire. L'Association recommande:

IV. Qu'à l'intérieur des CEGEP, des facilités de recyclage soient prévues afin que les infirmières techniciennes désireuses d'entreprendre des études universitaires puissent obtenir la formation pré-universitaire requise pour l'admission à l'Université.

Les universités songent actuellement à offir à ces personnes des modes accélérés de formation leur permettant d'obtenir un diplôme universitaire dans un minimum de temps tout en respectant les normes de l'enseignement universitaire.

La recherche

Les écoles universitaires de nursing partagent les vues de la Commission face à l'urgence de définir "la fonction des soins infirmiers,

le contenu et le partage des tâches actuellement dévolues à l'infirmière..." (cf. 1035, tome III, volume IV). Nous demandons que des membres de l'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, soient appelés à participer activement au "vaste programme de recherche, en vue de redéfinir les tâches et de reclassifier les emplois" (rec. 4, VIII. 159, tome III, volume IV).

Nous déplorons le fait que, parmi les membres permanents du Comité d'étude des professions auxiliaires de la santé, aucun d'eux n'appartient à une profession auxiliaire de la santé (appendice XI, I, tome IV, volume IV).

Les écoles universitaires de nursing se reconnaissent la responsabilité et le devoir de participer activement à toute recherche sur les problèmes touchant directement ou indirectement le nursing, soit l'évaluation des besoins de la population, les modes d'organisation, de distribution et d'évaluation de soins de qualité, le développement de nouveaux modes de soins, l'établissement de normes de compétence et de ressources humaines nécessaires pour assurer la qualité des soins de santé.

L'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, recommande:

V. Que l'Association Canadienne des Ecoles Universitaires de Nursing, région du Québec, soit représentée par un de ses membres au sein du Conseil de la Recherche sur la Santé, dont la création est recommandée par la Commission.

VI. Que des professeurs des écoles universitaires de nursing de la province de Québec fassent partie de tout comité de recherche, approuvé par les organismes gouvernementaux, dont le but est d'étudier les problèmes de santé touchant directement ou indirectement le nursing.

Relations entre l'université, les centres de santé et le CEGEP

Les écoles universitaires de nursing sont favorables à l'emploi de professeurs dans les centres de santé sous une double nomination (joint appointment), car ce mode d'emploi est apte à favoriser, chez les étudiants, l'intégration de l'apprentissage théorique et clinique.

Nous sommes conscients des problèmes occasionnés par le très grand nombre d'étudiants dans les centres de santé à vocation d'enseignement (cf. 1490, tome IV, volume IV). Il est important que l'accès aux champs cliniques, propices à la formation de l'infirmière univesitaire, soit facilité aux écoles universitaires de nursing dans ces centres de santé afin qu'elles assurent un enseignement de qualité.

References

(1) Lewis, Edith P. (ed.) *The Clinical Nurse Specialist.* New York : The American Journal of Nursing Co., 1970.

(2) American Nurses' Association. *Statement on Graduate Education in Nursing.* New York: A.N.A., 1969.

(3) Association des Infirmières Canadiennes. *Visées A.I.C.: Principes directeurs approuvés en 1970.* Ottawa: A.I.C., 1970, section "L'infirmière Clinicienne".

(4) Association des Infirmiers et Infirmières de la Province de Québec. *Philosophie de l'AI.P.Q. concernant. . . .* Montréal. A.I.I.P.Q:, 19, paragraphe I (b).

(5) A.I.C. op. cit.

(6) Faculté de Nursing. Extrait du projet d'addition au programme de maîtrise en nursing, présenté à la Commission des études de l'Université de Montréal, le 23 janvier 1968.

(7) Association des Infirmières Canadiennes. "La position de l'Association des Infirmières Canadiennes en regard de l'assistant médecin". Ottawa, 9 octobre 1970.

(8) Lettre du Dr. Mussalem, Executive Director of the Canadian Nurses Association, à A. Girard, doyen de la Faculté de Nursing, Université de Montréal, 11 décembre 1970.

ADAPTING SOCIAL MEASUREMENT FOR SPECIAL POPULATION GROUPS

by
RUTH C. MacKAY

ALL TOO OFTEN investigators are faced with a major measurement problem in estimating values for socio-cultural-psychological variables. If there is a tool available to measure the dimension in question, very often it is designed for use with a population group different in type from that with which the investigator is planning to work. Such differences may affect the measurements obtained.

PROBLEMS OF RELIABILITY, VALIDITY AND COMPARABILITY

Researchers who are faced with the question of using a tool on a population for which it was not designed, if they suspect reliability or validity may be compromised, seem to deal with the problem in one of four ways.

1. They ignore the problem. Since researchers are but mortal beings as are other men, some mental process seems to assist them in believing that (a) what can be ignored perhaps does not exist, or (b) what cannot readily be dealt with will surely go away.
2. They identify a problem connected with the use of different and specific population groups, either in the studies in which the tool was developed, or in the new study being designed. However, although there may be such differences identified, for purposes of the study such differences are assumed to be negligible, and the tool is used as it stands.
3. They identify the problem, and recognize that population differences may modify in unknown ways the measurements which could be obtained through the use of such a tool. They reject the tool, developing a new method to measure the dimension in question.

4. They adapt the measurement tool for use with a different type of population, seeking to establish similar standards for reliability and validity.

Many factors enter into the making of such decisions in the practice of research, the variety of which may be known perhaps only to the researcher. Time, expense, the availabily of populations suitable for study, the degree of measurement bias expected in the proposed study population, and the urgency of the research problem are just a few of the factors which may outweigh the disadvantages of pursuing the investigations with the tools readily at hand. Nonetheless, serious criticisms might be raised with the use of the first two ways of solving the problem, directed towards the obtaining of data which may be unreliable, invalid, or both. Following the course of action suggested in option 3, the development of a new measurement tool, raises other problems. The description of data measured with the new tool would not be comparable to that obtained in other studies, and the findings could not be compared directly. In fact, the definition of dimensions in social research is usually operational, which reduces the chances of developing a similar operational approach to define the same dimension. A new instrument, operationally at variance from the original, may sample a different variable dimension and cause problems of validity. Adapting a tool for use with a different population group seems to suggest the greatest opportunity to incorporate both reliability and validity into the measurements and allowing, at the same time, some basis for the comparison of findings with past studies.

PROBLEMS IN ADAPTING MEASURING INSTRUMENTS

When a decision has been made to adapt the measuring instrument for use in a new study, several problems invariably need to be solved. The study proper cannot proceed until the adapted tool is prepared and tested. Estimates of reliability and validity from the testing situations assist the researcher in refining the tool, allowing him to establish standards that are either comparable to the original tool, or at least as high as he is willing to accept as a minimum requirement.

The adaptation and refinement of measuring devices usually develop into a pilot study of a segment of the proposed project. Since research depends on the availability of funds from some source, very often an outside agency to the research body, the obtaining of such financial assistance depends, amongst other things, on the established reliability of the measuring devices outlined in the project proposal. Consequently a pilot study may very well have to precede an applica-

tion for assistance with research funding. This may leave the researcher to develop measuring instruments with little or virtually no resources, a realistic problem.

Presuming the investigator can find time and money to carry out a modest pilot study, there is still the difficulty of securing a study population similar in type to the population which he wishes to investigate in the project proper, without intruding on or contaminating that particular population group. This may pose problems when the population is limited in number, scattered over a wide geographical area, or in close communication one with another.

DEVELOPING THE ADAPTED INSTRUMENT FORM

Once a plan is made for carrying out a pilot study with the objective the adaptation of a specific measuring instrument, the next step is to prepare a new form of the instrument. Most researchers go to great lengths to describe the steps they have taken in developing a new instrument. These descriptions guide the adaptor in maintaining a similar approach in devising the new form. There may be a theoretical argument proffered for grasping the latent nature of the dimension in question. This dimension will then be connected to the use of one or more indicators which together are designed to sample differing quantities or degrees of the variable dimension characteristics. The sampling of indicators from the universe representing the manifest characteristics, and the combination of the weightings of indicators to produce an index, can follow the plan outlined by the creator of the original instrument. Some instruments are scales, perhaps composed in parts, which may or may not be balanced in some respect. Items in a scale may be specially grouped or dispersed randomly throughout the instrument; some may be reverse scored. Whatever the design may be, the closer the adaption can be to the original form, the more reliance one can place on the comparability of the study findings derived from the adapted instrument to those cited in studies using the original measuring tools, and the greater the chances of preserving validity. An example of the process used by the writer to produce an adapted form of a measuring instrument is given as illustration.

ADAPTING ROKEACH'S OPINIONATION SCALE

Opinionation is the name of a construct used by Rokeach in describing the way in which an individual holds values. The construct is built on the assumption that individuals with closed belief systems tend to accept those who agree with them and reject those who disagree with them more often than individuals with open belief systems.[1] Rokeach

identifies two subdimensions, opinionated acceptance and opinionated rejection. Opinionated acceptance statements are those "that imply the speaker believes something and, along with this, accepts others who believe it too".[2] "Opinionated rejection refers to a class of statements made by a speaker which imply that the speaker rejects a particular belief, and at the same time that he rejects people who accept it".[3] Opinionation would seem to have particular relevance to the helping professions: medicine, dentistry, nursing, social work, counselling, to name but a few. Does a highly opinionated nurse, for example, relate more closely or less closely to the patient? What is more, whether she relates closely or not, does it make any difference to the quality of care she gives to the patient in encounters dependent on interpersonal relationship? Quality of care might be measured in this instance by interviewing ability, by grades in a clinical nursing course involving interpersonal relationships, such as psychiatric nursing, or the number of disclosures a patient may make to the nurse in discussing his health problems. Is opinionation a dimension which is altered by the educational process, or more specifically, experiences in a nursing program, or is it a fairly stable attribute of the personality? It might be helpful, then, to be able to measure opinionation in nurses.

Although Rokeach has demonstrated the generality of his findings in several different cultures, in children as well as adults, and using observation as well as paper and pencil tests[4], nurses were not one of the specific population groups sampled when he established his reliability figures. His groups were drawn from university psychology students in the midwestern parts of the United States of America, New York City, and England, and from workers in a British automobile factory. These studies were carried out in the mid-nineteen fifties.[5]

The opinionation scale is composed of 40 items, 20 of which are opinionated acceptance, and 20 of which are opinionated rejection. The items cite issues which were relevant at the time and in the country in which subjects resided. American subjects, for example, considered a large variety of issues dealing with figures such as Roosevelt, Truman, McCarthy, and Alger Hiss; the British subjects had, amongst others, the Labour Government, Dr. Jagan, and freedom in the Colonies. Obviously a Canadian nurse population, and especially one composed of students or recent graduates, would hold few attitudes towards these issues. A shortened version of the scale was prepared at one time which omitted items including issues which perhaps might not be well-known to young Americans, and this scale was administered to student nurses in a baccalaureate program in nursing in the United States.[6] The scale readings proved inconclusive, corre-

lating with no other measurements studied, and the judgment was made that the shortened form of the scale was an insufficient stimulus to provide reliable measurement. Clearly a new form of the scale would need to be devised suitable for young adults in Canada if a Canadian nurse population is to be measured.

To prepare the scale, issues were chosen for their central relevance to the concerns of young adults in general, such as issues concerning life and death, suffering and war. Rokeach categorized the issues with which he was dealing as right or left opinionation, that is, agreement with the item placed it to the right or left of a mid-point. To determine which items are right and which left Rokeach states "an opinionated statement is right of center if most judges generally see it as being to the right of an oppositely worded statement with which it is compared."[7] Judges use as their frame of reference for right what they think most people believe. Forty items were either selected from Rokeach's Scale or written anew, then used in such a manner as to attempt to maintain the balance of the scale originally devised by Rokeach. Thus 10 items are right opinionated acceptance, 10 right opinionated rejection, 10 left opinionated acceptance, and 10 left opinionated rejection. These items were then placed in random order. To mask the nature of the opinionation scale, and to dilute possible feelings the subject might experience as a consequence of his exposure to it, twenty-three additional items, with a similar format but constituting a different scale, in this case one measuring humanitarianism, were randomly mixed in with the opinionation items. Rokeach also followed this practice.

The scale is prepared for use, at least initially, with baccalaureate nursing students. Measurement of all students on entering and graduating from a baccalaureate program in nursing is required for a longitudinal study. Since there is no other similar nursing population geographically accessible, the scale was tested on 24 students enrolled in a counselling and guidance class of a baccalaureate program in education.[8]

Following Rokeach's method of assessing reliability, product-moment correlation coefficients were computed for the total opinionation scale, the right opinionation subscale, and the left opinionation subscale. In each scale alternate items gave split-half scale scores, and the resulting coefficients were corrected using the Spearman-Brown Prophecy Formula. Additionally, right opinionation was correlated with left opinionation.[9] The resultant coefficients are given in Table 1 below, along with the range of Rokeach's reliability figures[10] with which they are compared.[11]

Although the sample population selected for testing is composed of

education majors in a baccalaureate program, rather than nursing students, the sample selected was made up of students in a class preparing guidance counsellors. Counselling and nursing are both examples of helping professions, and since there is no other baccalaureate nursing program geographically available, it is felt that these two groups are similar enough in the characteristics important to the dimension of opinionation to warrant testing the instrument in this way. The two groups did differ on one important attribute however. Whereas the nursing students to date are all female, 8 of the 24 educa-

TABLE 1
COMPARISON OF RELIABILITY COEFFICIENTS, ROKEACH'S OPINIONATION SCALES WITH THE ADAPTED FORM

	Rokeach's Scales			Adapted Form
	American Students	English Students	English Workers	
Total opinionation	.67 to .76	.75	.75	.74
Right opinionation	.67 to .77	.86 to .88	.91	.77
Left opinionation	.39 to .74	.89 to .90	.91	.73
Right opinionation with left opinionation	-.51 to .09	-.65 to -.61	-.62	.55

tion students are male. Testing the two subgroups, males and females, for differences in opinionation using the median test, because of the small numbers, shows a probability of finding differences of .3 under the null hypothesis. Although significant differences were not found with this small sample, as norms are developed with nursing and other control groups, sex differences may still exert some influence in the manifestation of opinionation and this characteristic will be included in the further work planned.

Reliability figures for the total scale and the right and left subscales are comparable to those published by Rokeach. The correlation of right opinionation with left opinionation produced a positive relationship, however, rather than the negative ones recorded in several of Rokeach's analyses, although findings reported by Rokeach on students at one university in the United States produced no correlation at all. Rokeach has noted wide variations and suggests it may reflect national and regional differences in character.[12] He mentions that Inkeles and Levinson suggest "that important differences exist in the organization of attitudes along a left-right dimension", and that this area of personality would be a fruitful one for further study with

respect to different regional population groups.[13] Certainly the findings from this small group of Canadian students supports Rokeach's suggestion. Further investigation of the left-right aspect of opinionation might disclose more clearly the left and right belief and disbelief configurations held by special population groups in Canada.

Since the reliability figures of the adapted form are consistent in general with those published by Rokeach, the decision is made to accept the new scale for studies on nursing populations in Canada. Norms derived from their use with different types of populations will further serve to distinguish as yet unknown differences in parameters within this hetergeneous group.

Footnotes

[1] Milton Rokeach, *The Open and Closed Mind,* (New York: Basic Books, Inc. 1960), p. 80.

[2] *Ibid.,* p. 81.

[3] *Ibid.,* p. 80.

[4] Discussed in an informal paper presented by Rokeach at the University of Kentucky, August, 1965.

[5] Rokeach, *The Open and Closed Mind,* p. 88.

[6] Ruth C. MacKay, "Effects of Interpersonal Difference, Social Distance, and Social Environment on the Relationship Between Professionals and Their Clientele" (unpublished dissertation, University of Kentucky, 1969), pp. 80, 91-92, 105-106.

[7] Rokeach, *The Open and Closed Mind,* pp. 81-82.

[8] The writer is indebted to Miss Mary Balanchuk, M. Ed., educational counsellor, associate professor Queen's University, for her critical review and helpful suggestions in the designing of new items for the adapted scale, and for her involvement in the testing of the instrument.

[9] Acknowledgement is made to Miss Frances Pishker, B.N., for her help during the analytic phase.

[10] Rokeach, *The Open and Closed Mind,* p. 92.

[11] A copy of the adapted scale may be obtained from the writer on request.

[12] *Ibid.,* p. 94

[13] *Ibid.,* p. 95.

PERCEIVED ROLE DIFFERENCES AND DISCREPANCIES AMONG NURSING SUPERVISORS

LARRY F. MOORE

Psychologists and sociologists have long been devoting considerable attention to the subject of role perception. A recent review of a number of landmark investigations may be found in the *Handbook of Social Psychology* (1). Researchers such as Taves, Corwin, Haas and others at Ohio State University have conducted studies of the role perceived and performed by the professional nurse (2). Ruth Anderson has provided insight into the present role of the head nurse as a leader of others and has shown that role preferences of head nurses are related to leader performance (3).

Little empirical evidence exists regarding the role of the nursing supervisor Crotin, in a study of the functions of nursing supervisors in six general short-term care hospitals found little agreement on functions which should be performed by nursing supervisors (4). Hagen and Wolff, in an investigation of nursing leadership behavior using a critical incident reporting approach, developed a list of behavioral statements related to the leadership effectiveness of the nursing supervisor. These statements were classified into twelve behavior (or role) categories (5). In that study, no leadership role for the supervisor emerged as being distinct from that of the director of nursing service or the head nurse. On the other hand, Nealey and Blood found that nursing leadership effectiveness, both in terms of performance and subordinate satisfaction, may require that the nursing supervisor fulfill a leadership role considerably different than that of the head nurse (6). For example, task-oriented head nurses received higher performance ratings while relationships oriented nursing supervisors rated higher. That is, head nurses who were perceived by their subordinates as more concerned with elements of the job or task *per se* received higher performance ratings, while

the nursing supervisors receiving the higher performance ratings were those who were more concerned with human relationships in the work setting.

The present study is focussed upon role perceptions and discrepancies among supervisors of nursing. Specifically an attempt has been made first to examine nursing supervisors' perceptions of their present and ideal role, and second, to examine differences in administrative role perceptions and discrepancies which may exist due to factors of hospital size and shift worked.

HYPOTHESES

The objective or mission of the modern hospital is to provide a high level of efficiency in caring for patients' needs. Because of the complexity of tasks and diversity of skill requirements, the hospital organization has traditionally been strongly bureaucratic in nature. There is a well developed administrative and positional hierarchy, particularly within the nursing service responsibility area. Task specialization abounds and a rather rigid system of rules, regulations and procedures closely governs the activities of all, including patients and visitors. There is a variety of scheduled routines. Finally, in most hospitals, a degree of impersonality exists; if not between members of the hospital staff and the patients, certainly among staff members at various levels.

As Weber noted, bureaucratic chraracteristics are developed with the intention of improving organizational efficiency (7). Nevertheless, sociologists such as Merton, Selznick and Gouldner, have pointed out a number of dysfunctional consequences of bureaucratic organization (8). Because of the demand for control which is made on the organization by the top hierarchy, a number of standard operating procedures or routines are instituted. These tend to reduce the freedom of action and the degree of decision-making at lower levels in the administrative hierarchy. Consequently, in the traditional bureaucratic organization, one often finds that middle-managers are not allowed to become involved in decision-making, lack identification with overall organization goals, are supervised too closely, supervise others too closely, and feel a great deal of tension.

Here, the position has been taken that the supervisor of nursing, who generally performs a middle-management role in a bureaucratic organization, will perceive her ideal role as different from the role she performs at present. With respect to administrative role perceptions stemming from the theory of bureaucracy the following hypotheses were made:

1. supervisors of nursing perceive their present role as emphasizing routine administrative more than managerial activities.
2. supervisors of nursing perceive their present role as emphasizing operational more than clinical activities.
3. supervisors of nursing perceive their ideal role as having a stronger managerial emphasis than at present.
4. supervisors of nursing perceive their ideal role as being less routinely administrative than at present.
5. supervisors of nursing perceive their ideal role as being less operational than at present.
6. supervisors of nursing perceive their ideal role as having a stronger clinical orientation than at present.

Although no relevant direct evidence was found regarding the influences of shift worked and hospital size on the role of the nursing supervisor, evidence from other organizational settings strongly suggests that some administrative role differences may be due, in part, to shift worked and organizational size (9). Interviews with a number of nursing supervisors and directors of nursing provided further indication that these two variables do affect the supervisor's role. In general, based on these *a priori* explanations, supervisors of nursing working the evening and night shifts and those working in small hospitals seem likely to have a greater degree of responsibility and autonomy in their roles, thus requiring a greater degree of involvement in all administrative role categories. At the same time, the usually greater degree of autonomy possessed by evening-night shift supervisors and by supervisors in small hospitals would be expected to lead to greater discrepancy (disagreement among role incumbents) in role perceptions within these two groups. Specifically, it was hypothesized that:

7. supervisors of nursing working evening or night shifts perceive themselves both presently and ideally as more heavily involved in all four administrative role categories than do day shift supervisors.
8. supervisors of nursing in small hospitals perceive themselves as more heavily involved in all four administrative role catecategories than do supervisors in large hospitals.
9. supervisors of nursing working evening or night shifts disagree to a greater extent than do day supervisors about their present or ideal role.
10. supervisors of nursing working in small hospitals disagree to

a greater extent than do supervisors in large hospitals about their present or ideal role.

METHOD

The hypotheses were tested through analysis of questionnaire data collected from a sample of nursing supervisors.

ROLE QUESTIONNAIRE

A two-dimensional administrative role typology was developed by using, as one dimension, approximately the same functional categories given for the supervisor of nursing service by the American Nurses Association (10). These are nursing care, personnel and personnel policies, physical environment, budget, and public relations. A second dimension was constructed in order to identify clearly four different categories of administrative activity.

The first administrative role category was termed "managerial". This category includes making decisions regarding many aspects of nursing service; establishing long and short range objectives; exercising judgment in complex intra-organizational situations; establishing organization structure policies, responsibility areas and controls; coordinating nursing service with other divisions; evaluating and modifying procedures; and establishing a motivational climate.

"Routine administrative" the second role category, involves collecting, transmitting and maintaining records and other information; interpreting and communicating policy; enforcing rules; scheduling and assigning tasks; maintaining inventory control and procuring supplies.

A third administrative role category, "operational," includes those role activities which require the direct but routine involvement of the supervisor. For example, routinely caring for patients through direct bedside contact; providing on-the-job instruction, leadership and motivation; and maintaining physical facilities and environment, can be classified as operational aspects of the supervisor's role.

Finally, a fourth category is increasingly being recognized as an important facet of the role of the supervisor of nursing (11). "Clinical" role activities call for the utilization of highly technical skill not possessed by most nurses and focus on complex, non-routine patient-care problems. The clinical role activity category includes training staff nurses in the use of therapeutic intervention.

Using the two-dimensional role typology as a guide, statements were developed to describe role elements which are attributable to the five functional categories and also to the corresponding four

administrative categories of the nursing supervisor's role. Two to four role element statements were developed for each of the twenty functional-administrative combinations. The major use of the five functional categories in this design was to ensure adequate role element description coverage across the broad range of functions performed by the supervisor of nursing. Some of the statements were adopted from similar statements taken from *Functions, Standards and Qualifications for Practice* (12) while numerous other statements were constructed following interviews with experienced nursing supervisors.

To check the composite of role statements for construct validity relative to the 5 x 4 category matrix, each statement was placed on a separate card so that a card deck could be obtained. A panel of three objective but highly knowledgeable experts was used in conducting a card sort. Working independently, each expert sorted the statements according to functional and administrative dimensions. The independent card sorts then were compared for item ambiguities. Item statements which were ambiguous were either eliminated from the deck or were rewritten in a more clear fashion and a post-sort was conducted. Following the card sort, a questionnaire was constructed utilizing 54 role statement items. A five point Likert Scale was utilized to measure the extent to which each role element was presently or was ideally perceived. A typical statement illustrating the method of scale construction is as follows:

> You are asked to mark the letter corresponding to the most appropriate descriptive word for each row.
>
> A = Always
> B = Often
> C = Occasionally
> D = Seldom
> E = Never
>
> Example:
> To evaluate detailed qualifications of every newly-hired staff nurse.
>
> In my *present* position this is my function A☐ B☐ C☐ D☐ E☐
> *Ideally* this should be my function A☐ B☐ C☐ D☐ E☐

Following the administration of the questionnaire, factor analysis was performed in order to check for cell independence and thus to re-assess construct validity. A Principle Components Analysis with Varimax Rotation was the factor analytic method employed. The pat-

tern of factor loadings was interpreted as indicating a high degree of cell independence.*

SAMPLE

The questionnaire was completed by all supervisors of nursing service in attendance at any one of a series of three identical workshops on problem-solving held in the province of British Columbia. The attending supervisors (usable N = 110) represented nearly 50% of the supervisors of nursing service working in hospitals throughout the province. Demographic data collected along with the questionnaire indicated valid representation in terms of regional dispersion, age, experience, shift worked, education and hospital type and size.

RESULTS

ROLE PERCEPTIONS

It was predicted that supervisors of nursing would perceive their present role as involving a greater degree of routine administrative than managerial (creative, decision oriented) activity, and that operational (direct routine care) activity would be seen as predominating over the clinical role. To test these two predictions, mean present role scores were calculated for all statements in each of the four administrative role categories. As indicated in Table 1, both predictions were confirmed. The mean present score on role statements categorized as routine administration was significantly higher than the mean present score on role statements in the managerial category. Similarly, the mean present score on operational role statements is significantly higher than the mean present score on clinical role statements.

Interestingly, the mean present managerial role statement score was lower than for the other three administrative role categories and the mean present operational role score is highest, possibly indicating an underemphasis on managerial role activities and an overemphasis on activities having to do with providing direct nursing care.

Table 1. Differences in Mean Perceived Present Administrative Role Scores for Supervisors of Nursing

Category	Mean Score	Significance Level (t test)
Managerial	2.55	$p < .01$
Routine Administrative	2.77	
Operational	3.24	$p < .01$
Clinical	2.81	

* The interested reader may obtain a copy of the factor matrix by writing to the author.

It was hypothesized that, ideally, supervisors of nursing would perceive their role as having a stronger managerial emphasis, that routine administrative activities should receive less emphasis, that operational activities ideally should be reduced ,and the role of the supervisor should have a stronger clinical orientation than at present. Mean present and ideal (P-1) scores were calculated for each role statement making it possible to test the P-1 hypotheses by examining the direction patterns of P-1 statement scores within each administrative role category. The findings are presented in Table 2. Thirteen of fourteen mean ideal role statement scores were significantly higher than the corresponding mean present role scores, confirming prediction three, that supervisors of nursing would perceive their ideal role as having a stronger managerial emphasis. There was no clear support for prediction four, that supervisors would perceive their ideal role as less routinely administrative. In only six of fifteen role items were mean P-1 differences significant at or beyond the .05 level, although four of the significant differences were negative in direction. Likewise, prediction five, that operational activities should be reduced, is not supported. Only four of fourteen P-1 differences were significant, and three of these were in a positive direction. In the clinical role category, seven of eleven P-1 differences were significant and positive in direction, supporting prediction six, that supervisors of nursing would perceive themselves ideally as performing more clinical activities than at present.

Table 2. Direction of Significant* Differences between Mean Present and Ideal Administrative Role Statement Scores of Supervisors of Nursing

Role Category	Total Statements (N = 54)	Direction of Significant Differences	
		Positive (present < ideal)	Negative (present > ideal)
Managerial	14	13	0
Routine Administrative	15	2	4
Operational	14	3	1
Clinical	11	7	0

* All differences shown in the table are significant at or beyond the .05 level of confidence as indicated by t-test.

It was predicted in hypothesis seven that evening and night shift supervisors would perceive their present and ideal role involvement to be heavier in all four categories than would day shift supervisors. Comparative mean role perception scores for evening and night versus day shift supervisors are shown in Table 3. Significant differ-

ences were found between evening-night and daytime nursing supervisor sub-samples mean perceived present administrative role scores in the managerial, routine administrative, and operational categories. Evening and night shift supervisors of nursing in this sample perceived themselves as presently and ideally performing to a significantly greater degree the managerial and routine administrative role activities than do their daytime counterparts. On the other hand, the daytime supervisors perceived themselves as presently and ideally performing to a greater degree the operational role. Although there was no significant difference between the sub-samples in perceived present performance of the clinical role, the evening-night supervisors perceived themselves ideally as performing the clinical role to a greater degree than did the daytime supervisors.

Table 3. Differences in Mean Present and Ideal Administrative Role Scores for Supervisors of Nursing Who Work Evenings and Nights Compared to Those Who Hold Daytime Positions. (Evening-Night N=34; Daytime N=76)

Role Category	Mean Score Evening-Night	Mean Score Day	Signif. Level*
Perceived Present Administrative Role			
Managerial	2.76	2.08	.01
Routine Administrative	2.95	2.37	.01
Operational	3.16	3.43	.01
Clinical	2.85	2.72	NS
Perceived Ideal Administrative Role			
Managerial	3.40	2.63	.01
Routine Administrative	2.83	2.42	.01
Operational	3.30	3.49	.01
Clinical	3.33	3.04	.01

* As indicated by t-test.

Concerning the influence of hospital size on the role of the supervisor of nursing, it was hypothesized that supervisors in small hospitals would perceive their present and ideal role involvement to be heavier in all four categories than would supervisors in large hospitals. Table 4 shows differences in mean administrative role scores for nurses working in small to medium (<500 beds) compared to large (>500 beds) hospitals. Supervisors in small to medium hospitals perceived themselves presently performing to a greater extent the operational and clinical roles and as ideally performing to a greater extent

ficant ($p < .01$). This finding applied to both present and ideal perceived role. No significant differences in degree of role discrepancy were revealed between supervisors of nursing in small and medium hospitals compared to those in large hospitals with respect to present or ideal perceptions in any of the four administrative role categories. Thus, hypothesis nine was supported only with respect to the operational category, while hypothesis ten received no support.

DISCUSSION

The results of this study indicate that supervisors of nursing perceive themselves as performing a role which consists more highly of routine administrative and operational activities and which does not afford enough opportunity to engage in managerial and clinical activities. This finding is in keeping with modern bureaucratic theorists who have indicated that, in a strongly bureaucratic hierarchy such as the nursing service administration in most hospitals, the degree of decision-making and opportunity to assume real responsibility is often restricted to the top levels (14). Additionally, middle-level managers are constrained by and must develop and enforce a large number of routines and procedures. As a consequence of being fettered by rules and procedures and at the same time having to spend a great deal of time engaged in role activities associated with bureaucratic maintenance, the supervisor of nursing is not permitted nor does she have time to engage to an ideal extent in those administrative activities of a managerial or clinical nature which allow the utilization and development of creative abilities important to job performance and personal satisfaction.

Interestingly, while the supervisors of nursing in this study clearly perceived their ideal role as being more strongly oriented toward managerial and clinical administrative activities, they did not clearly perceive themselves ideally as becoming less involved with routine administrative and operational functions. In most cases, the seasoned nursing administrator may have been conditioned to accept, support and almost cherish the routine of the hospital and her place in it, thus exaggerating the perceived importance of personally handling routine administrative activities. Moreover, operational or direct patient care activities historically have been an integral part of the professional nurse's role in accomplishing her service-oriented objective. Quite naturally, the head nurse and supervisor of nursing might be expected to retain an operational orientation as she moves into administration. Previous investigations have indicated that the professionally trained person has internalized skills, norms, and standards which may influence behavior even though the person's role has

the operational role than their counterparts in the larger hospitals reflecting the probably greater necessity in small hospitals for the supervisors to become directly involved with patient-care activities. On the other hand, their perceptions did not indicate a present or ideal managerial or routine administrative role involvement greater than that of supervisors in large hospitals.

Table 4. Differences in Mean Present and Ideal Administrative Role Scores for Supervisors of Nursing Who Work in Small and Medium Compared to Those Working in Large Hospitals (Small and Medium $\leq$ 500 beds, N=63; Large $>$ 500 beds, N=47)

Role Category	Mean Score Small-Medium	Mean Score Large	Signif. Level*
Perceived Present Administration Role			
Managerial	2.54	2.55	NS
Routine Administrative	2.75	2.84	NS
Operational	3.37	3.07	.01
Clinical	2.91	2.68	.01
Perceived Ideal Administrative Role			
Managerial	3.17	3.16	NS
Routine Administrative	2.65	2.77	NS
Operational	3.44	3.25	.01
Clinical	3.28	3.18	NS

* As indicated by t-test.

ROLE DISCREPANCY

Within each of the four role categories, present and ideal role statement score standard deviations were taken as a measure of role discrepancy. For each role statement within each administrative role category, appropriate corresponding sub-sample differences in standard deviation were assigned ranks, thus making possible the utilization of the Wilcoxon Matched Pairs Signed Ranks test for comparing the role discrepancy among night-evening versus daytime shift supervisors and among those supervisors working in small and medium versus large hospitals (13).

In each role category, there was a directional tendency toward greater discrepancy among evening and night supervisors; however, only in the operational category was the difference statistically signi-

changed (15). Both of these phenomena considered together may explain, in large measure, why the routine administrative and operational role categories were not perceived as requiring less involvement in the ideal setting.

Evening and night shift supervisors seem to be performing a role which involves a greater degree of decision-making and which simultaneously demands more involvement with routine administrative activities. At the same time, the evening-night group saw themselves ideally as having a greater involvement in these two role categories than did the daytime supervisors. It is likely that, because most other administrative figures, particularly the director of nursing, are off duty at night, the supervisor of nursing must function more nearly as a true administrator. She must make decisions, establish and modify policy and enforce rules without turning to others for guidance. In this role, she needs and must be delegated considerable discretionary authority. On the other hand the daytime supervisors perceived themselves as presently and ideally performing a greater operational role. Is this because the supervisor of nursing on daytime duty is not allowed or is too busy with routine to become as deeply involved in the managerial and clinical role areas, where a real challenge and involvement lies, or is it because of a legitimate need for the supervisor to become more heavily involved in direct operational care activities? Further research seems justified in order to investigate this question.

Although no difference was found with respect to degree of role discrepancy on the part of supervisors in small and medium compared to those from large hospitals, evening and night supervisors seem to disagree to a greater extent about their role, particularly in the operational category. Again this may be due to increased general responsibility which is placed on the night supervisor.

In general, this study in attempting to illuminate the administrative role dimension of the supervisor of nursing, strongly affirms the need to reexamine critically the role typically performed by the supervisor of nursing in the modern hospital. Further study must be directed toward the problem of integrating the role of the supervisor of nursing with those of the director of nursing service and the head nurse in order that these members of the nursing service administrative hierarchy may function as a coordinated team.

SUMMARY

This study investigated the role of the supervisor of nursing service as presently and ideally perceived by supervisors themselves. Following the definition of four administrative role categories applicable

to supervisors of nursing to measure both present and ideal role perceptions, a questionnaire utilizing a 5-point Likert scale was administered to supervisors attending a workshop on problem-solving. Usable responses were obtained from 110 supervisors. Supervisors of nursing perceive themselves as being more involved in routine administrative than in managerial (creative, decision oriented) activities and more involved in operational than in clinical role activities. Moreover, supervisors perceived themselves ideally as becoming more involved with managerial and clinical activities, but they did not perceive themselves as having a lesser involvement in the routine administrative or in the operational role areas.

Sub-sample comparisons seemed to indicate greater discrepancy in perception of present and ideal roles on the part of evening and night supervisors; particularly with respect to the operational role. No differences in degree of discrepancy were attributed to hospital size.

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