

national league for nursing



**PERCEIVED NEED FOR TECHNICAL SPECIALISTS
IN NURSING CARE OF HOSPITALIZED PATIENTS**

Helen H. Burnside

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HELEN H. BURNSIDE, Ed. D., R.N.

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It is recognized, however, that the time available at meetings and the pages of professional magazines are limited. Meanwhile, the projects in which NLN members are engaged and which they should be reported in detail; yet, such a recording would frequently exceed the limits of other media of communication. The League Exchange has been instituted to provide a means for making available useful materials on nursing that would otherwise not be widely available.

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It is hoped that NLN members will find the League Exchange useful in two ways: first, that they will derive benefit from the experience of others as reported in this series, and second, that they will find it a stimulus to the dissemination of their own ideas and information. There are undoubtedly many useful reports that are not published because of the lack of suitable space. NLN members are urged to write these reports and submit them for consideration in the League Exchange item.

Pub. No. 23-1523

LEAGUE EXCHANGE No. 102



NATIONAL LEAGUE FOR NURSING

New York

Printed in the United States of America

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Printed in the United States of America

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Especial thanks to—

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Mike Brick, who always gave sage and helpful counsel.

Curtis Burnside, my son, who endured the pains of my labor.

Carrie Lenburg, whose editorial and critique expertise contributed so much.

Assumptions

Limitations of the Study

Plan of Report

H.H.B.

2. PROCEDURES OF THE STUDY

Method

Development of the Instrument

Pilot Study

Parts of the Questionnaire

Part I—Background Information

Part II—Technical and/or Professional Nature of General Staff
Nurses in Hospitals

Part III—Appropriateness of Certain Functions and Activities
for Technical Nurses

Part IV—Areas of Service Responsibility and Nature of Services

Part V—Nurses in Specialty Units

Part VI—Technical Nursing Specialization

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Data Collection

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Chapter 1

INTRODUCTION

A state of confusion exists in the health delivery system in this country. New health careers with questionable career mobility and ill-defined functions are being developed in an attempt to give the public better care in sickness and in health. The demand for new kinds of nursing care has been precipitated by the changing emphasis in health delivery and the increasing complexity of medical knowledge.

Considering these changes, one must question the practice of preparing all nurses as nursing technician generalists. The words "technician" and "generalist," by dictionary definition, are, in fact, a contradiction. According to *Webster's Unabridged Dictionary* (1966), a "technician" is a specialist in the technical details of a subject, one who has learned the practical technical details and special techniques of an occupation. On the other hand, the dictionary defines a "generalist" as one who devotes himself to, is conversant with, or can handle several different skills, fields, or aptitudes—opposed to specialist. Traditionally, graduates of two- or three-year programs get a smattering of all the major nursing practice areas but, according to some nursing service personnel with whom the writer has had conversations, not enough of any particular one to function competently and confidently in the units of highly specialized, bureaucratic agencies to which they go to work following graduation. Therefore, this study will explore the need for the specialization of technical nurses as perceived by hospital nursing service personnel.

Other technical vocations have developed curriculums which prepare technicians to function with emphasis on certain specialized aspects of these fields. However, it must be noted that engineering, too, is asking for a clarification of function of its technicians. Aidala (1970, p. 11) suggests that industry would do well to clarify the technical employment picture by stating clearly its goals for technicians, making it easier for educational institutions to prepare a marketable technician.

In the field of engineering, even though some confusion still exists regarding the roles and functions of its technicians, this profession has prepared a large variety of highly specialized technicians, particularly as related to electrical and mechanical engineering. The titles of examples of these technologies, such as computer, aircraft electronics, electric design, diesel-gas turbine machine process, demonstrate the high degree of specificity attained.

Brodsky (1968) notes that the lists of specialized technologies related to mechanical engineering are separated into two groups, "those which are related almost exclusively to mechanical engineering (single-field emphasis) and those which are hybrids having a major relationship to mechanical engineering and at least one other engineering discipline (multifield emphasis) [p. 14]."

Associate degree nursing programs also could develop curriculums to prepare technicians with special emphasis in one or two areas of nursing.

There has been inadequate dialogue between nursing educators and nursing service personnel regarding the functioning and activities of the general staff nurses in the nursing situation. A cooperative appraisal of the product of the educational programs for the registered nurse would

be helpful in improving patient care in light of today's health care challenges. Nurses from service settings can help educators look at the specialized nature of nursing and give clues which may be helpful in determining the educational preparation necessary for the technicians who give nursing care.

Price (1967, p. 69), in the conclusions of her study regarding the inservice education of registered nurses, noted that the gap which exists between education and service needs to be narrowed. She believes that the confusion regarding program goals, roles, and competencies of graduates detracts from both nursing service and nursing education and that improved cooperation and understanding are necessary if both are truly dedicated to the welfare of the hospitalized patient and to society.

With this philosophy in mind, this investigator (who has spent many years as a nursing educator) believes that nursing service administrative personnel, as utilizers of the great majority of graduate nurses from all types of programs, have a unique perspective of nurses and nursing service needs. Consequently, it seems logical that their views should be investigated for potential directions in the endeavor of improving nursing education in order to improve the quality of patient care.

The nursing administrative personnel are familiar with the functions which registered nurses must carry out for patients to receive the kind of care essential to their recovery and well-being; their work focuses on nurses in patient care settings every day. Therefore, it is reasonable to consider that their continuous experience enables them to be commentators on changes necessary in the education programs which prepare nurses with whom they will have to work. Some nurse educators (including the author) believe that nursing service administrative personnel not only can but should contribute to the development of the curriculum for basic, associate degree programs if the patients in health care institutions throughout the country are to receive a level of care superior to that being criticized today.

Nursing advisory committees of community/junior colleges probably have one-third to one-half of their representation from health care facilities in the community and mostly from hospitals. But mostly the role of a nursing advisory committee has been to function as a public relations arm of the college in regard to the nursing program. Educators generally engage in an orientation of nursing service personnel to the educational program and evaluation of the conduct of learning in the service setting. Exploration as to the need for graduates is ongoing, but little is done to seek the opinion of nursing service personnel about the educational program or the type of graduate needed.

This investigation utilizes nursing service personnel for the study sample in an attempt to capitalize on their experience and point of view. If their responses are positive regarding the concept of technical nursing specialization and if they are willing to employ this new kind of nurse, then, perhaps, nurse educators would do well to reconsider and change the curriculum to reflect the changing needs and increasing complexity of patient care in the hospitals of today.

PROBLEM STATEMENT

What is the need for technical specialists in the nursing care of hospitalized patients as perceived by selected nursing administrative personnel in hospitals in the New York metropolitan area?

PURPOSES

1. To obtain information which may be helpful in determining if technical specialists are needed to give nursing care to hospitalized patients.

2. To determine the areas of specialization if technical specialists are needed to give nursing care to hospitalized patients.

3. To obtain information which may be helpful in determining the educational preparation necessary for those technical specialists.

NEED AND BACKGROUND

No longer can we accept as true the old adage that "a nurse is a nurse is a nurse; they can all do the same thing." Nurses can no longer be expected to be all things to all people and work in all settings in the hospitals of this country. Hartigan (1969) says,

If we are interested in quality of care, we cannot continue to assign nurses as replaceable cogs; i.e., "float" a nurse from one area of the hospital to another to provide "coverage." For example, the nurse skilled in obstetrical nursing cannot adequately fulfill the specialized needs of the patient in the cardiac care unit and vice versa. This kind of utilization of personnel would not be tolerated in industry, even momentarily, because it would be catastrophic [p. 1047].

The increasing complexity of medical care, the increasing emphasis on clinical nursing skills as differentiated from hospital management and the confusion and overlap of functions of new health career workers vis-à-vis nursing, necessitates a look at technical nursing practice in general, short-term hospitals. This study is an attempt to ascertain, in one urban area, how employers of technical nurses view their functioning today and for the future.

The growth of coronary care units from four hundred in 1967 to over fifteen hundred in 1969 and the estimate that six thousand four-bed units are needed, give credence to the increasing complexity of care. The American College of Cardiology, at a meeting in 1965, made a recommendation that the College establish liaison with the National League for Nursing to discuss strengthening the undergraduate curriculum with respect to cardiovascular nursing and all of its aspects. One might ask, "Should the associate degree nursing basic program prepare nurses to work in these units or is this the responsibility of the employing agency or continuing education?"

Over the past several years the increase in health career opportunities at the technical level has precipitated pages of rhetoric and many hours of deliberation. As yet, however, little study has been done to determine from employers the possible confusion and overlap in functions of these workers of which nurses are one large group. With greater specialization of nursing technicians, would less splintering of the job occur?

For many years it was possible to include in a nursing education program just about everything that was known in nursing practice. Upon graduation, a new nurse was more or less equipped to function in different units of the hospital and could be moved about, based upon the needs of the institution. Today, with the increasing complexity of medical care, the inordinate demands upon the physician's time, the increased use of auxiliary personnel who need supervision, and the patient's desire for greater confidence regarding his illness, the demands upon the registered nurse have grown tremendously.

Just the specialized knowledge needed to work with machines such as dialysis units, hyperbaric chambers, and all sorts of monitoring devices are enough to make nurses of the past reel with confusion. Is it possible that too much is being expected of a new nurse? Is the functional adequacy of the new graduate measured against the practitioner with several years of experience? Are there other educational approaches which might be used to capitalize on this almost overwhelming plethora of knowledge?

Simms (1970) remarks, "Perhaps, in our efforts to keep pace with the expanding practice field in nursing we are loading our curriculum with less and less about more and more so that, at the

completion of her program, the graduate knows practically nothing about everything [p. 38]."

In the findings and recommendations of the National Commission for the Study of Nursing and Nursing Education, the following statement is made: "In the growing complexity of health care and in the widening demands for nursing practice, it seems less possible than ever before to prepare every nursing student to function in all situations [Lysaught, 1970, p. 93]."

Lambertsen (1970), more than other nursing leaders, makes probably the greatest plea for a look at specialization in nursing. The following quote gives great impetus to the need for this study:

Practitioners of nursing are supported by a cadre of supportive personnel who all too frequently are forced to function as a substitute for the nurse rather than serving in the capacity of an extension of the nurse in selected, delegated and circumscribed areas of service. The persistent nature of the circumstances that lead to substitution has fostered new breeds of specialists—child-care assistants, emergency technicians, psychiatric technicians, etc.

A recognizable phenomenon affecting the provision of health services is that of increased options for specialization at the two extremes of the employment continuum for functional areas of services within particular health occupation groups that have clearly identified discreet areas of supportive services for the primary groups—the professionals. Within the context of scientific advances and technical expansion, supportive personnel evolve to assume responsibility for a delegated cluster of related activities, activities essential to the professional service that can be isolated and controlled.

The current issue that must be resolved is: are these emerging occupational groups, representing a specialized service formerly within the realm of nursing practice, nursing service personnel and, therefore, supportive to the professional practitioner of nursing or are they independent of nurses? Is this an irreversible trend toward specialization and highly circumscribed areas of nursing practice at the technical level? How does this trend affect the role and function of the general practitioner or the clinical specialist? Will this type of specialist enhance the quality of nursing service or further fragment nursing service [p. 9]. (Quoted with permission of the author and publisher.)

DEFINITION OF TERMS

Definitions of terms used in the questionnaire were deliberately kept to a minimum in order to avoid prejudicing the answers of the respondents. It was the feeling of the investigator that perception would differ with regard to words used, based upon the background of the individuals queried. The following definition was included in the explanation preceding a series of items in the questionnaire (Part VI, page 12):

Technical nurse specialist means a registered nurse graduated from an associate degree program who has had a period of concentrated education and experience in *one* of seven broad service areas (ambulatory care, long-term care, maternity, medical, pediatric, psychiatric, and surgical), as well as the major specialty units comprising that service area.

The definitions of generalist and specialist, as used in this study, already have been given in Chapter I above.

ASSUMPTIONS

For the purpose of this study, the following assumptions were made:

1. General hospitals have organizational units which can be considered as specialized in nature.
2. Directors of nursing and nursing supervisors are conversant with, and able to evaluate, the functioning of graduates employed in their institutions.

3. Nursing administrative personnel are aware of and anxious to meet patient needs on the units for which they have responsibility.
4. Nursing service personnel would like to have a voice in the education preparation of registered nurses and do have something positive to contribute.
5. Most graduates of associate degree nursing programs work in hospitals.

LIMITATIONS OF THE STUDY

This study was limited to the following:

1. General medical and surgical short-term hospitals and the three Veterans Administration Hospitals in the New York metropolitan area accredited by the Joint Commission on the Accreditation of Hospitals.
2. Nursing administrative personnel in the above described institutions.

PLAN OF REPORT

The report of the study consists of five chapters. Chapter II describes the procedures of the study. In Chapter III, a review of the literature on the background of associate degree nursing programs and current developments in nursing and the health care system provides the basis for statements of abilities needed by technical nurses in hospital settings today, in order for them to practice effectively. Chapter IV gives an analysis of the findings from the questionnaire sent to the nursing service administrative personnel. Chapter V is a summary of the study with implications and recommendations for associate degree nursing programs.

Chapter 2

PROCEDURES OF THE STUDY

METHOD

This study was designed to obtain the perceptions of selected nursing service personnel, so the investigator selected a descriptive survey method. A descriptive survey method was indicated, as it permits the selection of a sample of adequate size, with enough geographical spread throughout the prescribed community to enter the field under study and describe the existing perceptions in terms of the current situation and proposed future practices.

The descriptive survey method offers an acceptable, reliable means of collecting data which reflect perceptions regarding the nature of situations both present and future, thereby serving the purpose for analysis of views regarding technical nursing specialization.

DEVELOPMENT OF THE INSTRUMENT

To gather information related to the central question of the study, it was necessary to construct a questionnaire which would allow the respondents to give their opinions regarding the technical and/or professional nature of general staff nurses and the appropriateness of technical nurses for certain functions and activities. Questions relative to the respondent's area of responsibility led to questions regarding the nature of general staff nurses and their preparation for the units under the respondent's supervision.

Planned interviews with nursing service administrators, physicians, hospital service administrators, and students with nursing service administrative experience were carried out to identify necessary background information needed to lead directly to the central question of the study and, also, to help determine the most effective and least threatening way to approach this different concept in technical nursing.

After the literature had been reviewed and the results of the interviews studied, a specific scheme was used to develop the sets of items and to identify each item as it related to the functioning and preparation of general staff nurses in general and specialized units of the sample hospitals.

An initial draft of the questionnaire was developed and several graduate students and faculty members were requested to review it. As a result of this review, it was suggested that further clarification was needed in the directions for the completion of the questionnaire and for specific items. Corrections were made which resulted in Draft 2 of the questionnaire. Prior to the development of Draft 3, it was decided that the questions could best be answered by nursing service administrative personnel so, at the time of the revision, hospital administrators and physicians were deleted from the sample. A limited number of graduate students were then requested to review Draft 2. It was recommended that the format for some items be changed and that some questions be deleted. Draft 3 was then developed incorporating the suggestions given

and the 13-page questionnaire was then used to collect data used in the pilot study.

PILOT STUDY

A pilot study was done utilizing individuals in nursing service administrative positions in a hospital not included in the sample. The questionnaire was administered to a total of seven subjects comprised of one director of nursing service, one associate director, and five supervisors.

The purpose of the pilot was to determine if the instrument would provide the data needed to answer the research problem as well as to determine the clarity of the items and directions.

The results of the pilot study indicated that some revision was necessary in question design and overall format and wording. Several questions were reworded and some deleted as the time required to complete the questionnaire was considered too long. When the final questionnaire was completed, it was felt that it would take approximately twenty minutes to answer and would collect the data needed to answer the research problem.

The final instrument developed for the collection of data for this study following the pilot study was a structured questionnaire with six related parts (see Appendix C). Background information and questions related to the technical/professional nature of general staff nurses, the appropriateness of technical nurses for certain functions and activities, service areas of responsibility, nurses in specialty units, and technical nursing specialization. The validity of the instrument was satisfactorily established by experts in nursing and education. It was then coded for key punching and distributed by mail.

The six parts of the questionnaire are described in detail on the following pages.

PARTS OF THE QUESTIONNAIRE

Part I—Background Information

A minimum of background information was collected which provided material necessary to describe the respondents. Five items were selected as it was felt that there would be differences in perceptions due to these responses: position presently held, length of time in position, type of basic nursing education received, year graduated from basic nursing program, and highest credential held. This information was used for correlation with questions in other parts of the questionnaire.

Part II—Technical and/or Professional Nature of General Staff Nurses in Hospitals

The items in this part of the questionnaire were used to gain some basic opinions regarding the functioning of general duty nurses. Questions as to worker classification as technical or professional graduates of the three types of basic nursing education programs constituted one major aspect of this part. The other aspects focused upon the similarity of functions of baccalaureate and associate degree graduates and satisfaction with new associate degree graduates. Several questions were used in correlation with questions in the latter part of the questionnaire. Comments for clarification were encouraged.

Part III—Appropriateness of Certain Functions and Activities for Technical Nurses

The nucleus for the questions regarding functions and activities performed by technical nurses

was obtained from Betty Forest's (1968) study, "The Utilization of Associate Degree Nursing Graduates in General Hospitals," in which she gives the following as technical nursing functions:

1. Assist in planning nursing care.
 - a. Plan nursing activities for individual patients as assigned.
 - b. Assist patients to participate in their own care.
2. Give general nursing care.
 - a. Give hygienic care to patients.
 - b. Use measures to promote patient's comfort.
 - c. Assist patients in maintaining normal body functions.
 - d. Observe signs, symptoms, and changes in condition.
 - e. Perform therapeutic treatments in carrying out physician's plan of therapy.
 - f. Perform procedures to facilitate diagnostic tests.
 - g. Record and report signs, symptoms, and changes in condition.
3. Assist in evaluation of nursing care.
 - a. Report observations of patient's responses to therapy and nursing activities to nurse in charge [p. 26].

The following additional functions of technical nurses were included after interviews with nursing service personnel and graduate students and a review of the literature:

1. Perform specialized procedures.
2. Teach patients.
3. Counsel patients.
4. Interpret observations and determine appropriate action to be taken.
5. Perform clerical activities.
6. Be a team leader.
7. Assume head nurse responsibilities on evenings and nights when head nurse is off duty.
8. Be head nurse on days.

For purposes of this study, some of Forest's categories, namely 2.g., "Record and report signs, symptoms, and changes in condition," and 3.a., "Report observations of patient responses to therapy and nursing activities to nurse in charge" have been combined. Other activities of the Forest study were placed in new categories for clarification and to identify certain functions in progression from simple to complex.

Part IV—Areas of Service Responsibility and Nature of Services

The major units of general, short-term, medical-surgical hospitals were chosen as representative of units which would be the responsibility of nursing service personnel. The following areas were chosen after review of the literature and interviews with nursing service personnel and graduate students: ambulatory care, long-term care, maternity, medical, pediatric, psychiatric, and surgical. The specific units of these major areas were also delineated through literature review and interviews. The items comprising this part were intended to obtain the opinions of the nursing personnel working in the areas regarding the nature of their service and the special knowledge necessary to function there.

Part V—Nurses in Specialty Units

These questions were related to general staff nurses working on the specialty units of the areas of service responsibility of the nursing service administrative personnel.

Items were constructed to obtain points of view and comments concerning such areas as

factors generally considered in making assignments and present and proposed methods for the preparation of general staff nurses to work on specialty units.

Part VI—Technical Nursing Specialization

In this part, a definition was given for a worker called a "technical nurse specialist." The respondents were asked if, in their opinion, there was an existing need for such workers, if they would like them employed in their institutions and, if so, on what service areas.

SAMPLE

To determine the proper source of data about the functioning and preparation of graduate nurses on specific units of service areas in hospitals, it was necessary to identify the select group of respondents who would have firsthand information about the day-to-day functioning of general staff nurses in a hospital setting. Since directors of nursing, assistant directors of nursing, nursing supervisors, and nursing service administrative personnel have responsibility for general staff nurses, they were selected as the sample respondents for the study.

A plan was established to determine the hospitals to be used in a prescribed geographical area to be decided upon. Consequently, the following steps were taken:

1. The total number of hospitals in the New York metropolitan area as of August 1970 was identified.
2. Size, control, and service of hospitals from "Listing of Health Care Institutions" found in *Hospitals* of August 1970 [pp. 149-153] were established.
3. A geographical area was determined.

Identification of Region

The New York metropolitan area was selected because it has a large concentration of hospitals and they are separately identified in the Listing of Hospitals in the *Journal of American Hospital Association*.

Selection of Hospitals and Subjects

Hospitals of over three hundred beds classified as general medical and surgical short-term hospitals and three Veterans Administration hospitals were selected for the sample. It was felt that hospitals of this type and size would have the major service areas, giving a cross-section of specialty units.

The major service units chosen were ambulatory care, long-term care, maternity, medical, pediatrics, psychiatric, and surgical, making a possible total of 301 service units within the forty-three hospitals selected. However, not all hospitals had all units. As nearly as could be established, ten hospitals had all of the seven units specified, thirteen had six, sixteen had five, and four had four of the service units, making a potential total of approximately 244 units in the forty-three hospitals.

For the purposes of this study, the respondents were selected if they were employed as a director or assistant director of nursing or as a nursing service administrator on one of the following seven major service areas of a hospital: ambulatory care, long-term care, maternity, medical, pediatrics, psychiatric, or surgical. Consequently, the potential study sample included 244 subjects on these available units plus forty-three directors of nursing or their assistants, making a possible total of 287 subjects.

DATA COLLECTION

In mailing out the questionnaire, no attempt was made to be specific about which units were or were not available in the agency. Therefore, eight questionnaires were sent to each director of nursing at the forty-three selected hospitals. A cover letter to each director with a request for her participation was enclosed (see Appendix A). It was requested that she distribute the questionnaires to the supervisors of those major service areas selected and available in her institution and that she also answer one.

Attached to each questionnaire was a letter requesting that the individual participate in the study (Appendix B). Also included was a self-addressed, stamped envelope which would facilitate return of the questionnaire.

ANALYSIS OF DATA

The following procedures were used for data analysis and presentation:

1. The answers to all questions were key-punched by an expert and verified for correctness. The computer was used for analysis.

2. For all questions yielding frequency distribution, percentages were computed and the data analyzed descriptively and presented. The basis for computing percentages was the number of respondents replying to the question.

3. For all open-ended responses, a content analysis was used to determine categories. The data were descriptively presented.

4. In addition to frequency distributions for all variables, cross-tabulations were done between background characteristics (as primary, independent variables) and responses to remaining key questions as dependent variables. Certain attitude items also were used as independent variables in differentiating responses to items regarding technical nursing specialization.

The intent of this cross-tabulation analysis was to determine the relationships between position within the hierarchy, educational preparation, length of service, and attitudes toward technical nurses and the respondent's attitudes toward the need for employability of and suggested preparation for technical nursing specialists as well as the appropriateness of their performing selected nursing functions.

Chi-squares were computed to determine level of statistical significance between these variables.

The following chapter will consider the literature drawn from the areas of nursing, sociology, and education which are pertinent to this study.

Chapter 3

REVIEW OF THE LITERATURE

In reviewing the literature pertinent to the need for and interest in specialization in nursing, an array of historical and developmental factors which have been directly or indirectly influential will be utilized. Some of these relate to particular changes in the larger society such as the increased emphasis on higher education and the development of junior colleges in the post-war period, the vast increase in knowledge and technology necessitating the growth of specialization in many disciplines, changing patterns of health care delivery and payment, and the growing concern that work be meaningful and fulfill certain personal aspirations.

Other factors which will be considered relate to changes in nursing education and practice including, for example, the following: the decline of private nursing practice, the introduction of ancillary nursing personnel (LPNs and aides) into the hospital work force, the development and growth of associate degree nursing programs with consequent attempts to differentiate technical and professional practice, the unanticipated growth of the LPN movement, and the growth of specialty paramedical workers and specialization in medical practice.

In the succeeding pages, selected literature concerning these and related sociological conditions considered important in the development of specialization in nursing will be reviewed.

In the early 1920s, 75 percent of all registered nurses were engaged in private practice. Twenty-five years later, less than 25 percent remained in private practice and 75 percent were employed in hospitals or other agencies in staff nurse positions under supervision. During this era of private duty care, the nurse was satisfied with her close but subordinate relationship with the physician. At the same time, she nurtured the dependency role of patients, thereby insuring a domain of authority for herself.

For nearly a century, preparation for the practice of nursing, which was mostly private duty, followed the general pattern utilized by Florence Nightingale in the first organized school of nursing in 1860. However, as the number of hospitals increased, some of the characteristics which contributed most to the success of the Nightingale system disappeared. With the advent of more and improved health care, hospitals were built more rapidly than expert nurses could be educated to staff them; consequently, each hospital established a training school, primarily as a means of providing nursing care for patients. Work assigned to student members of the hospital nursing staff provided the principal means of learning for students but, at the same time, met the hospital's obligation for rendering patient care to welfare patients or to those unable to employ private duty nurses. For years, nursing educators assumed that the nursing needed by hospitalized patients matched the practice needed by the students. It was overtly assumed that the hospital needed the school and that the school should give primary consideration to the hospital's needs.

Brown (1966) describes the diploma program as follows:

During a three-year training period, students had ample opportunity to apply their technical skills and the social behavior expected of them since they were obliged to provide nearly all of the nursing care of ward

patients. They also had the opportunity to see themselves clearly as indispensable agents of patient welfare. Although general medical practitioners were numerous, medicine was relatively undeveloped. Methods had not yet been found for preventing or treating serious and widely prevalent diseases such as pneumonia, tuberculosis and scarlet fever. Under these circumstances, nursing care was considered of the utmost importance and its quality often determined whether or not the patient would "pull through" [p. 177].

Most graduates expected to enter private duty and took it for granted that they had learned all that was necessary for nursing practice of that day and the future. With improvements in medical education, the development of medical specialization and facilities necessary for its practice, came the movement of the private patient from his home to the hospital where private duty nursing was continued.

During the Depression years, certain basic changes in the delivery of nursing and medical care were initiated as a result of complex intermeshing of several sociological changes. These influential factors included at least the following. Because of severe economic stresses, the trend was established for patients to leave their homes and enter hospitals for care which shifted the environmental location and organizational arrangement for the delivery of most nursing care. There also was spreading national concern for improving the standards of quality of nursing education as exhibited by the well-known studies conducted during the 1920s and 1930s. Consequently, at least three important aspects emerged from this period which are relevant to this review: more patients were being cared for in hospitals, large numbers of nurses shifted from private home practice to institutional employment, and demands on students for service were lessened with somewhat more emphasis being placed on their learning.

However, the time and manner of nursing practice were guided largely by routines and policies established by persons other than nurses, particularly physicians and administrators. A small group of nurses was responsible for the administrative functions of nursing while the bulk of nursing care was given by a larger group of staff nurses with a role more technical than professional. The traditional role has been described as a "physician's handmaiden." The nurse gave unquestioned obedience to the physician and other persons in authority and was concerned with the apparent well-being of patients in all the units in the hospital.

When the United States entered World War II, it became apparent that there was not a sufficient number of graduate nurses to staff the expanded medical and hospital facilities. The armed forces adjusted to the situation by using nurses to plan, organize, and administer nursing services and to teach and supervise the persons who did most of the nursing. At the same time, in civilian hospitals, experiments were initiated to maximize the use of graduate nurses and introduce categories of assistant nursing personnel. Never again would only registered nurses give nursing care to patients.

However, it was hoped that conditions would return to what they were prior to the war. The nursing profession was reluctant to admit auxiliary workers to its ranks, but the socio-economic and medical developments forced the addition of workers to nursing staffs. They received little preparation except a short inservice training and were responsible for doing prescribed repetitive tasks under supervision. As nursing leaders came to realize that a category of intermediate personnel would be advantageous, the trained practical nurse made her appearance. Brown (1966) remarked, "Because the role of nursing had not been well defined, following the decline of private duty nursing and because thousands of graduate nurses had been prepared in weak hospital schools that could give them only narrow technical training, many viewed the introduction of aides and later of practical nurses as a threat to themselves [pp. 187-188]."

An official statement in 1947 by nursing leaders stated unequivocally that there were specific functions for assistant nursing personnel. However, in spite of this official statement, Brown (1948, p. 61) found in her travels around the country that individual nurses spoke disparagingly of the use of assistant personnel in caring for the sick and that there were two recurrent arguments which indicated sincere anxiety: in one instance, anxiety concerning patient care; in

the other, anxiety about the RN's own future.

Brown (1948) also stated, "We believe, furthermore, that in-service training rather than the operation of a school for the preparation of graduate nurses should progressively come to be the essential task of the majority of hospitals [p. 71]."

In 1948, Ginzberg, as Chairman of the Committee on the Function of Nursing, recommended that there be two categories of nursing personnel. He noted, "Our recommendation that only two categories of nursing personnel be eventually established does not involve too drastic a departure from the prevailing pattern. Many registered nurses have in the past received no better training than that which we recommend for the practical nurse of the future [p. 61]." Brown (1948), in her report *Nursing for the Future*, also made the same recommendation.

Ginzberg (1948, pp. 33, 35) reported the following figures for the number of nursing personnel in 1948: 280,500 active registered nurses, 167,400 in institutions, approximately 120,000 practical nurses and attendants in hospitals, of whom 10 percent or less had been trained in approximately fifty-eight approved schools. He also indicated that only 5 percent of the total number of graduate registered nurses were college graduates and that only two states had a mandatory licensing law for practical nurses, neither of which was currently operative.

It was visualized by both Brown (1948) and Ginzberg (1948) that the majority of registered nurses of the late 1940s were an intermediary between the true professional nurse and the trained practical nurse. Both envisioned the closing of the three-year diploma school and the education of nurses in the already existing educational institutions of the country, namely, the preparation of professional nurses in four-year colleges and universities and the preparation of the practical nurse in vocational or adult education units of the public school system. Brown (1948, p. 104) suggested that the period of training be one year and that there be a one-year practice under supervision but on full pay within a hospital or agency.

Both Ginzberg and Brown used similar definitions of professional nursing that were broad in scope and profound in nature, incorporating technical competence as only one component. The following comments regarding the abilities characteristic of the professional nurse are from Ginzberg's report (1948):

1. Observe and evaluate the manifestations of a person's health and the social and environmental factors which influence it.
2. Give complete and continuous nursing care, thereby reflecting an understanding of a person's total needs in relation to his health and to his environmental restrictions.
3. Assume responsibility for planning to meet the total nursing needs of a community.
4. Transmit to students preparing for the profession a sound body of nursing knowledge and skills through teaching and example.
5. Recognize health needs, initiate action and cooperate with others, such as the clergy, physicians and social workers, to bring about the most effective use of community resources to meet these needs.
6. Teach non-professional individuals and groups in the community such parts of her specialized knowledge as they may safely carry out for the conservation and restoration of health [p. 29].

Similarly, Brown (1948) reported the following definitional characteristics:

The professional nurse will be one who recognizes and understands the fundamental [health] needs of a person, sick or well, and who knows how these needs can best be met. She will possess a body of scientific nursing knowledge which is based upon and keeps pace with general scientific advancement, and she will be able to apply this knowledge in meeting the nursing needs of a person and a community. She must possess that kind of discriminative judgment which will enable her to recognize those activities which fall within the area of professional nursing and those activities which have been identified with the fields of other professional or non-professional groups.

She must be able to exert leadership in at least four different ways: (1) in making her unique contribution

to the preventive and remedial aspects of illness, (2) in improving those nursing skills already in existence and developing new nursing skills, (3) in teaching and supervising other nurses and auxiliary workers, and (4) in cooperating with other professions in planning for positive health on community, state, national and international levels [p. 73].

The trained practical nurse, as described by the Joint Committee on Auxiliary Nursing Service in Brown (1948), "is prepared to care for sub-acute, convalescent and chronic patients and to assist the registered professional nurse in the care of others. She works under the direction of a licensed physician and the supervision of the registered professional nurse. She may work in homes, hospitals, institutions, public health agencies, doctors' offices and in commercial and industrial firms [p. 69]."

The suggestion of placing nursing education programs in the main stream of education was sound and logical even though threatening and upsetting to nurses from that day to this.

Education in this country had a foremost place in the minds and hearts of Americans. As the country developed, always uppermost was the importance of schooling.

The battle for free public education, resulting in the establishment of the prevailing pattern of public high schools, is a tribute to the common man's belief in education. As America grew, hundreds of small, privately financed and controlled colleges demonstrated again the belief in the importance of education. For several years, private liberal arts colleges dominated the higher education scene. However, with the progression of time, publicly supported and controlled institutions of higher education began to appear.

The demand for higher education eventually became so great that, in the early twentieth century, a new institution developed in response to the need: the two-year, public junior college.

As the general principle of twelve years of free public education for our youth who could profit by it generally won public approval, further extension began to be advocated through the fourteenth year. The President's Commission on Higher Education, in 1948, recommended that "the time has come to make education through the fourteenth grade available in the same way that high school education is now available [p. 37]."

The passage of the G.I. Bill of 1944 gave the nation its first opportunity to observe closely the results of increased emphasis on higher education. As veterans realized that taking advantage of this opportunity could increase their earning power, social mobility, and personal satisfaction, other citizens also began to believe that they, too, should have the same opportunity. Furthermore, it was recognized that an almost unlimited number of highly educated individuals would be necessary if the United States was to sustain its scientific and technological superiority, its domestic economy, and its position in world leadership.

As the community colleges grew, certain concepts were advanced which provided the philosophical basis essential for the educational roles that the post-war period was to thrust upon these institutions. One idea was that these two-year colleges were to allow anyone to attend. They were not concerned only with the traditional first two years of college but also included technical education and community services to meet the needs of not only post-high-school youth but also those of adults.

The President's Commission on Higher Education, in 1948, gave some direction and description of a community college and others further defined the institution. Jesse Bogue (1950), long-time executive secretary of the American Association of Junior Colleges, in his book, *The Community College*, wrote in a summary paragraph an excellent description of the institution:

By examination of life situation, of identifiable problems that need solution on national, state and local levels, we arrive at conclusions regarding the basic functions of community colleges. They are guidance and counseling for all students and for the people of the community; general education for all students regardless of vocational objectives; technical and other vocational training, and that on a continuing basis, for students

who will not advance to upper division collegiate studies; the further democratization of higher education by surmounting barriers of geography and family financial difficulties; the popularization of higher education by breaking down family traditions and creating greater personal interest and motivation; adult education and university-parallel studies for those students who should continue formal education [p. 76].

The growth of community/junior colleges and the suggestion that nursing education be in the main stream of education gave impetus to Montag's innovative approach to the preparation of registered nurses, culminating in the development of associate degree nursing programs in the junior and community colleges of this country. Many of the ideas of twenty years ago used as a basis for her study continue to be true today and thus cause great confusion in functions and roles of nurses and allied health personnel. Times have changed and so should the education of nursing technicians. Montag defined technical training as one part of a three-part continuum, the other two being on-the-job training and professional education. Technical training was defined briefly as the intermediate functions requiring skill and some judgment. Brown (1948) also described nursing on a continuum.

Nursing functions at the left and right extremes of a horizontal line have been rather clearly delineated. It is recognized that certain functions at the left end of the line can be performed efficiently by nongraduate personnel; that other functions at the right end relating to complex clinical practice and the nursing specialties can be performed only by professional nurses. What is not yet known, as far as the writer can discover, is how far toward the middle of the line the two types of personnel can or should move. To what extent will the future practical nurse be able to carry a considerable burden for assisting under supervision with the care of the acutely ill? How far will the truly professional nurse be expected to engage in bedside care of illness which, although acute, may be relatively uncomplicated? [p. 107]

Montag discussed the factors which affected the needs of society for nursing services and, interestingly, they are not unlike the factors which affect nursing today. She mentioned that the changing emphasis in medical care—especially the development of preventive medicine—necessitated the need to prepare professional nurses for programs of preventive medicine. Assistance could be given by less highly skilled nurses, but mostly professional nurses were needed.

She also noted the advances in the field of science and the results of these advances. As physicians turned over responsibility for some activities which they had usually done, such as transfusions, the nurse must be prepared professionally for carrying on this work and "relieved of less demanding duties so that she is free to do those technics requiring a high degree of competence [Montag, 1951, p. 17]." She further notes: "The changes in the medical treatment have increased the responsibilities of the professional nurse and have opened the way for another group of nurses to carry on the more routine activities which are part of every patient's care. There is a need for more understanding of the relationship between the two groups, but there is considerable agreement that two groups are essential [p. 20]."

A third factor which Montag (1951, p. 23) discussed as having an impact on nursing service needs was the increase in life expectancy. With increased longevity, there is a concomitant increase in incidence of degenerative diseases commonly found among older people and an increase in deaths due to cancer and diseases of the heart and circulatory system. She pointed out that special functions associated with diagnoses and prevention would require the use of professional nurses, but that routine care of persons with degenerative diseases could be delegated to the less highly skilled nurse under the supervision and direction of the professional nurse.

This may have been a reasonable goal in 1950, but in 1972, when there are over 19,000 nursing homes with a potential occupancy of almost one million patients, such a dichotomy in function must be re-evaluated. Montag (1951, p. 27) saw the need for professional nurses in a

supervisory capacity because of the social, economic, and psychological implications of chronic illness. However, since the number of baccalaureate nurses continues to grow with agonizing slowness while the number with associate degree preparation is multiplying annually, all too often technically prepared nurses have assumed the responsibilities of supervision and direction as well as the routine tasks of nursing care.

Montag (1951, p. 31) also indicated three other factors which necessitated the addition of other nursing personnel, although she did not specify whether such workers should be at the technical or professional level. These factors included hospital and medical care insurance, health and welfare programs in industry, and the emphasis on mental health. She also discussed the development of industrial medicine as a new specialty area with the resulting need for nursing personnel to be prepared with parallel specific knowledge and skills.

Therefore, in a very real sense, twenty years ago Montag suggested both that there was a need for a new kind of nurse prepared in educational institutions for technical level functions and that specialty areas were developing which might be staffed by technical nurses. It should be noted that, in actuality—twenty years later—of the 20,000 nurses employed in industrial health, fully 92 percent were prepared in technical nursing programs, the majority of them in diploma programs (*Facts* 1970, p. 12).

In all of these areas, Montag discussed the complexities of care and the need for personnel to be involved in the prevention of illness and the teaching of patients. She concluded her overview with the statement:

That a large group of nurses with professional preparation will be needed is obvious. Because of the nature of the demands made on them, their preparation must be more comprehensive than it has ever been. To use this group both efficiently and economically, it must be relieved of all activities which can be carried on effectively, with supervision, by nurses with technical preparation or non-nursing personnel. Thus, each worker involved should be able to work at the top level of her capacity most of the time. In no other way can the worker be an efficient and satisfied person [Montag, 1951, p. 37].

Montag's creative development of the associate degree nursing program was a major step forward in breaking the lock-step traditions of nursing education and in meeting the health needs of the population. She realized that much of nursing involved specific routine tasks and could be capably executed by technical rather than professional nurses. In reference to their education she stated: "This implies a different preparation for the worker with technical functions than the worker with professional functions. A less broad and more specific preparation is needed by the person who is to carry on the more technical functions associated with nursing [p. 78]."

In these foregoing statements, it becomes quite clear that as Montag and others were forging the structure for a new and strikingly different approach to nursing education, they also were suggesting some perhaps unrecognized embryonic aspects of yet another potential innovation to be developed nearly twenty years later. This later innovation, emphasizing Montag's ideas of more specific, less broad technical preparation to facilitate both improved patient care and worker satisfaction, is the focus of this current investigation.

In her early report (1951), Montag defined the specific functions of the associate degree nurse as: "1) to assist in the planning of nursing care for patients, 2) to give general nursing care with supervision, and 3) to assist in the evaluation of the nursing care given [p. 70]." Montag (1951) believed "that the nurse with professional preparation would be able to do all that the nurse with technical preparation does. In addition, she would be able to do those complex activities which are beyond the scope of others concerned with nursing care [p. 71]."

Central to the development of this new approach to nursing was the concept that technical and professional nurses were to work together in a complementary patient-centered practice, predicated upon the notion that for each group of technical nurses there would be a professional nurse. The baccalaureate nurse would perform those functions beyond the realm of technical

practice, namely, teaching, counseling, and managing, while the technical nurse would perform those repetitive technical tasks which do not require professional judgment. The functions of teaching, counseling, and managing were clearly perceived as belonging to the domain of professional practice (Montag, 1951, 1963).

There seemed to be real concern with differentiating this new nurse technician and her preparation both from registered nurses prepared in other programs and the licensed practical nurse. In fact, Montag (1951) overtly cautioned that "the nursing technician should not be confused with the practical nurse for the two are not the same. This term, nursing technician, is not being used as a substitute for the term, practical nurse [p. 72]."

The practical nurse at this time was seen as capable of performing nursing care functions at a level only slightly higher than that of the uneducated aide. It is also possible that leaders during the later 1940s and the 1950s expected practical nurses and practical nursing educational programs to disappear and be replaced by the two categories of registered nurses.

But, as a matter of history, that did not happen. Practical nurse programs have had an unprecedented growth. By 1970, LPNs comprised some 46 percent of all graduates from programs preparing nurses for licensure or registration. The remaining 54 percent comprised graduates from all three types of programs preparing registered nurses. In raw numbers, there were 1,253 LPN programs which graduated 37,128 students in 1970. In the same year, 1,355 programs existed for the preparation of registered nurses which graduated some 43,639 students (Educational Preparation, 1971).

It seems clear that nurse manpower evaluation and planning of that day were not always viewed in the main stream of socio-economic forces and changes. In fact, Levine (1969, p. 292), who has had continued and intimate contact with nursing and health care over the years, noted that planning studies done in the early 1950s seemed rather detached and unrealistic and little cognizance was taken of the impact of social and economic forces.

Moreover, in 1961 Ewald B. Nyquist, in a speech delivered to directors and faculty members of nurse-preparing programs in New York, remarked, "It will be my thesis that this is a decade of decision for the nursing profession; that nursing and nursing education stand on a threshold of danger and that the present danger is, in part, the result of professional conservatism, indecision and disunity; widespread misunderstanding of the development of nursing as a profession and general abysmal ignorance of the economics of health care [p. 4]." It seems clear that this particular statement could be made about the 1970s. Clearly, hindsight provides a different perspective than standing on the brink of a developing innovation, and review of data available to nurse leaders in the 1950s might easily be interpreted differently today.

At the time of Montag's study in the early 1950s, it was necessary that registered nurses prepared in the associate degree program be able to do all that nurses prepared in diploma programs were able to do; only in this way would the product be acceptable to the world of nursing. However, it is interesting to note that in her writing there are several allusions to specific preparation. Perhaps there would be less confusion if the interpretation of "less broad and more specific preparation" had been more clearly defined. Would there be less confusion if technical nurses were indeed specialists in some area of nursing rather than generalists in all areas of nursing?

In a recent article, Geitgey (1972) points out:

There is general agreement about the competencies which can be expected realistically by employers of associate degree graduates. The major issue on which there is disagreement is that of leadership skills, an expectation of employers but not of nurse educators. Another issue, less well-defined, is that of the skill of the associate degree graduate in drawing inferences and using them in problem-solving in nursing situations. A third point of difference is in the area of referral of patients to appropriate social or helping agencies [p. 89].

Montag (1951) also proposed:

There should be one license for nurses—one which sets the minimum which is required for the safety of the public. The nursing profession should support a comprehensive accrediting program for all schools of nursing, carry on a positive program of information so the public may be informed and work for an inclusive, mandatory licensing program. The confusion which now exists both in the minds of nurses and the public would be eliminated if single licensing laws were in effect [p. 82].

The implementation of one licensure helped to maintain the stereotype of one nurse able to do all things and work in all areas. The idea of one license helped the associate degree program gain acceptance. Although, in her original writing, Montag suggested a less broad scope, in actuality she suggested that nurses continue to be prepared with broad scope and little specialty of content. There were other assumptions upon which Montag built her concept of technical nursing which have tended to bring about the confusion which exists in nursing today. There has not been the growth of baccalaureate education for nursing which was expected, so professional nurses were not available to carry on the functions which were to be theirs, namely, teaching, counseling, long-range planning, and management. Therefore, either these activities were to be left undone or carried on by an under-prepared nursing technician. If inservice education had been more adequately developed and used (another suggestion by Montag), perhaps the technical components of these activities could have been taught to the nursing technician.

It is fairly obvious that nursing leaders never expected practical nursing programs to blossom and grow to reach the tremendous proportions of today. The improvement in the curriculums of these programs also tends to confuse the occupation of nursing and the public and the differences between the nursing technician and practical nurse are not easily distinguished when it comes to patient care.

Following the publication of Montag's (1951) book, *The Education of Nursing Technicians*, the Division of Nursing Education of Teachers College, Columbia University, initiated and sponsored the Cooperative Research Project in Junior and Community College Education for Nursing under the direction of Dr. Mildred Montag. The project, beginning in 1952, extended through five years and enrolled the cooperation of seven junior and community colleges and one hospital school located throughout the United States.

Considerable skepticism and hostility were expressed by nurses and others about the practicability and wisdom of such a program which so markedly deviated from the familiar pattern of nursing education. If this project was successful, would it toll the death knell for the traditional three-year basic school? Many were afraid of such a consequence. McManus remarked in the Foreword to the final report on the project in *Community College Education for Nursing* (Montag, 1959):

At the time the program was launched, there was even less acceptance than there is today of the idea that education for nursing should be geared into the nation's system of higher education as recommended by Esther Lucile Brown in 1948. Few nurse educators sensed in 1952 that the junior and community college movement rapidly being extended across the country would attract an increasing proportion of youth, including many needed in nursing who would be lost to this field unless nursing programs became an integral part of the junior college curricula [p. vii].

McManus also says:

Even the concern about the impact of the experiment upon the nursing profession—the inevitable questions as to the relative professional status of RN's with different types of preparation—is being eased by a relentless march of events. The National League for Nursing has recognized that 67 percent of the positions for registered nurses in this country are in situations—the hospital, the doctor's office—where supervision or direction is available and expected. These, by definition, are technical positions. Perhaps, more than any one other factor, this recognition has paved the way for the acceptance of the new, two-year technical program

that has been shown to qualify nurses for technical positions [p. ix].

Two-thirds of the positions held by registered nurses in 1956 could have been defined as technical. At the same time, 20 percent were categorized as head nurses, public health nurses, and industrial nurses, functioning with greater independence and also responsible for the work of others. An additional 13 percent were in leadership positions as supervisors and administrators and as faculty in schools of nursing (*Nurses*, 1957, p. 21). Of this 33 percent who were assuming leadership roles, approximately 9 percent were prepared with a baccalaureate or higher degree (*Facts*, 1970, p. 10). This confusion continues today as technically prepared nurses function in positions requiring a greater independence and responsibility for the work of others because only 13 percent of RNs are prepared with baccalaureate or higher degrees (*Facts*, 1970, p. 10).

Although there was an attempt at the clarification of differences in purpose and nature of professional and technical education during the five years on the project, there still remains some confusion regarding these categories.

Not only does confusion exist between the technical and professional nature of nursing, but also between technical and vocational. Hospitals have become one of this country's large industries. The rapid increase in population (particularly of those at both ends of the age ladder), broad expansion of prepaid hospital plans, marked advances in diagnosis, treatment, and rehabilitation, and the use of machines of vast complexity have resulted in the necessity to treat patients in hospitals.

As these changes were taking place, the role of the graduate nurse was also being transformed. Brown (1966) notes, "Thus it appears that the role of those graduate nurses who are employed in general hospitals is fast becoming that of technical specialist, supervisor-administrator or teacher, while the practical nurse more nearly assumes the role she [registered nurse] formerly occupied [p. 189]."

Brown (1966) observed that nursing is task-oriented rather than patient-oriented and that nurses are dissatisfied with their jobs as they have only a small amount of patient contact. Again, looming in the background is the image of the private duty nurse. Also, some conflict may arise from the fact that practical nurses and aides spend more time with the patient than does the graduate nurse.

Brown (1966) commented on two types of studies done in the late 1950s and early 1960s. One type observed how nurses actually spend their work hours and the other focused on controlled experiments which insured time for nurses to be with patients.

The results of these investigations were indeed disillusioning to persons who had expected that the nurse, if given the opportunity, would engage in such undertakings as permitting the patient to talk about himself and his problems; attempting to assure him of her concern for his welfare, enlarging the rehabilitative aspects of his care, encouraging him as he progressed physically to regain psychological independence and advising him or his family about his convalescence at home, methods of self-help and what community resources were available [pp. 191-192].

In retrospect, the results of these experiments would not be unexpected. Very few professional nurses were available in hospitals and, at the time of these studies in the late 1950s, most had had only technical education. The majority of nurses were technically prepared and the undertakings mentioned above would not have been within their educational programs.

Even today, studies show that only about 50 to 75 percent of the skills of registered nurses are available for patient care services. One of the long-range consequences mentioned in the Report of SUM (1971) is related to the need for registered nurses:

In the absence of a new viable nursing model and enhanced professional performance of the RN under SUM, an issue that may arise is whether the RN, as we know her, is any longer needed. There appears to be the

feeling in the nursing service that she has a role to play but it is not clear exactly what it is. The problem is that much of what the RN at one time did has been delegated to the LPN and nurses' aide. With unit management assuming responsibility for the clerical and coordinating functions, it is not clear what is left of the RN's old duties other than supervisor or taking over some of the LPN level activities. Hospitals with RN shortages are using upgraded LPNs frequently to replace the RN. The general idea is that it may be possible to reconceptualize all present nursing activities into sets which can be carried out by specially trained technicians. One hospital in our study, for example, has tried this with medication technicians passing all medications and handling medication records. This appears to have worked out quite well. Possibly the new role for registered nurses will be one of more clinical responsibility [p. 77].

Assuming the responsibility for greater clinical expertise would necessitate a change in the basic nursing program and an appreciable increase in the number and kind of continuing education programs, many of which could be offered by community colleges. The utilization of unit managers to assume non-nursing functions is indeed admirable, but nurses are reluctant to give up these functions, fearing a loss of status and prestige. One might wonder if they were prepared with technical competence in specialized areas whether or not they would find greater acceptance in returning to the actual care of patients.

The compilation of studies in *Twenty Thousand Nurses Tell Their Story* (Hughes, 1958) shows that registered nurses have been moving further and further away from the patient for some time. General findings of the studies reported in Hughes (1958, p. 131) showed that bedside care is no longer the principal occupation of the registered nurse—the higher she rises in the hierarchy the less she sees of the patient, the bedside care of the patient being largely in the hands of auxiliary nurses, the nurses' aide providing a greater proportion of direct patient care than the LPN.

Hughes (1958, pp. 125, 82) also reported that hospital nursing is very unstandardized and that what a nurse does seems to depend on where she is. He also remarked that nurses in large hospitals are, first, administrators and teachers—directing a team of student nurses, PNs, and aides. That portion of the work which is primarily nursing has become specialized. Therefore, the general duty nurse is rapidly becoming a specialist.

Additional findings in these studies showed that the nurses who educate nurses cherish the most consistent opinions as to who does and who should perform given tasks. "In the manner of teachers, they are dogmatic. Removed to some degree from reality, they may preach an idealized version of hospital work [p. 144]."

Hughes (1958) reported incident after incident, in hospital after hospital, in which the registered nurse has become secretary, organizer, supervisor, and administrator while the nurse aide and practical nurse have taken over the bedside responsibilities which the registered nurse no longer has time to do. One wonders if it is possible to return the registered nurse to the bedside, that is, to return the primary caring, teaching, and counseling function to the nurse with adequate educational preparation to assess both physical and psychosocial needs of patients and to initiate care to meet those needs.

In spite of increased efforts over the years, there has not been the desired and necessary increase in numbers of baccalaureate graduates. However, knowledge related to health, medical, and nursing care has continued to increase at an alarming rate. The needs of society are changing and becoming more visible, but at the same time, the public is more aware of its right to have these needs met in ways which insure quality and dignity for both the consumer and the producer of services.

One way in which some of the growing health needs of the public may be met, while insuring improved quality and more satisfying work articulation for nurses, is through the introduction of technical nurse specialists prepared at the associate degree level. While specialization is already an actuality at higher levels of learning and across the entire spectrum in other disciplines, some nursing leaders are suggesting that specialization at the technical, or associate degree, level should be explored.

In 1969, Zschoche wrote: "It is becoming increasingly apparent that the hospital of the not too distant future may be an enormous complex, housing only patients requiring highly specialized medical and nursing care [p. 2370]."

Lambertsen (1969) has actively proposed the specialization concept in nursing for some time.

The phenomenon of specialization is shaping, and will continue to shape, the nature of the services of nurses. I predict that in the not too distant future nursing technicians (highly specialized) will increasingly be prepared in junior college programs as practitioners capable of assuming primary responsibility for nursing services for individuals or groups of individuals within circumscribed and persistent areas of nursing practice. We cannot perpetuate the myth that anyone admitted to, and graduated from, any educational program in nursing can practice effectively as a generalist. For, to be a generalist in today or tomorrow's complex health care system requires a scientific base and development of a mode of inquiry that transcends our current concepts of nursing practice. Is our current concept of the clinical specialist already obsolete? I postulate that it is, for, the role is too narrowly defined by many proponents [p. 10].

Crawford (1972) visualized, in a reorganization of nursing service in her institute, that special care units such as intensive care units, recovery rooms, operating rooms, delivery rooms, emergency wards, etc., will be staffed by technical nurses. She envisions the patient care units staffed primarily with practical nurses.

Edith Olson (1968) queried, "Should the technical nurse be prepared as a generalist in junior college programs or would it be more appropriate to prepare a highly specialized technical nurse for practice in a specialized environment, an increasing variety of which will be in the health agencies of the future [p. 1494]."

DeChow (1972), in a speech at the most recent meeting of the Council of Associate Degree Programs, makes a plea that the competencies of nurses be appraised continually and that there be a constant monitoring of the nursing field by both educators and service personnel so that curriculums and inservice programs can be up-to-date. She took a bold step when she said:

Thus, I am proposing that a future oriented associate degree program must change its curriculum pattern in order to prepare students to function in a variety of settings with beginning competence in the skills peculiar to these settings. I think it is time to move away from the concept that this program prepares a generalist. I think we should prepare students with a broad core of nursing experiences which will allow for mobility within the field and successful completion of state board exams. I am envisioning in our program this might encompass three semesters and a summer session. This would leave one semester for concentration or focus so that individuals might develop beginning competency in the more sophisticated skills that are peculiar to particular areas of practice. I believe these areas of concentration should be described according to the needs of the health care system as it is changing and growing [p. 7].

These writers do, indeed, give us food for thought. But a look at the actual numbers of various nursing personnel at work in the hospitals and nursing homes will clearly indicate that some changes must be made. These figures show vividly how few nurses are prepared and available to assume those functions normally thought of as professional and the tremendous preponderance of auxiliary personnel caring for patients in the two and a half million hospital and nursing care beds in this country.

For example, in 1970, there were in the United States 7,123 hospitals with approximately 1,650,000 beds. In 1968, about two-thirds of the employed registered nurses (totalling 411,664 full- and part-time) worked in hospitals (*Facts*, 1970, p. 24). Of this number, nearly 10 percent, or 40,000, held baccalaureate or higher degrees (*Facts*, 1970, p. 12). This indicates an average of five nurses with an education credential at the baccalaureate level or above per hospital. But, generally, nurses with baccalaureate degrees tend to congregate in medical centers and teaching

hospitals, further reducing their number in other hospitals. The number of licensed practical nurses employed in nursing service positions in hospitals in 1968 was 177,903 (*Facts*, 1970, p. 181), while the number of aides, orderlies, and attendants in nursing service was 496,895 (*Facts*, 1970, p. 187). This makes an average of 26.8 staff nurses and 59.6 allied nursing personnel per 100 patients in general and other special hospitals.

The National Center for Health Statistics estimated, in 1969, that there were 19,646 nursing homes with 994,211 beds, three-fourths of which were devoted to patients requiring some kind of nursing care (*Facts*, 1970, p. 219). Working in nursing homes in 1968 were approximately 41,000 registered nurses (*Facts*, 1970, p. 31), 10 percent (or 4,000) of whom had baccalaureate or higher degrees (*Facts*, 1970, p. 12). This indicates an average of one nurse with a baccalaureate or higher degree per three and one-half nursing homes. The number of practical nurses employed in nursing homes in 1968 was approximately 46,000 (*Facts*, 1970, p. 184), and the number of aides, orderlies, and attendants in 1968 was approximately 232,000 (*Facts*, 1970, p. 189).

In 1966, only 14 percent of all employed nurses held a baccalaureate or higher degree (*Facts*, 1970, p. 8). Over the ten-year span 1960 to 1970, there has been an estimated average annual increase of approximately 0.3 percent, or 5,250 nurses with baccalaureate and higher degrees (*Facts*, 1970, p. 10).

However, contrary to the philosophy of complementary technical-professional nursing practice proposed by Montag and others in the 1950s, these figures conclusively demonstrate the nature of existing nurse manpower deficits and the shortcomings of that philosophy. The figures suggest that not now nor in the foreseeable future will sufficient numbers of baccalaureate nurses be prepared and strategically placed to perform the entire range of teaching (both of patients and staff), long-range planning, and counseling of patients, and the managing of the patient care units in the multiplicity of settings in which they are required. However, perhaps there are *technical components* of these functions which could be taught to nursing students and/or graduates at the technical level, to relieve this strain.

In discussing educational problems facing nursing, Ginzberg (1967) pointed out an area with which professional nursing groups have been struggling for a long time.

[It is] the lack of a real resolution of the relationship between a variegated educational structure and a variegated utilization pattern. I refer to the relationships between educating students for a baccalaureate degree, for a diploma in three years, for an associate degree in two years, training in a practical nurses' school for one year and nurses' aides for three months, and the actual staffing patterns of nursing in and out of hospitals. This relationship has not been clarified and, I believe, never will be.

As a consequence, in part, of the preceding point, uncertainty and confusion continue to prevail in the relationships among the groups within the field of nursing services. There is pulling and hauling and tugging and shoving among these groups—an inevitable consequence of present realities [p. 27].

It has become clearer, with the passage of time, that another arrangement in nursing education probably should be designed if the nursing needs of hospitalized patients are to be met. It has been suggested that nursing care be conceptualized as on a continuum, with technical workers at one end, professional workers at the other, and areas of overlapping or role mix between them.

However, both the verbal and written deliberations of some leaders, both nurses and non-nurses, have suggested a conceptual divergence from the existing model in which the technical level nurse performs only those functions which previously have been considered technical while omitting those functions characterized as professional. The conceptual model which is suggested, both by this author and others (DeChow, 1972; Lambertson, 1969, 1970; Olson, 1969) as an alternative, especially for certain situations in which the baccalaureate nurse is absent and/or is not likely to be employed in sufficient numbers, envisions a redistribution of the range of nursing functions.

This proposed model contains two primary aspects which are distinctive. One is that the

technical level nurse be prepared at the beginning level to perform within a narrower range of patient care situations, that is, to concentrate her learning on a particular area instead of the current practice of scattering learning experiences over the five major patient care/institutional areas. The second aspect suggests that the technical level nurse be prepared at the beginning level to administer the full range of care required by patients and by the situation, within the limits of the area of her specialized learning. This would imply that technical nurses would perform teaching, counseling, and managing functions in the absence of professional (baccalaureate) nurses, or in other specified situations.

Stated more succinctly, this means that technical nurses would be prepared for a narrower scope of practice in order to learn the range of skills necessary for competent patient care and satisfaction in occupational performance. Thus, preparation of technical nurse specialists in selected community colleges at the associate degree level is suggested as an alternative model for meeting the needs of patients and institutions which care for them.

Nursing practice continues to become more and more complex. Scientific discoveries, technological innovations, and the development of new treatments have produced marked changes in health practices. National nursing studies, goals, and position papers have urged nurses to reexamine nursing practice and education and consider which aspects of the present system should be maintained and which aspects need to be changed. The ANA (1965) Position Paper and the Lysaught Report (1970) both stated that the education for those who work in nursing should take place in institutions of learning within the general system of education. The Position Paper further described, if somewhat vaguely, professional, technical, and vocational education, clearly suggesting the progressive demise of diploma and practical nursing programs. Of course, these three levels with differentiated functions would partially clear the muddled waters. But, the economics of health care and the desire for a credential after the shortest period of education has perpetuated the continued growth of practical nurse programs.

Kuhli (1970), as a participant in a clinic on technical education, makes some remarks which most nurses would find difficult to accept: "There is really no point to over-education; allied health exists because patients need many services which do not require the ten years of education it takes to prepare physicians. From a purely economic standpoint, we need the *least* trained person who can perform a particular function properly [p. 24]."

Even aides are being prepared as specialists in some places. More studies need to be done to determine the proficiencies and abilities of various types of nursing personnel to do the job safely, economically, and with satisfaction for the patient.

Specialization in medical practice is a post-World War II occurrence; as recently as 1940, 80 percent of physicians had not specialized. However, today nearly nine out of ten graduates of the nation's medical schools enter specialty training. Certainly this increase in specialization of physicians has implications for nursing education and practice.

Also, the concentration of health manpower in hospitals or institutions has reached major proportions in the post-World War II period. Hospitals are increasing the numbers of personnel in occupational categories other than nursing. The *Health Careers Guidebook* (1965) lists approximately two hundred careers in the health area. Kissick (1966, p. 7) remarks that, in the decade ending in 1960, there was a 42 percent increase of workers in the health occupations in contrast to a population growth of 19 percent. Interestingly, the rate of increase was greatest in those categories having the shortest periods of training (practical nurses, X-ray technicians, and hospital attendants).

The proportion of health workers with functions overlapping those of nurses further tends to confuse the picture. As an example, today, in many community colleges, mental health technicians are educated to care for patients in psychiatric hospitals. As the main emphasis in nursing programs has been in medical-surgical nursing and as programs of nursing were phased out of mental hospitals, a desperate need for "caring" personnel arose and, consequently, the preparation of a new worker doing the job which could have been done by a nurse with specialty

preparation. Perhaps there will be further splintering of the nursing role if curriculums within associate degree programs do not change to meet the demands of specialized patient care.

Moreover, as the problems of today are studied in the context of historical decisions and events in the search for solutions, it becomes somewhat clearer to some leaders that in addition to the giant step of dichotomizing technical and professional nursing preparation, patient care specialization also might have been introduced at the same time.

While definitions of practice functions and their boundaries have been a perpetual problem, most recently the Lysaught Report (1970, p. 92) has described progressive levels of nursing specialization: the staff nurse entry level, the clinical nurse level, and the master clinician level. These terms are explicitly defined in the Glossary of the Report (pp. 165-166). Although these terms and their definitions have not been unanimously accepted, it is suggested that the technical nurse specialist could perform many of the functions delegated to these categories. For instance, in some cases this would mean the technical specialist would work closely as a teammate with the master clinician, while in other settings she might work somewhat more independently where no master clinicians or baccalaureate nurses are employed. Just as the profession has been struggling to clarify these levels of practice and specialization, the term "technical nurse specialist" also will have to be more clearly defined over time through careful study and experience in various suggested settings.

In a recent article which reported the essence of a five-year curriculum study project at Loma Linda University, Longway (1972) reviewed the organization of nursing content in educational programs and changes made over the past. She indicated that an option other than rearrangement of content could have been used. In fact, she states: "Specialization in nursing preparation would have ameliorated the crisis, but nursing was not ready for the move. Such a change would do away with the tenet dear to the hearts of nurses and employers that 'a nurse is a nurse is a nurse'—an interchangeable part within the health care system [pp. 119-120]." She also notes that the drastic change in philosophy required by early specialization was too radical a departure from the traditional to deserve serious consideration at that time. Perhaps the time has now come for such serious consideration.

The research data presented in the next chapter give further impetus to the concept of specialization at the technical level.

Chapter 4

THE RESEARCH DATA: ANALYSIS AND DISCUSSION

A total of forty-three hospitals located in the New York metropolitan area was included in the proposed sample for this study; thirty-seven (86%) of these are actually represented in the study sample (see Appendix D). Of the questionnaires mailed to the directors of nursing, approximately 239 were distributed to nursing supervisory personnel representing the areas requested. Of this number, 191 questionnaires (80%) were completed and returned.

The demographic data and the data related to the perception of the respondents regarding the items in the questionnaire were analyzed separately. The demographic data were analyzed to describe the characteristics of the nursing service personnel and were used in cross-tabulation with selected items of the remaining questionnaires.

THE RESPONDENTS

The respondents in this study were directors of nursing service and/or their assistants, and nursing administrative personnel representing the major organizational divisions in their hospitals.

Profile of Nursing Administrative Personnel

Position. Twenty-four (13%) of the respondents were directors of nursing service and twenty-nine (15%) were associate or assistant directors of nursing service, making a total of 28 percent in top and assistant administrative positions. The largest segment of respondents (118, 62%) were nursing supervisors. The twenty (10%) remaining individuals represented such areas as clinical specialists and coordinators and inservice supervisors. Since the number in this last category is quite small, these twenty individuals were grouped together and classified as "other" throughout the report.

Year basic nursing education completed. The greatest preponderance of the respondents (37%) completed their basic nursing education between 1951 and 1960. The remainder of the respondents finished as follows: 1930 to 1940, twenty-four (12%); 1941-1950, sixty-one (32%); and 1961 to 1970, twenty-eight (15%). Seven (4%) of the respondents finished prior to 1930 or did not respond to the question. The majority (81%) graduated from the basic nursing education program prior to 1960. As it takes time to rise in the bureaucratic hierarchy, it was expected that the majority of the respondents would have graduated from a basic nursing program more than ten years ago.

Type of basic nursing education. The majority of respondents, 149 (78%), graduated from a diploma educational program. Graduates of generic baccalaureate programs represented 17 percent of the sample. A comparison of these data with national figures for the years 1955 to

1960 indicates that the number of generic baccalaureate graduates in this sample were approximately 4 to 7 percent higher than the national average, while graduates from diploma programs were 5 to 10 percent lower than the national average (*Facts*, 1968, p. 88). The availability of baccalaureate programs in the New York metropolitan area and the migration of graduates from generic baccalaureate nursing programs may account for the difference between findings from this study and national data. The remaining five of the respondents were graduates of associate degree programs (1%), approximately the same number as nationally on an average for years 1955 to 1960 and master's programs (4%). No statistics are available nationally for an initial program leading to a master's degree.

Length of time in this or a similar position. The greatest number of respondents, 188 (62%), had been in this or a similar position for five years or less. This figure tends to reflect the mobility of our society and, particularly, the mobility of nurses.

Table 1 indicates that, among nurses whose highest credential is the baccalaureate degree, more have held their current position for a shorter rather than longer period of time. The opposite trend seems true for those with diploma and master's degrees; more nurses in these two groups have held their current position for more than five years.

TABLE 1
Highest Credential Held By Position, Time in Position, and Basic Education

Highest Credential	Position								Years in Position				Basic Education					
	Total		Dir/Asst		Sup		Other		Less than 5		More than 5		Diploma		B.S.		M.S.	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Diploma ¹	50	27	4	8	42	36	4	20	27	23	23	32	50	33				
Baccalaureate	59	30	11	21	42	36	6	30	43	36	16	22	39	25	20	62		
Master's ²	82	43	38	71	34	28	10	50	48	41	34	46	62	42	12	38	8	100
Total	191	100	53	100	118	100	20	100	118	100	73	100	151	100	32	100	8	100

¹ Two associate degree graduates merged with diploma

² Two doctorate holders merged with master's

Highest credential held. In comparing this study sample with the latest national figures available for hospital nurses, they appear to be considerably better educated (ANA[b], 1969, p. 42). In 1966, nationally, 61 percent of directors and assistants held no degree, 21 percent had obtained baccalaureate, and 15 percent held master's or doctoral degrees. Proportions are quite reversed for directors and assistants in this study; 8 percent held a diploma or associate degree, 21 percent held a basic degree (which is identical with national figures), but 71 percent held master's or doctoral degrees.

The supervisors in this study also are considerably more educated than reflected in national figures. In 1966, only 2 percent of hospital supervisors held master's degrees while 28 percent in this current study hold master's degrees. Thirty-six percent in this study, compared with 22 percent nationally, hold baccalaureate degrees. The overwhelming majority of supervisors across the nation hold less than a baccalaureate degree, compared with only about one-third of this study sample.

In general, while the great majority of hospital registered nurses in administrative and supervisory positions across the nation have diploma preparation, approximately three-fourths of

this study sample hold baccalaureate (31%) or master's (43%) degrees. The discrepancy between dates of collection is acknowledged. However, other factors are also suggested for this above-average level of preparation. For example, it may be attributed to the availability of educational opportunities in the New York metropolitan area and to the mobility of nurses to such an area. However, for a variety of social, cultural, and occupational reasons (since education is an important variable which influences attitudes and other responses) awareness of the level of educational preparation of this study group should be kept in mind throughout the study report.

TECHNICAL AND/OR PROFESSIONAL NATURE OF GENERAL STAFF NURSES IN HOSPITALS

Table 2 gives a frequency distribution of technical/professional nature of general staff nurses graduated from three types of programs as perceived by the respondents. Associate degree graduates were considered to be technical workers by more than half of the respondents, while baccalaureate graduates were perceived as professional workers by 77 percent of the subjects. The greatest proportion of respondents (47%) also felt that the diploma graduate qualified as a professional worker.

Therefore, while there was little doubt that baccalaureate graduates were perceived as professional nurses, there was considerable uncertainty about the level of function for associate degree or diploma graduates. While a slight majority perceived associate degree nurses as technical, nearly one-fourth were unable to decide. Diploma nurses were perceived as professional by more than twice as many subjects as associate degree nurses. However, 37 percent perceived diploma graduates as technical and 16 percent were unsure of their opinion.

TABLE 2
Perceived Technical/Professional Nature of Nursing
By Type of Basic Educational Nursing Program

Perceived Function	Type of Program					
	Associate Degree		Diploma		Baccalaureate	
	No.	%	No.	%	No.	%
Technical	108	57	70	37	7	4
Professional	38	20	90	47	147	77
Not sure or no answer	45	23	31	16	37	19
Total	191	100	191	100	191	100

Table 2 illustrates the confusion which exists about the functions of associate degree and diploma graduates among those in administrative and management positions. Although many years have elapsed since the Brown (1948) and Ginzberg (1948) reports, the reporting of Montag's cooperative research project (1959), and the ANA Position Paper on nursing education (1965), many nurses in key administrative positions still believe diploma graduates are professional workers and a startling number (20%) believe associate degree graduates are professional nurses.

As suggested above, level of education is an influential variable which is illustrated in the analysis of technical/professional nature of associate degree and diploma graduates

TABLE 3
Perceived Technical/Professional Nature of Associate Degree
Graduates by Highest Credential Held¹

Perceived Function	Highest Credential Held							
	Total		Diploma		Baccalaureate		Master's	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Technical	108	56	22	44	40	68	46	56
Professional	38	20	21	42	5	8	12	15
Not sure	45	24	7	14	14	24	24	29
Total	191	100	50	100	59	100	82	100

¹ $\chi^2 = 23.07$; $df = 4$; $p < .001$

TABLE 4
Perceived Technical/Professional Nature of Diploma Graduates
By Highest Credential Held¹

Perceived Function	Highest Credential Held							
	Total		Diploma		Baccalaureate		Master's	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Technical	70	37	7	14	27	46	36	44
Professional	90	47	36	72	24	41	30	37
Not sure	31	16	7	14	8	13	16	19
Total	191	100	50	100	59	100	82	100

¹ $\chi^2 = 19.48$; $df = 4$; $p < .001$

by highest credential held. The level of significance reached the .001 level. As might be logically anticipated, the perceived function of others is at least in part a function of the level of education achieved. In this case, a greater number of those holding the diploma as the highest credential perceived associate degree and diploma graduates as professional and, conversely, those with bachelor's or master's degrees were more nearly in agreement that graduates of those two types of programs were technical workers. The cross-tabulation found in Tables 3 and 4 also indicates that, as education increased, the respondents became less sure about the technical/professional nature of the graduates of associate degree and diploma programs.

Regardless of type of activities performed, diploma nurses traditionally have been designated as professional, a practice which markedly accelerated following the introduction of other levels of nursing personnel in the 1940s. To regard any nurse as "technical" who legitimately uses the "RN" following her name is perceived as degrading by many nurses. However, it is more natural to attribute technical status to associate degree RNs since that educational program is still relatively new in the nursing context and was introduced with a technical nurse label attached. Furthermore, since associate degree graduates are regarded by many hospital and nursing administrators as having less occupational status than diploma nurses, it is easier to label them as technical workers.

Harris (1963), in the following remarks, explains why the area of title is so highly charged:

"Words and phrases mean different things to different people. Many an educational routine has foundered on the rocks of semantics. Words have an unusually high emotional threshold when they are used to define jobs, for a man's job is more than his livelihood—it is, in a very real sense, his personal status symbol [p. 97]."

There were differences of opinion regarding both the *actual* functioning of associate degree and baccalaureate graduates as general staff nurses and how the respondents believed these two kinds of graduates *should* function in general staff positions.

Frequency distributions presented in Table 5 show the similarity and differences of actual and expected functioning of baccalaureate and associate degree graduates as general staff nurses.

TABLE 5
Comparison of Actual and Expected Functioning of Baccalaureate
and Associate Degree Nurses as General Staff Nurses As
Perceived by Respondents

Response	Do Function the Same		Should Function the Same	
	No.	%	No.	%
Yes	70	37	87	46
No	106	55	76	40
Not sure or no answer	15	8	28	14
Total	191	100	191	100

Fifty-five percent felt that the graduates from these two programs function differently, whereas seventy (37%) believed they function the same. In response to the question of whether or not they *should* function the same, a noticeable shift in percentage occurs: seventy-six (40%) report "No," while eighty-seven (46%) of the respondents believed baccalaureate and associate degree graduates working as general staff nurses *should* carry out the same functions. Among this group, analysis indicated that the largest percentage held the diploma as the highest credential, significant at the .05 level.

These findings are confusing. Table 2 illustrates that baccalaureate graduates are perceived as professional workers by 77 percent and associate degree graduates as technical by 57 percent of the sample. However, Table 5 indicates that 37 percent of the subjects perceive associate degree and baccalaureate nurses actually doing the same functions and an even greater percentage (46%) believe they *should* function the same. And, to add to the confusion, 14 percent are not sure if nurses with these two different levels of preparation should function the same.

These findings seem to indicate that nursing administrators and supervisors in this study, regardless of their higher level of educational preparation, are either unable or unwilling to fully differentiate between technical and professional levels of nursing function.

As can be seen in Tables 6 and 7, there is a significant relationship (.05) between responses to the technical/professional nature of associate degree graduates and attitude toward the actual functioning of general staff nurses. Those respondents who believed associate degree graduates

TABLE 6
Perceived Technical/Professional Nature of Associate Degree
Graduates by Sameness of Functioning of
Associate Degree and Baccalaureate Graduates¹

Sameness of Functioning	Level of Nursing Functions by Associate Degree Nurses							
	Total		Technical		Professional		Not Sure	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	70	40	33	32	18	55	19	46
No	106	60	69	68	15	45	22	54
Total	176	100	102	100	33	100	41	100

¹ $\chi^2 = 6.09$; $df = 2$; $p < .05$

TABLE 7
Perceived Technical/Professional Nature of Associate Degree
Graduates by Expected Sameness of Functioning of
Associate Degree and Baccalaureate Graduates¹

Expected Sameness of Functioning	Level of Nursing Functions by Associate Degree Nurses							
	Total		Technical		Professional		Not Sure	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	87	45	37	34	23	61	27	60
No	76	40	56	52	8	21	12	27
Not sure	28	15	15	14	7	18	6	13
Total	191	100	108	100	38	100	45	100

¹ $\chi^2 = 16.67$; $df = 4$; $p < .01$

function as professional workers also believed baccalaureate and associate degree graduates function the same when employed as general staff nurses. Similar findings were obtained in an analysis of whether or not the baccalaureate and associate degree graduates should function the same (.01 level). This finding appears to be logically consistent: if two products are labeled professional, expectations of function would be the same. At this point, whether or not the two products *should* be labeled the same is not the question under discussion. However, one licensing examination for all registered nurses is one factor which adds to the confusion in the minds of nurses, employing institutions, and the public. A lack of clearly defined job descriptions and the educational preparation needed for specific jobs also tends to cause confusion.

Approximately one-third of the respondents submitted comments on these two questions. The comments for both questions fell in similar categories, such as feeling that both types of graduates need inservice and/or were lacking in experience (5 to 14%). Some (8 to 13%) commented that the job descriptions were the same so the workers should be the same, whereas 28 to 32 percent responded that the descriptions are different and that the baccalaureate graduate should assume additional functions.

A surprising percentage (7 to 14%) believed that differences in functioning as a general staff nurse were based upon individual differences and not the result of educational programs.

An overwhelming number of respondents (128, 67%) were dissatisfied with the way general staff nurses newly graduated from associate degree programs function. Thirty-seven (19%) were satisfied, while twenty-six (14%) were not sure or preferred not to answer. As seen in Table 8, there is a linear relationship (significant at the .001 level) between attitude toward technical/professional nature of associate degree graduates and satisfaction with performance of new associate degree graduates.

TABLE 8
Perceived Technical/Professional Nature of Associate Degree
Graduates by Satisfaction with Performance of
New Associate Degree Graduates¹

Satisfaction with Associate Degree Performance	Level of Nursing Function by Associate Degree Nurses							
	Total		Technical		Professional		Not Sure	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	37	19	15	14	7	18	15	33
No	128	67	86	80	20	53	22	49
Not sure or no answer	26	14	7	6	11	29	8	18
Total	191	100	108	100	38	100	45	100

$$\chi^2 = 23.33; df = 4; p < .001$$

Among those who expressed satisfaction with the performance of associate degree graduates, the largest proportion were unable to decide on their level of functioning. However, 80 percent of those who perceived associate degree graduates as technical were not satisfied with their performance, compared with 53 percent of those who perceived their functions as professional. Furthermore, among those who perceived their function as professional, nearly one-third (29%) were unable to say whether or not they were satisfied with associate degree graduates.

These findings are puzzling. However, it could be suggested that, to the extent the preparation of associate degree graduates is perceived as unsatisfactory, they are also perceived as technical workers. It also could be suggested that those who described associate degree performance as satisfactory are largely uncertain about the level of their nursing function. One might question whether or not the term "technical" is possibly a deterrent to positive perception regarding the functioning of new associate degree graduates. Perhaps, also, the functional adequacy of the new graduate is measured against the practitioner with several years of experience.

The findings from this study are relatively consistent with those of Forest's study in 1968. While some items of concern overlap, other areas in this study extend knowledge of associate degree graduates and their actual or expected role performance. Consequently, a comparative analysis is presented in the subsequent pages.

As suggested in earlier chapters, the associate degree nursing program is designed to prepare

technical nurses to perform the nursing functions commonly associated with the registered, or bedside, nurse. The functions they perform are considered technical, less complex, and more limited, or circumscribed, than those performed by professional baccalaureate nurses. Montag (1951, p. 70) designated three functions of the graduates of associate degree nursing programs: to assist in the planning of nursing care, to give general nursing care, and to assist in the evaluation of nursing care. Forest (1968, p. 28) used these functions as a basis for her study and also described additional functions of associate degree graduates mentioned by both the graduates and the directors of nursing or their assistants in the hospitals in which the graduates were employed. These additional functions included clerical, managerial, nursing role, cleaning, medical-technical, and unclassifiable.

Forest (1968, pp. 28-29) defined these functions as indicated below:

Clerical—Doing the paperwork and routines associated with institutional management.

Managerial—Assignment of duties to other personnel and the supervision of work of others. She further remarks here that there is some evidence that, when the activities were being carried out, the graduates were relieving the head nurse.

Nursing—Under this category, Forest included such activities as talking with patients, teaching, and counseling, all activities which she concludes to be readily classified under the major categories of the functions of nursing technicians previously described. She does not identify separate categories for teaching and counseling, indicating that these are not appropriate functions for the technical nurse.

Role—Under this category, specific activities were not defined, but the examples show that the graduates could function as team leaders and/or head nurses. One director made a very cogent remark, "But again, being very realistic, if you have one nurse on the floor and, if she's it, she would relieve whether she was ready or not [Forest, 1968, p. 45]."

Cleaning—Concerned with the care of equipment and supplies, including the sterilizing of equipment.

Medical-technical—Concerned with the collection or administration of intravenous fluids and the collection of blood samples.

Only one activity is included in the present study which was not mentioned in Forest's: Interpret observations and determine appropriate action to be taken. The area of cleaning, considered in Forest's study, was not included here.

Table 9 presents the frequency distribution of the responses to the appropriateness of functions as perceived by nursing service personnel. More than 88 percent of the respondents felt that each of the functions of technical nurses, as delineated by Forest, was appropriate. Fewer than 50 percent of the respondents considered performing clerical functions as appropriate for technical nurses. It is suggested this might reflect an overlap of function with ward secretaries and/or unit managers.

Table 9 also presents the list of nursing functions pertinent to this current study. An asterisk is used to identify those functions excluded from Forest's study but considered relevant here based upon actual and/or expected practice behavior of staff nurses. These (*) areas are generally considered inappropriate functions for technical nurses and are not usually taught in associate degree nursing programs. However, service demands and the inadequate supply of professional nurses have necessitated that all nurses share in these responsibilities regardless of their type of educational preparation. Consequently, administrative personnel and nurses have regarded all of the areas on the list as appropriate nursing functions. Table 9 presents, as well, the distribution of subjects who consider these functions appropriate or inappropriate for graduates of associate degree programs.

A comparison of the appropriateness of technical nursing functions, as perceived by nursing service administrators, and actual performance of those functions, as reported by associate degree graduates in Forest's study, is presented in Table 10.

Of the nine functions described by Forest (1968) and used in this study, six of them were

TABLE 9
Frequency Distribution of Appropriate and Inappropriate Functions of Technical Nurses
as Perceived by Respondents

	Appropriate		Inappropriate		No Answer		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
A. Plan Nursing Care								
Plan nursing activities for individual patients (i.e., organize assigned tasks, consider special needs of patients, discuss plan with nurse in charge).	167	88	20	11	4	2	191	100
B. Give General Nursing Care								
Give hygienic care to patients (i.e., care for skin, bathe, give mouth care).	186	96	2	1	3	2	191	100
Make patients comfortable (i.e., position, assist in getting up, talk with and listen to patients, arrange for or provide diversion).	181	95	6	3	4	2	191	100
Assist patients in maintaining normal body functions (i.e., feed/assist in eating, assist with elimination needs).	176	92	12	6	3	2	191	100
Perform procedures in meeting patient's needs for therapy (i.e., give medications, apply dressings, operate suction and oxygen equipment).	182	95	6	3	3	2	191	100
Perform procedures in meeting patients' needs for diagnosis (i.e., collect specimens, position for tests and examinations).	169	89	19	10	3	2	191	100
* Perform specialized procedures (i.e., do EKGs, start IVs, work with machinery such as dialysis units, inhalation equipment).	98	52	86	44	8	4	191	100
C. Tell, Teach, Counsel								
Assist patients to participate in own care (i.e., show method of performing simple hygienic procedure, e.g., brush teeth; tell method of taking prescribed drugs).	179	93	7	4	5	3	191	100
* Teach patients (i.e., teach patients and families about disease condition, treatment, and how to carry out therapy, e.g., diabetic patients).	156	81	30	16	5	3	191	100
* Counsel patients and their families (i.e., talk with and listen to patients and families regarding problems; refer to appropriate agencies on basis of discussion).	127	66	57	30	7	4	191	100
D. Evaluate Nursing Care Given								
Observe signs, symptoms, changes in conditions (i.e., take vital signs, observe physical condition and behavior, measure intake and output).	184	96	2	1	5	3	191	100
Report signs, symptoms, changes in conditions (i.e., record vital signs and observations of physical condition and behavior on patient's record; report unusual or sudden change in condition to nurse in charge or physician).	184	96	2	1	5	3	191	100
* Interpret observations and determine appropriate action to be taken (i.e., initiate action based on sudden or unusual changes in patient).	139	73	47	24	5	3	191	100

TABLE 9 (continued)

	Appropriate		Inappropriate		No Answer		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
E. Management of Patient Care Unit								
*Perform clerical activities (i.e., fill out requisitions, transcribe orders, etc.)	81	43	104	54	6	3	191	100
*Is team leader (i.e., assign and supervise personnel in patient care on day-to-day basis).	130	67	55	28	6	3	191	100
*Assume head nurse responsibilities when she is off duty and on evenings and nights (i.e., assign team leaders and other nursing personnel; keep unit running smoothly).	122	64	64	33	5	3	191	100
*Is head nurse on days (i.e., assign and evaluate team leaders and other personnel; keep unit running smoothly).	98	53	88	44	5	3	191	100

*Those functions added to the original functions as delineated by Montag and Forest.

TABLE 10
Comparison of Appropriateness of Technical Nursing Functions
as Perceived by Nursing Service Administrators and
Performance of Those Functions Reported by
Associate Degree Graduates in A Study
by Forest (1968)

Functions	Current Study		Forest's Study		Current Study
	Appropriate		Graduates Performing Functions		
	No.	%	No.	%	% Diff.
Plan patient care	167	88	45	88	0
Give hygienic care	186	96	33	65	+31
Make patients comfortable	181	95	45	88	+7
Assist patients maintain normal body functions	176	92	32	63	+29
Perform procedures for therapy	182	95	50	98	-3
Perform procedures for diagnosis	169	89	44	86	+3
¹ Perform special procedures	98	51	4	10 ²	41 ²
Assist patients in own care	179	94	36	71	+23
¹ Teach and counsel	141	74	10	20 ²	+54 ²
Observe signs	184	96	50	98	-2
Report signs	184	96	46	90	+6
¹ Interpret signs	139	73	—	—	—
¹ Clerical	81	42	24	48 ²	-6 ²
¹ Team leader	130	68	40	80 ²	-12 ²
¹ Head nurse (evenings and nights)	122	64	38	75 ²	-11 ²
¹ Head nurse	98	52	13	20 ²	+32 ²

¹Those functions added to the original functions delineated by Forest.

²Estimate based on descriptive presentation.

within several percentage points of congruence. While there was nearly unanimous agreement in this study regarding the appropriateness of technical nurses giving hygienic care and in assisting patients in their own care and in maintaining body functions, approximately 30 percent fewer of Forest's associate degree graduates reported actually performing these functions. However, such findings are not necessarily contradictory. These functions are often delegated to practical nurses and aides to allow time for registered nurses, including associate degree graduates, to assume clerical and managerial responsibilities.

There was a high degree of correspondence between the two studies regarding clerical and managerial functions. When these related areas are averaged, 60 percent of the nursing administrative personnel indicated that the functions of team leaders and/or head nurses were appropriate and approximately 56 percent of the associate degree nursing graduates actually performed these functions. Clerical duties were performed by 48 percent of the graduates, whereas 42 percent of the sample in this study believed this was an appropriate function.

Analyses of team leading and head nursing functions by occupational position were sufficiently related to reach .02 and .05 levels of significance. A much higher percentage of directors, assistants, and supervisors felt that these were more appropriate functions for technical nurses than did those nurses in the category labeled "other." It should be recalled that the twenty persons in the "other" category were individuals with primarily clinical specialization or inservice teaching responsibilities.

As can be seen in Table 11, basic education was highly associated (.001) with the appropriateness of planning patient care. Twenty percent more graduates of associate degree and diploma programs believed it was more appropriate to plan patient care than did graduates of baccalaureate and master's programs. Also, basic education was meaningfully related to items on relieving the head nurse and the head nurse categories (.01 level). Associate degree and diploma graduates felt that it was significantly more appropriate for technical nurses to relieve the head nurse and to actually become head nurses than those who had graduated from a baccalaureate or master's basic nursing education program.

TABLE 11
Appropriateness of Technical Nurse Planning Patient
Care by Basic Education of Respondents as
Perceived by Respondents¹

	Basic Education					
	Total		Associate Degree/ Diploma		Baccalaureate/ Master's	
	Freq.	%	Freq.	%	Freq.	%
Plan Nursing Care						
Appropriate	167	89	138	93	29	74
Inappropriate	20	11	10	7	10	26
Total	187	100	148	100	39	100

¹ $\chi^2 = 11.52$; $df = 1$; $p < .001$.

Analysis of items about appropriateness of assuming head nurse and team leader functions and highest credential held also was statistically significant. For all of these managerial functions, those with the least education reported that it was appropriate for technical nurses to carry out the functions of team leading and/or head nursing, while those with higher credentials tended to think it was inappropriate. Figures in Tables 12, 13, and 14 indicate the more education a nurse

TABLE 12
Appropriateness of Technical Nurse Assuming Team Leader
Function by Highest Credential Earned as
Perceived by Respondents¹

	Highest Credential Earned							
	Total		Diploma		Baccalaureate		Master's/ Doctor's	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Team Leader								
Appropriate	130	70	41	85	36	64	53	65
Inappropriate	55	30	7	15	20	36	28	35
Total	185	100	48	100	56	100	81	100

$$^1\chi^2 = 7.13; df = 2.0; p < .05.$$

TABLE 13
Appropriateness of Technical Nurse Assuming Head Nurse Relief
Function by Highest Credential Earned as Perceived by Respondents¹

	Highest Credential Earned							
	Total		Diploma		Baccalaureate		Master's/ Doctor's	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Head Nurse Relief								
Appropriate	122	66	41	85	35	61	46	57
Inappropriate	64	34	7	15	22	39	35	43
Total	186	100	48	100	57	100	81	100

$$^1\chi^2 = 11.58; df = 2; p < .01.$$

TABLE 14
Appropriateness of Technical Nurse Assuming Head Nurse
Function by Highest Credential Earned as Perceived by Respondents¹

	Highest Credential Earned							
	Total		Diploma		Baccalaureate		Master's/ Doctor's	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Head Nurse								
Appropriate	98	53	37	77	25	45	36	44
Inappropriate	88	47	11	23	31	55	46	56
Total	186	100	48	100	56	100	82	100

$$^1\chi^2 = 15.45; df = 2; p < .001.$$

has, the less appropriate she believes it is for technical nurses to carry out managerial functions. However, since the number who believe that managing is an appropriate function is so large, the question may be raised as to why content in this area is not systematically included in the basic technical program to better prepare nurses for tasks they must assume following graduation.

Since the inception of associate degree education, one of the philosophical tenets has been that managerial (as well as teaching) functions were outside the domain of technical practice. However, also since the associate degree graduates began nursing practice, sooner or later a large proportion have been required to function as team leaders, charge nurses, or head nurses. While the knowledge and abilities to perform these functions are role behaviors normally expected by the employing institutions, but are not ordinarily included in the basic curriculum, associate degree nurses have had to learn on the job under sink-or-swim conditions. Thus, another philosophical aspect is raised: Is the function of the basic educational program to prepare the practitioner for the realities of current nursing practice or to prepare the practitioner for an ideal role which some nursing educators hope will materialize in the ambiguous future? While this study does not deal specifically with this issue, nor does it attempt to resolve the issue, the data presented does suggest the need to reevaluate components of the associate degree curriculum to accommodate the needs of service institutions.

AREA OF SERVICE RESPONSIBILITY AND NATURE OF SERVICES

In the analysis by respondent's area of service responsibility, only a few general observations can be made due to the nature of the data obtained. Some individuals indicated responsibility for more than one service area and checked items accordingly. Furthermore, not all units existed in all of the hospitals and thus were not uniformly represented. Some subjects were responsible for only one unit, while others were responsible for many units. Those who were responsible for supervision of the entire institution answered some questions regarding a particular or primary unit, but the figures also indicate that some subjects answered items regarding more than one unit.

The greatest number (70%) of respondents were responsible for medical-surgical areas. There was great similarity between responses for similar specialty units. Neither medical or surgical administrative personnel thought of the actual patient care units as specialty units. However, approximately 40 percent or more believed that general staff nurses have (and *should* have) special knowledge, skills, and attitudes to work in these areas. In units such as intensive care, both medical and surgical, operating room, recovery room, and coronary care, approximately 80 percent thought of them as specialty units requiring specialized knowledge by nurses. Approximately 50 percent of the coronary care units utilized clinical specialists, while only about 10 percent were reported functioning in recovery rooms. The other units reported percentages between those two, with a greater number of clinical specialists in medical units than in surgical units. In all of the specialty units just mentioned, an overwhelming majority believed that general staff nurses have (and *should* have) *specific* knowledge, skills, and attitudes to function in these areas.

In all of the specialty units mentioned in the maternity, ambulatory, pediatric, and psychiatric areas, the study sample responded positively and overwhelmingly that nurses employed in each of these areas were expected to have specific knowledge, skills, and attitudes.

The items related to service area of responsibility give an overview of the respondents' attitudes about the specialized nature of the units and the knowledge necessary to work there. One or more specialty units were reported to exist in each of the major service areas studied. General staff nurses working in these specialty units were considered to be specialized by 37 percent of the respondents, whereas 49 percent did not consider them to be specialized. Among those who commented on this item, 49 percent believed that a nurse must have certain experiences or further education in order to be considered specialized.

NURSES IN SPECIALTY UNITS

The assignment to a specialty unit was most frequently determined by the nurse's preference (37%) or by prior specialty training in her background (31%). Service needs and supervisor's choice constituted 22 percent of the reasons for assignment to a specialty unit. These findings seem consistent with Forest's study, that associate degree graduates were assigned to units on the basis of preferences, service needs, and other previous experience and educational preparation (Forest, 1968, p. 39).

Several questions were asked relating to preparation for working in specialty units. A large majority of subjects reported that inservice education was the most commonly used method (74%). The majority of subjects (65%) also indicated satisfaction with the performance of staff nurses on specialty units. However, when asked if another method of preparing nurses to work on such units was preferable, respondents were slightly more inclined to answer affirmatively (41%) than negatively (37%). These findings suggest that, while inservice education is quite popular, an almost equal proportion of subjects believe it is not the best method to prepare nurses to perform the highly technical functions required on specialty units.

The feeling of satisfaction with staff nurses seemed to be an influential factor in attitudes of appropriateness of certain nursing functions. Tables 15 through 18 clearly demonstrate that those who felt satisfied with the performance of general staff nurses on specialty units also believed the following were appropriate functions for the technical nurse: plan nursing care, give general nursing care, tell and counsel patients about their illness and care, evaluate care given and manage the patient care unit. The tables for planning care, counseling patients, and assuming team leader and head nurse responsibilities indicate significance at the .001 level. Relieving head nurse when she is off duty was also significant at the .01 level. Interestingly, the association between greater satisfaction and the customary staff nurse functions (technical in nature) of giving hygienic care and observing and reporting signs and symptoms are at a lower significance level (.05).

TABLE 15
Appropriateness of Technical Nurses to Plan Nursing Care by
Satisfaction with Staff Nurse's Performance on
Specialty Units as Perceived by Respondents¹

Plan Nursing Care	Total		Yes		No		No Answer	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Appropriate	167	89	117	96	30	77	20	77
Inappropriate	20	11	5	4	9	23	6	23
Total	187	100	122	100	39	100	26	100

¹ $\chi^2 = 15.99$; $df = 2$; $p < .001$.

When asked to select alternative methods of preparing nurses for specialty units, a large proportion (42%) continued to prefer the traditional approach of inservice education. About one out of every three subjects (35%) selected continuing education in educational institutions which emphasized specialty preparation. However, 13 percent of the respondents preferred that specialty preparation be provided in basic nursing education programs.

About one-half of the subjects (52%) believed that new nursing technicians entering the institutions should have the traditional ability to function generally in all major areas without specific specialty preparation. Most of the remaining subjects (33%), however, believed nurses should begin nursing practice with general basic skills but intensively prepared in one or more specialty units. The others (9%) were not sure which would be best. Even though this indicates a

TABLE 16
Appropriateness of Technical Nurses to Counsel
Patients by Satisfaction with Staff Nurse's
Performance on Specialty Units as Perceived by Respondents¹

	Total		Yes		No		No Answer	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Counseling								
Appropriate	127	69	95	80	17	44	15	58
Inappropriate	57	31	24	20	22	56	11	42
Total	184	100	119	100	39	100	26	100

$$^1\chi^2 = 19.86; df = 2; p < .001.$$

TABLE 17
Appropriateness of Technical Nurse Assuming Team Leader
Functions by Satisfaction with Staff Nurse's Performance
on Specialty Units as Perceived by Respondents¹

	Total		Yes		No		No Answer	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Team Leader								
Appropriate	130	70	95	79	17	44	18	69
Inappropriate	55	30	25	21	22	56	8	31
Total	185	100	120	100	39	100	26	100

$$^1\chi^2 = 17.84; df = 2.0; p < .001.$$

TABLE 18
Appropriateness of Technical Nurse Assuming Head Nurse
Functions by Satisfaction with Staff Nurse's Performance
on Specialty Units as Perceived by Respondents¹

	Total		Yes		No		No Answer	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Head Nurse								
Appropriate	98	53	77	64	11	28	10	38
Inappropriate	88	47	44	36	28	72	16	62
Total	186	100	121	100	39	100	26	100

$$^1\chi^2 = 17.30; df = 2.0; p < .001$$

large segment in favor of continuing the traditional educational pattern, it also clearly demonstrates that many nurses in service administrative positions believe a new method of preparing technical specialists in nursing is required to meet the service needs of both patients and the institution.

TECHNICAL NURSING SPECIALIZATION

The perceived need for new and different patterns of preparation and delivery of nursing service was clearly demonstrated in the series of questions explicitly related to technical nurse

specialists. The majority of respondents (59%) overtly reported an existing need for such specialized nurses; an additional 22 percent were not certain or were hesitant to commit themselves. Only 19 percent definitely believed this kind of nurse was not needed.

In addition to this data supporting the recognized existing need for technical nurse specialists, the majority of these administrative personnel (64%) also reported that, if such nurses were currently available, their employment would be desirable in their institution. While 23 percent of the subjects were unsure, only 14 percent indicated no desire to employ such nurses if they were available.

Furthermore, most respondents (64%) believed that the service needs of current specialty units would permit the utilization of these technical nurses skilled in specialized areas. An additional 26 percent were unsure, indicating at least some affirmative attitude toward the idea. Only 9 percent answered negatively, indicating that service needs would not enable the utilization of such nurses.

When asked to indicate which service areas could advantageously use technical nurse specialists, each of the seven service areas was included by 28 to 45 percent of the respondents. The areas most frequently selected were pediatrics, 45 percent; surgical units, 42 percent; medical and maternity units, 41 percent each. Thirty-nine percent thought such nurses would be helpful on long-term care units and 28 percent indicated the same for ambulatory care units. Only 22 percent of the 191 subjects in the study group stated they did not believe in technical nursing specialization. An additional 9 percent were not sure of their attitude or commitment on this item.

SUMMARY

A total of 191 nursing service administrative personnel responded to the mailed questionnaire. The majority of the respondents were nursing supervisors, had completed a diploma basic nursing program prior to 1960, had continued their education to obtain a master's degree, and had been in their present positions for less than five years.

Perception of the technical/professional nature of general staff nurses in hospitals showed that the majority of respondents felt that associate degree graduates were technical workers while diploma and baccalaureate were considered professional. In all cases, approximately one-fifth of the respondents showed confusion in this area and therefore did not answer the question or responded to the "not sure" category.

Frequency distribution of the similarity and differences of actual functioning of baccalaureate and associate degree graduates as general staff nurses indicated that the majority of respondents feel they do not function the same. However, in response to whether or not they *should* function the same, a noticeable shift occurred with the majority believing they *should* function the same.

Two-thirds of the respondents were dissatisfied with the way general staff nurses newly graduated from associate degree programs function. A list of functions from Forest's (1968) study was used as a basis for determining the appropriateness of these functions for technical nurses as perceived by the respondents. The main areas as delineated by Forest were planning nursing care, giving nursing care, and evaluating nursing care. Added to these functions were teaching and counseling and management of the patient care unit which, interestingly enough, were also included in the text of Forest's study but were not dealt with in depth. The functions usually considered within the purview of the technical nurse were considered appropriate by approximately 90 percent of the respondents. For other functions usually not considered the responsibility of the technical nurse, well over 50 percent of the respondents, in most cases, felt that these activities were appropriate for technical nurses.

In the majority of the specialty units in each of the major service areas, the study sample responded positively and overwhelmingly that nurses employed in each of these areas were

expected to have specific knowledge, skills, and attitudes.

In the series of questions explicitly related to technical nursing specialization, the majority of respondents saw an existing need for such specialized nurses. These nursing service administrative personnel also were favorable to the employment of specialized nurses in their institutions and could see technical nurse specialists meeting the service needs of specialty units.

The following chapter will present the conclusions and implications of these findings.

Chapter 5

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

SUMMARY

This study was undertaken to investigate the perception of nursing service administrative personnel regarding the concept of technical nursing specialization. Specifically, the purposes of this study were to investigate the need for and receptivity toward employment of technical nurse specialists, to determine clinical areas in which they would be especially useful, and to obtain recommendations regarding the educational preparation of such technical nurse specialists.

A packet of eight questionnaires was mailed to the nursing service directors of forty-three hospitals in the New York metropolitan area which had three hundred or more patient beds. The directors were asked to complete one questionnaire and to distribute the remaining ones to the nursing supervisors responsible for the major clinical areas in the institution. Approximately 80 percent of the potential sample completed and returned the questionnaires. These were coded, key punched, and computer analyzed, as previously described.

The final study sample, therefore, consisted of 53 directors or assistants, 118 supervisors, and twenty others, including nurses responsible for inservice education, clinical specialists, etc. Of these, 25 percent had held their present positions for less than two years, 37 percent had been so employed for two to five years, and the remaining 38 percent had held their positions for more than five years. Nearly 80 percent of the sample had received their basic nursing education in diploma programs; 17 percent had graduated from basic baccalaureate programs. However, 75 percent of these nursing service personnel had acquired a baccalaureate or higher degree by the time of this study, 42 percent now held master's, and two respondents had obtained doctoral degrees. These figures clearly indicate that this sample is considerably more highly educated than the national average of nurses in similar positions.

The major findings of this study show that little distinction was made by the sample between the functions of associate degree and baccalaureate graduates. A large number of respondents reported that these two types of nurses function the same in the clinical areas. Furthermore, an even larger proportion reportedly believed they *should* perform the same functions.

It is also interesting that this group of superiorly educated administrative nurses perceived both of those functions usually considered technical and professional as appropriate functions for a technical nurse. Specialization was considered to be an existing reality in almost every kind of nursing unit. The special knowledge and skills required on these units are taught to the general staff nurses as a part of their inservice preparation.

In the study hospitals, nurses were assigned to these specialty units largely on the basis of their personal preference, the specialty background previously obtained, or because of the service needs of the institution. Preparation for working on specialty units was overwhelmingly through inservice programs as reported by the sample. However, the respondents indicated this was not necessarily the best method to prepare nurses for performing the special and highly complex functions required in these units. When asked for alternative methods, many still selected

inservice education programs, but more than one-third suggested continuing education programs located in educational institutions and especially designed for those requiring specialty preparation. Thirteen percent reported that the one method best suited to prepare specialists in nursing was through the basic educational program. However, even though half the sample indicated preference for the present pattern of nursing education (i.e., *general* preparation for all major clinical areas, with special functions learned later), one out of every three respondents indicated preference for a new pattern of nursing education which would include specialty preparation in the basic nursing program.

A series of questions was asked to obtain the perspective of this sample toward potential curriculum developments in associate degree nursing programs emphasizing the concept of technical nurse specialization. The responses were overwhelmingly positive. For example, only one-fifth thought there was no place for technical nursing specialists; well over half the sample definitely thought the need existed for such nurses while others were not quite sure.

Even more importantly, nearly two-thirds of this sample of nursing service administrative personnel reported that they would like to have such technical nurse specialists employed in their particular institution; few overtly reported a negative response. Carrying the process one step further, two-thirds of this sample also reported that the service needs of their hospitals would enable the utilization of such nurses prepared as technical specialists. Less than 10 percent reported a negative response to this suggestion.

Furthermore, when asked to indicate the service areas in which such nurses would be advantageous, most of the major areas were strongly represented. The most frequently chosen areas were pediatric, surgical, medical, maternity, long-term and psychiatric care units.

Therefore, the findings from this study clearly indicate the recognition of the need for nurses prepared on the technical level who are also able to perform specialized functions. These findings also demonstrate a positive inclination toward both the concept of technical nursing specialization and the employment of such nurses in most of the major patient care areas within the hospitals represented in this study.

CONCLUSIONS

It is obvious from the findings presented in this study and from the literature that the division of labor in hospitals is still so blurred that no unique nursing role—professional or technical—can be clearly identified.

As suggested by contributors to the growing volume of nursing literature, these respondents further corroborated the perceptions that several functions traditionally considered only within the domain of the professional nurse are also deemed appropriate for the technical nurse. This confusion regarding professional and technical functions has resulted in large-scale misutilization of nurses prepared at either level. This is particularly true of the graduate prepared to provide general technical nursing care who, on the contrary, is required to accept the responsibility for managing patient care units and supervision of others on the health team as well as teaching and counseling patients and their families. Also, the bureaucratic nature of most hospitals and other reasons militate against the baccalaureate graduate being able to function as a professional worker and has, instead, seen her function as a technical nurse.

The utilization of a single registered nurse licensure has tended to perpetuate the notion that "a nurse is a nurse" and therefore should be prepared to carry out any functions deemed necessary by nursing service to meet the needs of the hospital system. The fact that educators have said that technical nurses are not prepared for teaching and management functions has been regarded largely with a deaf ear.

However, hospital administration has been—and continues to be—presented with the problem of having either too few baccalaureate graduates prepared to perform those functions attributed

to professional nurses or too little money to attract and retain them.

Nor is the prospect of adequate proportions of professional to technical nurses any brighter in the foreseeable future. While the numbers of associate degree graduates continue to grow rapidly, the percent of baccalaureate graduates is still well below desirable levels and increases only slightly from year to year.

As discussed in this report, one consideration is that of modifying the imagery and boundaries of technical nursing practice and increasing the effectiveness of these nurses by encouraging specialization in the basic preparation and in the employing institutions.

The data from this study clearly support the tenet that registered nurses, regardless of type of basic background, are expected to have specialized knowledge and skills in order to function effectively in most units of the modern metropolitan hospital. The data also demonstrate that such specialized skills are usually obtained through inservice programs at the expense of the hospital. The knowledge explosion, growth of specialization in medical care, changes in the health delivery systems, and other changes occurring in our increasingly complex technocracy all amply illustrate the need for, and provide the impetus for, developing programs to prepare specialists at the technical level in nursing. Furthermore, a question from the not-too-distant past is raised again: Should the expense of adequately preparing nurses for the job to be done be borne by the sick, disabled, and/or institutionalized, or by society at large?

IMPLICATIONS

Nursing is not unique in facing the dilemma of technological expansion and knowledge explosion. The fact of the matter is that most areas of society, including various health care disciplines, have become more dependent upon specialized knowledge and skills in order to satisfactorily meet their responsibilities. In order to fulfill its occupational objectives and philosophical commitments, nursing, as well as some of the other service-oriented groups, has come to the point of decision regarding its position toward specialization. Some health occupations already have become specialized and consequently have improved their likelihood for more productive survival.

The consequences of current expanding technocracy are reflected not only in the growing inadequacy of educational preparation but also in frustrations and lack of fulfillment in the performance of the job. The literature, as well as personal experiences, indicates that many individuals, including nurses, find it increasingly difficult to experience satisfaction in their daily work, to feel a sense of control over the sphere of skills, technics, and procedures and the background knowledge necessary to adequately meet the demands of their jobs. An increasing role overload, combined with a lack of self-fulfillment and concomitant occupational frustration, militate against one of the central elements of humanitarian disciplines such as nursing. That innate desire to reach out and help other human beings in their health needs and to assist them to find some relief for their distressed conditions is blocked.

In this context, Lambertsen (1969, 1970), DeChow (1972), Olson (1968), Brown (1970), and other leaders have suggested a rearrangement of occupational roles and functions which potentially could overcome some of these problems. Their writings indicate that, if the scope of educational preparation required for clinical performance were more reasonably circumscribed, nurses would have the opportunity to practice bedside care more thoroughly and competently. Furthermore, this would include aspects such as teaching patients and families about their illness and related care, and managing the nursing care unit or its nursing teams more efficiently and humanely. A circumscribed scope of practice would permit nurses to keep better informed of new developments in their area of concern. Considering all of these factors, more individual

control could be exercised over the dehumanizing frustrations which ultimately hinder occupational performance and fulfillment.

It hardly needs stating that hospitals are highly complex bureaucratic systems which have highly structured demands for performance. With the multiplicity of paramedical workers involved, a system—Weberian or otherwise—must be implemented for the most efficient and economic operation of the institution. However, in the past and in the present, hospitals have insisted that nurses remain generalists as one means of maintaining their prerogative of shifting them from unit to unit, depending upon the economic and personnel needs of the institution. Often this was done regardless of the ability or desire of the particular nurse.

But, as documented in previous chapters, as patient care becomes increasingly more complex and technically specific, it also becomes more and more obvious that generalist nurses are not equipped to adequately meet the specialized needs of patients and the demands of a specialty-oriented health care system. Technical specialization in nursing would not only lessen the work strain related to excessive demands for knowledge and skill, but also would enhance the nurse's opportunity to be more prepared to fulfill the full range of desirable nursing responsibilities generally ascribed to nursing. Furthermore, the nurses would have increased potential to experience more rewarding relationships with patients, co-workers, and the employing institution.

Consequently, nurses seem to be standing at the proverbial crossroads, trying to choose between one of two directions. Should they continue to try to be all things to all people—generalists in an era of specialization and rapid technical turnover? Or should opportunities be developed for some nurse students and practitioners to learn and practice specialization along the nursing continuum, in order to more effectively cope with the demands of institutional practice?

Little doubt remains in the minds of many nursing leaders and service administrators that, in order to meet the needs of patients and the institutions in which patients receive care, nurses will have to become better prepared in manual skills, decision-making, and management abilities. The concept of technical specialization has been suggested as one means of meeting these needs.

Moreover, with all the concern over mushrooming paramedical occupations and the recent moratorium on licensing, perhaps the nursing profession would be wise to concentrate on reassessment of functions and goals and consider educational reorganization of an already existing and legitimized occupation rather than allowing new occupations to emerge unnecessarily. Such a reorganization could be built upon the associate degree nursing concept developed by Montag more than twenty years ago which repeatedly has proven its value and vitality and continues to be the fastest growing segment of nursing education in the country. There are nearly five hundred such programs, located in institutions of higher learning in metropolitan areas and small towns in all fifty states as well as the U.S. Territories of Guam, Virgin Islands, and Puerto Rico.

Lambertsen (1969, 1970), DeChow (1972), and others have suggested that the curriculum for associate degree nurses could be modified to increase the technical competence in a particular major specialty area of practice and thereby meet some of the common needs confronting nurses, physicians, hospitals, and the consumers of nursing care. The author of this study agrees and suggests that, if students were permitted to select a nursing specialty area for study during their basic educational program, the likelihood would be greater that nurses would be better equipped to begin functioning, could work more effectively in a complex health care setting, would feel more confident and satisfied in their work, and, consequently, would tend to remain in their jobs for longer periods of time.

The findings of this study could have major implications for changes in nursing education, nursing service, and potentially for the processes governing consumer safety and nurse practice through the credentialing systems.

Both the literature and findings from this study present an existing bipolar dilemma. On the

one hand, there is the perpetual imbalance in the ratio of professional (baccalaureate) to technical (diploma and associate degree) nurses, with only a dim prospect of adequately producing the needed complement of baccalaureate nurses. On the other hand, nurse leaders from both the service and education sectors seem to maintain an unrealistic and traditional attitude toward the functions and boundaries of practice in spite of the absence of a satisfactory delineation of either professional or technical nursing. Regardless of the fact that nurses are taught that major differences exist between types of nurse practitioners, in most institutional settings nurses continue to perform similar tasks and assume nearly identical responsibilities along the entire continuum from practical nurses to baccalaureate graduates.

Nursing currently seems to be caught in a kind of schizophrenic discord. Nursing students in technical programs are taught that their responsibilities lie in the area of performing technical bedside nursing care, which generally does not include teaching, counseling, and management functions. Baccalaureate students are taught that their responsibilities will include assessing, planning, and implementing patient care with an emphasis on teaching and counseling patients and families, and on executing leadership in the nursing care unit. However, when nurses from either of these programs are employed, they soon learn that functions in the real world are not so clearly demarcated. Technical nurses find they are expected to assume many management responsibilities and, furthermore, due to lack of adequate numbers of baccalaureate nurses, must also assume responsibilities for patient-family teaching—if it is to be done at all. And baccalaureate nurses soon realize that their time is occupied in an excess of management duties and are often quickly escalated into higher status positions within the hierarchy—again because of deficient numbers of professionally prepared nurses. Therefore, they frequently are not on the units, or have limited time to assess and plan, teach and counsel patients. Therefore, they are not readily accessible to pick up where the technical nurses leave off, assuming the so-called "professional nursing functions."

The schizophrenic dichotomy between what one is taught and what one performs is not new, but the gap between them does seem to be widening. Consequently, the search for a variety of potential solutions is all the more compelling.

The implications for nursing education include modifications in program philosophy and design, curriculum content and method, use of clinical facilities, and faculty utilization.

In addition to the implications for education, implications for nursing service also were suggested by the responses of the nursing service personnel in this study. There is the overt recognition of the need for staff nurses to be more prepared and adept to work in highly specialized patient care units. The subjects in this study clearly indicated their desire to have such technical nurse specialists employed on most of the hospital units in an effort to improve patient care.

Only gross implications for service can be suggested here; another study is required to determine detailed results of implementing such a program. At least two different applications are envisioned—one for large metropolitan teaching centers and another for smaller community hospitals.

Medical centers and metropolitan hospitals generally attract baccalaureate graduates, utilize clinical nurse specialists, and employ other paramedical specialty workers. In these settings, units are more highly specialized and there is an unusual concentration on treating patients with complex medical problems. In such settings, the technical nurse specialist would function as a skilled team worker under the direction of the master nurse clinician, freeing the professional's time for more assessing, planning, evaluating patient care, and preparing the patient and family for post-hospital care. The technical nurse truly would practice as a skilled bedside nurse exercising her abilities in performing physical-technical care, teaching and providing emotional support, and managing aspects of patient care at a technical level under the guidance of the professional nurse.

However, in smaller community hospitals, nursing homes, or other care facilities (such as

industries, offices, and clinics) a different utilization is envisioned for technical nurse specialists. In such settings, frequently there is a conspicuous absence of baccalaureate nurses and master clinical specialists with a concomitant burden of responsibility placed on technical graduates (from diploma or associate degree programs). In these settings, where the technical nurses are expected to assume the full range of technical and professional functions, preparation as a specialist would be an invaluable asset to the nurse, the institution, and to the patients receiving care.

If principles of teaching, counseling, and management on the technical level were included in the basic curriculum for technical nurses, combined with the concept of patient care area specialization, graduates of such programs would be far better prepared to function in settings devoid of adequate professional nurses. It is speculated that more patients and families would be taught more about their care, both in and out of the institution, that nurses would feel less conflict which often arises from information deficit, and that they would be better equipped to assume the management functions expected of them. In general, the opportunity for fulfilling both personal and institutional expectations would be better met if the nurse was prepared in a narrower area, but with more depth within that area to allow her to perform the full range of functions expected of her.

Consideration also should be given to the implications arising from this study for the current system of legal control of nursing practice behavior. It is difficult to explicitly define these implications from this study alone, and an additional study is suggested. However, it is recognized that the rules for governance of practice potentially would be changed—whether by initial licensure, renewed licensure, or other methods of awarding appropriate credentials for improved practice.

Current licensing requirements necessitate testing in all five major content areas. Unless such requirements are modified, the proposed specialists curriculum would have to include sufficient material to permit students to pass State Board Examinations. However, considering the two-year length of the program, such a requirement would essentially destroy the most positive elements of the new approach.

RECOMMENDATIONS

It is suggested that selected associate degree programs develop pilot projects to prepare specialists in the major medical care areas for acute and long-term patients in hospitals and nursing homes. Specialties to be developed should be determined by college, health, and community representatives and should reflect the needs of the community. It is envisioned that, through both local and regional planning, there will be variation from community to community regarding the specialty programs to be developed.

A tentative model for an associate degree program designed to prepare technical specialists is suggested as follows. The first-year nursing courses could constitute a nursing core and include the fundamental motor and interpersonal skills necessary to care for patients in uncomplicated situations in hospitals and/or nursing homes. Emphasis could be placed upon psychological aspects and development of more understanding of human potential growth, with the hope that more humaneness and actual concern for patients as people will be returned to the institutional milieu. The concepts from these areas drawn from general and nursing education courses will need to be applied to the nursing area by a well-qualified faculty. A faculty conversant enough with the natural and social sciences is strongly recommended in order to teach the basic principles from these disciplines to students and to assist them to apply them in clinical situations.

In the second year, it is suggested that nursing courses be devoted to specialization in one or two of the major medical care areas, as determined by the individual student. Since some areas

have overlapping functions and conditions, such as medical and surgical nursing, it is envisioned that a student could specialize in both of these areas or similarly related areas. Furthermore, consistent with the notion of full-performance specialization as introduced earlier, elementary principles of the teaching-learning process, counseling, and management as related to the particular area of specialization chosen by the student would also be introduced at the second-year level. Students, with faculty advisement, could develop lesson plans, or nursing care plans for teaching and counseling patients and/or families about the major aspects of their illness and care—within the limits of their technical knowledge and competence in that specialty area. By learning certain basic principles of teaching in the educational program, with time and experience, the nurse graduate could modify and amplify the emphasis on teaching as a systematic part of her patient care, incorporating her own and shared learning from practice.

Much of the content from the areas of teaching, counseling, and management could be programmed, using the principles of modular presentation, and offered to students when they feel ready to partake of this kind of experience. If the didactic material of the major practice area was developed through the use of well-designed performance objectives and then programmed, students could proceed at their own pace and review as often as they felt the need or were encouraged to do so by the faculty.

In addition to an emphasis on specialization in the basic preparatory program, it also is suggested that the concept of full-performance technical specialization has major applications for the continuing education movement. Nursing, like other disciplines, is realizing the importance of implementing a system for assisting its members to continue learning in order to keep up with rapid changes, to upgrade their performance and institutional rewards. Some states already have initiated a procedure for making renewal of licensure conditional upon evidence of continuing learning and upgrading in some aspects related to nursing practice.

One aspect which might be considered in the development of continuing education programs is the concept of technical specialization. As discussed previously, implementation of this concept is deemed as one method of improving both quality of patient care and job satisfaction for nurses, whether instituted in the basic technical educational program or in a continuing educational program for graduates.

If such programs were developed, graduates of traditional associate degree and diploma programs could be encouraged to return to institutions of higher learning (community college or other facilities depending upon the availability in the immediate locale). In this way, they could obtain further preparation in a specialty area of their choosing, one which might augment their expertise in a current area of work interest, or another one thought to be of parallel importance. Such programs would provide opportunities for both horizontal and vertical mobility.

Modularized programmed content areas described previously could be adapted and used as the basis for such continuing education programs for graduates. Sophisticated systems could be developed, using such technology as computer simulation, television, and programmed learning methods. Such students could learn at a pace suitable to their work and home schedules and could bank credits at the institution toward their desired goal.

Obviously, should technical nurse specialists be employed, the institution would be required to assign them consistently to the units of their specialized expertise. This would retard the common practice of rotating nurses from unit to unit, depending on the hospital's need. In some situations, this would be a definite disadvantage and would militate against employment of such technical specialists.

However, if an institution were committed to the concepts suggested in this study, certain steps could be taken toward their implementation. In some situations, the hospital should work with local educational facilities to develop needed continuing education programs. In other settings which do not have educational facilities readily available, inservice programs should be developed in consultation with nurse educators and experts in the specialty areas of interest.

The basic requirement is an understanding that one or more different methods of preparing

nurses to meet the increasing needs of society must be explored. Technical nursing specialization is one such innovation, and, based upon the findings of this study, is deserving of further study and selected implementation.

Alternatives to this would be licensure in specific areas, as is practiced in England, or the issuance of a license with limitations. Since research into the entire licensing process is currently under way by Seldon and the State Board Test Pool Examination Research Steering Committee, perhaps the question of specialization might be permitted in a scheme of flexibility to meet a variety of societal and educational changes.

Perhaps another method of recognizing and legitimizing the practice of such new specialists could come through the American Nurses' Association. It is currently investigating ways of recognizing and rewarding nursing practice through a system of peer review and academy membership.

The following recommendations are proposed for further research in duplication of the present study or for expanding the concept of specialization:

Replicate this study, Forest's study, and/or combinations of these studies using different geographical areas, different settings, such as nursing homes and psychiatric institutions, and different sample groups. Suggestions for participants are staff nurses, recent graduates, nursing leaders, head nurses, and hospital and medical personnel.

Establish pilot projects to investigate feasibility of basic associate degree nursing programs to prepare technical nursing specialists as described in the previous pages.

Establish performance objectives for a nursing core and specialty areas.

Establish pilot projects to investigate feasibility of using modules of the associate degree nursing specialty curriculums as a basis for continuing education.

Implement pilot projects to study the differentiation between baccalaureate and associate degree workers in hospitals and nursing home settings and the particular curricular differences.

Study characteristics of those who are prepared to commit their occupational future to a particular specialization area, and equitable mechanisms for selecting such students for programs in technical nursing specialization to facilitate their successful entry into the institutional system.

Study faculty perceptions of specialization, on a technical and/or professional level, and attitudes toward developing such programs.

Compare content and proposed specialized nursing curriculums and curriculums of other health technologies with a nursing care component (i.e., psychiatric technicians and maternity technicians).

Compare the functions and activities of practical nurses and technical nurses in various settings and regions of the country, and the influence of specialization on both of these groups.

Explore the articulation, with senior institutions, if specialization is a reality available to future graduates of associate degree programs.

Specialization at the technical level in nursing is offered as a suggestion to improve the nursing care of institutionalized patients in this country. The time has come to take a bold, new look at associate degree nursing curriculums and to up-date these curriculums in light of the knowledge explosion and the ever expanding technocracy.

"Greater than the tread of mighty armies is an
idea whose time has come."

—Victor Hugo

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LETTER TO DIRECTORS

Office of Doctoral Studies
Student Workroom

July 3, 1971

Over the past fifteen years I have been director of three associate degree nursing programs and have been actively involved in trying to improve patient care through improving nursing education. For a number of years I have been interested in learning the views of nursing service personnel regarding the functioning of technical nurses. I personally believe that nursing service personnel have significant contributions to make in determining the type of education necessary for nurses.

APPENDIX

The research dissertation required for my doctoral degree has finally provided me with the opportunity for studying the opinions of nursing administrators regarding the utilization of technical nurses. The letter attached to the questionnaire gives particulars regarding the study.

Enclosed are eight questionnaires with attached return envelopes. Would you please answer one questionnaire and distribute the others to each of the nursing supervisors or nursing department heads who have responsibility for the following services: Ambulatory Care, Long-Term Care, Maternity, Medical, Pediatric, Psychiatric, and Surgical. If the organizational structure of your institution is not consistent with that of the service areas delineated, would you please distribute the questionnaires in a way in which you feel would best elicit information regarding the service areas requested.

Since analysis of the data cannot begin until all of the questionnaires are returned, your cooperation and observance of the August 10 return date will be greatly appreciated. Thank you.

Sincerely yours,

Helen H. Burnside

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LETTER TO DIRECTORS

Office of Doctoral Studies
Student Workroom

July 9, 1971

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The research dissertation required for completing a doctoral degree has finally provided me with the opportunity for studying the opinions of nursing administrators regarding the utilization of technical nurses. The letter attached to the questionnaire gives particulars regarding the study.

Enclosed are eight questionnaires with attached return envelopes. Would you please answer one questionnaire and distribute the others to each of the nursing supervisors or nursing department heads who have responsibility for the following services: Ambulatory Care, Long-Term Care, Maternity, Medical, Pediatric, Psychiatric, and Surgical. If the organizational structure of your institution is not consistent with that of the service areas delineated, would you please distribute the questionnaires in a way in which you feel would best elicit information regarding the service areas requested.

Since analysis of the data cannot begin until all of the questionnaires are returned, your cooperation and observance of the August 16 return date will be greatly appreciated. Thank you.

Sincerely yours,

Helen H. Burnside

LETTER TO RESPONDENTS

Office of Doctoral Studies
Student Workroom

July 9, 1971

Dear Respondent,

With the increasing complexity of medical care, the increasing emphasis on clinical nursing skills as differentiated from hospital management and the confusion and overlap of functions of new health-career workers vis-à-vis nursing, I propose to find out how directors of nursing service and selected nursing supervisors perceive the need for technical nursing specialists in their institutions. Such a study should have implications for the curricula of both associate degree nursing programs and continuing education programs offered by community colleges.

I am requesting your assistance in gathering information necessary for my dissertation to fulfill the requirements for the Degree of Doctor of Education at Teachers College, Columbia University. My area of specialization is Nursing Education Administration and the research project concerns technical nursing specialists in the care of hospitalized patients.

The sample is comprised of nursing personnel in general medical surgical hospitals of over 300 beds in the New York metropolitan area. The questionnaire is designed for a minimum of writing and should take only 20 to 25 minutes to complete. The number of individuals participating in this study is limited, therefore *your* response is very much needed and appreciated. I will be grateful if you return the questionnaire no later than August 16, 1971, in the envelope provided.

I assure you that all information obtained for the study will be regarded with confidence and discretion. Neither the individuals nor the institutions will be singled out in the report. A summary of the findings will be sent to the Director of Nursing upon request.

Sincerely yours,

Helen H. Burnside

QUESTIONNAIRE: A STUDY OF NURSES IN SPECIALTY UNITS

This questionnaire is designed to obtain *your* opinions and points of view; there are no right or wrong answers. It is important that you provide the information requested as completely as possible for each question. Your cooperation is appreciated and your responses will be treated confidentially and with discretion.

Please place a check (✓) in the space provided and comment freely where indicated.

I. Background Information

1. Position presently held (check one)

- ☐ Director of Nursing Service
- ☐ Nursing Supervisor or Department Head
- ☐ Other (please specify) _____

2. Length of time in present or similar position (check one)

- ☐ Less than 2 years
- ☐ From 2 to 5 years
- ☐ More than 5 years

3. Type of basic nursing education received (check one)

- ☐ Associate degree
- ☐ Diploma
- ☐ Baccalaureate degree
- ☐ Master's degree

4. Year basic nursing education completed

19____

5. Highest educational credential held (check one)

- ☐ Associate degree
- ☐ Diploma
- ☐ Baccalaureate degree

- ☐ Master's degree
☐ Doctorate

II. Much has been written regarding the technical and/or professional nature of general staff nurses in hospitals. In your opinion:

1. Do you think graduates of *associate degree* programs function as technical or professional workers?

- ☐ Technical
☐ Professional
☐ Not sure

Comments: _____

2. Do you think graduates of *diploma* programs function as technical or professional workers?

- ☐ Technical
☐ Professional
☐ Not sure

Comments: _____

3. Do you think graduates of *baccalaureate* programs function as technical or professional workers?

- ☐ Technical
☐ Professional
☐ Not sure

Comments: _____

4. Do you consider the functions of general staff nurses to be of a technical or professional nature?

- ☐ Technical
☐ Professional
☐ Both technical and professional
☐ Not sure

Comments: _____

5. Among the general staff nurses in your institution do you consider that graduates of baccalaureate and associate degree nursing programs function in pretty much the same way?

___ Yes, the same
___ No, differently

Please explain: _____

6. Do you believe that graduates of baccalaureate and associate degree (or diploma) programs working as general staff nurses should carry out the same functions?

___ Yes
___ No
___ Not sure

Please comment: _____

7. Generally speaking, are you satisfied with the way general staff nurses newly graduated from an associate degree program are able to perform in your service areas of responsibility?

___ Yes
___ No
___ Not sure

Please comment: _____

- III. For each of the following items regarding functions and activities, please circle the number to indicate *your opinion* as to its appropriateness for TECHNICAL NURSES (graduates of diploma or associate degree programs).

1 means very appropriate
2 means appropriate
3 means inappropriate
4 means very inappropriate

Very Very
Approp Approp Inapp Inapp

A. PLAN NURSING CARE

Plan nursing activities for individual patients (i.e., organize assigned tasks, consider special needs of patients, discuss plan with nurse in charge).

1 2 3 4

	Very Approp	Approp	Inapp	Very Inapp
B. GIVE GENERAL NURSING CARE				
Give hygienic care to patients, i.e., care for skin, bathe, give mouth care).	1	2	3	4
Make patients comfortable (i.e., position, assist in getting up, talk with and listen to patients, arrange for or provide diversion).	1	2	3	4
Assist patients in maintaining normal body functions (i.e., feed/assist in eating, assist with elimination needs).	1	2	3	4
Perform procedures in meeting patients' needs for therapy (i.e., give medications, apply dressings, operate suction and oxygen equipment).	1	2	3	4
Perform procedures in meeting patients' needs for diagnosis (i.e., collect specimens, position for tests and examinations).	1	2	3	4
Assume head nurse responsibilities when she is off duty and on evenings and nights (i.e., assign team leaders and other nursing personnel; keep unit running smoothly).	1	2	3	4
Is head nurse on days (i.e., assign and evaluate team leaders and other personnel; keep unit running smoothly).	1	2	3	4

IV. Areas of Service Responsibility

1. Please check the services below for which you have responsibility.

<input type="checkbox"/> Ambulatory care	<input type="checkbox"/> Pediatric care
<input type="checkbox"/> Long-term care	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Maternity care	<input type="checkbox"/> Surgical care
<input type="checkbox"/> Medical care	<input type="checkbox"/> Entire hospital

2. The following pages contain questions which refer to areas of responsibility which you indicated above. Separate space is devoted to each of seven major services.

Across the top of the page are possible units which may be part of your service. (For purposes of this study, an all-inclusive list of units is not necessary. Examples of major units will suffice.)

Please answer all questions for each of the services under your responsibility by placing your answers in the appropriate box in the grid.

A. AMBULATORY SERVICE	Out-patient Department	Emergency Room	Private Ambulatory	Home Care	Methadone Program	Other (specify)
1. Check those units which comprise this service.						
2. Check those units which you consider to be "specialty" units.						
3. Check units which utilize clinical nurse specialists (RN with master's in clinical area).						
4. Check units where general staff nurses have specified knowledge, skills, and attitudes obtained after basic nursing program.						
5. Check units where you <i>think</i> general staff nurses <i>should</i> have special knowledge, skills, attitudes obtained after basic nursing program.						
B. LONG-TERM CARE SERVICE	Long-term Care Patient Unit	Rehabilitation	Extended Care Patient Unit			Other (specify)
1. Check those units which comprise this service.						
2. Check those units which you consider to be "specialty" units.						
3. Check units which utilize clinical nurse specialists (RN with master's in clinical area).						

B. LONG-TERM SERVICE (Continued)	Long-term Care Patient Unit	Rehabili- tation	Extended Care Patient Unit	Out- patient Unit	Pre- mature Nursery	Abortion Unit	Other (specify)
4. Check units where general staff nurses have specific knowledge, skills, and attitudes obtained after basic nursing program.							
5. Check units where you <i>think</i> general staff nurses <i>should</i> have special knowledge, skills, and attitudes obtained after basic nursing education.							

C. MATERNITY SERVICE	Labor & Delivery	Newborn Nursery	Post Partum	Out- patient Unit	Pre- mature Nursery	Abortion Unit	Other (specify)
1. Check those units which comprise this service.							
2. Check those units which you consider to be "specialty" units.							
3. Check units which utilize clinical nurse specialists (RN with master's in clinical area).							
4. Check units where general staff nurses have specific knowledge, skills, and attitudes obtained after basic nursing program.							
5. Check units where you <i>think</i> general staff nurses <i>should</i> have special knowledge, skills, and attitudes obtained after basic nursing program.							

	Medical Patient Care Unit	Coronary Care Unit	Intensive Care Unit	Metabolic Unit	Rehabili- tation Unit	Renal Dialysis Unit	Other (specify)
D. MEDICAL SERVICE							
1. Check those units which comprise this service.							
2. Check those units which you consider to be "specialty" units.							
3. Check units which utilize clinical nurse specialists (RN with master's in clinical area).							
4. Check units where general staff nurses have specific knowledge, skills, and attitudes obtained after basic nursing program.							
5. Check units where you <i>think</i> general staff nurses <i>should</i> have special knowledge, skills, and attitudes obtained after basic nursing program.							
E. PEDIATRIC SERVICE							
1. Check those units which comprise this service.							
2. Check those units which you consider to be "specialty" units.							
3. Check units which utilize clinical nurse specialists (RN with master's in clinical area).							
4. Check units where general staff nurses have specific knowledge, skills, and attitudes obtained after basic nursing program.							
5. Check units where you <i>think</i> general staff nurses <i>should</i> have special knowledge, skills, and attitudes obtained after basic nursing program.							

V. Nurses in Specialty Units

The following questions are related to general duty nurses working in specialty units of your service. Please check the response which you think is most appropriate and comment on your point of view in the space provided.

1. Do you consider a general staff nurse "specialized" if she works on one of the specialty units checked on the preceding pages?

☐ Yes
☐ No
☐ Not sure

Please comment: _____

2. Of the following factors, which *one* most generally determines whether or not a general staff nurse is assigned to work in a specialty unit of your service?

☐ Nurse's preference
☐ Service needs
☐ Supervisor's choice
☐ Specialty training in background
☐ Not sure
☐ Other (specify) _____

(48) Comments: _____

3. Of the following methods, which *one* is most commonly used to prepare general staff nurses to work on the specialty units of your services?

☐ Inservice education
☐ Workshops
☐ Courses at educational institutions
☐ Skills available prior to employment
☐ Not sure
☐ Other (specify) _____

Comments: _____

4. Are you satisfied with the way general staff nurses function on the "specialty" units of your services?

☐ Yes
☐ No
☐ Not sure

Comments: _____

5. Would you prefer having general staff nurses prepared to work in the "specialty" units in a way different from the current pattern you are using?

____ Yes
____ No
____ Not sure

Please comment: _____

6. Listed below are some alternate ways of preparing nurses to work in "specialty" units. Please check the *one* method which you think would be *best suited* for the preparation of nurses to work in "specialty" units in your hospital.

____ Basic education to include specialty preparation
____ Inservice education planned for specialty preparation
____ Continuing education in an educational institution for specialty preparation
____ Post-baccalaureate education in specialty area
____ Other (specify) _____

7. General speaking, what preparation would you prefer new nursing technicians to have upon entering your institution?

____ Ability to function generally in the major service areas of an institution with limited ability to function in "specialty" units. (The present pattern of education.)
____ Ability to perform basic nursing skills and intensively prepared to work in one service area and several of its "specialty" units. (A new pattern of education.)
____ Not sure
____ Other (specify) _____

Comments: _____

VI. For purposes of this study, the term "technical nurse specialist" means a registered nurse graduated from an associate degree (or diploma) program who has had a period of concentrated education in *one* of seven broad service areas (Ambulatory Care, Long-term Care, Maternity, Medical, Pediatric, Psychiatric, and Surgical) as well as the major specialty units comprising that service area. On each of the questions below, please check the appropriate spaces and comment freely. Your responses will help provide direction to future curriculum development in community/junior college nursing programs.

1. Do you think there is an existing need for "technical nurse specialists" in your institution?

- ☐ Yes
☐ No
☐ Not sure

Please comment: _____

2. If "technical nurse specialists" were available, would you like to have them employed in your institution?

- ☐ Yes
☐ No
☐ Not sure

Please comment: _____

3. If nursing technicians were prepared with intensive technical knowledge, skills, and attitudes in one major service area and several of its specialty units, would the service needs of your institution enable you to utilize them in their area of specialization?

- ☐ Yes
☐ No
☐ Not sure

Please comment _____

4. In which of the following service areas (including specialty units) do you feel specialization at the technical level would be advantageous to the occupation of nursing?

- ☐ Ambulatory Care
☐ Long-term Care
☐ Maternity
☐ Medical
☐ Pediatric

- ☐ Psychiatric
☐ Surgical
☐ Not sure
☐ Don't believe in technical nursing specialization

VII. The space below is provided for any additional comments, opinions, or observations you may wish to make regarding any of the questions on the previous pages, the study subject, or the questionnaire.

LIST OF HOSPITALS

Albert Einstein College of Medicine—Bronx Municipal Hospital Center	Methodist Hospital of Brooklyn
Bellevue Hospital Center	Metropolitan Hospital Center
Beth Israel Medical Center	Misericordia Hospital
Bronx-Lebanon Hospital Center	Montefiore Hospital and Medical Center
Brookdale Hospital Center	Morrisania City Hospital
Brooklyn Hospital	Mount Sinai Hospital
Cumberland Hospital	New York Medical College—Flower and Fifth Avenue
St. John's Queens Hospital	New York University Hospital
City Hospital Center at Elmhurst	Presbyterian Hospital in New York
Coney Island Hospital	Queens Hospital Center
Flushing Hospital and Medical Center	Roosevelt Hospital
Fordham Hospital	Society of the New York Hospital
New York Polyclinic Hospital Division	St. Clare's Hospital
Harlem Hospital Center	St. Luke's Hospital Center
Hospital for Joint Diseases and Medical Center	St. Vincent's Hospital and Medical Center of New York
Jewish Hospital and Medical Center of Brooklyn	St. Vincent's Medical Center of Richmond
Kings County Hospital Center	State University Hospital, Downstate Medical Center
Kingsbrook Jewish Hospital Center	Veterans Administration Hospital, First Avenue
Lenox Hill Hospital	Veterans Administration Hospital, Kings- bridge Road
Lincoln Hospital	Veterans Administration Hospital, Brooklyn
Long Island College Hospital	Wyckoff Heights Hospital
Maimonides Medical Center	

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